Community Mental Health

Provider Manual
Volume II

December 1, 2017

New Hampshire
Medicaid

Table of Contents

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. This date is also included in the text box located on the left margin where the content change was updated.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Sub-Section/Page	Section number(s)/page number(s) to which the change(s) are made. If page change is not applicable "no pagination change" is stated.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s). If the reason is an administrative rule change, the rule number is added to the column.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, Control Memo, etc.).

Date Change to Manual	Effective Date	Section/Sub-Section	Change Description	Reason	Related Communication
12/2017	1/1/2018		Rebrand Document	Remove actual name of fiscal agent; replace with "fiscal agent"	

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 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 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 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.

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, 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 the fiscal agent. 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 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 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 the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

Community Mental Health (CMH) providers approved prior to August 22, 1997 shall be authorized to continue to provide NH Medicaid Program funded community mental health services pursuant to He-M 426. CMH providers shall only provide those services for which they have received approval pursuant to applicable New Hampshire Administrative Rule.

Community Mental Health Programs

To participate in NH Medicaid as a Community Mental Health Program (CMHP), all CMHP's must be approved pursuant to He-M 403 and enrolled in NH Medicaid. The CMHP, or its subcontractors, shall be authorized to provide the NH Medicaid funded CMH services.

CMHPs shall meet all applicable requirements in New Hampshire Administrative Rules Chapter He-M 400.

Staff Qualifications for Community Mental Health Programs and Providers

Coverage is limited to those services that the provider is legally qualified to practice under New Hampshire Law. Provider qualifications for CMHC services can be found in New Hampshire Administrative Rule He-M 426.

3. Covered Services & Requirements

New Hampshire provides benefits for CMH rehabilitative services. Services recommended by a licensed or certified practitioner of the healing arts shall be provided in accordance with NH Administrative Rules and state and federal laws. It is the provider's responsibility to be familiar with all state and federal regulations. All information is subject to change as state or federal regulations impacting NH Medicaid are revised or implemented.

Covered Services

The services listed in Appendix A are covered CMH services, available under the NH Medicaid program to all eligible NH Medicaid members when provided or recommended by a licensed practitioner of the healing arts pursuant to all requirements specified in NH Administrative Rules He-M 400. Eligibility determination requirements are specified in He-M 401. Documentation requirements are specified in He-M 408. Service requirements are specified in He-M 426. Specific attention should be given to billing of Individualized Resiliency and Recovery Oriented Services (IROS) as noted below.

The following IROS services shall be billed separately from one another, with one claim submitted per day for each category

1. Illness management and recovery, group;
2. Illness management and recovery, individual;
3. Evidence-based supported employment;
4. Crisis intervention;
5. Group therapeutic behavioral services; and
6. Individual therapeutic behavioral services, family support services, and medication support services.

The CMHP shall separately aggregate the minutes for each category listed in 1-6 above that are provided in a single day into a single claim before determining the number of billable 15 minute units for each category

1 unit: ≥ 8 minutes through 22 minutes

2 units: ≥ 23 minutes through 37 minutes

3 units: ≥ 38 minutes through 52 minutes

4 units: ≥ 53 minutes through 67 minutes

5 units: ≥ 68 minutes through 82 minutes

6 units: ≥ 83 minutes through 97 minutes

7 units: ≥ 98 minutes through 112 minutes

8 units: ≥ 113 minutes through 127 minutes

CMH programs may provide all services identified in Appendix A. CMH providers shall only provide those services for which they have received approval.

CMH services provided in an inpatient hospital setting are only reimbursable through NH Medicaid if provided by a legally qualified psychiatrist.

CMH services provided in an Institute for Mental Disease are not reimbursable.

General Requirements

Individual Service Plans (ISPs) must be written and signed by a psychiatrist recognized under NH law prior to services being provided.

Progress notes for services billed must be documented in accordance with all state and federal regulations prior to services being billed.

CMH services shall be overseen by a psychiatrist responsible for the member's care as documented in the ISP.

Periodic (at least every 90 days) reviews shall be done to document the individual's progress or continued need for services in accordance with He-M 401.

Pursuant to He-M 401 services available to individuals who meet Bureau of Behavioral Health eligibility requirements shall only be billed for dates of service that fall within the eligibility period.

All services covered under other primary insurance must be billed to the primary insurance prior to billing NH Medicaid. "Covered" means that the service is included within the plan benefit. Non-payment for service, where insurance conditions are not met, does not meet the definition of non-covered.

Waivers to CMH Administrative Rules

The Administrative Rules for covered CMH services can be found in He-M 400, Community Mental Health, and He-M 1002, Certification Standards For Behavioral Health Community Residences.

A CMHP or a member may make a written request to the Department for a waiver of specific procedures outlined in the administrative rule. A waiver request shall include a specific reference to the section of the rule for which a waiver is being sought, a full explanation of why a waiver is necessary, and a full explanation of alternative provisions or procedures proposed by the CMHP or member. No provision or procedure prescribed by statute shall be waived.

A request for a waiver shall be granted after the Department determines that the alternative proposed by the CMHP, or the member meets the objective or intent of the rule, and:

- Does not negatively impact the health or safety of the member(s); or
- Is administrative in nature, and does not affect the quality of member care.

Upon receipt of approval of a waiver request, the CMHP's or the member's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which waiver was sought.

Waivers shall be granted in writing for a specific duration not to exceed five years except as noted.

Those waivers which relate to the following shall be effective for the CMHP's current certification period only:

- Fire safety
- Other issues relative to member health, safety or welfare that require periodic reassessment

A CMHP or a member may request a renewal of a waiver from the Department within the timeframes outlined in Chapter He-M 400 of the NH administrative rules.

Service Limits

A CMHP or CMH provider may make a written request to the Department for a waiver of the service limits outlined in He-M 426.

