

HOSPITALS,
HOSPITAL-BASED
RURAL HEALTH CLINICS
(RHC-HB), and SWING BED
HOSPITALS*

Provider Manual
Volume II

December 2014

*Swing Bed Hospitals should also reference the Nursing Facility Billing Manual for information regarding provider participation requirements, service authorizations, and utilization review

New
Hampshire
Medicaid

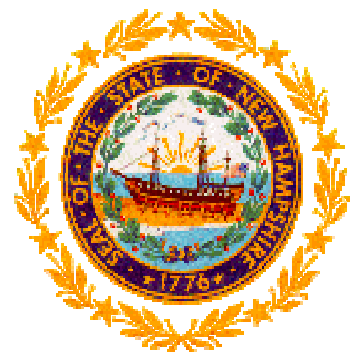


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1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider’s staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- **The General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to NH Medicaid such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The Appendices section encompasses a wide range of supplemental materials such as Fee Schedules, Contact Information, Provider Type List, Sample Forms and Instructions, as well as other general information.
- **The Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for health care providers, their staff, and provider-designated billing agents.

These manuals are *not* designed for use by NH Medicaid members (hereinafter referred to as members).

Provider Accountability

Providers should maintain both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to providers by the Communications staff of Xerox, the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between Xerox and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media, including provider bulletins, provider notices, e-mail notices, memos, letters, web site updates, newsletters and/or updated pages to the General Billing Manual – Volume I, and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their billing agents and staff.

Billing Manual updates are distributed jointly by the Department and Xerox. Providers receive notification of manual updates through a message sent to each provider's message center inbox via the web.

Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the Xerox Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the Xerox Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

HOSPITALS

To participate in the NH Medicaid Program, all in-state, out-of-state, and border hospital providers must:

1. Be licensed by the Department in accordance with RSA 151, or the same state licensing authority in the state within which the provider operates;
2. Meet Medicare participation requirements; and
3. Be an enrolled New Hampshire Medicaid provider in accordance with the following:
 - a) In-state hospitals will be enrolled as in-state hospital providers;
 - b) Out-of-state hospitals will be enrolled as out-of-state hospital providers; and
 - c) Border hospitals, which are defined as those hospitals located in a state bordering NH, will be enrolled as border hospitals except as follows:
 - Enrollment as an out-of-state hospital will be granted to any border hospital that requests such enrollment, either upon initial enrollment or at a later date; and
 - Border hospitals that are enrolled as out-of-state hospitals will be subject to all out-of-state hospital requirements. (for example, see the service authorization section of this billing manual).

DISTINCT PART UNITS (DPU's) OF MEDICAID ENROLLED HOSPITALS

To participate in the NH Medicaid Program, a DPU must be certified by Medicare as a distinct part unit.

SWING BED HOSPITALS

Nursing facility services for individuals age 21 or over may be provided by hospitals that have an approval from CMS to furnish skilled nursing services in the Medicare program. Please refer to the Nursing Home Provider Specific Billing Manual – Volume II for program details and requirements such as provider participation, service authorizations and utilization review. Please refer to the appropriate sections in *this* manual for swing bed billing instructions.

HOSPITAL-BASED RURAL HEALTH CLINICS

To participate in the NH Medicaid Program, all hospital-based rural health clinic providers must be:

1. Certified as a Hospital Based Rural Health Clinic by Medicare;
2. Enrolled in the NH Medicaid program;
3. Composed of licensed and NH Board-certified practitioners; and
4. Able to provide medical care on an outpatient basis.

3. Covered Services & Requirements

Covered services include those services described in the covered services sections of the various Provider Billing Manuals – Volume II, as well as in the Department’s Medicaid rules and which may be provided in a hospital setting as either an inpatient or outpatient hospital service. A hospital means any hospital providing acute care services, to include acute care rehabilitation services, not operating as a psychiatric hospital or an institution for mental diseases (IMD) and which meets the requirements of 42 CFR 440.10.

Inpatient Hospital Service

Members are eligible to receive inpatient hospital services when those services are rendered:

- Under the direction of a physician or dentist per 42 CFR 440.10;
- To a member who has been admitted to a hospital as an inpatient;
- For a continuous period of 24 hours or longer;
- By a hospital offering room, board and professional services;
- By a NH Medicaid participating hospital which meets the requirements described in the “Provider Participation and Ongoing Responsibilities” section above; and
- As psychiatric services to members who are admitted to a distinct part psychiatric unit of a general hospital. Members must have a DSM IV diagnosis as the primary diagnosis.

For NH and border hospitals, the Quality Improvement Organization (QIO), which is established in accordance with 42 CFR 475 and which is contracted by the Department to perform retrospective utilization and quality control peer reviews in accordance with 42 CFR 476, determines the quality, necessity, and appropriateness of care and length of stay. Payment for inpatient care in NH and border hospitals is made for acute care days only as approved by the QIO.

Inpatient hospital services provided at an out-of-state hospital will be covered pursuant to the service authorization requirements detailed in the “Service Authorization” section below.

Outpatient Hospital and Observation Bed Services

Members are eligible to receive outpatient hospital and observation bed services when those services are rendered:

- As preventive, diagnostic, therapeutic, rehabilitative, emergency, or palliative outpatient services;
- By or under the direction of a physician or dentist per 42 CFR 440.20;
- To a member who has not been admitted as an inpatient;
- For a period of time not to exceed 24 hours;

- By a NH Medicaid participating hospital which meets the requirements described in the “Provider Participation and Ongoing Responsibilities” section above; and
- In accordance with the service limit requirements detailed in the “Service Limits” section below.

Observation bed services are defined as those services furnished by a hospital on the hospital’s premises, including the use of a bed and periodic monitoring by a hospital’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the hospital as an inpatient. This period of time is not to exceed 24 hrs. It may span 2 calendar days.

Hospital-Based Rural Health Clinic Services

Hospital-Based Rural Health Clinic encounters include:

- The services of a physician (to include physician assistants under the supervision and direction of a physician in accordance with NH RSA 328-D:1), when the physician has an agreement to be paid by the clinic for such services;
- The services of a nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker, visiting nurse, provided within the scope of his/her training and/or certification; and
- The services and supplies that are furnished as incidental to the professional services of a physician, physician assistant, nurse practitioner, or certified nurse midwife; as well as medical supplies, other than drugs and biologicals, for visiting nurse care.

Organ Transplants

Organ transplant procedures and procurements will be covered when performed as an inpatient service at an organ transplant facility approved by Centers for Medicare and Medicaid Services (CMS). The following organ transplants from a human donor to a member shall be covered subject to service authorization and in accordance with the applicable coverage criteria in Milliman Care Guidelines, 17th edition (February/March 2013).

- (1) Kidney transplants;
- (2) Heart transplants;
- (3) Heart and lung transplants;
- (4) Lung transplants;
- (5) Allogeneic bone marrow transplants;
- (6) Autologous bone marrow transplants;

- (7) Liver transplants;
- (8) Pancreas transplants; and
- (9) Pancreas and kidney transplants.

Abortions, Sterilizations, Hysterectomies

For detailed information on these services, please see the “Abortions, Sterilizations, Hysterectomies” Provider Billing Manual – Volume II.

