Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Provider Manual
Volume II

July 2026

Department of
HEALTH &
HUMAN SERVICES

Division of
Medicaid
Services

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Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication

1.0 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 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 the Provider Specific Billing Manuals – 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 the NH Medicaid Program 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 General Billing Manual – Volume I Appendices Section encompasses a range of supplemental materials such as Contact Information, Common Acronyms, and 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*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

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

1.2 Provider Accountability

Participating providers must know the content of 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.

1.3 Document Disclaimer/Policy Interpretation

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

1.4 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, memos, letters, website 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 service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 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.

1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's 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 fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2.0 Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

Each participating provider shall:

- Meet the state licensing or board certification requirements, of the state in which they practice, to provide medical or dental care;
- Be a NH enrolled Medicaid provider;
- Perform the necessary components whether in whole or in part required for each EPSDT examination; and
- Request and obtain prior authorization from the Department before providing services which require prior authorization, in accordance with He-W 530 and He-W 546.06.

3.0 Covered Services & Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit these requests can be found in this Provider Specific Billing Manual - Volume II.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT), as defined in 42 CFR 440.40(b), provides comprehensive preventive, diagnostic, and treatment services for Medicaid-enrolled individuals under age 21. EPSDT emphasizes early identification and treatment of health conditions and includes preventive care, developmental screenings, dental, vision, behavioral health, and medically necessary treatment services.

The Department shall cover EPSDT diagnostic and treatment services, if medically necessary and in accordance with administrative rules from the Centers for Medicare and Medicaid Services pertaining to EPSDT.. In the context of EPSDT, a service or item should be deemed medically necessary if the service minimally prevents the worsening of a physical or behavioral health condition for a child up to age 21.

The following EPSDT services are covered:

(1) Comprehensive and age-appropriate medical assessments and screenings of a child's physical and mental status in accordance with the American Academy of Pediatrics' 2023 periodicity schedule entitled "Recommendations for Preventive Pediatric Health Care", available as noted in Appendix A, including:

a. Comprehensive health and developmental history;

b. Comprehensive unclothed physical examination;

c. Developmental and behavioral assessment with a standardized validated tool of the provider's choice;

d. Measurements of the child's height, weight, head circumference, and blood pressure;

e. Appropriate immunizations;

f. Appropriate laboratory tests to include:

1. Testing for lead toxicity for EPSDT eligible children at 12 and 24 months of age; and

2. Testing for lead toxicity for EPSDT eligible children between 36 and 72 months of age, if not previously screened for lead toxicity;

g. Appropriate vision testing;

h. Appropriate hearing testing;

i. Assessment of nutritional status;

j. Health education about the benefits of healthy lifestyles and practices; and

k. Anticipatory guidance about child safety and injury prevention; and

(2) Dental screening services furnished by direct referral to a dentist for diagnosis and treatment, and in accordance with the periodicity schedule contained in the American Academy of Pediatric Dentistry's "Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents" (2022 revision).

Any services not listed in He-W 522 through He-W 589 as covered services, including experimental or investigational services which are medically necessary and given prior authorization, shall be given independent review by the Department for coverage based on medical necessity in accordance with He-W 546.06 and in accordance with administrative rules from the Centers for Medicare and Medicaid Services pertaining to EPSDT.

Transportation services, pursuant to He-W 574, 42 CFR 431.53, and 42 CFR 441.62, shall be covered:

(1) For EPSDT-eligible children;

(2) For any person who needs to accompany an eligible child to the child's medical service; and

(3) If a child is receiving residential or facility-based care, for a parent, family member, or caregiver if their presence is necessary to actively participate in the treatment or intervention for the direct benefit of the child, without the child present.

3.1 Service Limits

Services in excess of the service limits in He-W 530 shall be covered for EPSDT-eligible children, if medically necessary, in accordance with the requirements in He-W 546.06 and in accordance with administrative rules from the Centers for Medicare and Medicaid Services pertaining to EPSDT.

4.0 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 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.

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 will be responsible for payment. If this occurs, the Department suggests that the service provider maintain in their files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

Non-covered services include:

- Any service for which there is no medical necessity or for which the medical necessity has not been established;
- Services which are not medical or dental in nature, except that transportation shall be covered in accordance with He-W 546.05(d);
- Services that have not been proven to be safe or effective, as documented in medical peer review literature; and
- Services which are more costly than other services which could be expected to provide the recipient with the same outcome.

