

# NURSING FACILITIES AND SWING BED HOSPITALS\*

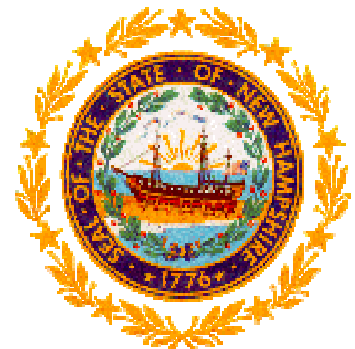
Provider Manual  
Volume II

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\*Swing Bed Hospitals should also reference the Hospital Billing Manual for information regarding payment and claim submittals

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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, 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 the Department and/or its associated organizations. The change log is located at the front of this document.

## Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the Xerox Provider Relations Unit. See the Appendix for specific 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

All Nursing Facilities (NF's) and all hospitals containing swing beds shall be licensed pursuant to RSA 151, be enrolled as New Hampshire Medicaid Program providers, and be certified by Medicare as a nursing facility. Hospitals that provide post hospital skilled nursing care, also known as swing bed services, shall be licensed pursuant to RSA 151, and be certified to provide skilled nursing facility care under 42 CFR 482.66 or, if the hospital is designated as a Critical Access Hospital, under 42 CFR 485.645.

Before or upon admission of a Medicaid applicant/member to a nursing facility, and before Medicaid payment can be authorized, the nursing facility shall obtain a physician's order for admission in accordance with 42 CFR 440.40, and a clinical approval for care in accordance with He-E 802.

All nursing facility providers must establish the following:

1. Plans of care in accordance with He-E 802.12;
2. Temporary Absence policy in accordance with He-E 802.15; and
3. Annual Cost Reporting in accordance with He-E 806.02.

A nursing facility shall inform the Bureau of Elderly and Adult Services (BEAS) via a "Change of Status/Transfer/Discharge Form", incorporated by reference in He-E 802.18(a), of any change in the resident's status, including:

- (1) Death of the resident;
- (2) Transfer to a different facility; and
- (3) Transition to a community setting.

The "Change of Status" form in (b) above shall include the source of facility reimbursement and be submitted within 5 business days of the change, except that a transition to a community setting, either home care or residential care, shall require notification no later than 14 days prior to the discharge date from the facility. The change of status form is available on E-Studio.

E-Studio is an on-line system that allows the secure exchange of data between DHHS and approved external parties.

### 3. Covered Services & Requirements

Nursing facility services shall be covered to the extent that they are required in each resident's care plan, pursuant to 42 CFR 483 and in accordance with He-E 802 and He-E 806, and are described below.

Pursuant to 42 CFR 483, the following services shall be covered nursing facility services:

- (1) Nursing services in accordance with 42 CFR 483.30, including:
  - a. Services provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care; and
  - b. Services provided on a 24-hour basis in accordance with resident care plans;
- (2) Dietary services in accordance with 42 CFR 483.35, including:
  - a. Providing each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident;
  - b. Employing a qualified dietician either full-time, part-time, or on a consultant basis; and
  - c. Providing therapeutic diets, as prescribed by the attending physician;
- (3) Activities program services in accordance with 42 CFR 483.15(f), including an ongoing program of activities directed by a qualified professional and designed to meet, in accordance with the residents' assessments, the interests and the physical, mental, and psychosocial well-being of each resident;
- (4) Medically related social services, in accordance with 42 CFR 483.15(g), including:
  - a. Services provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; and
  - b. Employing a qualified social worker if the facility has more than 120 beds;
- (5) A non-private room;
- (6) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry;
- (7) Specialized medical services in accordance with 42 CFR 483.45, including, but not limited to, physical therapy, speech-language pathology, occupational therapy, inhalation therapy including oxygen, laboratory, radiology, mental health services, and those ancillary services listed in He-E 806.06, and provided by the facility or obtained by the facility from a qualified outside provider;

- (8) NH Medicaid-eligible residents of a nursing facility shall receive routine and emergency dental services as part of the care provided by the nursing facility to the same extent as those NH Medicaid dental services are covered under the Title XIX State Plan for recipients who are not in a nursing facility. This means that dental services are to be provided by the nursing facility or at its expense for comprehensive dental services for NH Medicaid eligible children from birth to age 21, and for dental treatment for acute pain and infection for adults over the age of 21 years. Payment to the dental provider will be made by the nursing facility for NH Medicaid covered services. NH Medicaid covered dental services are the financial responsibility of the nursing facility and not the resident. Services include assistance with making dental appointments, arranging for transportation to and from the dentist's office and prompt referrals to a dentist for lost or damaged dentures;
- (9) Pharmacy services in accordance with 42 CFR 483.60, including:
- a. Following procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident;
  - b. Medical supplies, pharmaceutical items, and non-legend drugs, that is, drugs prescribed by a licensed practitioner that are normally purchased over the counter, which are stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities to meet the needs of each resident; and
  - c. Pharmacy service consultation of a licensed pharmacist;
- (10) Physician services in accordance with 42 CFR 483.40; and
- (11) Specialized services in accordance with 42 CFR 483.120 for residents with an intellectual disability or mental illness.

### **Atypical Services**

The following shall be covered in an atypical non-behavioral long-term care unit:

- (1) Coma management services;
- (2) Cognitive rehabilitation service shall be available and continue for as long as progressive, significant and measurable improvement is documented by the nursing facility and verified by the bureau in accordance with He-E 802.07;
- (3) Care, treatment and management of residents who are ventilator-dependent;
- (4) Care, treatment and management of residents who require nursing intervention to provide enteral nutrition services; and
- (5) Care, treatment and management of residents who require nursing interventions of a highly specialized nature.