Service Limits

Service limits are counted based on the state fiscal year beginning July 1 and ending June 30. The following hospital related service limits apply:

- Outpatient hospital services are limited as follows:
 - Outpatient hospital services are limited to 12 visits per member per state fiscal year;
 - Services provided in an emergency department (ED) or urgent care setting shall not count toward the 12 visit limit;
 - Observation bed services shall not count toward the 12 visit limit; and
 - Services that are described individually in component parts of the Medicaid He-W 500 chapter rules, such as physical, occupational and speech therapy services or radiology services (see below), and provided in outpatient departments of hospitals, will be subject to the limits which apply to that individual service;
- Physician and APRN services will be limited as follows:
 - Services performed in the inpatient hospital setting will be limited to one visit per QIO approved day of stay;
- Except for therapy services provided as part of an inpatient hospital stay and which are not limited, therapy services, including physical, occupational and speech therapy, will be limited to 80, 15-minute units per member. The 80 units may be used for one type of therapy or for any combination of therapies;
- Radiology services will be limited as follows:
 - X-ray services for diagnostic purposes will be limited to 15 x-rays;
 - X-ray services provided for radiation therapy will not be limited;
- For hospital based rural health clinic services, the only services that are counted toward the various service limits associated with individual services are those “other ambulatory services” that have service limits. See the various Provider Billing Manuals - Volume II and the Service Limits Section of the Provider Billing Manual – Volume I.

4. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those listed below or those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the “Non-Covered Services” section of the General Billing Manual – Volume I.

Hospital providers should also review the covered and non-covered services sections of the other provider specific billing manuals – Volume II – because services that are not described as covered or that are described as non-covered in the various billing manuals or in the Medicaid He-W Chapter 500 service rules are also non-covered if provided in the inpatient or outpatient hospital setting.

If a non-covered service is provided to a member, the provider must inform the member, **prior to** delivery of the service, that it is non-covered by NH Medicaid and that should the member still choose to receive the service, then the member is responsible for payment for the service. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that s/he understands that the service is non-covered and that s/he agrees to pay for it.

In addition to any listings referenced above, other specific non-covered hospital and hospital based rural health clinic services include:

- Services ancillary to, or directly related to, or a complication as the result of, a non-covered service or procedure;
- Experimental or investigational procedures, or admissions for such procedures, described as such in the current edition of the “Medicare National Coverage Determination Manual,” including thermogenic therapy, sex change operations, and electrosleep therapy;
- Reversal of voluntary sterilization;
- Operations for impotency;
- Operations, devices, and procedures for the purpose of contributing to or enhancing fertility or procreation;
- Plastic surgery, to include cosmetic surgery, for the purpose of preserving or improving appearance or disfigurement, except when required for the prompt repair of accidental injury or for the improvement in functioning of a malformed body part;
- Services or items that are free to the public;
- Hospital inpatient care which is not medically necessary, to include days not approved by the QIO;
- Autopsies;
- Admissions that have not received a service authorization in accordance with NH Medicaid program policy;

- Admissions other than for an emergency to out of state facilities for services which are available in state or in border hospitals unless a service authorization is obtained;
- Admissions and/or continued stays which are strictly for member convenience and not related to the care and treatment of the member;
- Inpatient admissions for services that could be performed in an outpatient setting.

5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization of payment for a specific item or service.

Service authorizations are reviewed by a service authorization agent under contract with the Department. Because the service authorization agent can vary depending on the type of service provided, the Contact Information in the Appendices or on the SA form itself should be consulted for the name and method of contact.

Inpatient hospital services provided at out of state hospitals require service authorization as follows:

(a) Out-of-state hospitals shall obtain an SA from the Department *before* providing inpatient hospital services to members, except that authorization for emergency hospital services must be obtained within 72 hours of admission.

(b) Inpatient hospital services at out-of-state hospitals shall meet the following requirements in order for the Department to consider approval of a service authorization:

(1) For members who are absent from the state, one of the following conditions must be met:

- a. Medical services are needed because of a medical emergency; or
- b. Medical services are needed and the member's health would be endangered if s/he were required to travel to her/his state of residence; or
- c. Needed medical services, or necessary supplementary resources, are more readily available in the other state; or

(2) For members (regardless of age) who are in state but request to receive services out of state, one of the following conditions must be met:

- a. Medical services are needed because of a medical emergency; or
- b. The member's attending physician has:
 1. Proposed out-of-state hospitalization; and
 2. Determined and documented that the proposed treatment plan is medically necessary; and
 3. Determined and documented that the proposed treatment is not available from resources and facilities within the state; or
- c. The member's attending physician has:
 1. Proposed out-of-state hospitalization; and
 2. Determined and documented that the proposed treatment plan is medically necessary; and

3. Determined and documented that redirection to an in-state facility would jeopardize either the treatment of an episode of care or a long standing medical relationship between the member and a specific physician; or
- d. For members age 18 or younger, the member’s attending physician has:
 1. Proposed out-of-state hospitalization; and
 2. Determined and documented that the proposed treatment plan is medically necessary; and
 3. Determined and documented that referral to a pediatric specialist is appropriate and there is no such pediatric specialist available in New Hampshire; or
 - e. The out-of-state hospital is an enrolled provider and only the Medicare deductible and co-insurance are to be billed to NH Medicaid; or
 - f. The out-of-state hospital care is provided prior to a member’s eligibility determination and coverage is retroactive to the time period in which the hospitalization occurred and the hospital is a Medicaid enrolled provider; or
 - g. It is the general practice for members in a particular NH locality to use medical resources in another state and the costs of obtaining care at the out-of-state hospital will result in no higher costs than the costs of obtaining in state hospital care.
- (c) Prior authorization requests must be submitted on Form 272H, “Request for Prior Authorization for Out of State Inpatient Admission,” which can be found on the NH Medicaid Health Enterprise website at www.nhmmis.nh.gov.
- (d) The Department shall grant service authorization if the documentation on Form 272H supports the requirements in (b) above.
- (e) If the Department approves the SA request, the Department’s fiscal agent will send written confirmation of the approval to the provider.
- (f) The provider is responsible for determining that the member is NH Medicaid eligible on the date of service.
- (g) A provider who is not enrolled with NH Medicaid when the service authorization is requested must become an enrolled NH Medicaid provider before payment can be made to the provider.
- (h) If the Department denies the prior authorization request, the Department will forward a notice of denial to the member and the ordering provider on the Department Form 272a, “Medical Assistance Program Denial for Prior Authorized Services,” which includes the following information:
- (1) The reason for, and legal basis of, the denial; and
 - (2) Information that a fair hearing on the denial may be requested within 30 calendar days of the date on the notice of the denial.

6. Documentation

Hospital service(s) providers and hospital based rural health clinic providers must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement. See the “Record Keeping” section of the General Billing Manual – Volume I for documentation requirements.

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer.

7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse. These utilization review activities are required and carried out in accordance with Federal regulations at 42 CFR 455 and 42 CFR 456, and they are done to ensure that accurate and proper reimbursement has been made, for care, services and/or supplies that have been provided to a member, and for which a provider has received payment.

Utilization review activities may be conducted prior to payment, following payment, or both. These activities include, but are not limited to, conducting provider reviews. These reviews may be selected at random, generated from member complaints, other providers, anonymous calls, or from the SURS reporting system.

