

Division for Children, Youth & Families (DCYF)

Provider Manual
Volume II

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New Hampshire
Medicaid



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1. NH Medicaid Provider Billing Manuals Overview

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

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

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to 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 Communications staff of Xerox, the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between Xerox and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

Notifications & Updates

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

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

Description of Change Log

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

Contacts for Billing Manual Inquiries

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

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

2. Provider Participation & Ongoing Responsibilities

To be eligible to provide residential, community-based, or individual service option foster care services to Division for Children, Youth and Families (DCYF) clients, a provider must first be certified for payment pursuant to He-C 6339, He-C 6350, or He-C 6355, and then be enrolled as a NH Medicaid provider agency. Once DCYF certification has been completed, DCYF staff will notify the provider to submit their application online to the NH Medicaid fiscal agent.

Provider participation and ongoing responsibilities specific to provider types 83 (Private Non-Medical Institutions) and 85 (Community-Based In-Home Services and Individual Service Option (ISO) Foster Care Program) are included in this section.

Private Non-Medical Institutions (PNMI) Residential Child-Care Services - Provider Type 83:

To be eligible to provide residential child care services to DCYF clients a residential child care facility shall:

- Be licensed in NH in accordance with RSA 170-E or RSA 151, or from another state, and be certified for payment pursuant to He-C 6350, Certification for Payment Standards for Residential Facilities;
- Be an enrolled NH Medicaid provider agency;
- Be in compliance with He-C 6420, Medicaid Covered Services;
- Employ or contract with a prescribing practitioner who demonstrates approval of the NH Medicaid covered services by signing the child and family's treatment plan; and
- Accept NH Medicaid payment as payment in full.

A review of continued certification compliance shall occur every year from date of issue pursuant to He-C 6350. Continuance of certification shall be based on a review and verification of the provider's compliance with He-C 6350.

Community-Based In-Home Services – Provider Type 85

Community-Based In-Home services include:

- Child Health Support services
- Home-Based Therapeutic services
- Therapeutic Day Treatment services
- Adolescent Community Therapeutic services
- Individual Service Option (ISO) – In-Home services

To be eligible to provide community-based in-home services to DCYF clients a provider shall:

- Be certified for payment pursuant to He-C 6339, Certification for Payment Standards for Community-Based In-Home Service Providers: Child Health Support, Home-Based Therapeutic, Therapeutic Day Treatment, Adolescent Community Therapeutic Services and Individual Service Options In-Home;
- Be an enrolled NH Medicaid provider agency;
- Employ or contract with a prescribing practitioner who demonstrates approval of the NH Medicaid covered services by signing the child and family's treatment plan; and
- Accept NH Medicaid payments as payment in full.

A review of continued certification compliance shall occur every three years from date of issue. Continuance of certification shall be based on a review and verification of the provider's compliance with He-C 6339.

Foster Care Home - Individual Service Option – Provider Type 85

To be eligible to provide individual service option- foster care to DCYF clients, a provider shall:

- Be licensed in accordance with RSA 170-E and be certified for payment pursuant to He-C 6355, Certification for Payment of Foster Care Programs;
- Be in compliance with He-C 6446, Foster Family Care Licensing
- Be in compliance with He-C 6448, Standards for Child Placing Agencies;
- Be in compliance with He-C 6420, Medicaid Covered Services;
- Be an enrolled NH Medicaid provider agency;
- Employ or contract with a prescribing practitioner who demonstrates approval of the NH Medicaid covered services by signing the child and family's treatment plan;
- Accept NH Medicaid payment as payment in full; and
- Be in compliance with RSA-E:25, IV or He-C 4001, New Hampshire Residential Child Care Licensing rules; or
- Have a current license to operate a residential facility or child placement agency in New Hampshire or any other state.

A review of continued certification compliance shall occur every two years from date of issue pursuant to He-C 6355. Continuance of certification shall be based on a review and verification of the provider's compliance with He-C 6355.

Quality Assurance Activities & Monitoring of DCYF Service Providers

The provider shall participate in quality assurance activities conducted by DCYF using a variety of activities that may include a combination of record reviews, performance data measurements and visits to providers pursuant to He-C 6339, He-C 6350 or He-C 6355.