An atypical behavioral long-term care unit shall provide extensive specialized care in behavioral approaches which meet the needs addressed in the resident's behavior modification plan.

## 4. Non-Covered Services

Pursuant to 42 CFR 483.10(i)(f), the following items and services shall not be covered:

- (1) Telephone;
- (2) Television/radio for personal use;
- (3) Personal comfort items, including smoking materials, notions and novelties, and confections;
- (4) Cosmetic and grooming items and services in excess of those covered under He-E 802.08(a)(6);
- (5) Personal clothing;
- (6) Personal reading matter;
- (7) Gifts purchased on behalf of a resident;
- (8) Flowers and plants;
- (9) Social events and entertainment offered outside the scope of the activities program, provided under He-E 802.08(a)(3);
- (10) Non-covered special care services such as privately hired nurses or aides;
- (11) Private room, except when therapeutically required, for example, isolation for infection control;
- (12) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by He-E 802.08(a)(2); and
- (13) Barber and beauty services.

## 5. Service Authorizations and Utilization Review

### **Service Authorizations (SA)**

Nursing facility services must be authorized by BEAS. NFs are notified by a “Letter 100,” sent by the Division of Client Services, when an applicant has been approved for long-term NF services. NFs and hospitals are notified through E-Studio by BEAS when an applicant has been approved for a short term skilled stay, an atypical stay or for care in a swing bed.

Only BEAS shall change the period of authorization for care and/or the authorized level of care.

Providers shall verify the following before providing a service.

- The member is eligible on the date(s) of service;
- The performing and billing NH Medicaid providers are actively enrolled providers on the date(s) of service; and
- The procedure code(s) and billing modifier(s) are active codes and valid combinations for billing under NH Medicaid.

### **Utilization Review (UR):**

BEAS conducts utilization reviews for continued placement for short term skilled nursing care, rehabilitative services, atypical services and for services in a swing-bed.

(a) For individuals approved to receive short-term skilled nursing care or rehabilitative services, the following shall apply:

- (1) The initial authorization shall be for up to 30 days;
- (2) The individual shall be eligible for up to 2 additional 30-day authorization periods, based on a utilization review conducted by the Bureau;
- (3) The facility shall have submitted to the Bureau a completed “Utilization Review Form,” incorporated by reference in He-E 802.18(b), and any supporting documentation, no later than 14 days prior to the end of the current authorization period; and
- (4) The Bureau shall determine continued placement authorization if, based on the documentation in item (3) above, the eligibility criteria in He-E 802.04(b) are met.

(b) For individuals approved to receive atypical non-behavioral long-term care services, the following shall apply:

- (1) The initial authorization shall be for one year;
- (2) The individual shall be eligible for additional one-year authorization periods, based on a utilization review conducted by the Bureau;
- (3) The facility shall submit to the Bureau a completed assessment pursuant to He-E 802.05(a)(1)b. and any supporting documentation no later than 14 days prior to the end of the current authorization period; and
- (4) The Bureau shall determine continued placement authorization if, based on the documentation in item (3) above, the eligibility criteria in He-E 802.04(c) are met.

(c) For individuals approved to receive atypical behavioral long-term care services, the following shall apply:

- (1) The initial authorization shall be for 6 months;
- (2) The individual shall be eligible for an additional 6-month authorization period for a total of one year, after which additional authorization periods shall be for one year, based on a utilization review conducted by the Bureau;
- (3) The facility shall have submitted to the Bureau, no later than 14 days prior to the end of the current authorization period, a completed “Utilization Review Form”, incorporated by reference in He-E 802.18(b), and the following supporting documentation:
  - a. A psychological evaluation;
  - b. A behavioral plan;
  - c. The Bureau’s “Memory and Behavior Checklist,” incorporated by reference in He-E 802.18(c); and
  - d. A behavior summary which:
    1. Includes the same information as the Bureau’s “Behavior Summary Report,” incorporated by reference in He-E 802.18(d); and
    2. Describes the recommended transition plan from the behavioral unit;
- (4) The supporting documentation in item (3) above shall have been completed no earlier than 30 days prior to its submission;
- (5) After one year, in addition to the documentation in (3) above, the facility shall also submit to the Bureau a completed assessment pursuant to He-E 802.05(a)(1)b.; and
- (6) The Bureau shall determine continued placement authorization if, based on the documentation in items (3)-(5) above, the eligibility criteria in He-E 802.04(d) are met.

(d) For individuals authorized for placement in a swing bed, the following shall apply:

- (1) For residents with a temporary placement, the requirements in (b) above shall apply; and
- (2) For residents with a pending placement, the following shall apply:
  - a. The initial authorization shall be for 30 days;
  - b. The individual shall be eligible for additional 30-day authorization periods, based on a utilization review conducted by the Bureau;
  - c. The facility shall have submitted to the Bureau a completed “Utilization Review Form,” incorporated by reference in He-E 802.18(b), and any supporting documentation no later than 14 days prior to the end of the current authorization period unless otherwise directed; and
  - d. The Bureau shall determine continued placement authorization if, based on the documentation in c. above, the eligibility criteria in He-E 802.04(e) are met.

If the facility fails to submit timely utilization review documentation and supporting documentation in accordance with this section, the authorization for services and the payment for services provided shall end.