A request for a waiver shall include a specific reference to the section of the rule for which a waiver is being sought, a full description of why a waiver is necessary, and a full explanation of alternative provisions or procedures proposed by the CMHP or CMH provider. No provision or procedure prescribed by statute shall be waived.

A request for a waiver shall be granted after the Department determines that the alternative proposed by the CMHP or CMH provider meets the objective, or intent of the rule, and:

- Does not negatively impact the health or safety of members; or
- Does not affect the quality of CMHP or CMH provider services.

Upon receiving an approval of a waiver request, the CMHPs, or CMH provider's subsequent compliance with the alternative provisions, or procedures approved in the waiver, shall be considered compliance with the rule for which the waiver was sought.

Waivers shall be granted in writing for a specific duration not to exceed five years, except as in those waivers which relate to fire safety or other issues relative to member health, safety or welfare that require periodic reassessment.

A CMHP or CMH provider may request a renewal of a waiver from the Department. Such a request shall be made prior to the expiration of a current waiver, as outlined in the Chapter He-M 426 of the New Hampshire administrative rules.

Providers may, with the consent of the member, request a waiver to enable members to receive case management by both the behavioral health and developmental service systems. The Department shall grant a waiver if a review of the person's clinical condition establishes that the person has symptoms that are acute or severe and that require multiple services from the secondary service provider.

Billing for functional support services provided to each individual, except for crisis intervention services, and all functional support services provided to individuals eligible to receive children's program services under He-M 401, shall be limited as follows:

1. Individual therapeutic behavioral services, family support services, and medication support services shall be limited to a combined total of 10 units per day; and
2. Group therapeutic behavioral services shall be limited to 10 units per day.

15 minute billing units for IROS services shall be calculated based on the following:

- Group therapeutic behavioral services shall be limited to 10 units per day; and
- All National Correct Coding Initiative limits shall apply to CMH services.

Medication Related Services

Pharmacologic management is considered part of and Evaluation and Management (E/M) service.

E/M services provided on the same day as psychotherapy shall be billed using the appropriate E/M code as well as the appropriate add-on psychotherapy code. The two services must be significant, and separately identifiable. There must be distinct and separate documentation for each service.

Nursing assessment and evaluation shall be limited to no more than one procedure billed per member per day.

Nurse assessment and evaluation, brief office visit, or evaluation and management shall be limited to one service per day, and shall not be billed on the same day.

Brief office visits, nursing assessment and evaluation, or evaluation and management for the purpose of pharmacologic management shall not be billed for members on days during which the member is in attendance at a partial hospitalization program.

Comprehensive medication service for clozapine/clozaril management may be provided up to a maximum of once per day when a documented drop in the member's white blood cell count (WBC) occurs. Third party billing rules also apply to this procedure.

Administration of medication by injection and medication check may be billed, using the respective billing codes, as part of the same visit.

Psychotherapeutic Services

Psychiatric Diagnostic Codes:

- Can be reported once per day;
- Cannot be reported on the same day as E/M by the same provider; and
- Cannot be reported with psychotherapy service on the same day.

The following shall apply to Individual Psychotherapy:

- Individual therapy with medication management shall be billed as two procedures including the E/M component as well as the add-on psychotherapy component;
- Psychotherapy time includes face-to-face time spent with the individual and/or family member;
- When time with patient and/or family crosses half of the time for the code, that code can be used;
- Psychotherapy of less than 16 minutes is not reported; and
- Recipient must be present for all or some of the service.

Crisis psychotherapy shall be a covered service when provided by individuals meeting psychotherapy requirements outlined in He-M 426. Crisis psychotherapy shall be billed in 15-minute units. When crisis psychotherapy goes beyond one hour, the add-on code for crisis psychotherapy shall be used. Reimbursement for this service is limited to 6-15 minute units per day.

Emergency Services

As follow-up to the initial emergency response, a member shall be eligible to receive a maximum of five emergency service sessions. Billing shall consist of no more than six 15-minute face-to-face units per session, for the purpose of ***stabilization of the emergency situation*** prior to intake or referral to another service or agency.

Emergency services shall be billed in 15-minute units, and shall be limited to six units per member per day to a maximum of six sessions per period of acute psychiatric crisis.

Evaluations and Testing

Psychiatric diagnostic interview exam shall be billed as one event for the initial intake service.

All E/M services shall be billed as one event when provided on the same day by the same provider.

Psychological testing shall be a covered CMHP service, and consist of psychometric, or projective tests, or both with a written report. This procedure shall be billed per hour and be limited to six hours per member per six month period. Only persons licensed by state statute to provide psychological services shall provide this service.

Neuropsychological tests shall be billed per hour, and be limited to six hours per member per six month period.

Partial Hospital Services

Programs shall operate a minimum of six hours per day on weekdays and 4 hours per day on holidays and weekends for each day for which services are billed.

Billing for partial hospitalization services shall be in half day or full day units, as follows:

- One half day of partial hospitalization shall be attendance at staff directed programs for at least two and less than three hours; and
- A full day of partial hospitalization shall be attendance at staff directed programs for three or more hours.

  Reimbursement for partial hospitalization services shall be limited to services for outpatients.

  On a day that a member receives partial hospitalization services, no reimbursement for other covered services shall be made except as follows:
  - Case management services when provided under an approved case management option of the NH Medicaid program;
  - Emergency visits if they occur outside of the normal operating hours of the partial hospitalization program;
  - Services provided by a continuous treatment team;
  - Individualized resiliency and recovery oriented services;
  - Medication checks for clozaril/clozapine management; and
  - Psychiatric evaluation for NH Medicaid eligibility.

Intensive Partial Hospitalization

Participation shall not exceed 20 treatment days per acute episode without a written order from a psychiatrist and a documented service plan review. There shall be no reimbursement from NH Medicaid for any treatment exceeding 30 days per episode, or 90 days per state fiscal year.