There are various outcomes that may result from Program Integrity review activities. They include, but are not limited to:

- Recovery of erroneous and improper provider payments
- Provider education regarding appropriate documentation to support the submission and payment of claims
- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid Program
- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG)
- Potential termination from the NH Medicaid Program
- Other administrative actions

If a provider is found to have abused the NH Medicaid Program requirements, the provider may be restricted, through suspension or otherwise, from participating in the NH Medicaid Program for a reasonable period of time. In addition, the provider may also have their claims placed on a prepayment pend or hold status for additional review by the Program Integrity Unit.

Quality Improvement Organization (QIO) Utilization Review

Inpatient hospital services provided by in-state and border hospitals are also subject to utilization review carried out by the Quality Improvement Organization (QIO). The QIO reviews and determines medical necessity and appropriateness of admissions, treatment, and transfers, as well as appropriateness of setting (inpatient or outpatient). The QIO applies quality of care screens to all cases reviewed and issues notifications and recommendations when problems involving patient care, erroneous billing, or documentation are identified. Reviews of specific cases are conducted following the payment of hospital claims. A provider's failure to provide the complete medical record within the time frame specified may result in recovery of payment for that case.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" Section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the *payer of last resort*. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume 1. Providers who receive payment in full from a third party are not required to file zero-payment claims with NH Medicaid.

A provider must first submit a claim to the third party within the third party’s time limitations. If a third party or primary insurance plan does not pay at or in excess of the applicable NH Medicaid Program reimbursement level, a provider may submit a claim to NH Medicaid which is processed based on the applicable reimbursement rate minus any payment received from all other resources. Commercial health insurance coverage often provides a higher payment than does NH Medicaid

When a third party denies a claim, for any reason, a copy of the notice of denial from the third party *must be included* behind the claim submitted to NH Medicaid. When Medicare denies a claim, a copy of the Explanation of Medicare Benefits must be attached behind the claim that is submitted. For claims not submitted on paper, the Medicare or third-party denial is considered a claim attachment.

Detailed Medicare/Third Party Liability (TPL) information is found in the General Billing Manual, including handling discrepancies in TPL resource information, correcting erroneous TPL information, and exceptions to third party filing requirements.

When a member is also covered by Medicare, the provider must bill Medicare for all services before billing NH Medicaid. The provider must accept assignment of Medicare benefits in order for the claim to “*cross over*” to NH Medicaid. The crossover process works only for Medicare approved services; Medicare denied services and Medicare non-covered services are addressed in this section. NH Medicaid pays cross over claims only if the service is covered by NH Medicaid.

Certain services that are not covered by Medicare *may* be covered by NH Medicaid for dually eligible members. Services identified in the Medicare billing manual and HCPCS coding manuals as non-covered by Medicare may be billed directly to NH Medicaid who will determine whether or not the service is covered and can be reimbursed by NH Medicaid.

This does not apply to QMB Only members whose benefits are limited to the Medicare premiums and payment toward the Medicare deductible and coinsurance. Therefore, if Medicare does not cover the service, there is no NH Medicaid payment available for QMB members.

For Medicare recipients, the 60-day “lifetime reserve” for Medicare inpatient hospital benefits must be used before NH Medicaid will pay for inpatient hospital services. (Note: The 60-day “lifetime reserve” does not affect Part B Medicare coverage.)

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

Payment for hospital services will be made at rates established by the department in accordance with RSA 161:4, VI(a).

- Hospital providers should submit claims for payment to the department’s fiscal agent using the paper form or electronic format currently designated and approved by the Centers for Medicare and Medicaid Services for this purpose.
- For newborn billings, the fiscal agent will help facilitate the process of obtaining a NH Medicaid identification number for the newborn. If hospital providers need to bill for newborns who do not have their own NH Medicaid identification number (payment is guaranteed for the first 30 days), hospitals should complete the paper claim form as follows:
 - The newborn’s name will be entered in the patient field;
 - The NH Medicaid identification number field will be left blank; and
 - The mother’s name and NH Medicaid identification number will be entered in the remarks section.
 - Mail paper claim form to :
Attention Newborn Claims
PO Box 2003
Concord NH 03302-2003
- Payment for inpatient hospital services will be made for QIO-approved acute care days of stay only.
- All outpatient hospital services rendered to a member within 3 calendar days prior to his/her inpatient admission, with a calendar day beginning at 12:00 AM and ending at 11:59 PM, will be inclusive of the inpatient payment and not be billed separately, with the exception of:
 - Prenatal outpatient services; and
 - Diagnostic and non-diagnostic outpatient services which are unrelated to the member’s inpatient hospital admission.

Inpatient Hospital Payment

The NH Medicaid Program reimburses by a prospective payment system based on diagnostic related groups (DRG) for all inpatient hospital services.

The DRG system for inpatient hospital services includes the following provisions and components:

- The Medicare table of MS-DRG coding and the Medicare grouper used to assign DRG's.
- Medicare relative weights are utilized, except where otherwise specified.

- Generally, the table of DRG's relative weights is updated concurrently with Medicare changes.
- A Price-per-Point is determined by NH Medicaid taking into account available NH Medicaid funds and other economic indicators.
- DRG reimbursement is calculated by multiplying the Price-per-Point times the relative weight assigned to the DRG.
- Pricing is prospective; actual payments will be retrospective upon discharge.

All hospitals, in-state, border and out-of-state are paid the same rate per DRG point, except for certain psychiatric and physical rehabilitation facilities and psychiatric and physical rehabilitation distinct part units and for certain neonatal DRG's, as follows:

- Psychiatric DRG's 880 through 887 in Medicare certified Distinct Part Units (DPU's) of in-state hospitals only, are paid a higher peer group rate.
- Psychiatric DRG's 880 through 887 in Designated Receiving Facilities (DRF's) of in-state hospitals only, are paid a higher peer group rate.
- Rehabilitation DRGs 945 and 946 of in-state physical rehabilitation specialty hospitals and of Medicare certified Distinct Part Units are paid at a flat rate per discharge with NO outlier payments allowed. Refer to the annual DRG provider notice for details.
- Neonatal DRG's 789 through 794 are reimbursed on a per diem basis of 65% of the full outlier amount.

Interim billing and/or periodic interim payments (PIP's) are not made.

Direct medical education (DME) costs are allowed as pass-through payments for in-state facilities only. Payments are made semi-annually when funded.

Indirect medical education costs (IME) for in-state teaching hospitals only, are recognized and paid per discharge, as an addition to the DRG/outlier amount when funded.

Day outliers only for children under the age of 6 years, except where otherwise specified, are allowed and reimbursed on a per diem basis, at 60% of the full per diem amount.

Cost outliers are neither recognized nor reimbursed.

Payment rates are based on the relative weights and price per point in effect at the time of discharge.

Observation room services may not be billed separately if the member is subsequently admitted. These services are covered as part of the inpatient stay. Any outpatient services rendered to a NH Medicaid recipient within 3 calendar days prior to the date of his/her inpatient admission, with a calendar day beginning 12:00 a.m. and ending 11:59 p.m., are included in the inpatient payment and should not be billed separately. The only exceptions are prenatal outpatient services and diagnostic and non-diagnostic services which are unrelated to the recipient's inpatient hospital admission.