When, as a result of utilization review, the medical condition of a resident in a specific placement no longer meets the criteria specified in He-E 802.04 for the specific placement, a notice of the determination and the right to request an appeal shall be sent to the resident and the nursing facility, pursuant to He-E 802.05(h).

If BEAS approves a continued stay, BEAS sends a Notice of Eligibility to the facility.

## 6. Documentation

Nursing facility providers shall maintain complete and timely records for each member receiving services and 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 general 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 resolution of any legal action(s) commenced in the six year period, whichever is longer.

A NF provider shall maintain accurate financial and statistical records, which substantiate the cost reports, for a period of 6 years in accordance with He-E 806.03.

The records of the NF provider shall include, but not be limited to, information regarding:

- Provider ownership, organization, operation, fiscal and other record keeping systems;
- Federal and state income tax information related to the operation of the facility;
- Asset acquisition, lease, sale or other action;
- Franchise or management arrangement;
- Patient service charge schedule;
- Information regarding cost of operation and amounts of income received; and
- Flow of funds and working capital.

Additional documentation required of nursing facility providers is described below.

### Plan of Care:

Nursing Facility providers shall establish a Plan of Care for each resident, as required by He-E 802.12.

(a) The facility shall write a plan of care for each resident upon admission, which shall be part of the facility’s permanent resident record.

(b) The plan of care shall be updated at least every 90 days by the physician and other personnel involved in the care of the resident.

(c) The facility shall include the following information in the resident’s plan of care:

- (1) The resident’s:
  - a. Full name;
  - b. Address;
  - c. Gender;
  - d. Date of birth;
  - e. Identification number;
  - f. Admission date; and

- g. Any other pertinent identifying information;
- (2) Diagnosis, symptoms, complaints and complications indicating the need for admission or continuing care;
- (3) The resident's life history, significant relationships and personal preferences;
- (4) A description of the resident's functional level;
- (5) Written objectives and approaches by responsible personnel, including the dates when goals are achieved;
- (6) Orders for:
  - a. Medications;
  - b. Treatments;
  - c. Restorative and rehabilitative services;
  - d. Therapies;
  - e. Diet;
  - f. Activities;
  - g. Social services; and
  - h. Special procedures designed to meet these objectives;
- (7) Progress notes that shall be written at least every 90 days;
- (8) Plans for continuing care, including provisions for review and necessary modifications of the plan; and
- (9) Discharge planning initiated within 7 days of admission.

Utilization Review and Change of Status Forms:

Facilities are responsible for completing and submitting the required utilization review documentation for individuals approved to receive short-term skilled nursing care or rehabilitative services. The facility shall submit to BEAS a completed "Utilization Review Form," incorporated by reference in He-E 802.18(b), and any supporting documentation, no later than 14 days prior to the end of the current authorization period.

## 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.

## 9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the *payer of last resort*. All third party obligations must be exhausted before claims can be submitted to 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 Program reimbursement level, a provider may submit a claim to NH Medicaid which is processed based on the applicable reimbursement rate minus any payment received from all other resources. Commercial health insurance coverage often provides a higher payment than does NH Medicaid.

When a third party denies a claim, for any reason, a copy of the notice of denial from the third party *must be included* behind the claim submitted to NH Title 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 Medicaid billing manual and the 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

Payment policies outlined below are applicable to nursing facilities. Swing bed hospitals should refer to the Hospital Billing Manual – Volume II for payment policies.

Reimbursement for nursing facility services is made pursuant to He-E 806. Providers are required to submit timely cost reports as required in He-E 806.02.

The Department shall reimburse NF's based on actual allowable costs. To be allowable, costs, including compensation, shall be reasonable and necessary for services related to resident care and pertinent to the operation of the NF.

To be reasonable, the compensation shall be such as would ordinarily be paid for comparable services by comparable facilities, for example, facilities of similar size and level of care; and to be necessary, the service shall be such that had the individual not rendered the services, another person would have had to have been employed to perform the same services.

Allowable costs for services and items directly related to resident care shall be included in the per diem rate unless the service or item is reimbursable under Medicare or covered by the drug rebate program through the Department. Please refer to the Appendices for further detail.

### Per Diem Rates and Payment for Nursing Care

A NF shall be reimbursed for direct and indirect costs as determined by the bed days of care and the NF's prospective per diem rate. Payment rates shall be pursuant to the provisions of He-E 806.

Decisions governing the allowability of costs not specifically detailed at He-E 806 shall be pursuant to the Medicare Provider Reimbursement Manual, Part I, HCFA-Pub 15-1 and Part II, HCFA-Pub 15-2 in effect at the time of such determination.

### Rate Setting and Payment Limitations for General Nursing Facility Care

Rate setting and payment limitations for NF care shall be determined as specified in He-E 806.

The per diem rate shall be calculated in accordance to the methodology outlined in He-E 806. The bed days basis will be the greater of either the actual days of service rendered, including reserved bed days; or the number of resident days computed at 85% of the certified bed capacity.

In no case shall payment exceed the NF's customary charges to the general public for such services, or, where applicable, the Medicare rate of reimbursement, whichever is less.

When a Medicaid per diem rate is established as a condition for a health services planning review board approval, pursuant to RSA 151-C, and that rate differs from the Medicaid rate established by the Department, payment shall be made at the lesser of the 2 rates and where a rate limitation is applied as a health services planning review board condition, a NF provider may, if aggrieved, appeal such limitation in accordance with He-C 200.