Programs shall operate a minimum of six hours per day on weekdays and four hours per day on holidays and weekends for each day for which services are billed.

Restorative Partial Hospitalization

Placement and participation in restorative partial hospitalization services shall be based on the needs of the member as documented in the ISP, and functional deficits identified in the eligibility determination process pursuant to He-M 401.

Individualized Resiliency and Recovery Oriented Services (IROS)

Only members certified to receive long-term care services pursuant to He-M 426.18 shall be eligible to receive IROS.

IROS shall not be eligible for reimbursement if provided in an office setting with the exception of Illness Management and Recovery (IMR), crisis intervention and medication support.

Billing for functional support services provided to each individual, except for crisis intervention services, and all functional support services provided to individuals eligible to receive children's program services under He-M 401, shall be limited as follows:

- Individual therapeutic behavioral services, family support services, and medication support services shall be limited to a combined total of 10 units per day; and
- Group therapeutic behavioral services shall be limited to 10 units per day.

A CMHP or CMH provider may request a waiver of the 10 unit daily limit by submitting the request in writing to the Department in accordance with He-M 426.

The following procedure codes and modifier combinations have a daily 10 unit limit.

Procedure Code	Modifier	Modifier	Modifier	Modifier	Modifier
H0034		HW	U1	U2	U5
H2015		HW	U1	U2	U5
H2019		HW	U1	U2	U5
H2019	HQ	HW	U1	U2	U5
T1027		HW	U1	U2	U5

In order to exceed the 10 unit limit, a service authorization is required. Approved services must be billed with an additional modifier of UA (ex: H0034 HW U1 UA or H2109 HQ HW U1 UA). All services billed on the same day shall be billed under a single claim.

When requesting the service authorization from Bureau of Behavioral Health (BBH) providers must specify how many visits, and units are being requested, and the time period for which authorization is requested based on the current individual treatment plan.

A CMHP or CMH provider may request a waiver of the 10 unit daily limit by submitting the request in writing to the Department in accordance with He-M 426. In addition to the requirements in He-M 426, the waiver request shall include the following:

- Supporting documentation that the provision of functional support services beyond the 2.5 hours per day is necessary to allow the individual to achieve the desired outcome;

- A statement by the clinician most familiar with the needs of the individual that there are no other treatment modalities available, such as peer support, community support or other natural supports, that will enable the individual to achieve the desired outcome;
- A copy of the current and previous ISP, signed by the psychiatrist, which specifies the frequency, duration and purpose of the requested functional support services in excess of 10 units per day;
- A copy of the current eligibility determination form; and
- The date range for the waiver, which shall not exceed the date range specified on the ISP.

A waiver request shall be granted by the Department in accordance with He-M 426 and the following:

- The Department determines that there are extenuating circumstances unique to the individual that would make a denial of the waiver request clinically contraindicated; or
- The Department determines that approval of the waiver can reasonably be expected to prevent the need for more costly services within the following 12 months, including prevention of hospitalization or institutionalization.

Community Residence

Reimbursement for IROS at the per diem rate shall preclude the possibility of billing for IROS in 15-minute units within the community residence with the exception of IMR provided by non-residential staff. For any day on which a member receives per diem services, residential staff of the same program shall not also bill for IROS in 15-minute units for that member.

Reimbursement for services provided on a per diem basis in an acute psychiatric residential treatment program designated pursuant to He-M 1005.04 shall preclude the possibility of billing for any other service described in He-M 426 except case management services, emergency services, and psychological testing.

Fiscal Year Limits

Except for those NH Medicaid members eligible to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) pursuant to He-W 546, or eligible to receive long-term care services in accordance with He-M 400, the NH Medicaid payment limit per fiscal year for all CMH services shall be the limit established by the Department with approval of the US Department of Health and Human Services Centers for Medicare and Medicaid Services as an amendment to the State Plan in accordance with He-W 520 and Section 1902(a) of the Social Security Act. The state fiscal year (SFY) runs from July 1 to June 30. Individual service limits shall still apply.

As of June 25, 2004 the limit for all CMH services shall be $1,800 (NH Medicaid reimbursement) per member per state fiscal year. NH Medicaid members shall qualify to exceed the $1,800 limit if the CMHP certifies that the member meets the criteria for one of the Bureau of Behavioral Health (BBH) eligibility categories. However, those individuals who meet eligibility criteria as Adults with Severe or Severe and Persistent Mental Illness with Low Service Utilization shall not

be allowed to exceed a $4,000 state fiscal year cap unless approved through a waiver request submitted to DBH. All CMH Medicaid payments made during this fiscal year will be counted toward the service limits outlined above.

A member shall qualify for services in excess of the annual NH Medicaid payment limit if that member has been certified for long-term care services by:

- Determination by the CMHP that the member is eligible to receive Department-funded services pursuant to He-M 401, or
- Determination by a CMHP that a child through age 17 is eligible for services pursuant to He-M 401 unless the psychiatrist has approved the child to remain until age 21 in a children's program pursuant to He-M 401.

CMH Services - Inpatient Setting

Services provided in an inpatient hospital setting shall only be reimbursable through NH Medicaid if provided by a legally qualified psychiatrist.

Other Services

Copying a portion of a member's record to be used for NH Medicaid eligibility determination shall be limited to one unit per six-month period

Psychiatric evaluation for NH Medicaid eligibility shall be limited to one session per member per six-month period.

Case management shall be billed only by the agency that is the primary service provider for individuals who receive services from both the behavioral health and developmental services systems. Comprehensive case management must be provided in accordance with state and federal laws including a comprehensive assessment, individual care plan, referral, linkage and monitoring of the identified needs.

NH Medicaid billing for evidence based supported employment shall be limited to community based, direct, active, face-to-face clinical interventions necessary for the individual to achieve the goals and objectives identified on the ISP.

Only members certified to receive long term care services pursuant to He-M 426.18 shall be eligible to receive IROS services.