The DRG payment is considered to be all inclusive of necessary diagnostic testing, treatment, and transportation rendered to a member by another acute care hospital while an inpatient of the billing hospital. If a member obtains necessary treatment or diagnostic testing at another acute care hospital while still an inpatient at the originating hospital, the originating hospital is considered to have received payment for such testing and treatment, as well as for any necessary transportation, as part of the DRG. No other hospital or transportation provider (e.g., ambulance providers) may bill for these services.

Please Note: If the patient was admitted through the Emergency Room, Urgent Care, or Outpatient Department, the admission date should be the date the inpatient order was written, and the charges for the 72 hours prior to the admission are rolled into the inpatient admission.

Payment for Transfer Services

ACUTE FACILITY TO ACUTE FACILITY

Hospitals that transfer patients to the same type of provider/sub provider are paid at the outlier per diem basis (100% of the full per diem) not to exceed the DRG rate allowed. When the hospital bills, the UB 04 must indicate a patient status code 02 in form locator 17.

Hospitals that transfer patients to a different type of provider/sub provider are paid according to the straight DRG payment (plus an outlier payment when appropriate). When the hospital bills, the UB 04 must indicate a patient status code 05 in form locator 17.

For Psychiatric Units, a transfer to NH Acute Psychiatric Service (APS) State Hospital is considered the same type of facility. Receiving acute hospitals and distinct part units will continue to be paid the DRG rate plus an outlier payment when appropriate.

ACUTE FACILITY TO DIFFERENT FACILITY AND RETURN TO ACUTE FACILITY

If the patient is Medicaid eligible for the entire hospital stay, and the patient has been transferred to different levels of care, i.e. acute care to psychiatric care and then returned to acute care, please use the following guidelines:

If the member is transferred back to the original facility, the claim should be continued on the original care claim started from the first stay. This one claim should be submitted as follows:

1. Date of Service - Must include the actual date of admit and the actual final discharge date for the first facility. Must also include the admit date and final or second discharge date.
2. Billed Amount - Must include the total billed amount minus the non-covered service days (inclusive in non-covered days, all ancillary charges) the patient was at the other facility.
3. Patient Status - Patient status code will be the actual disposition at the time of the final discharge.
4. Use appropriate revenue code for accommodation days; total units needs to include ALL days from the first and last part of the patient stay.
5. For ALL non-covered days, use Revenue Code 0180 or 0182 for the days the member was at the other type of facility.
6. Use value code 80 for the number of covered days:
 - Enter the number of covered days

7. Non-covered days – use value code of 81 or 82:
- Enter the number of non-covered days (days reflected with the use of revenue codes 0180 or 0182)

Payment for Readmissions

A separate payment shall not be made for readmission to any hospital for the same diagnosis if the readmission occurs within 30 days of discharge, except for those cases where the department and QIO have given medical necessity approval.

Payment for Split Eligibility

Split billing is necessary when the patient is NOT NH Medicaid eligible for the entire length of the acute, inpatient hospital stay. When a NH Medicaid patient is eligible for only a part of the hospital stay, the NH Medicaid reimbursement shall be paid at the outlier per diem, not to exceed the DRG allowed amount. The DRG rate shall be considered payment in full for all services rendered on those days for which the patient was eligible for NH Medicaid.

When submitting a split claim for payment, if the member is eligible for only a portion of the hospital stay, NOT including the date of discharge, bill with patient status code 14 in field 17 on the UB04. The covered days MUST EQUAL THE DATES of service on the claim.

When submitting a split claim for payment, if the member is eligible for only a portion of the hospital stay, which INCLUDES the date of discharge, bill with patient status code 15 in field 17 on the UB04. The covered days MUST EQUAL THE DATES of the patient's eligibility MINUS THE DISCHARGE.

Patient Status is 14 - When the member is eligible for only a portion of hospital stay, not including day of discharge

Patient Status is 15 - When the member is eligible for only a portion of hospital stay, including day of discharge

Use value code 80 for the number of covered days:

- Enter the number of covered days

Non-covered days – use value code of 81 or 82:

- Enter the number of non-covered days (days reflected with the use of revenue codes 0180 or 0182)

Acute Facility Billing a Stay Which Includes Non-Acute Days

If the patient is Medicaid eligible for the entire hospital stay, but a portion of the patient's stay was deemed NOT MEDICALLY NECESSARY by the QIO, the claim needs to be rebilled with the non-acute days being rebilled as non-covered days using Revenue Code 0180 (leave days) in order for the claim to reflect the admit and discharge dates.

If a claim is submitted when a portion of the member's stay was deemed not medically necessary, the claim should be rebilled as follows:

1. Date of Service - Must include the actual date of admit through to actual discharge date.
2. Billed Amount - Must include the total billed amount minus the non-covered service days the patient was treated at the Acute Facility.
3. Patient Status - Patient status code will be the actual disposition at the time of the final discharge field 17.
4. Use appropriate revenue code for medically necessary accommodation days. For non-covered days, use Revenue Code 0180.
5. Non-covered days – use value code of 81 or 82:
 - o Enter the number of non-covered days (days reflected with the use of revenue codes 0180 or 0182)

Note: Any claim which includes Revenue Code 0180 must be submitted on a paper UB 04 claim form.

Outpatient Hospital Payment

The Department will reimburse outpatient services as an interim payment based on a percent of charges. Final payment is made in accordance with a percent of costs. An audit of each hospital's actual costs eligible for reimbursement shall be performed by the Department's third party contractor in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data audited by the Department's third party contractor.

Laboratory services provided as part of an outpatient hospital or RHC-HB visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit. In order for the add-on payment to be made, laboratory services, revenue codes 0300 through 0319, MUST be billed with the corresponding HCPC code identified in Field 44. Reimbursement will be according to fee for service rates established for the HCPC procedure codes, and are final and not subject to cost settlement.

Hospitals are required to bill for outpatient services on the UB-04 claim form using the appropriate Revenue Codes and descriptive HCPC codes for the services rendered.

Payment for Observation Room Services

Observation room services may be billed as outpatient hospital services if the member is not subsequently admitted, but must be for a period of time not to exceed 24 hours.

Payment and Billing for Swing Bed Care

Payment of, and billing for swing bed care is as detailed below.

When member is Medicaid prime (non-crossover)

1. Submit a claim with TOB 018X (indicating inpatient)
2. Revenue Code 0101 (Room and Board), 0182 (Other LOA), or 0185 (LOA). This covers the room and board. As a Swing Bed provider, you are set up in the MMIS with a per diem rate, and the member is set up with the appropriate LTC span. The claim processes and prices as a Nursing Home claim.
3. Use form locator 39-41 to indicate dates of non-medically necessary.

Form Locator 39-41**Required**

Use value code 80 for the number of covered days:

- Enter the number of covered days

For non-covered days use value codes of 81:

- Enter the number of non-covered days

4. Ancillary charges are submitted on a second claim with TOB 023X (Skilled Nursing Outpatient-to indicate SNF level of care), or TOB 089X (Specialty Facility-Other-to indicate ICF level of care). The claim processes and prices as an Outpatient claim.