The cost of physician or psychologist services performed in rendering direct resident care shall not be allowable in the per diem rate.

### Bed Days and Temporary Absences

Bed days shall include the day of admission, but not the day of discharge. If admission and discharge occur on the same day, one bed day shall be allowed.

A facility shall establish and follow a written policy regarding bed-hold periods which is consistent with RSA 151:25 and which indicates when a facility has not received payment for a period of temporary absence or when the absence is longer than 10 days:

- (1) The resident shall have the option to return to the facility to the next available bed; and
- (2) If more than one person has a right of readmission, vacancies shall be allocated on a first request made, first request honored basis, and without regard to the source of payment.

When a resident is absent from a nursing facility due to therapeutic leave, the facility may bill for reserved bed days pursuant to 42 CFR 447.40, subject to the following conditions:

- (1) Such days shall be specified in the resident's plan of care;
- (2) The plan of care shall describe provisions for continuity of care while the resident is out of the facility;
- (3) Such days shall not be for hospitalization or for transferring to another facility;
- (4) The facility may not bill for more than 30 reserved bed days per resident per state fiscal year; and
- (5) When a recipient is on reserved bed day status, the department shall not pay separately for any services covered as part of the facility's rate pursuant to He-E 806.

### Rate Setting and Payment Limitations for Atypical Nursing Care

A provider of atypical care shall be a NF or a distinct part of a NF which possesses the physical characteristics and appropriate staffing for, and devotes its services exclusively to, highly specialized care, the nature of which renders that NF or unit incomparable to other NF's for the purpose of calculating and applying cost and/or occupancy limits.

Examples of such care described shall include services for children with severe physical or mental disabilities, brain/spinal injured patients, ventilator dependent patients; or other specialized services.

The Department shall determine the rate of reimbursement utilizing cost documentation submitted by the NF provider, which clearly identifies the cost of the atypical care. The rate shall include routine care costs, ancillary costs and capital costs, take into consideration any additional amount necessary to assure access to necessary and appropriate services for NH Medicaid residents with specialized care needs; and be exempt from comparative cost and occupancy limits.

In order to qualify as a provider of atypical care a NF provider shall make application in writing which requests to be considered a provider of atypical care, describes the care or services to be provided; and documents the costs of such care.

The Department shall determine if a NF is qualified to provide and be paid for atypical care based on documentation submitted by the NF, and on whether there is a documented need for these services as determined by the availability of such services in the locality.

Applications for approval of atypical care providers which have been denied may be appealed.

### Reimbursement for Out-of-State Nursing Care

The Department shall base the reimbursement rate on the rate set by the Medicaid agency of the state in which the out-of-state NF is located for services at that NF. In cases where the out-of-state Medicaid rate

does not exist or is not sufficient to allow access of NH residents in need of services, a rate shall be determined by the Department.

Incorrect Payments

If a NF was paid incorrectly, interest shall not be paid on underpayments nor collected on overpayments.

If an appeal decision is in favor of the NF, the Department shall make the appropriate rate adjustment(s), and payments, including any necessary retroactive payments. Any outstanding resident credit balances over 6 months shall be reported to the Department on a quarterly basis.

## 11. Claims

Claims instructions outlined below are applicable to nursing facilities. Swing bed hospitals should refer to the Hospital Billing Manual – Volume II for claims completion instructions.

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

Providers participating in the NH Medicaid Program are responsible for timely and accurate billing. If 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](http://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.

## 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](http://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 & Revenue Codes

Nursing facilities bill with Revenue Codes. The following revenue codes are acceptable for billing NH Medicaid a non-crossover claim:

- 0100 All Inclusive Room and Board plus Ancillary
- 0182 Patient Convenience or Other Leave of Absence
- 0185 Leave of Absence for Hospitalization

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis codes.

ICD-9-CM diagnosis codes are required for all services billed on institutional claim forms (UB-04). Claims without the required diagnosis will be denied.

## Service Authorizations (SAs)

Service authorizations are not required for nursing homes.

## 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).

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 Nursing Homes

### UB04 Paper Completion Instructions –Nursing Home Only

#### **Form Locator 01**

Provider name, address and telephone number

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

#### **Form Locator 02**

Billing Provider's Designated Pay-to Address

- **Optional**

#### **Form Locator 03a**

Patient control number

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

#### **Form Locator 03b**

Medical/Health Record Number

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

#### **Form Locator 04**

Type of Bill (TOB)

- **Required**
- Enter appropriate type of bill, based on list below
- UB04 guidelines require a four-digit TOB. The first digit beginning with '0'
- Only valid TOBs for NH Medicaid nursing home services are:
  - SNF

- TOB=21X
- ICF
- TOB= 65X, 66X
- X=
- 1-Admit through discharge
- 2-Interim bill-first in a series of claims
- 3-Interim bill-continuing claim
- 4-Interim bill-last claim
- Frequency codes 7 and 8 are **only** accepted electronically (X12/web portal) to void or submit a replacement claim

**Utilize the TOB list below for SNF care when Medicare is prime**

**(refer to your provider manual for when this is allowed)**

- 211 Skilled Nursing (Medicare Part A) – Admit through Discharge
- 212 Skilled Nursing (Medicare Part A) – First Interim Bill
- 213 Skilled Nursing (Medicare Part A) – Continuing Claim
- 214 Skilled Nursing (Medicare Part A) – Last Interim Bill
- 221 Skilled Nursing (Medicare Part B) – Admit through Discharge
- 222 Skilled Nursing (Medicare Part B) – First Interim Bill
- 223 Skilled Nursing (Medicare Part B) – Continuing Claim
- 224 Skilled Nursing (Medicare Part B) – Last Interim Bill

