Ambulance

Provider Manual
Volume II

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New Hampshire
Medicaid

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Change Log

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

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date. This date is also included in the text box located on the left margin where the content change was updated.
Section/Sub-Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, Control Memo, etc.).

Date Change to Manual	Effective Date	Section/Sub-Section	Change Description	Reason	Related Communication

1. NH Medicaid Provider Billing Manuals Overview

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

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

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The Appendices section encompasses a wide range of supplemental materials such as Fee Schedules, Contact Information, Provider Type List, Sample Forms and Instructions, as well as other general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for health care providers, their staff, and provider-designated billing agents.

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

Provider Accountability

Providers should maintain both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

Document Disclaimer/Policy Interpretation

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

Notifications & Updates

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

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

Description of Change Log

All changes made to this manual are under change control management and are approved by 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 (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

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

2. Provider Participation & Ongoing Responsibilities

This manual applies to ambulance service providers, including both ground and air ambulance transportation.

In order to provide NH Medicaid ambulance services, the ambulance provider must:

(a) Be licensed in the state in which they operate; and

(b) Be an enrolled New Hampshire Medicaid provider.

3. Covered Services

The following ambulance services are covered:

Ambulance services, in the case of an emergency medical condition, are covered as follows:

(1) Transportation to the nearest acute care hospital with appropriate treatment facilities, including loaded mileage and routine, disposable supplies used en route;

(2) Transportation from one acute care hospital to another acute care hospital when the necessary treatment or diagnostic testing cannot be provided by the originating hospital and the member is discharged from the originating hospital; and

(3) Waiting time as follows:

- Prior to transporting the member while the member is being stabilized; and
- Up to a maximum of 2 hours, rounded to the nearest half-hour.

Scheduled and routine ambulance transportation, which means transportation by ambulance for the purpose of attending an appointment to obtain a Medicaid covered service from a Medicaid enrolled provider when the use of any other mode of transportation would likely endanger the health and safety of the member and when the Medicaid covered service is not to treat an emergency medical condition, is covered as follows:

(1) Transportation is covered to and from the destination, including loaded mileage and routine disposable supplies used en route;

(2) Transportation must be authorized in accordance with the service authorization requirements in the "Service Authorization" section below; and

(3) Waiting time for non-emergency scheduled and routine ambulance transportation authorized pursuant to the requirements described under the "Service Authorization" section below shall be covered up to a maximum of 2 hours, rounded to the nearest half hour

Air ambulance services, in the case of an emergency medical condition, shall be covered if the member's condition is such that:

(1) The member cannot be safely transported in a timely basis via an ALS ground transportation with appropriate staff; and

(2) The member is at imminent risk of losing life or limb if the fastest means of transport is not utilized to move the member to the nearest facility capable of treating the member.

Air ambulance service claims will be reviewed retrospectively, on a case-by-case basis, to determine if the member was at imminent risk of losing life or limb if the fastest means of transport was not utilized to move the member to the nearest facility capable of treating the member, and the member could not be safely transported in a timely manner via an ALS ground transportation with appropriate staff. Payment for air ambulance services provided to a member shall only be allowed when the noted conditions are met and only when supported by medical documentation on file.

Service Limits

There are no service limits on ambulance transportation at this time.

4. Non-Covered Services

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

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

Non-covered ambulance services include:

(1) Transportation for a member whose condition permits transport in any type of vehicle other than an ambulance, such as a private vehicle or a wheelchair van, without endangering the member's health.

(2) Transportation which is not:

- Scheduled and routine ambulance transportation (as defined in the "Terminology" section below); or
- For an emergency medical condition (as defined in the "Terminology" section below);

(3) Transportation by ambulance only for the member's or his or her family's convenience;

(4) Transportation to and from medical providers, unless authorized as described in the "Service Authorization" section below;

(5) Transportation from one acute care hospital to another acute care hospital for necessary treatment or diagnostic testing while the member maintains inpatient status with the originating hospital;

(6) Waiting time as follows:

- Waiting time that exceeds 2 hours; and
- Waiting time for transportation in the case of an emergency medical condition when the wait is not due to the member needing to be stabilized.

5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is a request (typically made in advance) for authorization of payment for a specific item or service.

Service authorizations are required for all scheduled and routine ambulance transports, and may be submitted prior to, or within 30 days of, the service being delivered.

Service authorization requests must include the following forms, which can be downloaded from the Provider Portal website, and which should be submitted to the Department by mail or FAX as noted on the forms:

(1) Form 272AMB – "Scheduled and Routine Ambulance Transportation Authorization Request Form" signed and dated by the ambulance provider; and

(2) Form 273MN – "Medical Necessity for Ambulance Services Form" dated and signed by the member's attending physician, doctor of osteopathy, physician assistant, clinical nurse specialist, advanced practice registered nurse, registered nurse, licensed practical nurse, or discharge planner employed by the facility where the member is being treated.