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.

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.

Services provided in an Institution for Mental Disease shall not be reimbursable. Services provided in an inpatient setting shall not be covered when provided by non-physician practitioners.

The Evidence Based Supported Employment components shall not be a NH Medicaid billable service when they, either:

- Do not include the member, or
- Do not address symptoms related to an individual's mental illness

The Vocational Assessment components of Evidence Based Supported Employment, including competency testing, screening for exclusionary criterion, work readiness evaluations, vocational testing, interest inventories, situational assessments, and transitional employment shall not be billed to NH Medicaid.

Office Based IROS – IROS shall not be eligible for reimbursement if provided in an office setting, with the exception of IMR, crisis intervention and medication support. Office setting includes any meeting room where the CMH staff and members are scheduled to meet to the exclusion of non-CMH members coming and going. The intent is for IROS services to be provided in the individual's home or community.

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 related to covered services are described in this section.

Service authorizations are reviewed by the Department. The contact information in the Appendices or on any applicable SA forms should be consulted for the name and method of contact.

Unit Cap for Functional Support Services

Functional Support Services for adults meeting shall be limited to:

- Individual therapeutic behavioral services, family support services, and medication support services provided to adults meeting BBH Health Long Term Care eligibility, shall be limited to a combined total of 10 units per day; and
- Group therapeutic behavioral services provided to adults meeting BBH Long Term Care eligibility shall be limited to 10 units per day

A CMHP or CMH provider may request a waiver of the 10 unit daily limit by submitting the request in writing to the Department in accordance with He-M 426. In addition to the requirements in He-M 426, the waiver request shall include the following:

- Supporting documentation that the provision of functional support services beyond the 2.5 hours per day is necessary to allow the individual to achieve the desired outcome;
- A statement by the clinician most familiar with the needs of the individual that there are no other treatment modalities available, such as peer support, community support or other natural supports, that will enable the individual to achieve the desired outcome;
- A copy of the current and previous ISP, signed by the psychiatrist, which specifies the frequency, duration and purpose of the requested functional support services in excess of 10 units per day;
- A copy of the current eligibility determination form; and
- The date range for the waiver, which shall not exceed the date range specified on the ISP.

A waiver request shall be granted by the Department in accordance with He-M 426 and the following:

- The Department determines that there are extenuating circumstances unique to the individual that would make a denial of the waiver request clinically contraindicated; or
- The Department determines that approval of the waiver can reasonably be expected to prevent the need for more costly services within the following 12 months, including prevention of hospitalization or institutionalization.

If the request is approved, a service authorization number will be assigned; this number is optional when billing for the related services.

If the request is denied, the member may appeal the decision pursuant to He-C 200.

Approval or Denial of Service Authorization Requests

The Department will make a decision on the service authorization request based on approved clinical guidelines. Once a decision is made, the department will either:

- Grant approval by mail or by facsimile after the service authorization request was been made, or
- Issue a denial.

When a service authorization request is denied, written notice of the denial is mailed to the member, and a copy of the denial faxed to the ordering practitioner to include the following:

- Reason for the denial, and a copy of the approved clinical guidelines used to make the decision;
- Information on how the member can file an appeal; and
- Information that the member may appeal a denial within 30 calendar days from the date the denial was issued.

Notices of approval are faxed to the ordering provider, and to the service provider. Written denials are mailed to members, and faxed to the ordering provider.

6. Documentation

CMH providers must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement. Please 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.

The CMHP or CMH provider shall maintain clinical information, and documentation of services, as required by federal regulation, and He-M 400 (including 401, 408 and 426). This clinical record shall include:

- The signature of the service provider;
- The service provider's credentials;
- The legible name of the service provider, including a typed name, name stamp, or printed name within proximity of the credentials and signature of the service provider;
- The date of service; and
- The date of documentation.

All documentation in the clinical record of a CMHP service shall comply with the following requirements:

- The specific services rendered;
- The date and actual time the services were rendered;
- Who rendered the services;
- The setting in which the services were rendered;
- The amount of time it took to deliver the services;
- The relationship of the services to the treatment regimen described in the Plan of Care (PoC) PoC; and
- Updates describing the patient's progress

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.

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

Additionally, CMH service(s) providers shall have multidisciplinary staff conferences pursuant to He-M 401 to review the progress of current cases. Each CMHP shall have a quality assurance program including utilization and peer review to evaluate the effectiveness of covered services

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, state laws, or Department rules, policies or procedures. See the "Adverse Action" section of the General 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 NH 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 (see "Third Billing" below) or in the General Billing Manual – Volume I. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

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 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 crossover 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.

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

Third Billing

Some services not covered by Medicare, or other primary insurance, include service components, such as psychotherapy or evaluation and management, that are covered by Medicare or primary insurance. Examples include emergency service, restorative partial hospital, Cypress Center Per Diem. Medicaid Policy requires that any service covered by other insurance be billed to the other insurance so long as the

service is provided by an eligible provider. This is referred to as Third Billing. The following procedures must be followed:

- Bill Medicare or other primary insurance first;
- Let Medicare cross the claim over to NH Medicaid, or bill Medicaid for coinsurance and/or deductible following general billing practices:
  - Submit paper EOMB, if necessary;
- Record the NH Medicaid payment;
- Submit a HCFA 1500 Claim form with the following:
  - In box 9a and 11 indicate primary insurance;
  - The Statement of **"NOT A X-OVER. THIRD BILL" must be in** Box 19;
  - Use a third billable procedure code from the applicable list below;
  - Record the amount previously paid from all sources in Box 29.

Procedure codes that can be third billed are:

- H2010 Clozaril
- H2011 Emergency Service
- S0201 IPH Full Day
- H2001 RPH Half Day
- H2018 RPH Full
- H0035 IPH Half
- S9485 Crisis Per Diem

10. Payment Policies

NH Medicaid is the payer of last resort. It is the provider's responsibility to correctly bill all services to the primary payer. Services incorrectly billed to NH Medicaid will be subject to recovery and/or referral to the Program Integrity Unit.