**Form Locator 05**

Federal Tax Number

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

**Form Locator 06**

Statement Covers Period – From/Through

- **Required**
- Valid date format as month, date and year (MMDDCCYY)
- Crossover Claims
  - Enter the begin date ( must match EOMB)
- Examples 12012007 or 120107

**Form Locator 07**

Reserved for Assignment by the NUBC

- N/A

**Form Locator 08a** –

Patient ID

- **Optional**
- Enter the patient’s NH Medicaid ID

- NH Medicaid ID numbers are 11 characters

**Form Locator 08b**

Patient Name

- **Required**
- Enter patient's full name, separate first and last with a comma
- Do not use titles
- Hyphenate names if applicable
- Leave a space between a suffix

**Form Locator 09**

Patient Address

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

**Form Locator 10**

Patient Birth Date

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

**Form Locator 11**

Patient Sex

- **Optional**
- "M" = male
- "F" = female
- "U" = unknown

**Form Locator 12**

Admission Date

- **Required**
- Inpatient
- Enter the date the patient was admitted to receive SNF/ICF care
- Date must be in either mmddccyy or mmddy format
- Examples 12012007 or 120107

**Form Locator 13**

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

- **Required**

**Form Locator 14**

Admission Type – Code indicating the priority of this admission/visit.

- **Required**
- Inpatient claims

- Enter the applicable admission code

Code	Description
1	Emergency
2	Urgent

### **Form Locator 15**

Admission Source – Code indicating the patient origin for this admission or visit

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

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

### **Form Locator 16**

Discharge Hour

- **Required if discharging patient**

### **Form Locator 17**

Patient Discharge Status

- **Required**
- 01= Discharged/transferred to home self-care (routine discharge)
- 02= Discharged/transferred to another short-term general hospital
- 03= Discharged/transferred to a skilled nursing facility (SNF)
- 04= Discharged/transferred to an intermediate care facility (ICF)
- 05= Discharged/transferred to a Designated Cancer Center of Children's Hospital
- 06=Discharged/transferred to home under care of organized home health service organization for covered skilled care
- 07= Left against medical advice or discontinued care
- 20= Expired

- 30= Still a patient

**Form Locators 18-28**

Condition Codes

- **Optional**

**Form Locators 32-36**

Occurrence and Occurrence Span Dates

- **Optional**

**Form Locator 38**

Responsible Party Name and Address

- **Optional**

**Form Locator 39-41**

Value Codes and Amounts

- **Required**
- For covered days used value code 80
- For non-covered days use value code of 81
- Enter as 00.00

**Form Locator 42 (lines 1-22)**

Revenue code

- **Required**
- Enter the revenue code that identifies a specific accommodation according to the following list.
  - 0100 All Inclusive Room and Board plus Ancillary
  - 0182 Patient Convenience or Other Leave of Absence
  - 0185 Leave of Absence for Hospitalization
- **Do not** bill ancillary charges on the Nursing Home claim

**Form Locator 43 (lines 1-22)**

Revenue Description

- **Required**
- Enter narrative description of the revenue codes as listed above

**Form Locator 44 (lines 1-22)**

HCPCS/Accommodation Rates/HIPPA Rate Codes

- **Required**
- Enter daily room rate
- Must be in a valid currency format dd.cc, e.g., 24.00

**Form Locator 45 (lines 1-22)**

Service Date

- **Required**
- Enter the “Service Date” (from date of service) for any accommodation revenue code listed
- Date must be in either mmddccyy or mmddy format
- Examples 12012007 or 120107
- Refer to Form Locator 42 for a list of the accommodation codes
- Line 1 must be same date as Form Locator 6 “From” date

**Form Locator 46 (lines 1-22)**

## Service Units

- **Required**
- Units of service for all accommodation days must be totaled and entered to correspond with each detail.
- The total units of service for all accommodation details on the claim should equal the covered days listed with the value code field

**Form Locator 47 (lines 1-22)**

## Total Charges

- **Required**
- Enter the total charges pertaining to the related revenue codes for each detail line
- Must be in a valid currency format dd.cc, e.g., 24.00
- Enter the total amount in the ‘TOTALS’ field of line 23
  - The total line must equal the sum of all of the individual line charges in Form Locator 47
  - Please note: NH Medicaid does not accept multi-pages claims; therefore do not utilize line 23 for page count.

**Form Locator 48 (lines 1-22)**

## Non-covered Charges

- **Optional**

**Form Locator 50 (A-C)**

## Payer Name

- **Situational**
- Record the NH Medicaid carrier code if member has other insurance
- 4 characters
- Carrier Codes can be found by:
  - Viewing the provider website go to Documentation, Documents and Forms, Carrier ID for the most up-to-date list

**Contact the provider relations unit at 1-866-291-1674**

**Form Locator 51**

## Health Plan Identification Number

- N/A

**Form Locator 52**

Release of Information Certification Indicator

- N/A

**Form Locator 53**

Assignment of Benefits Certification Indicator

- N/A

**Form Locator 54**

Prior Payments

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

**Form Locator 55**

Estimated Amount Due- Payer

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

**Form Locator 56**

National Provider Identifier – Billing Provider

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

**Form Locator 57**

Other (Billing) Provider Number

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

**Form Locator 58 –**

Insured's Name

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

**Form Locator 59**

Patient's Relationship to Insured

- N/A

**Form Locator 60**

Insured's Unique Identifier

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

**Form Locator 61**

Insured's Group Name

- **Situational**

**Form Locator 62**

Insured's Group Number

- **Situational**

**Form Locator 63 (A-C)**

Treatment Authorization Code

- N/A

**Form Locator 64**

Document Control Number (DCN)