When member is Medicare prime (crossover)

1. Submit a claim with TOB 018X (indicating inpatient)
2. Revenue code 012X (Room and Board), 0182 (Other LOA), or 0185 (LOA). This covers the room and board. The claim processes and prices as an inpatient Crossover Claim.
3. Use form locator 39-41 to indicate dates of non-medically necessary.

Form Locator 39-41**Required**

Use value code 80 for the number of covered days:

- Enter the number of covered days

For non-covered days use value codes of 81:

- Enter the number of non-covered days

4. Ancillary charges are submitted on a second claim to TOB 023X (Skilled Nursing Outpatient-to indicate SNF level of care), or TOB 089X (Specialty Facility-Other-to indicate ICF level of care). The claim processes and prices as an Outpatient Crossover Claim.

NH MEDICAID SWING ANCILLARY ACCEPTABLE REVENUE CODES TOB 023X OR 089X	
Revenue Code	Description
0250	PHARMACY GENERAL
0251	PHARMACY GENERAL
0252	PHARMACY NON-GENERIC
0253	TAKE HOME DRUGS
0254	LESS THAN EFFECTIVE DRUGS
0255	PHARMACY - RADIOLOGY
0256	DRUGS
0257	PHARMACY NON-PRESCRIPTION
0258	PHAMACY IV SOLUTION
0259	PHARMACY OTHER
0270	MEDICAL SURGICAL SUPPLIES GENERAL
0272	MEDICAL SURGICAL SUPPLIES STERILE SUPPLY
0273	MEDICAL SURGICAL SUPPLIES TAKE HOME
0274	MEDICAL SURGICAL SUPPLIES PROSTHETIC DEVICE
0275	MEDICAL SURGICAL SUPPLIES PACEMAKER
0276	INTRAOCULAR LENS
0277	OXYGEN TAKE HOME
0278	MEDICAL SURGICAL SUPPLIES OTHER IMPLANTS
0279	MEDICAL SURGICAL SUPPLIES OTHER
0300	LABORATORY GENERAL
0301	LABORATORY CHEMISTRY
0302	LABORATORY IMMUNOLOGY
0303	LABORATORY RENAL
0304	LABORATORY NON ROUTINE DIALYSIS
0305	LABORATORY HEMATOLOGY
0306	LABORATORY BACTERIOLOGY MICROBIOLOGY
0307	LABORATORY UROLOGY
0309	LABORATORY OTHER
0310	PATHOLOGICAL GENERAL
0311	PATHOLOGICAL CYTOLOGY
0312	PATHOLOGICAL HISTOLOGY
0314	PATHOLOGICAL BIOPSY
0319	PATHOLOGICAL OTHER
0320	RADIOLOGY DIAGNOSTIC GENERAL
0321	RADIOLOGY DIAGNOSTIC ANGIOCARDIOGRAPHY
0324	RADIOLOGY DIAGNOSTIC CHEST X-RAY
0329	RADIOLOGY DIAGNOSTIC OTHER
0350	CT SCAN GENERAL
0351	CT SCAN HEAD
0352	CT SCAN BODY
0359	CT SCAN OTHER
0360	OPERATING ROOM GENERAL
0370	ANESTHESIA GENERAL
0391	BLOOD STORAGE PROCESSING ADMINISTRATION
0402	X-RAY OTHER IMAGING SERVICE ULTRASONIC
0410	RESPIRATORY SERVICES GENERAL

0412	RESPIRATORY SERVICES INHALATION
0413	RESPIRATORY SERVICES HYPERBONIC OXYGEN
0419	RESPIRATORY SERVICES OTHER
0420	PHYSICAL THERAPY GENERAL
0421	PHYSICAL THERAPY VISIT CHARGE
0422	PHYSICAL THERAPY HOURLY CHARGE
0423	PHYSICAL THERAPY GROUP RATE
0424	PHYSICAL THERAPY EVALUATION RE-EVALUATION
0429	PHYSICAL THERAPY OTHER
0430	OCCUPATION THERAPY GENERAL
0431	OCCUPATION THERAPY VISIT CHARGE
0432	OCCUPATION THERAPY HOURLY CHARGE
0433	OCCUPATION THERAPY GROUP RATE
0434	OCCUPATION THERAPY EVALUATION RE-EVALUATION
0439	OCCUPATIONAL THERAPY OTHER
0440	SPEECH THERAPY GENERAL
0441	SPEECH THERAPY VISIT CHARGE
0442	SPEECH THERAPY HOURLY CHARGE
0443	SPEECH THERAPY GROUP RATE
0444	SPEECH THERAPY EVALUATION RE-EVALUATIO
0449	SPEECH THERAPY OTHER
0460	PULMONARY FUNCTION GENERAL
0730	EKG/ECG GENERAL
0801	INPATIENT RENAL DIALYSIS INP HEMODIALYSIS
0946	COMPLEX MEDICAL EQUIPMENT - ROUTINE

Hospital-Based Rural Health Clinic Payment

Payment for hospital based rural health clinic services shall be made as an interim payment based on a percentage of charges. Final payment is made in accordance with a percent of costs. An audit of each hospital's actual costs eligible for reimbursement shall be performed by the Department's third party contractor in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data audited by the Department's third party contractor.

Laboratory services provided as part of a health clinic visit are paid a fee in addition to the percentage of cost payment and are final and not subject to cost settlement. When billing lab services, revenue codes 0300 through 0319 MUST be billed with the corresponding HCPC code identified in Field 44.

Member encounters with more than one health professional, or multiple encounters with the same health professional, which take place on the same day for the same diagnosis or treatment, are counted as one encounter. In instances in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment on the same day, the additional encounter may be billed as a separate encounter.

Denial of Payment for Provider Preventable Conditions

The Department does not make payment for health care acquired conditions (HCAC) and other provider preventable conditions which includes three erroneous surgeries (never events). Claims with a present on admission code of “N” or “U” will receive a reduced payment for treatment of the HCAC, but not for the procedure itself.

See the “Claims” section below for claim submittal requirements.

11. Claims

All providers participating in NH Medicaid must submit claims to the fiscal agent in accordance with NH Medicaid guidelines. Providers should note that NH Medicaid claim completion requirements may be different than those for other payers, previous fiscal agents, or fiscal agents in other states.

Providers participating in the NH Medicaid Program are responsible for timely and accurate billing. If the NH Medicaid does not pay due to billing practices of the provider which result in non-payment, the provider cannot bill the member.

Claim completion guidelines in this manual should be followed for instructions on specific fields. The NH Specific Companion Guide, which can be found at www.nhmmis.nh.gov (see provider manuals under the provider tab), should be used for electronic claim filing instructions. While field-by-field requirements are shown for paper claims; the same required data is captured through web portal claim entry and through electronic submissions to EDI. Web portal submissions feature step-by-step claim completion instructions as well as tools such as Online Help to assist providers in correct claim completion.

Regardless of the method claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

The following claim-related topics are found in the General Billing Manual – Volume I:

- Claims Submission via EDI, web portal, paper
- Claims processing – edits & audits, transaction control numbers, line item vs header processing, claim status, remark/EOB codes
- Claim Resubmission
- Claim adjustments and voids
- Medicare cross-overs
- Claims payment
- Remittance Advice

Providers will be notified of payment or denial via a Remittance Advice, usually received in electronic format or via the web portal.

Denied claims should be resubmitted only if the reason for the denial has been corrected.