The NH Medicaid Program shall reimburse CMHPs and CMH providers only when supervision of providers occurs, and is documented.

The Department will recover any NH Medicaid payments in excess of the NH Medicaid payment limit per state fiscal year for a member including, but not limited to, each of the following circumstances:

- The member's record lacks a properly completed eligibility statement which covers long-term care services billed for the period under review;
- The eligibility period has expired and the redetermination of eligibility has not been completed;
- Documentation in the clinical record fails to substantiate that the member meets the criteria for certification for long-term care; and
- The member's diagnosis does not meet the criteria in He-M 401.

NH Medicaid payments shall be made for CMHP services rendered to members with both psychiatric and mental retardation diagnoses for services related to the psychiatric diagnosis. Medical and billing records shall support this classification. The claim shall indicate the primary diagnosis related to the service rendered.

CMH services shall be paid at rates set by the Department based on the audited costs of covered services as determined by units of services provided by all CMH providers divided by the sum of costs for member transportation, staff, and staff related costs to provide such services incurred by all CMH providers.

MIPPA - Section 102 of Medicare Improvement for Patients and Providers Act (MIPAA) requires that the current 62.5% outpatient mental health treatment limitation (under which Medicare pays 50% of the approved amount, and the patient pays 50%) is reduced as follows: ***2010-2011***=68.75% - Medicare pays 55% and the patient pays 45%; ***2012***=75% Medicare pays 60% and the patient pays 40%; ***2013***= 81.25% - Medicare pays 65% and the patient pays 35%; and ***2014 and onward***=100%-Medicare pays 80% and the patient pays 20%.

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 NH Medicaid are responsible for timely and accurate billing. If 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 charge can be resubmitted.

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.

Except for claims for people not eligible for NH Medicaid, claims for service shall be submitted to the fiscal agent designated by the Department. Claim completion instructions for the CMS 1500 claim form are found in the Appendices.

Claims for Medicare-eligible NH Medicaid members shall be submitted to Medicare for all Medicare-covered services prior to submitting claims to NH Medicaid.

Claims for services necessary to determine the appropriateness of nursing home referral through the Preadmission Screening and Resident Review (PASARR) process, for people who are not eligible for NH Medicaid shall be submitted to the address shown in the General Billing Manual Appendices.

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 members whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above.

Diagnosis & Procedure Codes

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

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

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

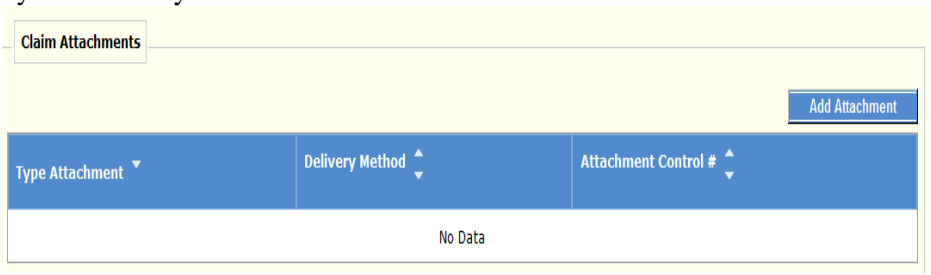
Service Authorizations (SAs)

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, the NH Medicaid Program 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.



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:**
  NH Medicaid 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 Community Mental Health Centers

Community Mental Health Centers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P. 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 or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent 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.

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

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.

Use of Modifiers

CMH claims billed to NH Medicaid as primary must be accompanied with the required modifiers. The following sequence of modifiers shall apply:

- HE shall always be in the first modifier position;
- HW shall always be in the first modifier position;
- U codes shall always be in the second modifier position; and
- All other modifiers will follow the HE or HW U1-U9 modifiers.

After waiver approval, CMHCs will be notified in writing by the BBH, and will be assigned a service authorization (SA). For these claims, modifier "UA" must be reported following the U1-U9 modifier.

CMS-1500 Claim Form Instructions

Item #	Description	Instructions
1		**Required**-Indicate NH Medicaid coverage by placing an X in the appropriate box. Only one box can be marked.
1A	Insured's ID Number	**Required** - Enter the NH Medicaid ID number (11 characters) shown on the ID card.
2	Patient's Name	**Required -** Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
3	Patient's Birth Date, Sex	**Required-**Enter the patient's 8-digit birth date (MM ǀ DD ǀ YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave blank.
4	Insured's Name	**Optional-** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
5	Patient's Address (Multiple Fields)	**Optional-** Enter the patient's permanent residence address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. A temporary address or school address should not be used.
6	Patient Relationship to Insured	**N/A**
7	Insured's Address (multiple fields)	**Situational -**Enter the insured's address. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.
8	Reserved for NUCC Use	**N/A-** This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.

Item #	Description	Instructions
9	Other Insured's Name	**Situational -**If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
9A	Other Insured's Policy or Group Number	**Situational** – The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9. This field allows for the entry of 28 characters, alpha or numeric
9B	Reserved for NUCC Use	**N/A** -This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.
9C.	Reserved for NUCC Use	**N/A** -This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.
9D	Insurance Plan Name or Program Name	**Required -** If other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code Codes can be located on the NH MMIS Health Enterprise Portal under documents section This field allows for the entry of 28 characters.
10A-C	Is Patient's Condition Related To?	**Required-**When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.
10D	Claim Codes (Designated by NUCC)	**N/A** -When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes.