Services listed in He-W 522 through He-W 589 as non-covered services shall not be covered unless the service is determined to be medically necessary for the recipient pursuant to He-W 546.06 and in accordance with administrative rules from the Centers for Medicare and Medicaid Services pertaining to EPSDT.

5.0 Service Authorizations (SA)

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

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The Contact Information in the Appendices of the General Billing Manual or on the SA form itself should be consulted for the name and method of contact.

5.1 EPSDT Service Authorization Process

Prior authorization is required for services in excess of the service limits and for any services not listed in He-W 500 as covered, including experimental and investigational services. All prior authorizations requested for a member under 21 years of age will be reviewed on an individualized case by case basis per EPSDT requirements.

Requests for prior authorization shall include the following:

(1) The recipient's name, address, and Medicaid identification number;

(2) The recipient's diagnosis and prognosis, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition;

(3) An estimation of the effect on the recipient if the requested service is not provided;

(4) Medical justification for the services or equipment being requested;

(5) The recommended timetable of the prescribed treatment;

(6) A discussion of why the service is medically necessary as defined in He-W 546.01 and in accordance with administrative rules from the Centers for Medicare and Medicaid Services pertaining to EPSDT;

(7) The expected outcome of providing the requested service;

(8) The recommended timeframe to achieve the expected outcome;

(9) A summary of any previous treatment plans, including outcomes, which were used to treat the diagnosed condition for which the requested service is being recommended;

(10) Listings of individuals or agencies to whom the recipient is being referred; and

(11) Assurance that the requested service is the least restrictive, most cost-effective service available to meet the recipient's needs.

Requests for prior authorization shall include a statement signed by a provider acting within their scope of practice indicating that they concur with the request.

Prior authorizations for coverage of services requested in accordance with He-W 546.06 shall be approved by the Department if the Department determines that the information provided demonstrates medical necessity.

Confirmation of Department approvals will be sent to the treating provider in writing.

If the requested service is denied, or denied in part, by the department, the department will forward a notice of denial to the recipient and the treating provider with the following information:

(1) The reason for, and the legal basis of, the denial; and

(2) Instructions that a fair hearing on the denial may be requested by the recipient within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

Decisions made by the Department shall not be superseded by the treating or consultative provider's prescription, orders, or recommendations.

6.0 Documentation

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. See the "Record Keeping" section of the General Billing Manual – Volume I for more detailed documentation requirements.

7.0 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 Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations, CMS transmittals, provider manuals, fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services, or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

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

8.0 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.

9.0 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 exclusions as outlined in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume 1.

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

10.0 Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third-party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

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

11.0 Claims

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

Regardless of the method through which 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.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis & Procedure Codes

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

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

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

11.2 Service Authorizations (SAs)

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.

11.3 Claim Completion Requirements for Therapies

Providers are required to submit claims to NH Medicaid using the appropriate claim for the service, such as the CMS1500 paper form or the electronic version, an 837P.

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 NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. 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.
7. DO use only black or blue ink on ALL claims or adjustments that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291- 1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

For additional guidance on how to complete a CMS1500 claim form please refer to the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

12.0 Terminology

Department means the New Hampshire (NH) department of health and human services.

Early and periodic screening, diagnosis and treatment (EPSDT) services means a program, as defined in 42 CFR 440.40(b), designed to provide preventative health care, diagnostic services, and early detection and treatment of disease or abnormalities to Medicaid eligible individuals under age 21.

Medicaid means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

Medical means related to the following:

(1) Treatment of disease;

(2) Maintenance of health; or

(3) Prevention, alleviation, or curing of disease.

Medically necessary in the context of EPSDT covered services means reasonably calculated to prevent, diagnose, correct, cure, alleviate, ameliorate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient .

Periodicity schedule means a regularly recurring schedule of preventive health care, dental care, or screening services as determined by standards of practice.

Primary care physician means the physician who routinely provides health care to the recipient.

Recipient means an individual who is eligible for and is receiving medical assistance under the Medicaid program.

Title XIX program means the joint federal-state program described in Title XIX of the Social Security Act and administered in NH by the Department under the Medicaid program.

Title XXI means the joint federal-state program described in Title XXI of the Social Security Act and administered in NH by the Department under the Medicaid program.

Treating physician means the physician who is managing a present illness or condition, in conjunction with or aside from the recipient's primary care physician.