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

**Form Locator 65**

Employer Name

- **Optional**

**Form Locator 66**

Diagnosis and Procedure Code Qualifier

- N/A

**Form Locator 67**

Principal Diagnosis Code

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

**Form Locator 67 (A-Q)**

Other Diagnosis Codes

- **Situational**
- Enter any other ICD-9-CM codes that may exist at the time of the admission, or develop subsequently
- Alphanumeric, up to 5 characters in length

- **Do not** use punctuation

**Form Locator 68**

Reserved for Assignment by NUBC

- N/A

**Form Locator 69 –**

Admitting Diagnosis Code

- **Situational**
- Required for inpatient claims

**Form Locator 70 (A-C) –**

Patient's Reason for Visit

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

**Form Locator 71**

Prospective Payment System (PPS) Code

- N/A

**Form Locator 72 (A-C)**

External Cause of Injury (ECI) Code

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

**Form Locator 73**

Reserved for Assignment by the NUBC

- N/A

**Form Locator 74 –**

Principal Procedure Code and Date

- **N/A for nursing homes**

**Form Locator 75**

Reserved for Assignment by NUBC

- N/A

**Form Locator 76 –**

Attending Provider Name and Identifiers (Attending Physician ID)

- **Required**
- Record provider's 10 digit NPI in the correct field
- **OR**, record the NH Medicaid provider ID for the physician that was principally responsible for the care of the patient upon admission

- Record the last name, first name of the Principal physician

**Form Locator 77 –**

Operating Physician’s Name and Identifiers

- **N/A for nursing homes**

**Form Locator 80**

Remarks Field

- **Situational**

Add any additional information needed for processing this claim

**Form Locator 81 (A-D)**

Code Field

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

**Form Locator 81cc**

Code Field

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

## 12. Appendices – Services Associated with the Nursing Facility Per Diem

### Services Associated with the Nursing Facility Per Diem (ICF, ICF-Atypical, ICF-MR, SNF, SNF-Atypical)

Item	Included in the Per Diem	Corresponding Rule Citation	Comments
Alcohol, swabs and rubbing	Yes	He-E 806.06 Routine Services	
Alt. Pressure pad/pump	Yes	He-E 806.06 Routine Services	
Alternating pressure pads, air mattresses, “egg crate” mattresses, gel mattresses	Yes	He-E 806.06 Routine Services	
Amputee Kits	No	He-W 571, DME	Refer to DME Services
Apnea electrodes/leads	Yes	He-E 806.06 Routine Services	
Apnea Monitors	Yes	He-E 806.06 Routine Services	
Applicators	Yes	He-E 806.06 Routine Services	
Audiology Services	Yes	He-E 806.08 Ancillary Services	
Bandages (Kling)	Yes	He-E 806.06 Routine Services	
Band-aids	Yes	He-E 806.06 Routine Services	
Basins	Yes	He-E 806.06 Routine Services	
Battery Charger for wheelchair/ power chair	No	He-W 571 DME	Refer to DME Services
Bed pans	Yes	He-E 806.06 Routine Services	
Bed rails	Yes	He-E 806.06 Routine Services	
Beds (standard hospital type, not therapy beds)	Yes	He-E 806.06 Routine Services	
Beds, specialty, e.g., Clinitron	No	He-W 571 DME	Rental only for care of wounds acquired pre-LTC admission

<b>Item</b>	<b>Included in the Per Diem</b>	<b>Corresponding Rule Citation</b>	<b>Comments</b>
Betadine solution	Yes	He-E 806.06 Routine Services	
BIPAP/CPAP	Yes	He-E 806.06 Routine Services	
BIPAP/CPAP supplies	Yes	He-E 806.06 Routine Services	
Blood pressure equipment	Yes	He-E 806.06 Routine Services	
Bottles (water)	Yes	He-E 806.06 Routine Services	
Canes	Yes	He-E 806.06 Routine Services	
Catheters and supplies (urinary, intermittent, indwelling, drain bags, strapping, tubing, irrigation supplies – syringes & sterile water)	Yes	He-E 806.06 Routine Services	
Chairs (standard, geriatric, recliner, with seat lift mechanism)	Yes	He-E 806.06 Routine Services	
Combs	Yes	He-E 806.06 Routine Services	
Commodes	Yes	He-E 806.06 Routine Services	
Corner chair	Yes	He-E 806.06 Routine Services	
Cotton	Yes	He-E 806.06 Routine Services	
Cotton tipped applicators – sterile	Yes	He-E 806.06 Routine Services	
Crutches (Canadian, standard)	Yes	He-E 806.06 Routine Services	
Dental Services – Dentures	No	Medicaid State Plan	Refer to Dental Unit
Dental Services – Extractions	Yes	He-E 806.06 Routine Services	For treatment of acute pain or infection
Dental Services – Restorations	No	Medicaid State Plan	Refer to Dental Unit
Diabetic test strips/supplies	Yes	He-E 806.06 Routine Services	
Dietary supplements	Yes	He-E 806.06 Routine Services	
Disinfectants	Yes	He-E 806.06 Routine Services	
Disposable Diapers	Yes	He-E 806.06 Routine Services	