Item #	Description	Instructions
11	Insured's Policy, Group or FECA Number	**Situational** - Enter the insured's policy or group number as it appears on the insured's NH Medicaid identification card. If Item Number 4 is completed, then this field should be completed.
11A	Insured's Date of Birth, Sex	**Optional -**Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.
11B	Other Claim ID (Designated by NUCC)	**N/A**
11C	Insurance Plan or Program Name	**N/A**
11D.	Is There Another Health Benefit Plan?	**Situational-** Enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.
12	Patient's or Authorized Person's Signature	**N/A**
13	Insured's or Authorized Person's Signature	**N/A**
14	Date of Current Illness, Injury, Pregnancy	**Situational –** Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line**.**

Item #	Description	Instructions
15	Other Date	**Situational-**Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) format. Enter the applicable qualifier to identify which date is being reported. 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines.
16	Dates Patient Unable to Work in Current Occupation	**Optional-**If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.
17	Name of Referring Provider or Other Source	**Situational –** Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Enter the applicable qualifier to identify which provider is being reported. DN Referring Provider DK Ordering Provider DQ Supervising Provider Enter the qualifier to the left of the vertical, dotted line**.**

Item #	Description	Instructions
17A.	Other ID #	**Situational –** The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.).
17B	NPI Number	**Situational –** Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b**.**
18	Hospitalization Dates Related to Current Services	**Optional -**Enter the inpatient 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization**.**
19	Additional Claim Information (Designated by NUCC)	**Situational-**Please refer to the most current instructions from the public or private payer regarding the use of this field. NH Medicaid-Used for providers to communicate information particular to this claim, not a duplicate or not covered by other insurance and why.
20	Outside Lab? $ Charges	**Optional -**Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim**.**

Item #	Description	Instructions
21	Diagnoses or Nature of Illness or Injury	**Required -** Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the l
22	Resubmission and/or Original Reference Number	**Optional-**List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field (e.g., code). When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. 7 Replacement of prior claim 8 Void/cancel of prior claim This Item Number is not intended for use for original claim submissions**.**
23	Prior Authorization Number (Service Authorization)	****Not being used at this time**** **Situational-** Enter any of the following: prior authorization number, as assigned by the payer for the current service. The "Prior Authorization Number" is the payer assigned number authorizing service(s)
24A	Date(s) of Service (lines 1–6)	**Required -** Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. The number of days must correspond to the number of units in 24G. Date(s) of Service" indicates the actual month, day, and year the service(s) was provided.

Item #	Description	Instructions
24A	Shaded Area Supplemental Information	**Situational-**Enter the National Drug Codes (NDC), for J, Q and S drug procedure codes. The NDC Qualifier N4 should be entered in the first two positions, then the 11 digit NDC code without dashes or spaces. The NDC units of measure qualifier and NDC drug quantity should follow. The following qualifiers are to be used when reporting NDC unit/basis of measurement: F2 International Unit ME Milligram UN Unit GR Gram ML Milliliter
24B	Place of Service lines(1–6)	**Required -** In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The "Place of Service" Code identifies the location where the service was rendered. The Place of Service Codes are available at: www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf.
24C	EMG (lines 1–6)	**N/A**
24D	Procedures, Services or Supplies (Lines 1-6)	**Required-**Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description.
24E	Diagnosis Pointer (Lines 1-6)	**Required** - In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. This field allows for the entry of 4 characters in the unshaded area

Item #	Description	Instructions
24F	$ Charges (Lines 1-6)	**Required -** Enter the charge for each listed service. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. "Charges" is the total billed amount for each service line**.**
24G	Days or Units (Lines 1-6)	**Required -** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers left justified in the field. No leading zeroes are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management"). "Days or Units" is the number of days corresponding to the dates entered in 24A

Item #	Description	Instructions
24H.	EPSDT/Family Plan (Lines 1-6)	**Situational-**For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only. If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is right justified in the shaded area of the field. The following codes for EPSDT are used in 5010A1: AV- Available – Not Used (Patient refused referral.) S2- Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) ST- New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) NU- Not Used (Used when no EPSDT patient referral was given.) If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field.

Item #	Description	Instructions
24I	ID Qualifier (Lines 1-6)	**Required-**Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.) The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24J.	Rendering Provider ID Number (Lines 1-6)	**Required-**The individual rendering the service should be reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care.
25	Federal Tax ID Number	**Optional-**Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. Do not enter hyphens with numbers. Enter numbers left justified in the field.

Item #	Description	Instructions
26	Patient's Account Number	**Optional-**Enter patient account number. Do not enter hyphens with numbers. Enter numbers left justified in the field.
27	Accept Assignment?	**Required-** Enter an X in the correct box. Only one box can be marked. Report "Accept Assignment?" for all payers. The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	**Required –** Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. The "Total Charge" is the total billed amount for all services entered in 24F (lines 1–6).
29	Amount Paid	**Required-** Enter total amount the patient and/or other payers paid on the covered services only. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. The "Amount Paid" is the payment received from the patient or other payers**.**
30	Reserved for NUCC Use	**N/A -**This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated**.**
31	Signature of Physician or Supplier Including Degrees or Credentials	**Required –** "Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1. Enter the legal signature of the practitioner or supplier, or signature stamp Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY) the form was signed. This date must be on or after the last date of service on the claim. The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title.

Item #	Description	Instructions
32	Service Facility Location Information	**Situational-**The name and address of facility where services were rendered identifies the site where service(s) were provided. Enter the name, address, city, state, and ZIP code of the location where the services were rendered. NH Medicaid utilizes this information to assist with the NPI crosswalk**.**
32A	NPI #	**Situational -**Enter the NPI number of the service facility location in 32a. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.
32B	Other ID#	**Optional-** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number LU Location Number The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

Item #	Description	Instructions
33	Billing Provider Info & Ph #	**Required –** Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP Code Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code, including the hyphen. Do not use a hyphen or space as a separator within the telephone number. 5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here. The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.
33A.	NPI#	**Required** - Enter the NPI number of the billing provider in 33A. Not required for Atypical providers.