Paid claims cannot be resubmitted; resubmission of a paid claim will result in a denial as a duplicate. Paid claim corrections must be made through the adjustment process. If a paid claim has a line item denial, the individual line item can be corrected and resubmitted, or the original claim can be adjusted with the revised information.

Please see "Timely Filing" below for claims resubmitted as a result of QIO review.

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information which is now corrected. Providers should never resubmit claims that are currently in process (suspended).

Any claim denied for failure to be submitted or resubmitted in accordance with timely filing standards will not be paid. Denied claims that have been corrected must be resubmitted as a new claims transaction on paper, via the web portal, or electronically via EDI.

Provider Preventable Conditions

Note that federal reporting requirements require that providers submit claims for erroneous surgeries and related services. Claims indicating any one of three erroneous surgeries and related services will be reviewed and denied if appropriate. This includes hospitalizations, services in the operating room, and services of any providers who could bill for operating room services such as hospitals, practitioners, ambulatory surgical centers, and other appropriate types of providers.

Claims for the above erroneous surgeries are identified by diagnosis E codes or CPT/HCPCS modifiers and include:

E-codes:

- a. E876.5 Performance of wrong operation (procedure) on correct patient
- b. E876.6 Performance of operation (procedure) on patient not scheduled for surgery
- c. E876.7 Performance of correct operation (procedure) on wrong side/body part

CPT/HCPCS Modifiers:

- a. PA: Surgical or other invasive procedure on wrong body part
- b. PB: Surgical or other invasive procedure on wrong patient
- c. PC: Wrong surgery or other invasive procedure on patient

Timely Filing

In accordance with federal and state requirements, all providers must submit all initial claims within one year following the earliest date of service on the claim.

Except as noted below, NH Medicaid will *not* pay claims that are *not* submitted within the one-year time frame.

Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper, along with Form 957x, “Override Request,” located on the NH MMIS Health Enterprise Portal web site at www.nhmmis.nh.gov. A copy of the RA with the original billing date and the denial circled must also be attached. This resubmission *must* be received *within 15 months* of the date of service. If this time frame is not met, the claim will be denied.

The only other circumstance eligible for consideration under the one-year override process is for claims for NH Medicaid covered services for clients whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above except that the claim must be submitted within 6 months of the retroactive eligibility determination.

For hospitals that are under QIO review and who resubmit a claim as directed by the QIO, if the claim is over the timely filing limit, claim submission should be made on a regular UB 04 claim form using a C1 indicator in the condition code field, form locator 18. This will allow the system to override the timely filing limit for that claim.

Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes. One revenue code must be provided for each charge billed.

For medical services, the NH Title XIX Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

ICD-9-CM diagnosis codes are required for all services billed on medical and institutional claims forms (CMS-1500 and UB-04). For dental services, the NH Medicaid Program requires the use of Claims without the required diagnosis or procedure codes will be denied.

Hospitals are required to bill for outpatient services on the UB-04 claim form using the appropriate Revenue Codes and descriptive HCPC codes for the services rendered.

Laboratory services provided as part of an outpatient hospital or RHC-HB visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit. In order for the add-on payment to be made, laboratory services, revenue codes 0300 through 0319, MUST be billed with the corresponding HCPC code identified in Field 44. Reimbursement will be according to fee for service rates established for the HCPC procedure codes.

RHC-HB Encounter Code Billing

New Hampshire Medicaid requires that Hospital Based Rural Health Clinics bill their encounters using the revenue code 0521 and the appropriate descriptive HCPC codes on the UB-04 claim form.

Additional Services Billing

Certain procedures performed in a Hospital Based Rural Health Clinic can be billed in addition to the encounter code. Below is a listing of revenue codes which may be billed.

Covered Hospital Based Rural Health Clinic Revenue Codes

0300	Laboratory, General
0301	Laboratory, Chemistry
0302	Laboratory, Immunology
0304	Laboratory, Non-Routine Dialysis
0305	Laboratory, Hematology
0306	Laboratory, Bacteriology & Microbiology
0307	Laboratory, Urology
0309	Laboratory, Other Laboratory
0310	Laboratory Pathology, General Classification
0311	Laboratory Pathology, Cytology
0312	Laboratory Pathology, Histology
0314	Laboratory, Biopsy
0319	Laboratory, Other Laboratory Pathology

VACCINES

If vaccinations are given as part of or incidental to a medical or behavioral encounter visit at an RHC-HB, the vaccine administration is considered to be part of the service encounter and is not reimbursed separately by NH Medicaid.

If the vaccine administration is the only service performed, the administration can be billed separately using the clinic visit revenue code 0521 and will be reimbursed at the interim rate at a percent of charges which is subsequently cost settled.

For adults age 19 and over, RHC-HB providers may bill for the vaccine itself using the pharmacy revenue code 0250 and will be paid at an interim rate which is subsequently cost settled.

Service Authorizations (SAs)

A Service Authorization (SA), also known as a Prior Authorization (PA), is an advance request for authorization of payment for a specific item or service.

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, NH Medicaid does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

Required Claim Attachments

All attachments must be submitted in hardcopy or via fax. Providers that submit claims on paper claims should have the claim attachment stapled behind the claim form. Providers that submit claims electronically or via the NH MMIS Health Enterprise Portal must first submit the claim and obtain a Transaction Control Number (TCN) for the line requiring the attachment. Attachments in hard-copy format must then be sent to the fiscal agent with a cover sheet identifying the TCN for the claim. Failure to provide the TCN on the submitted attachments could result in claim denial due to missing or incomplete information.

When submitting a claim via the NH MMIS Health Enterprise Portal, providers must indicate in the claim form if there is an attachment to support the claim. Providers should answer yes to the question “Does this claim have attachments?” and click “Add Attachment” **Note:** Please select Delivery Method “by Mail” or “by Fax” to submit attachments.

The screenshot shows a web interface titled "Claim Attachments". At the top right is a blue button labeled "Add Attachment". Below it is a table with three columns: "Type Attachment" (with a dropdown arrow), "Delivery Method" (with up and down arrows), and "Attachment Control #" (with up and down arrows). The table currently contains one row with the text "No Data" centered in the cell.

Following claim submission a confirmation page will generate. Please print the confirmation page and submit it as a cover page with the claim attachments. If you are unable to print the confirmation page please write the 17 digit TCN on the attachment.

- **Please mail claim attachments to:**
 Xerox Claims Unit
 PO Box 2003
 Concord, NH 03302

- **Please fax claim attachments to:**
 (888) 495-8169

If you are submitting EDI claims, paper attachments to Electronic 837P claims are indicated in the 2300 PWK segment, the 2400 PWK segment, or both. The hard copy attachment is submitted via fax or on paper and linked to the related claim by means of an Attachment ID (your TCN).

Examples of , but not inclusive of, when a claim attachment is required are when another insurer is primary and has denied coverage for the service or a 957x form is required because the filing limit was not met.

Claim Completion Requirements for Hospital

Hospital providers are required to submit claims to NH Medicaid using the UB04 form or the electronic version, an 837I. Unless you are submitting a claim after Medicare has paid or allowed the charge, this claim would be a crossover and you would submit the same claim type you submitted to Medicare.

Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted area show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
4. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
5. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
6. DO use only black ink on ALL claims or adjustment that you submit to Xerox. The Xerox imaging/OCR system reads blue and black ink.
7. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
8. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

Paper claims and other documents can be mailed to:

Xerox State Healthcare LLC
PO Box 2003
Concord, NH 03302-2003

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. An actual signature or signature stamp is required – typed provider name or signature on file will not be adequate. Please note that anyone authorized by the provider or company is allowed to sign the form based on the company's own policy for authorized signers.

Once your claim is processed you will receive a claim number or transaction control number (TCN). This is a 17 digit number.

Example: 13091831230000050 *Breakdown:* 13091 8 3123 000005 0

The format is: YYDDD M BBBB NNNNNN T, where

- YYDDD is the Julian date when the batch was created.
- M is the media source, such as 1-web, 2-Elec Xover, 3-EMC, 4-System Generated, 5-Encounter, 7-OCR and 8-Paper.
- BBBB is the batch number.
- NNNNNN is the document number.
- T is the transaction type.

NH Medicaid requires the submission of a carrier code to identify other insurance coverage. A carrier code is a ten (10) digit code created by New Hampshire which identifies who the primary insurance carrier is. It is used in place of the insurance carrier name to streamline the claims processing. This code is used in the appropriate field on a claim, for:

- CMS-1500 (or professional claim), it is box 9D.

For example: One of the most common used is Medicare Part D carrier ID: 0000008888.

The list of Carrier IDs for other insurance companies can be accessed on nhmmis.nh.gov Web Site

- On the Documentation menu, click Documents & Forms.
- On the Documents & Forms page, click the Carrier ID link
- To print a copy, right click and select Print to your local printer.

If the insurance company is not listed, contact the Third Party Liability Call Center at (603) 223-4774 or 1 (866) 291-1674 for the correct code to use.

UB04 Paper Completion Instructions

Hospital Only

Form Locator 01

Provider name, address and telephone number

- Record Billing Provider's Name on line 1
 - **Required field**
 - Name must match what is on file with Xerox
- Record Billing Provider's Street Address on line 2
 - **Required field**
- Record Billing Provider's City, State, and Zip on line 3
 - **Required field**
- Record Billing Provider's telephone number on line 4
 - **Required field**

Form Locator 02

Billing Provider's Designated Pay-to Address

- **Optional**

Form Locator 03a

Patient control number

- **Optional**
- Record the patient's unique alphanumeric number assigned by the provider
- 12 character Form Locator
- If you enter patient account number, we will report it back to you on your remittance advice (RA)

Form Locator 03b

Medical/Health Record Number

- **Optional**
- Record the number assigned to the patient’s medical/health record by the provider
- Up to 20 characters

Form Locator 04

Type of Bill (TOB)

- **Required**
- Up to 4 characters with leading 0
- NH Medicaid does not accept interim claims
- Frequency codes 7 and 8 are **only** accepted electronically (X12/web portal) to void a or submit a replacement claim
- Inpatient, TOB=(0)111
- Outpatient, TOB= (0)131

Form Locator 05

Federal Tax Number

- **Optional**
- Record the Tax ID Number assigned to the provider

Form Locator 06

Statement Covers Period – From/Through

- **Required**
- For services performed on one day, use the same date “From” and “Through”
- Valid date format as month, date and year (MMDDCCYY)
- Inpatient
 - Include all acute and non-acute days in the span
- Outpatient
 - Span dates are **not** allowed
 - “From” and “through” dates **must be** the same date

Form Locator 07

Reserved for Assignment by the NUBC

- N/A

Form Locator 08a –

Patient ID

- **Optional**
- Enter the patient’s NH Title XIX ID
- NH Medicaid ID numbers are 11 characters

Form Locator 08b

Patient Name

- **Required**
- Enter patient’s full name, separate first and last with a comma

- Do not use titles
- Hyphenate names if applicable
- Leave a space between a suffix

Form Locator 09

Patient Address

- **Optional**
- Record the street address, city, state, and zip code of the patient

Form Locator 10

Patient Birth Date

- **Optional**
- Valid format month, day, and year (MMDDCCYY)

Form Locator 11

Patient Sex

- **Optional**
- “M” = male
- “F” = female
- “U” = unknown

Form Locator 12

Admission Date

- **Required**
- For inpatient claims-begin date is the day of admission
- Outpatient claims- the date the episode of care began
- Record the date as month, date, and year (MMDDCCYY)

Form Locator 13

Admission Hour – Code referring to the hour when the patient was admitted for inpatient care

- **Required**
- Inpatient claims
- Enter the applicable code which corresponds with the time

Form Locator 14

Priority (Type) of Admission or Visit

- **Required**
- Inpatient claims
- Enter the applicable admission code

Code	Description	Code	Description
1	Emergency	5	Trauma
2	Urgent	6-8	Reserved
3	Elective	9	Information not available
4	Newborn		

Form Locator 15

Point of Origin for Admission or Visit

- **Required**
- Inpatient claims
- Enter the applicable code

Source Code	Description	Source Code	Description
1	Non-Health Care Facility Point of Origin	8	Court/Law Enforcement
2	Clinic or Physician's Office	9	Information not Available
3	Reserved	A	Reserved
4	Transfer from Hospital (different facility)	B	Transfer from HHA
5	Transfer from SNF/ICF/ALF	D	Transfer from a DPU
6	Transfer from another Health Car Facility	E	Transfer from Ambulatory Surgery Center
7	Reserved	F	Transfer from Hospice Facility

Form Locator 16

Discharge Hour

- **Required**
- Inpatient claims
- Record discharge hour code for when the patient was discharged from inpatient claims
- Use Table from Form Locator13
- 4 characters HHMM

Form Locator 17

Patient Discharge Status

- **Required**
- All inpatient claims
- Record the disposition or discharge status of the patient at the end of the service for the period covered as reported in FL 6, Statement Covers Period

Code	Description	Code	Description
01	Discharge to Home	05	Discharge Transfer to Other Type of Institution
02	Discharge Transfer to Short Term Hospital	06	Discharge Transfer to Home Under Home Health Care
03	Discharge Transfer to SNF	07	Left Against Medical Advice
04	Discharge Transfer to ICF	20	Expired

Form Locator 18 - 28

Condition Codes

- **Situational**
- Record the code used to identify the conditions or events that may affect processing as related to this bill

Form Locator 29

Accident State

- **Optional**

Form Locator 30

Reserved for Assignment by NUBC

- N/A

Form Locator 31-34

Occurrence Codes and Dates

- **Required**
- Use 11- “onset of illness”
- Record all dates as month, date, and year (MMDDCCYY)

Form Locator 35-36

Occurrence Span Codes and Dates

- **Situational**
- Record a code and the related dates that signify an event that relates to the payment of this claim.

Form Locator 37

Reserved for Assignment by NUBC

- N/A

Form Locator 38

Responsible Party Name and Address

- **Optional**
- Enter the name and address of the party being billed

Form Locator 39-41

Value Codes and Amounts

- **Required- inpatient**
- Use value code 80 to determine number of days
- Non-covered days use value code of 81 or 82
- Enter the number of non-covered days

Form Locator 42

Revenue Code

- **Required**
- Identify specific accommodations, ancillary service or unique billing circumstances
- 4 digits
- Inpatient services involving more than one service for the same item should combine the services under the applicable revenue code and record the total number of units that correspond to those services.
- Outpatient services enter the applicable HCPCs for the services in conjunction with the date of the service and revenue code.