3. Covered Services & Requirements

DCYF service providers shall comply with the service requirements pursuant to the applicable Certification for Payment Rule, as follows:

He-C 6350 - Certification For Payment Standards For Residential Facilities

- Private Non- Medical Institution (PNMI)

He-C 6339 - Certification For Payment Standards For Community-Based In-Home Providers

- Requirements for Child Health Support Services;
- Requirements for Home-Based Therapeutic Services;
- Requirements for Therapeutic Day Treatment Services;
- Requirements for Adolescent Community Therapeutic Services; and
- Requirements for Individual Service Options (ISO In-Home) Services.

He-C 6355 - Certification For Payment Of Foster Care Programs

- Individual Service Options (ISO Foster Care)

Rule Reference	DCYF Service	Provider Type	Procedure Code	Billing Unit	Procedure Code Description	Short Description
He-C 6339	Adolescent Community Therapeutic	85	H2022	Day	Community wrap around services	Community Wrap Around Services
He-C 6339	Child Health Support	85	T1027	Quarter Hour	Training and counseling for child development, per 15 minutes	Family Counseling
He-C 6339	Home Based Therapeutic	85	99341	Day	Home visit- new patient level 1	Level 1 Home Visit
He-C 6339	ISO, In-home	85	H0040	Day	Assertive community treatment program, per diem	In Home Treatment
He-C 6355	ISO, Out of Home, Agency Specific	85	H0043	Day	Supported housing, per diem	Supported Housing
He-C 6355	ISO, Out of Home, Child Specific	85	H0018	Day	Behavioral health short term residential (non hospital residential treatment program) without room and board, per diem	PNMI
	Out of Home One on One Aid	85	T1025	Hour	Intensive extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per diem	Intensive Extended Service
He-C 6350	Private Non-Medical	83	H0019	Day	Behavioral health long-term residential (non-medical, non-acute care in a residential treatment	PNMI Daily Rate

Rule Reference	DCYF Service	Provider Type	Procedure Code	Billing Unit	Procedure Code Description	Short Description
	Institution (PNMI)				program where stay is typically longer than 30 days) without room and board, per diem	
He-C 6339	Therapeutic Day Treatment	85	T1020	Day	Personal care services, per diem, not for inpatient or resident of a hospital; nursing facility, ICF/MR or IMD, part of the individualized plan of treatment	Personal Care Per Diem

Modifiers
HU= Child Protection, H9 = Court Ordered
HY = Juvenile Justice, H9 =Court Ordered

Service Limits

Service limits are set forth in He-C 6339, He-C 6350 and He-C 6355.

Coverage for Services in Excess of the Service Limits Based on Medical Necessity for EPSDT members (Under Age 21) is not applicable.

Service Limit Overrides for Age 21 & Older is also not applicable.

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, the member will be responsible for payment. If this occurs, the Department recommends that the provider maintain in their files a statement signed and dated by the member that indicates that the member understands that the service is non-covered and that s/he agrees to pay for this service.

Non-covered services for residential child care facilities (Provider Type 83) are pursuant to He-C 6420, Medicaid Covered Services.

Coverage for Services Based on Medical Necessity (including services in excess of the service limits) for EPSDT members (Under Age 21) is not applicable.

Service Limit Overrides for Age 21 & Older is also not applicable.

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 or by a service authorization agent under contract with the Department. Because the service authorization agent can vary depending on the type of service provided, the contact information in the Appendices should be consulted for the name and method of contact.

A Service Authorization must be obtained from the responsible DCYF Child Protection Social Worker (CPSW) or Juvenile Probation and Parole Officer (JPPO) and, when required by policy, approved by the CPSW or JPPO supervisor for all DCYF related services. The service authorization is for the specific service requested and must be obtained **before** the delivery of service.

For routine service authorizations at Provider Specific rates:

- The responsible DCYF CPSW or JPPO will determine the effective start/stop dates and number of units for the requested service. This information will be forwarded to the DCYF Fiscal Specialist.
- The DCYF Fiscal Specialist will enter the service authorization into NH Bridges. A DCYF Supervisor will approve the service authorization in NH Bridges when required by policy. Service authorization information entered into NH Bridges will be transferred to the NH MMIS on a nightly basis. The NH MMIS will assign a service authorization number and transfer this information back to NH Bridges the following day.
- A copy of the service authorization will be generated by the NH MMIS and mailed by the NH Medicaid fiscal agent to the provider within 24 hours. Providers that bill NH Medicaid electronically will be able to access the service authorization on the NH MMIS and will not be mailed a paper copy of the service authorization.