Item	Included in the Per Diem	Corresponding Rule Citation	Comments
Douche trays (disposable)	Yes	He-E 806.06 Routine Services	
Dressings	Yes	He-E 806.06 Routine Services	
Enema equipment	Yes	He-E 806.06 Routine Services	
Enteral feedings, supplies and equipment	Yes	He-E 806.06 Routine Services	
Gauze bandages (sterile or unsterile)	Yes	He-E 806.06 Routine Services	
General services including oxygen and related medication administration, hand feeding, incontinency care, tray services, and enemas	Yes	He-E 806.06 Routine Services	
Gloves (sterile or unsterile)	Yes	He-E 806.06 Routine Services	
Glucometer	Yes	He-E 806.06 Routine Services	
Gowns	Yes	He-E 806.06 Routine Services	
Hearing Aids	No	He-W 571, DME/PA	Refer to DME Services
Hemorrhoidal preparations	No	He-E 806.09 Drugs and Institutional Pharmacy Costs  He-W 570 Pharmacy Services	Refer to Pharmacy Services
High Frequency Compression Vests	Yes	He-E 806.06 Routine Services	
Hoyer slings (all types)	Yes	He-E 806.06 Routine Services	
Hygiene and grooming supplies: Supplies for routine shaving, shampooing, bathing, & nail clipping unless specified as a separately covered service by a podiatrist. This includes shampoo, i.e., regular, medicated and no tears baby shampoo.			
Ice bags	Yes	He-E 806.06 Routine Services	

Item	Included in the Per Diem	Corresponding Rule Citation	Comments
Incontinent supplies (full brief – all sizes, beds pads, undergarment liners - disposable or reusable, under pads)	Yes	He-E 806.06 Routine Services	
Invalid ring	Yes	He-E 806.06 Routine Services	
Irrigation trays	Yes	He-E 806.06 Routine Services	
IV equipment including pump, supplies, tubing	Yes	He-E 806.06 Routine Services	Pumps are paid for outside of the per diem for Cedarcrest only
Ketostix	Yes	He-E 806.06 Routine Services	
Lambskin pad	Yes	He-E 806.06 Routine Services	
Laundry services - personal (supplies and equipment)	Yes	He-E 806.06 Routine Services	
Lumbar pillows	Yes	He-E 806.06 Routine Services	
Lymphadema pads	Yes	He-E 806.06 Routine Services	
Medicated mist equipment	Yes	He-E 806.06 Routine Services	
Mouthwash	Yes	He-E 806.06 Routine Services	
Nebulizer - machine and supplies (IPPB equipment, PA 400 compressors, tubing, aerosol dispenser, water, mask)	Yes	He-E 806.06 Routine Services	
Nebulizer - medication	No	He-E 806.09 Drugs and Institutional Pharmacy Costs  He-W 570 Pharmacy Services	Refer to Pharmacy Services
Ophthalmic lubricants (tears, ointments)	No	He-E 806.09 Drugs and Institutional Pharmacy Costs  He-W 570 Pharmacy Services	Refer to Pharmacy Services
Ostomy supplies (bags, tubing, drainage, care, barriers w/or w/o flanges, wipes, adhesives)	Yes	He-E 806.06 Routine Services	

<b>Item</b>	<b>Included in the Per Diem</b>	<b>Corresponding Rule Citation</b>	<b>Comments</b>
Oximeter – machine and supplies (probes -reusable or disposable, breathing circuits)	Yes	He-E 806.06 Routine Services	
Oxygen (contents, face mask, nasal cannula, tent, concentrators)	Yes	He-E 806.06 Routine Services  He-E 806.08 Ancillary Services	
Parenteral solutions, supplies and equipment	Yes	He-E 806.06 Routine Services	
Pillows	Yes	He-E 806.06 Routine Services	
Pitchers (water)	Yes	He-E 806.06 Routine Services	
Podiatry	No	He-W 532.02 Recipient eligibility	Direct billed to the Medicaid Program.
Portable E Set-up, oxygen	Yes	He-E 806.06 Routine Services	
Positioning devices – non-custom (basic wedges for beds/cribs, basic blocks for WC/ Geri-chairs)	Yes	He-E 806.06 Routine Services	
Powders (medicated and baby)	Yes	He-E 806.06 Routine Services	
Prone boards	Yes	He-E 806.06 Routine Services	
Replacement mattresses	Yes	He-E 806.06 Routine Services	
Respiratory supplies	Yes	He-E 806.06 Routine Services	
Restraints (posey, thoracic chest supports, tilt in space chairs, wedge pillows, gait belts, etc.)	Yes	He-E 806.06 Routine Services	
Re-usable diapers	Yes	He-E 806.06 Routine Services	
Sheepskin	Yes	He-E 806.06 Routine Services	
Shower chairs	Yes	He-E 806.06 Routine Services	
Soap (regular, hypoallergenic)	Yes	He-E 806.06 Routine Services	
Special dietary supplements	Yes	He-E 806.06 Routine Services	
Specimen containers	Yes	He-E 806.06 Routine Services	