- If more than one service is performed on the same day for related services with the same HCPCS, the provider should combine the related services for each date and enter the date along with the number of units, as well as the revenue code.

Form Locator 43

Revenue Description/IDE Number/Medicaid Drug Rebate

- **Required**
- Enter narrative description of the revenue codes
- Outpatient claims that need a NDC the following information is to be recorded
 - Record the NDC qualifier of N4 in the first 2 positions on the left side of the field
 - Record the NDC 11-digit numeric code which is given in a “5-4-2” format – **no** hyphens are to be used.
 - Record the NDC Units of Measurement Qualifier
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit
 - Record the NDC quantity, up to 3 decimal places, ex. 1234.567

Form Locator 44

HCPCS/Accommodation Rates

- **Situational**
- Accommodation revenue codes must have a corresponding accommodation rate; for the following revenue codes, (**outpatient services only**) you must enter a corresponding HCPCS code

0260-0269
0273-0277
0280-0290
0300-0369
0380-0620
0622-0637
0681-0709
0721-0729
0730-0799
0820-0821
0900-0989

- When billing with a NDC enter the appropriate HCPCS related with the NDC

Form Locator 45

Service Date

- **Required**

- Record the service date in valid format (MMDDCCYY) for any accommodation revenue code
- Line one must correlate with FL 6 “From” date

Form Locator 46

Service Units

- **Required**
- Record units of service for all accommodation days
- Must correlate with each detail
- The sum of all units for all accommodation details need to correspond with the covered days listed in FL 7.
- If using an NDC code, enter the number of HCPCS units provided

Form Locator 47

Total Charges

- **Required**
- Record the sum of all charges related to the applicable revenue codes for each detail line
- Record in appropriate currency format DD.CC
- Record revenue code 0001 for a total charge for the claim
- **OR**...enter the total charges in the “TOTALS” of line 23. Total line must be the sum of all individual line items in FL 47

Form Locator 48

Non-Covered Charges

- **Situational**
- Line item non-covered charges
- Record the sum of the non-covered charges on Line 23 of the final claim page using Revenue Code 0001
- Valid currency format DD.CC

Form Locator 49

Reserved for Assignment by NUBC

- N/A

Form Locator 50 (A-C)

Payer Name

- **Situational**
- Record the NH Title XIX carrier code and carrier name if member has other insurance
- Carrier code- 10 digits. The original 4-digits with 6 preceding zeros.
- Carrier Codes can be found by:
- Viewing the provider website and quarterly bulletins for the most up-to-date list or
- Contact the provider relations unit at 1-866-291-1674

Form Locator 51

Health Plan Identification Number

- N/A

Form Locator 52

Release of Information Certification Indicator

- N/A

Form Locator 53

Assignment of Benefits Certification Indicator

- N/A

Form Locator 54

Prior Payments

- **Situational**
- Record 0.00 if there is no payment made by insurance or if payment was applied to coinsurance or deductible
- Valid currency format DD.CC

Form Locator 55

Estimated Amount Due- Payer

- **Required, if applicable**
- Record the estimated amount due to the payer
- Valid currency format DD.CC

Form Locator 56

National Provider Identifier – Billing Provider

- **Situational, if billing X12/web portal**
- Record 10 digit NPI

Form Locator 57

Other (Billing) Provider Number

- **Situational**
- Record the NH Title XIX Provider ID Number, **IF** FL 56 is empty

Form Locator 58 –

Insured's Name

- **Situational**
- Record the member's last name, first name as they are shown on the NH Title XIX ID Card
- Do not use titles
- Hyphenate names if applicable

Form Locator 59

Patient's Relationship to Insured

- N/A

Form Locator 60

Insured's Unique Identifier

- **Required**
- Record the NH Title XIX Member ID number
 - When other insurances is involved in paying claim use the line applicable to the order off payment; A= Primary, B= Secondary, and C – Tertiary

Form Locator 61

Insured's Group Name

- **Situational**

Form Locator 62

Insured's Group Number

- **Situational**

Form Locator 63 (A-C)

Treatment Authorization Code

- **Not Required, at this time**

Form Locator 64

Document Control Number (DCN)

- **Situational**
- Resubmission of an untimely denied claim
- Record NH Transaction Control Number (TCN) from original claim

Form Locator 65

Employer Name

- **Optional**

Form Locator 66

Diagnosis and Procedure Code Qualifier

- N/A

Form Locator 67

Principal Diagnosis Code and Present on Admission Indicator

- **Required**
- Record the ICD – 9- CM code

Form Locator 67 (A-Q)

Other Diagnosis Codes and Present on Admission (POA) Indicator

- **Situational, inpatient claims**

- Record the POA code(s) when other conditions are present or develop during the member’s treatment.

POA Indicator	Description
Y	Dx Present at time of inpatient admission
N	Dx Not present at time of inpatient admission
U	Documentation insufficient to determine
W	Clinically undetermined
I	Unreported/not used; exempt from POA

Form Locator 68

Reserved for Assignment by NUBC

- N/A

Form Locator 69 –

Admitting Diagnosis Code

- Required for inpatient claims**

Form Locator 70 (A-C)

Patient’s Reason for Visit

- Situational**
- Outpatient visit
- Record the ICD-9-CM code for reason of visit at time of registration

Form Locator 71

Prospective Payment System (PPS) Code

- N/A

Form Locator 72 (A-C)

External Cause of Injury (ECI) Code and Present on Admission (POA) Indicator

- Situational**
- Record ECI and POA indicator if injury, poisoning or adverse effect is reason for obtaining medical treatment or happens during the medical treatment

Form Locator 73

Reserved for Assignment by the NUBC

- N/A

Form Locator 74 –

Principal Procedure Code and Date

- Required for inpatient claims**
- Valid date form, month, date, and year (MMDDCCYY)
- Record the ICD-9-CM code that names the primary procedure performed

Form Locator 75

Reserved for Assignment by NUBC

- N/A

Form Locator 76 –

Attending Provider Name and Identifiers (Attending Physician ID)

- **Situational**
- Record provider's 10 digit NPI in the correct field
- **OR**, record the NH Title XIX provider ID for the physician that was principally responsible for the care of the patient upon admission
- Record the last name, first name of the Principal physician

Form Locator 77 –

Operating Physician's Name and Identifiers

- **Situational**
- Record if procedure is billed
- Record the name and ID number of the physician who performed the surgical procedure(primary)

Form Locator 78 – 79

Other Provider (Individual) Names and Identifiers

- **Situational**
- Record information if the provider is eligible for an NPI

Form Locator 80

Remarks Field

- **Situational**
- Add any additional information needed for processing this claim

Form Locator 81 (A-D)

Code Field

- **Situational**
- Utilizing Field a-b enter a qualifier code of "B3" in two-digit field
- Enter the taxonomy code associated to the billing provider's NPI number used in Form Locator 56
- Enter on the same line as the "B3"
- Strongly suggested that a taxonomy code be provided when an NPI is in Form Locator 56
- The NPI number and corresponding taxonomy code must be on file with Xerox