

# Private Duty Nursing

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 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 complies 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

Participating 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 service providers, 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 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

Each participating provider of Private Duty Nursing (PDN) shall:

- a. Be a home health care provider licensed in accordance with RSA 151:2, I(b), and He-P 809;
- b. Require all staff providing PDN to be an R.N. or an L.P.N. licensed by the state in which s/he practices;
- c. Request and obtain service authorization from the department or its service authorization agent, before providing PDN; and
- d. Upon initiating PDN, provide to each member or the member's caregiver if the member is a minor, the home health care provider's written grievance policy that includes the phone number of the Department's ombudsman's office.

### 3. Covered Services & Requirements

PDN shall be a covered service when:

- a. It is part of the member's medical regimen and rendered under the order and general direction of the member's physician;
- b. It is provided in one of the following locations:
  1. The member's home; or
  2. In locations other than the member's home when routine life activities take the member outside of the home if the services would have otherwise been provided in the member's home; and
- c. Prior authorization has been requested and obtained.

### Service Limits

There is no service limits associated with the provision of PDN services.

## 4. Non-Covered Services

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

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

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

PDN shall not be a covered service when the member resides in any one of the following:

1. A nursing facility licensed pursuant to RSA 151:2 and He-P 803;
2. A hospital licensed pursuant to RSA 151:2 and He-P 802;
3. An assisted living residence-supported residential health care (ALR-SRHC) facility licensed in accordance with RSA 151:2 and He-P 805;
4. A private non-medical institution as defined in 42 CFR 434.2, and licensed pursuant to RSA 151:2 and He-P 800;
5. An intermediate care facility for the mentally retarded (ICF/MR) as described in 42 CFR 150; and
6. An institution for mental diseases (IMD) as defined in 42 CFR 435.1010.

Services that consist only of assistance with activities of daily living or other non-skilled services needed to live at home that do not require a nurse, including but not limited to assistance with grooming, toileting, eating, dressing, getting into or out of a bed or chair, and walking shall not be covered as PDN.

## 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. Services Authorizations are required for all PDN services.

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

A service authorization does not guarantee payment. Providers should verify the following before providing a service:

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

Service authorization requests must contain sufficient current medical and psycho-social information to enable the SA agent to evaluate the request and make a determination. The information must include, but not be limited to,

1. A written, signed and dated physician's order as described in "Documentation" below;
2. A nursing assessment as described in "Documentation" below;
3. A plan of care as described in "Documentation" below.

### Approval or Denial of Service Authorization Requests

The service authorization agent will make a decision on the service authorization request based on approved clinical guidelines, administrative rules or medical necessity criteria. Once a decision is made, the service authorization agent will either:

1. Grant approval no longer than ten business days after the request for service authorization has been made, either by mail, by facsimile, or via the service authorization agent's web site, OR
2. Issue a denial

When a service authorization request is denied, written notice of the denial is mailed to the member with the following:

1. Reason for and the legal basis of the denial
2. Information on how the member can file an appeal
3. Information that a denial may be appealed by the member within 30 calendar days from the date the denial was issued.

Notices of approval and written denials are mailed to the requesting service provider. Members receive only a copy of the written denial at this time.

## 6. Documentation

The PDN service provider 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 resolution of any legal action(s) commenced in the six year period, whichever is longer.

For each member, PDN service providers shall maintain complete and timely records as follows:

