Nurse Midwife Payment Policy

Policy

The Plan will reimburse for covered services provided by credentialed and contracted nurse midwives that are within the legal scope of practice for the nurse midwife. This policy applies to nurse midwives who bill independently.

Definitions

Certified nurse-midwives (CNMs) are registered nurses who graduate from a nurse-midwifery program accredited by the American College of Nurse-Midwives and pass a national certification exam. CNMs are educated in both nursing and midwifery.

Reimbursement

Coverage is limited to those services a nurse midwife is legally authorized to perform in accordance with state law.

Nurse midwives may bill under his/her provider number for covered services provided directly by the contracted nurse midwife.

Referral/notification/prior authorization requirements

Nurse midwives must abide by the same requirements as Plan-contracted physicians.

Billing/coding guidelines

Payment for nurse midwife services is made only to the nurse midwife or his/her employer. Nurse midwives are required to submit claims with their own billing identification numbers for services rendered without direct physician supervision. When nurse midwives provide services in an office setting under direct physician supervision, the services may be covered as incident to, in which case incident to requirements would apply.

Several conditions must be met to satisfy the “incident to” standard:

- The nurse midwife must be an employee of or a leased individual to the physician group;
- The services must be medically necessary, within the scope of practice for the nurse midwife, and of the type normally performed at the practice site;
- The adequate level of supervision (based on CMS definitions and guidelines) must be provided;
- The physician must have contact with all new members or members who have new medical problems, if the patient has never been seen or treated within that practice site.

The physician would bill under his/her provider number for covered services when incident to requirements apply.

Nurse midwives should use modifier SB to report professional services provided independently and should use reduced service modifiers to report when they have not provided all the services covered by a global allowance.

Ancillary services should not be reported with the SB modifier.

Place of service

This policy applies to services furnished by nurse midwifes in all areas and settings permitted under applicable laws. The Plan does not reimburse for deliveries in a home setting.

Policy history

Origination date:	11/285/01
Previous revision date(s):	05/10/06, 07/19/06, and 06/20/07

	05/01/09 – Clarified use of modifier –SB and conditions to satisfy the “incident to” standard. 01/01/2016 - Updated reimbursement section and moved to new Plan template. 09/01/2016 - Annual review.
Connection date & details:	July 2017 – Annual review. July 2018 – Clarified SB modifier billing. July 2019 – Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.