Item #	Description	Instructions
33B	Other ID#	**Required –** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.) The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field. The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional**.**

12. Appendices

Appendix A

2013 Codes	Service Description	Mod	Mod	Mod	Mod	Mod	Mod	Mod	Medicare Covered
90791	Assessment including history, mental status and recommendations. May include communication with family, others and review and ordering of diagnostic studies.	HE	HW	U1	U2	U5	U6	U7	Yes
90792	With medical services and provided by a physician includes those in 90791 AND: medical assessment beyond mental status as appropriate. May include communication with family, others, prescription medications, and review and ordering of laboratory or other diagnostic studies.	HE	HW	U1	U2	U5	U6	U7	Yes
90832	Psychotherapy with patients and/or family 30 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
90833	30 minutes psychotherapy add on to EM same day provider	HE	HW	U1	U2	U5	U6	U7	Yes
90834	Psychotherapy with patients and/or family 45 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
90836	45 minutes psychotherapy add on to EM same day provider	HE	HW	U1	U2	U5	U6	U7	Yes
90837	Psychotherapy with patients and/or family 60 minutes psychotherapy	HE	HW	U1	U2	U5	U6	U7	Yes
90838	60 minutes psychotherapy add on to EM same day provider	HE	HW	U1	U2	U5	U6	U7	Yes
90839	Psychotherapy for Crisis 60 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
90840	30 additional Crisis minutes	HE	HW	U1	U2	U5	U6	U7	Yes
96372	Therapeutic, Prophylactic, or Diagnostic injection (specify substance or drug); Subcutaneous or Intramuscular)	HE	HW	U1	U2	U5	U6	U7	Yes
90846	Family Psychotherapy w/o client present	HE	HW	U1	U2	U5	U6	U7	Yes
90847	Family Psychotherapy with client present	HE	HW	U1	U2	U5	U6	U7	Yes
90853	Group Psychotherapy	HE	HW	U1	U2	U5	U6	U7	Yes
90889	Preparation of report of patients psychiatric status, history, treatment or progress for other physicians, agencies or insurance carriers	HE	HW	U1	U2	U5	U6	U7	Yes

2013 Codes	Service Description	Mod	Mod	Mod	Mod	Mod	Mod	Mod	Medicare Covered
96101	Psychological Testing per hour of the psychologist or physician's time face to face with the patient and time interpreting results and preparing the report	HE	HW	U1	U2	U5	U6	U7	Yes
96102	Psychological Testing with qualified health care professional interpretation & report by tech per hour technician time, face to face	HE	HW	U1	U2	U5	U6	U7	Yes
96103	Psychological testing administered by a computer, with qualified health care professional interpretation & report	HE	HW	U1	U2	U5	U6	U7	Yes
96116	Neuropsychological Testing	HE	HW	U1	U2	U5	U6	U7	Yes
96118	Neuropsychological Testing per hour of the psychologist or physician's time face to face with the patient and time interpreting results and preparing the report	HE	HW	U1	U2	U5	U6	U7	Yes
96119	Neuropsychological Testing with qualified health care professional interpretation & report by tech per hour technician time, face to face	HE	HW	U1	U2	U5	U6	U7	Yes
96120	Neuropsychological testing administered by a computer, with qualified health care professional interpretation & report	HE	HW	U1	U2	U5	U6	U7	Yes
99201	New Patient Office or Other outpatient visit - E&M 10 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99202	New Patient Office or Other outpatient visit - E&M 20 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99203	New Patient Office or Other outpatient visit - E&M 30 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99204	New Patient Office or Other outpatient visit - E&M 45 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99205	New Patient Office or Other outpatient visit - E&M 60 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99211	Evaluation and management of patient that may not require the presence of a physician, typically 5 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99212	Evaluation and management of patient, typically 10 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99213	Evaluation and management of patient, typically 15 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99214	Evaluation and management of patient, typically 25 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99215	Evaluation and management of patient, typically 40 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99218	Initial Observation care, per day E&M - low severity	HE	HW	U1	U2	U5	U6	U7	Yes

2013 Codes	Service Description	Mod	Mod	Mod	Mod	Mod	Mod	Mod	Medicare Covered
99219	Initial Observation care, per day E&M - moderate severity	HE	HW	U1	U2	U5	U6	U7	Yes
99220	Initial Observation care, per day E&M - high severity	HE	HW	U1	U2	U5	U6	U7	Yes
99221	Initial Hospital Care, per day, for E&M of a patient - 30 minutes with patient & on floor or unit	HE	HW	U1	U2	U5	U6	U7	Yes
99222	Initial Hospital Care, per day, for E&M of a patient - 50 minutes with patient & on floor or unit	HE	HW	U1	U2	U5	U6	U7	Yes
99223	Initial Hospital Care, per day, for E&M of a patient - 70 minutes with patient & on floor or unit	HE	HW	U1	U2	U5	U6	U7	Yes
99231	Subsequent hospital care, per day for E&M of a patient - 15 minutes with patient & on floor or unit	HE	HW	U1	U2	U5	U6	U7	Yes
99232	Subsequent hospital care, per day for E&M of a patient - 25 minutes with patient & on floor or unit	HE	HW	U1	U2	U5	U6	U7	Yes
99233	Subsequent hospital care, per day for E&M of a patient - 35 minutes with patient & on floor or unit	HE	HW	U1	U2	U5	U6	U7	Yes
99234	Observation or inpatient hospital care, E&M of a patient - low severity	HE	HW	U1	U2	U5	U6	U7	Yes
99235	Observation or inpatient hospital care, E&M of a patient - moderate severity	HE	HW	U1	U2	U5	U6	U7	Yes
99236	Observation or inpatient hospital care, E&M of a patient - high severity	HE	HW	U1	U2	U5	U6	U7	Yes
99238	Hospital Discharge Day Management 30 minutes or less	HE	HW	U1	U2	U5	U6	U7	Yes
99239	Hospital Discharge Day Management more than 30 minutes - unit based by 15 minute increment	HE	HW	U1	U2	U5	U6	U7	Yes
99281	ER visit for E&M of a patient - self-limited or minor severity	HE	HW	U1	U2	U5	U6	U7	Yes
99282	ER visit for E&M of a patient - low to moderate severity	HE	HW	U1	U2	U5	U6	U7	Yes
99283	ER visit for E&M of a patient - moderate severity	HE	HW	U1	U2	U5	U6	U7	Yes
99284	ER visit for E&M of a patient - high severity no immediate or significant threat to life or physiologic function	HE	HW	U1	U2	U5	U6	U7	Yes
99285	ER visit for E&M of a patient - high severity pose an immediate or significant threat to life or physiologic function	HE	HW	U1	U2	U5	U6	U7	Yes
99304	Initial Nursing Facility Care, per day Low severity 25 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99305	Initial Nursing Facility Care, per day Moderate severity 35 minutes	HE	HW	U1	U2	U5	U6	U7	Yes