- a. A written, signed and dated physician’s order for care provided, updated and signed every 60 days, which shall include:
  1. The member’s diagnosis, with a description of the severity of the illness or condition; and
  2. A detailed explanation of the medical need for PDN, including:
    - a. The specific nursing services that are required; and
    - b. A description of the specific medical complications necessitating PDN;
- b. A nursing assessment with information that supports the need for PDN including, but not limited to, the following:
  1. Member identification information including:
    - a. Member name;
    - b. Medicaid identification number (MID); and
    - c. Date of birth;
  2. Contact information of the member’s parent/guardian or primary caregiver including addresses and phone numbers;
  3. Private health insurance information including coverage dates;
  4. Information regarding the member’s participation in any Medicaid program, including Medicaid to schools, waiver programs, and licensed nursing assistant (L.N.A.) services, or participation in the special medical services program;
  5. Name and contact information of the member’s treating physicians, including the primary care physician and any specialists;
  6. A summary of the member’s physical and behavioral health status including:
    - a. A list of the member’s current conditions; and
    - b. A history of the conditions leading to the need for PDN;
  7. An assessment of the member’s body systems;
  8. A functional assessment of the member’s physical and cognitive status;
  9. A description of the household make-up including the nature of the household member’s relationship with the member and their ability and availability to provide care and support to the member;
  10. Information about the member’s school participation including whether a nurse or aide is available to assist the member while at school and the number of hours per week the member attends school;

11. The member's emergency plan in the event that the primary caregiver is unable to provide care; and
  12. Any additional medical or social information that the member wants to provide that supports the need for PDN, such as family stressors and their impact on the mental and emotional health of the member.
- c. A plan of care documenting the extent of the member's nursing needs, prepared by the PDN service provider, signed and dated by the member's physician, and updated every 60 days in accordance with 42 CFR 484.18;
- d. Nurses' notes that fully document, for each date of service, the provision of services and the care and treatment provided to the member, including:
1. The location of where the care was provided, and the time that the nursing shift began and ended;
  2. A description of each nursing service provided, including the type of nursing service, the time of the service delivery, and the member's response to the service so that an independent reviewer can replicate what happened during the shift;
  3. Details showing that the nursing services are consistent with the care plan and orders of the member's physician;
  4. Any adverse findings and, if so, a plan of action to address those findings; and
  5. The member's progress towards established goals; and
- e. Documentation of a face-to-face encounter between the member's physician and the member within 90 days prior to, or within 30 days following the start of, the PDN service provision, as established by sections 1845(a)(2)(C) and 1835(a)(2)(A) of the SSA and in accordance with 42 CFR 440.

## Professional Principles of Documentation

Nursing documentation is any written or electronically generated information about a member that describes the member status or the care or service provided to that member. Nursing documentation must provide an accurate and honest account of what occurred and when during a nursing shift. It should be factual, accurate, complete, timely and organized. These principles apply in every practice setting.

Nurses should record relevant and member focused information. Data collected through all aspects of the nursing process, e.g., assessment data, nursing interventions and evaluation of outcomes should be recorded. This type of documentation allows for assessment of member progress and determination of which nursing interventions are effective and ineffective and identification of changes required to the plan of care. A good test to evaluate whether a member's record is a satisfactory clinical document is to answer the question: "if another nurse had to step in and provide care, does the record provide sufficient information for the seamless delivery of care: Both subjective and objective data may be included in the documentation. For subjective data, use quotation marks to delineate actual statements made by either the member or parent/guardian if relevant, rather than characterizing the statement or behavior. Write "patient smiling, asking staff about their day," rather than in "good spirits" The purpose of doing so gives the nurse following you a clearer picture of the situation than using a phrase in which you make a judgment. Objective data is the result of direct observation and measurement. It should contain descriptive, objective data about what the nurse sees. For objective data, avoid vague descriptions such as "status unchanged," "assessment done," "slept well," "vital

signs stable.” These are conclusions without supported facts. Be specific, “Slept quietly from 12 pm to 6 am.”

### Frequency of documentation:

The timeliness of documentation will be dependent on the member’s medical condition. When member’s acuity, complexity and variability are high, documentation will be more frequent than when members are less acute, less complex and their medical condition is less variable.

## 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; or
- 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. Refer to 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 I. Providers who receive payment in full from a third party are not required to file zero-payment claims with NH Medicaid.