<b>Item</b>	<b>Included in the Per Diem</b>	<b>Corresponding Rule Citation</b>	<b>Comments</b>
Stethoscope	Yes	He-E 806.06 Routine Services	
Stocking-gradient (basic stockings - non-custom made)	Yes	He-E 806.06 Routine Services	
Suction machine	Yes	He-E 806.06 Routine Services	
Sunscreen	Yes	He-E 806.06 Routine Services	
Suture sets	Yes	He-E 806.06 Routine Services	
Swabs, medicated or unmedicated	Yes	He-E 806.06 Routine Services	
Syringes and needles	Yes	He-E 806.06 Routine Services	
Tapes	Yes	He-E 806.06 Routine Services	
Testing materials - used by staff or facility	Yes	He-E 806.06 Routine Services	
Thermometers	Yes	He-E 806.06 Routine Services	
Tissues	Yes	He-E 806.06 Routine Services	
Tongue depressors	Yes	He-E 806.06 Routine Services	
Toothbrush	Yes	He-E 806.06 Routine Services	
Toothpaste and denture cleanser	Yes	He-E 806.06 Routine Services	
Towels, washcloths	Yes	He-E 806.06 Routine Services	
Tracheotomy - specialized	No	He-W 571, DME/PA	Refer to DME Services
Tracheotomy - suction machine and supplies (catheters, collars, tubing, care kits, cleaning brushes)	Yes	He-E 806.06 Routine Services	Facility owned machine
Traction equipment	Yes	He-E 806.06 Routine Services	
Transfer boards	Yes	He-E 806.06 Routine Services	

Item	Included in the Per Diem	Corresponding Rule Citation	Comments
Transportation of residents to medical office or hospital when using a facility-owned vehicle. Transportation of laboratory specimens when using a facility-owned vehicle.		He-E 806.11	Emergency transportation by ambulance is not included in the rate. Wheelchair van transportation is not included in the rate unless the NF owns the van.
Trapezes	Yes	He-E 806.06 Routine Services	
Tub seats	Yes	He-E 806.06 Routine Services	
Urinals	Yes	He-E 806.06 Routine Services	
Ventilators and related supplies	Yes	He-E 806.06 Routine Services	Ventilator care is included in the specialized ventilator per diem rate set for Cedarcrest, Crooked Mountain, Laconia Rehab Ctr, and Edgewood
Walkers	Yes	He-E 806.06 Routine Services	
Walkers – wheeled	Yes	He-E 806.06 Routine Services	
Wheelchair cushion – standard	Yes	He-E 806.06 Routine Services	
Wheelchairs - powered	No	He-W 571, DME/PA	Refer to DME Services
Wheelchairs – standard (including those with removable arms and leg rests, pediatric, “hemi” chairs, reclining wheelchairs)	Yes	He-E 806.06 Routine Services	
Wound vac, and related supplies for decubiti – Post Admission	Yes		
Wound vac, and related supplies for decubiti – Pre Admission	No	He-W 571, DME/PA	Prior authorization requirements apply if the wound is acquired pre-admission or during an acute care episode.

Bed Type	Rule Citation	Rule Language
<b>ICF SNF Atypical</b>	He-E 806.06 Routine Services.	(1) All general nursing services including, but not limited to, administration of oxygen and related medications, hand feeding, incontinency care, and tray service; (2) Items furnished routinely and commonly to most or all residents, such as resident gowns, water pitchers, and basins; (3) Routine personal hygiene and grooming supplies such as deodorant, lotion, shampoo, soap and toothpaste; (4) Medical supplies, pharmaceutical items, and non-legend drugs, that is, drugs prescribed by a licensed practitioner that are normally purchased over the counter, which are stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities; (5) Laundry services for routine NF requirements and residents’ personal clothing; and (6) Routine and emergency dental services defined by the Medicaid State Plan rendered to NF residents.
	He-E 806.07 Physician Services, Psychologist Services and Pharmacist Consultant Services.	(a) The cost of physician or psychologist services performed in rendering direct resident care shall not be allowable in the per diem rate. (b) The cost of indirect services performed in an administrative or advisory capacity, such as the cost of a medical director or a consultant psychologist, or the cost of a pharmacist consultant rendering administrative services and drug reviews shall be included in the per diem rate.
	He-E 806.08 Ancillary Services.	(a) The costs of ancillary services provided by the facility, except for prescribed drugs, shall be included in the NF rate determination. (b) Ancillary services shall include, but not be limited to: (1) Occupational, physical and speech therapy; (2) Inhalation therapy, including oxygen costs; (3) Laboratory; and (4) Radiology. (c) The net cost of Medicaid ancillary services not previously reimbursed by another payor source shall be included in the NF rate determination, provided that NF’s maintain revenue and cost data of all ancillary services provided to Medicaid residents of the facility separately from all other ancillary services and costs.

Bed Type	Rule Citation	Rule Language
<b>ICF SNF Atypical</b>	He-E 806.09 Drugs and Institutional Pharmacy Costs.	The cost of operating an institutional pharmacy and the cost or charges of prescribed legend drugs shall not be an allowable cost in the per diem rate as the NH Medicaid program reimburses these costs to the provider of these services through a direct billing process on a fee for service basis in accordance with He-W 570Pharmacy Services.
	He-E 806.10 Barber and Beauty Services.	(a) The direct costs of barber and beauty services shall be non-allowable for purposes of Medicaid reimbursement. (b) The fixed costs for space and equipment related to providing the services described in (a) above shall be allowable.

<b>Bed Type</b>	<b>Rule Citation</b>	<b>Rule Language</b>
<b>Atypical</b>	He-E 806.36 Rate Setting and Payment Limitations for Atypical Nursing Care	(1) Include routine care costs, ancillary costs and capital costs; (2) Take into consideration any additional amount necessary to assure access to necessary and appropriate services for NH Medicaid residents with specialized care needs;