For service authorization at Child Specific Rates (T1025: One-on-One Aide Out-of-Home and H0018: ISO Out-of-Home, Child Specific Rate):

- The responsible DCYF CPSW or JPPO will request authorization for these two services at child specific rates by submitting a treatment plan and budget to the appropriate DCYF Administrator.
- The DCYF Administrator will approve the service at a child specific rate, and approve the effective start/stop dates and number of units for the service authorization.
- The DCYF Administrator will forward the request for service authorization to the Provider Relations Supervisor for entry into NH Bridges. The child specific rate is included on the service authorization entered into NH Bridges and will be transferred to the NH MMIS on a nightly basis. The NH MMIS will assign a service authorization number and transfer this information back to NH Bridges the following day.
- A copy of the service authorization will be generated by the NH MMIS and mailed by the NH Medicaid fiscal agent to the provider within 24 hours. Providers that bill NH Medicaid

electronically will be able to access the service authorization on the NH MMIS and will not be mailed a paper copy of the service authorization.

6. Documentation

DCYF service(s) 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.

Also refer to additional documentation requirements pursuant to He-C 6339, 6350 and 6355.

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.

8. Adverse Actions

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

Denial of Application and Revocation of Provider Certification

An application shall be denied if a provider voluntarily surrenders certification or there has been a revocation of certification.

Notification of Denial or Revocation

If DCYF denies an application or revokes certification, a letter shall be sent to the applicant or provider by registered mail, which sets forth the reasons for the determination.

Request for Certification Reconsideration

A request for certification shall be made pursuant to He-C 6339, He-C 6350 or He-C 6355.

Appeals

Applicants or providers who wish to appeal a decision to deny an application, or to revoke or suspend a certification shall file an appeal with the Commissioner of the Department of Health and Human Services, pursuant to RSA 170-G:4-a and He-C 6339, He-C 6350 or He-C 6355.

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 Xerox in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume 1. Providers who receive payment in full from a third party are not required to file zero-payment claims with 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 the 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.

10. Payment Policies

Reimbursement is based on rates established by DCYF. Providers rendering service to Medicaid eligible members must agree to accept the payment made by NH Medicaid as payment in full and make no additional charge to the member or their parent/guardian.

Providers shall submit bills at least on a monthly basis as identified in He-C 6339. Claims can be submitted either by electronic submission or by completion of a CMS 1500 form mailed to the NH Medicaid fiscal agent. All claims shall be submitted within one year of the date of provision of service or they will be denied pursuant to RSA 126 A: 3.

Questions related to billing can be directed to the Xerox Provider Relations Unit as detailed the General Billing Manual – Volume I.

Usual and Customary

Reimbursement for services provided is based on fees or rates established by the Department's DCYF. The maximum reimbursement for services rendered will not exceed, and no provider shall bill or charge the Department more than, the provider's usual and customary charges (see RSA 126-A:3, III(a) (i.e., the rates charged by the provider for non-DCYF children). Reimbursement will be at the rates established by DCYF or the provider's usual and customary charge, whichever is lower.

Date Span Billing

Home Based Therapeutic, Therapeutic Day Treatment, Adolescent Community Therapeutic, and ISO In-Home services have a maximum unit of one per day. Providers can bill for a date span as long as the number of days from the first date of service to the last date of service match the number of units billed.

Child Health Support services do not have a maximum number of units per service date. Providers can bill for a date span or bill individual dates of service as long as the total number of units billed does not exceed the number of units approved on the service authorization.

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 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.

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.

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

ICD-9-CM diagnosis codes are required for all services billed on medical claims forms (CMS-1500). 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.

Type Attachment	Delivery Method	Attachment Control #
No Data		

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

- Please mail claim attachments to:**
 Xerox Claims Unit
 PO Box 2003
 Concord, NH 03302
- Please fax claim attachments to:**
 (888) 495-8169

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

Claim Completions Requirements for DCYF Providers

DCYF providers 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 ink on ALL claims or adjustment that you submit to Xerox. The Xerox imaging/OCR system reads blue and black ink.
7. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
8. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

Paper claims and other documents can be mailed to:

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

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

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

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

The format is: YYDDD M BBBB NNNNNN T, where

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

- BBBB is the batch number.
- NNNNNN is the document number.
- T is the transaction type.