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

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

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

When a NH Medicaid 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

In the situation where nursing care involves two siblings or two beneficiaries residing in the same household, and who are being cared for by one nurse at the same time, billing shall be as follows:

The first child shall be billed at the full hourly rate for the hours authorized and the second child shall be billed at the full hourly rate but one half the hours. In other words, one and a half times the hourly rate for the 2 individuals.

## 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](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 claims.

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 & Procedure Codes

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

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

ICD-9-CM diagnosis codes are required for all services billed on medical and institutional claims forms (CMS-1500 and UB-04). Claims without the required diagnosis or procedure codes will be denied.

## Service Authorizations (SAs)

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

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

## Required Claim Attachments

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

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

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 Completions Requirements for Private Duty Nursing Providers

Private Duty Nursing 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](http://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	<b>Required</b> - Enter the NH Title XIX ID number (11 characters) shown on the ID card.
2	Patient's Name	<b>Required</b> - Enter the last name, first name, and middle initial as shown on the ID card.
3	Patient's Birth Date (8 digits), Sex	<b>Required</b> 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

Item #	Description	Instructions
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.
9 a.	Other Insured's Policy or Group Number	<b>Situational</b> – provide policy number if applicable. Must be 12 or less alpha-numeric characters.
9 b.	Other Insured's Date of Birth	N/A
9 c.	Employer's Name or School Name	N/A
9 d.	Insurance Plan Name or Program Name	<b>Required</b> ~ if other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code Codes can be located on the NH MMIS Health Enterprise Portal under documents section
10 a-c	Is Patient's Condition Related To?	<b>Required</b> 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	<b>Situational</b> ~ 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

Item #	Description	Instructions
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, Injury, Pregnancy	<b>Situational</b> – Enter if "YES" is present in Item #10 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	<b>Required</b> – 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	<b>Optional</b> 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	<b>Required</b> – Relate Items #1, #2, #3 or #4 to

Item #	Description	Instructions
	Illness or Injury	#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)	<b>Required</b> - if applicable enter Service Authorization Number. Must be 12 characters <b>**Not being used at this time**</b>
24 a.	Date(s) of Service (Lines 1-6)	<b>Required</b> - 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)	<b>Required</b> - 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)	<b>Required</b> - 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 ( <b>pointer</b> ) as shown in Item 21 to relate the date of service and the procedures performed	<b>Required</b> 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

	for the primary diagnosis.	justified in the field. Do <u>not</u> use commas between the numbers.
24 f.	\$ Charges (Lines 1-6)	<b>Required</b> -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)	<b>Required</b> - 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)	<b>Required</b>  The Rendering Provider is the provider who rendered or supervised the care.  Report the Identification Number in Items #24I and #24J only when different from data recorded in Items #33a and #33b.  In the shaded area of #24I, enter the qualifier identifying if the number is a non-NPI.  Providers can bill with ZZ for taxonomy (with NPI) or a Medicaid ID qualifier. Must be 2 characters long.
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	<b>Required</b> Enter patient account number
27	Accept Assignment	Only one box may be checked.
28	Total Charge Total charges for the	<b>Required</b> - Enter total charges for the services (i.e., total of all charges in #24F)

	services (i.e., total of all charges in 24F)	Must be 9 digits or less.
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	<b>Required</b> – Enter total amount due (subtract Amount Paid Item #29 from Total Charge Item #28. Must be 9 digits or less.
31	Signature of Physician or Supplier Including Degrees or Credentials	<b>Required</b> – legal signature of provider or provider's authorized representative. Include date. Must be an actual signature or signature stamp or signature on file. Date format mm/dd/ccyy
32	Service Facility Location Information	<b>Required if applicable</b> - 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	<b>Required</b> – Enter the provider's or supplier's billing name, address, zip code and phone number.
33 a.	NPI Number	<b>Required</b> – except for Atypical providers. Must be 10 numeric digits.
33 b.	Other ID Number	<b>Required</b> – the two-digit qualifier identifying the non-NPI number followed by the ID number.