A properly completed service authorization request shall be approved by the Department if:

(1) The member has a condition such that all other methods of transportation are contraindicated by the member's condition and therefore, the member cannot be transported by any other means from the origin to the destination without endangering the member's health; or

(2) The member is bed confined, meaning the member is (a) unable to get up from bed without assistance, (b) unable to ambulate; and (c) unable to sit in a chair or wheelchair.

Authorizations shall be approved for a specified number of trips over a specified period of time, not to exceed a maximum of 3 months, after which a new, complete service authorization request must be submitted.

6. Documentation

Each ambulance provider 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.

Each ambulance provider shall maintain documentation in their records to fully support each claim billed for services, including:

(1) For emergency transportation, documentation of the nature of the member's emergency medical condition; and

(2) For all ambulance transportation, documentation that justifies the level of service, whether ALS or BLS, claimed.

For each trip billed, the ambulance provider shall maintain a run sheet or patient care report that includes at a minimum the following information, which is legibly written:

(1) Member name and Medicaid identification number;

(2) Date of service;

(3) Origin and destination;

(4) Member vital signs;

(5) Member signs and symptoms upon arrival at the point of pick-up;

(6) Member status en route;

(7) Services provided;

(8) The name of the person who provided the service or care in the ambulance, including signature and credentials; and

(9) The response code that indicates the mode of response for the ambulance making the trip.

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

Payment for ambulance services shall be made in accordance with the rates established by the department.

Payment shall be made for loaded miles only, which means the distance traveled while transporting members from a pick-up point to a drop-off point, including mileage incurred on the way to pick up a member or after dropping off a member.

NH Medicaid now allows for the reporting of fractional mileage amounts on ambulance claims in order to improve reporting and payment accuracy. Providers and suppliers who are submitting fractional mileage must use a decimal point in the appropriate place.

Payment shall consist of the following separate components, as applicable:

(1) A base rate;

(2) A mileage rate, which shall be paid for the most direct route to and from a destination and for loaded miles only, which:

- Shall be the distance traveled while transporting a member from a pick-up point to a drop-off point; and
- Does not include mileage incurred on the way to pick up a member or after dropping off a member;

(3) Payment for waiting time (as allowed under the "Covered Services" section); and

(4) Payment for routine disposable supplies used en route.

Payment shall be made for only one mileage charge per trip regardless of the number of members transported.

Payment shall be based on the level of service provided, not on the vehicle used, even if the local government requires an ALS response for all calls.

The ambulance provider shall not bill NH Medicaid for transporting a member from an acute care hospital to another acute care hospital or medical provider to obtain necessary treatment or diagnostic testing not available while the member is still an inpatient of the originating acute care hospital. The transport is considered to be part of the DRG payment billed by the hospital.

The ambulance provider shall submit claims for payment to Xerox, the department’s fiscal agent. Ambulance service providers may submit claims to the fiscal agent using paper or electronic billing.

Air ambulance service claims will be reviewed retrospectively, on a case-by-case basis, to determine if the member was at imminent risk of losing life or limb if the fastest means of transport was not utilized to move the member to the nearest facility capable of treating the member, and the member could not be safely transported in a timely manner via an ALS ground transportation with appropriate staff. Payment for air ambulance services provided to a member shall only be allowed when the noted conditions are met and only when supported by medical documentation on file. Claims for air ambulance services that do not meet these criteria will be denied for payment, and it will be the responsibility of the hospital that requested the service to pay the cost of the claim.

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 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 (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. 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 for the date of service on the claim.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and/or the Current Procedural Terminology (CPT) codes and modifiers. One procedure code must be provided for each charge billed.

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

Dates of service occurring on or after implementation of ICD-10-CM must be billed on a separate claim form from any dates of service occurring prior to implementation of ICD-10-CM.

Transportation procedure codes include two levels of ambulance services: Basic Life Support and Advanced Life Support. These are recognized by specific procedure codes used for billing.

Ambulance transportation cannot be billed with span dates. Each mileage occurrence must be billed with one date of service per claim. NH Medicaid now allows for the reporting of fractional mileage amounts on ambulance claims in order to improve reporting and payment accuracy. Providers and suppliers who are submitting fractional mileage must use a decimal point in the appropriate place.

Service Authorizations (SAs)

A service authorization (SA), also known as a Prior Authorization (PA), is a request (typically in advance) for authorization of payment for a specific item or service. Service authorizations are required for scheduled and routine ambulance transportation as detailed in the "Service Authorization" section.

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.

Claim Completion Requirements for Ambulance Services

Ambulance 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 or blue 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.

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

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers. These authorized users msut be list in the provider's appclaiton as authorized users and these indivduals will be vetted during the enrollment screening process.