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

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

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

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

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

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

CMS-1500 Claim Form Instructions

Item #	Description	Instructions
1		Check Medicaid
1a.	Insured's ID Number	Required - Enter the NH Title XIX ID number (11 characters) shown on the ID card.
2	Patient's Name	Required - Enter the last name, first name, and middle initial as shown on the ID card.
3	Patient's Birth Date (8 digits), Sex	Required Must be valid date mm/dd/ccyy
4	Insured's Name	Last Name, First Name, MI
5	Patient's Address (Multiple Fields) Member's mailing address	City, State, Zip Code
6	Patient Relationship to Insured	N/A
7	Insured's Address	If selected, city, state, zip code, and telephone. If not selected default to "self".
8	Patient Status	N/A
9	Other Insured's Name	When additional group health coverage exists, enter other insured's full name if it is different from that shown in Item Number 2. Last Name, First Name, MI If Item # 11d is marked, complete fields #9 and #9a-d, otherwise leave blank.
9a.	Other Insured's Policy or Group Number	Situational - provide policy number if applicable. Must be 12 or less alpha-numeric characters.
9b.	Other Insured's Date of	N/A

Item #	Description	Instructions
	Birth	
9 c.	Employer's Name or School Name	N/A
9 d.	Insurance Plan Name or Program Name	Required ~ if other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code Codes can located on the NH MMIS Health Enterprise Portal under documents section
10 a-c	Is Patient's Condition Related To?	Required Enter an X in the correct box to indicate whether one or more of the services described in Item # 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Mark <u>one</u> box only on each line.
10 d.	Reserved for Local Use	
11	Insured's Policy, Group or FECA Number	Situational ~ Enter the insured's policy or group number as it appears on the insured's health care identification card.
11 a.	Insured's Date of Birth (8 digits)	Must be valid date mmddccyy
11 b.	Insured's Employer's Name or School Number The name of the insured's employer or school.	N/A
11 c.	Insurance Plan or Program Name	N/A
11 d.	Is There Another Health Benefit Plan?	Enter an X in the correct box. If marked "YES," complete #9 and # 9a-d and list denial in #19 or payment in #29. Mark <u>one</u> box only.
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,	Situational – Enter if "YES" is present in Item #10

Item #	Description	Instructions
	Injury, Pregnancy	Must be a valid format mmddccyy
15	If Patient Has Had Same or Similar Illness	Date format mm/dd/ccyy
16	Dates Patient Unable to Work in Current Occupation	Date format mm/dd/ccyy
17	Name of Referring Provider	Required – when billing radiology, Lab , DME Last name, First Name, and MI If multiple providers are involved, enter one provider using the priority order: #\1. Referring Provider, 2. Ordering Provider, 3. Supervising Provider
17 a.	Other ID Number (2 digits)	Use two digit qualifier ZZ and the appropriate Taxonomy Code. Enter up to 9 characters.
17 b.	NPI Number	Enter the NPI number of the referring, ordering, or supervising provider. Entry must be 10 numeric digits.
18	Hospitalization Dates Related to Current Service	Optional Date format mmddccyy
19	Reserved for Local Use	
20	Outside Lab? \$ Charges	“Y” or “N” or Blank. Amount must be between 0 and 999999.
21	Diagnoses or Nature of Illness or Injury	Required – Relate Items #1, #2, #3 or #4 to #24E by line Enter the patient’s diagnosis/condition. List up to four ICD-9-CM diagnosis codes. Do <u>not</u> provide narrative description in this field. Must be a valid diagnosis.
22	Medicaid Resubmission Code	List the original Transaction Control Number (TCN) for resubmitted claims.
23	Service Authorization Number (12 characters)	Required - if applicable enter Service Authorization Number. Must be 12 characters **Not being used at this time**

