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718.1 MIDWIFE SERVICES

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, the New Mexico Medical Assistance Division (MAD) pays for covered services furnished by midwives [42 CFR § 440.165].

This section describes eligible providers, types of services furnished by midwives that are covered by Medicaid, service limitations, and general reimbursement methodology.

718.11 Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Participation Agreements by MAD, the following providers are eligible to be reimbursed for providing midwife services to recipients:

1. Individuals licensed by the Board of Nursing as registered nurses and licensed by the Public Health Division of the Department of Health as certified nurse midwives;

2. Individuals licensed as midwives by the Public Health Division of the Department of Health; and

3. Physicians, physician groups, or clinics where services are performed by certified nurse midwives or licensed midwives who meet the criteria listed above.

Once enrolled, providers receive a packet of information, including Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

718.12 Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER

POLICIES.

Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES.

718.13 Covered Services and Service Limitations

Medicaid covers services furnished by certified nurse midwives or licensed midwives within the scope of their practice, as defined by state laws and regulations.

(A) Separate trimesters completed and/or routine vaginal delivery can be covered if a recipient is not under the care of one provider for the entire prenatal, delivery and postnatal periods.

(B) Medicaid covers laboratory and diagnostic imaging services related to essentially normal pregnancies. These services can be billed separately.

(C) Pharmacy services are limited to injectable medications. See Section MAD-753, PHARMACY SERVICES.

718.14 Noncovered Services

Midwife services are subject to the limitation and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific services furnished by midwives:

1. Oral medications or medications, such as ointments, creams, suppositories, ophthalmic, and otic preparations which can be appropriately self-administered by the recipient; and

2. Services furnished by an apprentice.

718.15 Prior Approval and Utilization Review

All Medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

(A) Certain procedures or services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

(B) Prior approval of services does not guarantee that individuals are eligible for Medicaid. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

(C) Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.

718.16 Reimbursement

Midwives must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

Reimbursement to providers is made at the lesser of the following:

1. The provider's billed charge; or

2. The MAD fee schedule for the specific service or procedure.

(A) The provider's billed charge must be their usual and customary charge for services.

(B) "Usual and customary charge" refers to the amount which the individual

provider charges the general public in the majority of cases for a specific procedure or service.

(C) Reimbursement for midwife services is based on one global fee, which includes prenatal care, delivery and postnatal care. Services related to false labor are included as part of the global fee. Certified nurse midwives are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at seventy-seven (77%) percent of the rate paid to physicians for furnishing similar services.

(D) If partial services are furnished by a midwife, such as prenatal care only, one or two trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code. Total payments made to all providers involved in furnishing services cannot exceed the total single global fee.

(E) If the services furnished include a combination of services performed by a midwife and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the certified nurse midwife or licensed midwife.

(F) Medicaid pays boarding fees only when recipients are accommodated for two (2) hours or more in the midwife's home or a birthing center prior to delivery.

(G) Medicaid covers postnatal care as a separate service only when the midwife does not perform the delivery.

(H) Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are Medicaid providers. The need for the assistance based on the medical condition of the recipient must be documented on the claim.