2013 Codes	Service Description	Mod	Mod	Mod	Mod	Mod	Mod	Mod	Medicare Covered
99306	Initial Nursing Facility Care, per day High severity 45 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99307	Subsequent nursing facility care, per day E&M - patient is stable, recovering or improving (based on 10 minute E&M rate)	HE	HW	U1	U2	U5	U6	U7	Yes
99308	Subsequent nursing facility care, per day E&M - patient is responding inadequately to therapy or developed minor complication (based on 20 minute E&M rate)	HE	HW	U1	U2	U5	U6	U7	Yes
99309	Subsequent nursing facility care, per day E&M - patient developed significant complication or significant new problem (based on 30 minute E&M rate)	HE	HW	U1	U2	U5	U6	U7	Yes
99310	Subsequent nursing facility care, per day E&M - patient developed significant new problem requiring immediate physician attention (based on 45 minute E&M rate)	HE	HW	U1	U2	U5	U6	U7	Yes
99324	Domiciliary or rest home visit E&M new patient- low severity 20 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99325	Domiciliary or rest home visit E&M new patient- moderate severity 30 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99326	Domiciliary or rest home visit E&M new patient- moderate to high severity 45 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99327	Domiciliary or rest home visit E&M new patient- high severity 60 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99328	Domiciliary or rest home visit E&M new patient- patient is unstable & needs immediate physician attention - 75 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99334	Domiciliary or rest home visit E&M established patient self-limited to minor severity 15 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99335	Domiciliary or rest home visit E&M established patient-low to moderate severity 25 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99336	Domiciliary or rest home visit E&M established patient-moderate to high severity 40 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99337	Domiciliary or rest home visit E&M established patient-moderate to high severity may be unstable or new significant problem 60 minutes	HE	HW	U1	U2	U5	U6	U7	Yes
99341	Home visit for E&M of a new patient - 20 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99342	Home visit for E&M of a new patient - 30 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99343	Home visit for E&M of a new patient - 45 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99344	Home visit for E&M of a new patient - 60 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes

2013 Codes	Service Description	Mod	Mod	Mod	Mod	Mod	Mod	Mod	Medicare Covered
99345	Home visit for E&M of a new patient - 75 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99347	Home visit for E&M of an established patient - 15 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99348	Home visit for E&M of an established patient - 25 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99349	Home visit for E&M of an established patient - 40 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
99350	Home visit for E&M of an established patient - 60 minutes face to face	HE	HW	U1	U2	U5	U6	U7	Yes
H0034	Medication Training and Support per 15 minutes (IROS/FSS)		HW	U1	U2	U5	U6	U7	No
H0035	Mental Health Partial Hospitalization Treatment Less Than 24 Hours - IPH 1/2		HW	U1	U2	U5	U6	U7	yes
H2001	RPH Half Day		HW	U1	U2	U5	U6	U7	No
H2010	Comprehensive Medication Service	HE	HW	U1	U2	U5	U6	U7	No
H2011	Emergency Visit	HE	HW	U1	U2	U5	U6	U7	No
H2015	Comprehensive Community Support Services per 15 minutes (consolidated FSS)		HW	U1	U2	U5	U6	U7	No
H2018	RPH Full Day		HW	U1	U2	U5	U6	U7	No
H2019	Therapeutic Behavioral service per 15 minutes (IROS/FSS)		HW	U1	U2	U5	U6	U7	No
H2019-HQ	Therapeutic Behavioral service per 15 minutes (IROS/FSS)-Group	HQ	HW	U1	U2	U5	U6	U7	No
H2020	Therapeutic Behavioral service per diem (IROS/FSS)		HW	U1	U2	U5	U6	U7	No
H2023	Supported Employment		HW	U1	U2	U5	U6	U7	No
H2027	Psychoeducation (IMR) per 15 minutes		HW	U1	U2	U5	U6	U7	No
H2027	Psychoeducation (IMR) per 15 minutes-Group	HQ	HW	U1	U2	U5	U6	U7	No
M0064	Brief Office Visit	HE	HW	U1	U2	U5	U6	U7	Yes
S0201	IPH Full Day		HW	U1	U2	U5	U6	U7	Yes
S9484	Crisis intervention mental health service (IROS/FSS)		HW	U1	U2	U5	U6	U7	No
S9485	Crisis Care APRTP, Per Diem		HW	U1	U2	U5	U6	U7	No
S9982	Copy Medical Records	HE	HW	U1	U2	U5	U6	U7	No
T1001	Nursing Assessment	HE	HW	U1	U2	U5	U6	U7	No
T1016	Case Management		HW	U1	U2	U5	U6	U7	No
T1023	Psychiatric Exam for NH Medicaid Eligibility	HE	HW	U1	U2	U5	U6	U7	No
T1027	Family Training and counseling (IROS/FSS)		HW	U1	U2	U5	U6	U7	No