24 a.	Date(s) of Service (Lines 1-6)	Required - Enter dates of service, from and to. If one date of service only, enter that date under "from." Leave "to" blank or re-enter "from" date. Date format: mmddccyy If services are grouped on the same line they must have the same place of service, procedure code, charge and individual provider. The number of days must correspond to the number of units in #24G.
24 a.	Shaded Area	Required if Applicable-Enter the NDC code, if required, N4, the NDC qualifier should be entered in the first two positions, then the NDC. The NDC units of measure qualifier and NDC quantity should follow:
24 b.	Place of Service (Lines 1-6)	Required - Enter the two-digit code for each item or service. VV Must be numeric characters
24 c.	EMG (Lines 1-6)	N/A
24 d.	Procedures, Services or Supplies (Lines 1-6)	Required - Enter CPT/HCPCS and modifier(s) if applicable. This field accommodates the entry of up to four two-digit modifiers.
24 e.	Diagnosis Pointer (Lines 1-6) The diagnosis code reference number (pointer) as shown in Item 21 to relate the date of service and the procedures performed for the primary diagnosis.	Required ICD-9-CM diagnosis codes must be entered in Item #21 <u>only</u> . Do <u>not</u> enter them in #24E. When multiple services are performed, the primary diagnosis pointer for each service should be listed first, other applicable pointers should follow. The diagnosis pointers(s) should be #1, or #2, or #3, or #4; or multiple numbers. Enter numbers left justified in the field. Do <u>not</u> use commas between the numbers.
24 f.	\$ Charges (Lines 1-6)	Required -Enter the total billed amount for each service. Do <u>not</u> use commas or dollar signs. Negative dollar amounts are <u>not</u> allowed.
24 g.	Days or Units (Lines 1-6)	Required - Enter the number of days or units. If only one service is performed, enter #1.

24 h.	EPSDT/Family Plan (Lines 1-6)	Must be "AV", "ST", "S2", "NU", "Y", "N" or Blank
24 i.	ID Qualifier (Lines 1-6)	<p>Required</p> <p>The Rendering Provider is the provider who rendered or supervised the care.</p> <p>Report the Identification Number in Items #24I and #24J only when different from data recorded in Items #33a and #33b.</p> <p>In the shaded area of #24I, enter the qualifier identifying if the number is a non-NPI.</p> <p>Providers can bill with ZZ for taxonomy (with NPI) or a Medicaid ID qualifier. Must be 2 characters long.</p>
24 j.	Rendering Provider ID Number (Lines 1-6)	If provider has NPI please indicate in the unshaded area. If the provider cannot be assigned an NPI(atypical provider) the Medicaid ID number should be entered in the shaded portion of the field
25	Federal Tax ID Number	Must be 9 characters or less.
26	Patient's Account Number	<p>Required</p> <p>Enter patient account number</p>
27	Accept Assignment	Only one box may be checked.
28	Total Charge Total charges for the services (i.e., total of all charges in 24F)	<p>Required – Enter total charges for the services (i.e., total of all charges in #24F)</p> <p>Must be 9 digits or less.</p>
29	Amount Paid	Total amount the patient or other payers paid on the covered services only. TPL Only. Must be 9 digits or less
30	Balance Due	Required – Enter total amount due (subtract Amount Paid Item #29 from Total Charge Item #28. Must be 9 digits or less.
31	Signature of Physician	Required – legal signature of provider or provider's authorized representative. Include date. Must be an

	or Supplier Including Degrees or Credentials	actual signature or signature stamp or signature on file. Date format mm/dd/ccyy
32	Service Facility Location Information	Required if applicable - if different than Box #33.
32 a.	NPI Number	Must be 10 characters long, numeric only.
32 b.	Other ID Number	N/A
33	Billing Provider Info & Phone Number	Required – Enter the provider's or supplier's billing name, address, zip code and phone number.
33 a.	NPI Number	Required – except for Atypical providers. Must be 10 numeric digits.
33 b.	Other ID Number	Required – the two-digit qualifier identifying the non-NPI number followed by the ID number.

12. Terminology

Child Protection Service Worker (CPSW): means an employee of the Division for Children, Youth and Families who has expertise in managing cases to ensure families and children achieve safety, permanency and well-being.

Juvenile Probation and Parole Officer (JPPO): means an employee of DJJS who discharges the powers and duties established by RSA 170-G:16, and supervises paroled delinquents pursuant to RSA 170-H.