Paper claims and other documents can be mailed to:

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

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

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

The format is: YYDDD M BBBB NNNNNN T, where

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

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

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

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

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

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

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

Required Claim Attachments

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

When submitting a claim via the NH MMIS Health Enterprise Portal, providers must indicate in the claim form if there is an attachment to support the claim. Providers should answer yes to the question

"Does this claim have attachments?" and click "Add Attachment" **Note:** Please select Delivery Method "by Mail" or "by Fax" to submit attachments.

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

- **Please mail claim attachments to:**
  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). Refer to the Companion Guide for the instructions.

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.

CMS-1500 Claim Form Instructions

Item #	Description	Instructions
1		**Required**-Indicate NH Medicaid coverage by placing an X in the appropriate box. Only one box can be marked.
1A	Insured's ID Number	**Required** - Enter the NH Medicaid ID number (11 characters) shown on the ID card.
2	Patient's Name	**Required -** Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Item #	Description	Instructions
3	Patient's Birth Date, Sex	**Required-**Enter the patient's 8-digit birth date (MM | DD | YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave blank.
4	Insured's Name	**Optional-** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
5	Patient's Address (Multiple Fields)	**Optional-** Enter the patient's permanent residence address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. A temporary address or school address should not be used.
6	Patient Relationship to Insured	**N/A**
7	Insured's Address (multiple fields)	**Situational -**Enter the insured's address. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.
8	Reserved for NUCC Use	**N/A-** This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.
9	Other Insured's Name	**Situational -**If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
9A	Other Insured's Policy or Group Number	**Situational** – The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9. This field allows for the entry of 28 characters, alpha or numeric
9B	Reserved for NUCC Use	**N/A -**This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.
9C.	Reserved for NUCC Use	**N/A -**This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.

Item #	Description	Instructions
9D	Insurance Plan Name or Program Name	**Required -** If other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code Codes can be located on the NH MMIS Health Enterprise Portal under documents section This field allows for the entry of 28 characters.
10A-C	Is Patient's Condition Related To?	**Required-**When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.
10D	Claim Codes (Designated by NUCC)	**N/A -**When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes.
11	Insured's Policy, Group or FECA Number	**Situational -** Enter the insured's policy or group number as it appears on the insured's NH Medicaid identification card. If Item Number 4 is completed, then this field should be completed.
11A	Insured's Date of Birth, Sex	**Optional -**Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

Item #	Description	Instructions
11B	Other Claim ID (Designated by NUCC)	N/A
11C	Insurance Plan or Program Name	N/A
11D.	Is There Another Health Benefit Plan?	**Situational**- Enter an X in the correct box. If marked “YES”, complete 9, 9a, and 9d. Only one box can be marked.
12	Patient's or Authorized Person's Signature	N/A
13	Insured's or Authorized Person's Signature	N/A
14	Date of Current Illness, Injury, Pregnancy	**Situational –** Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line.
15	Other Date	**Situational**-Enter another date related to the patient’s condition or treatment. Enter the date in the 6-digit (MM│DD│YY) or 8-digit (MM│DD│YYYY) format. Enter the applicable qualifier to identify which date is being reported. 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines.
16	Dates Patient Unable to Work in Current Occupation	**Optional**-If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date must be shown for the “from–to” dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Item #	Description	Instructions
17	Name of Referring Provider or Other Source	**Situational –** Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Enter the applicable qualifier to identify which provider is being reported. DN Referring Provider DK Ordering Provider DQ Supervising Provider Enter the qualifier to the left of the vertical, dotted line.
17A.	Other ID #	**Situational –** The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.).
17B	NPI Number	**Situational** – Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.
18	Hospitalization Dates Related to Current Services	**Optional -**Enter the inpatient 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Additional Claim Information (Designated by NUCC)	**Situational-**Please refer to the most current instructions from the public or private payer regarding the use of this field. NH Medicaid-Used for providers to communicate information particular to this claim, not a duplicate or not covered by other insurance and why.

Item #	Description	Instructions
20	Outside Lab? $ Charges	**Optional -**Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim.
21	Diagnoses or Nature of Illness or Injury	**Required -** Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the l
22	Resubmission and/or Original Reference Number	**Optional-**List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field (e.g., code). When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. 7 Replacement of prior claim 8 Void/cancel of prior claim This Item Number is not intended for use for original claim submissions.
23	Prior Authorization Number (Service Authorization)	****Not being used at this time**** **Situational-** Enter any of the following: prior authorization number, as assigned by the payer for the current service. The "Prior Authorization Number" is the payer assigned number authorizing service(s)

Item #	Description	Instructions
24A	Date(s) of Service (lines 1–6)	**Required -** Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. The number of days must correspond to the number of units in 24G. Date(s) of Service" indicates the actual month, day, and year the service(s) was provided.
24A	Shaded Area Supplemental Information	**Situational-**Enter the National Drug Codes (NDC), for J, Q and S drug procedure codes. The NDC Qualifier N4 should be entered in the first two positions, then the 11 digit NDC code without dashes or spaces. The NDC units of measure qualifier and NDC drug quantity should follow. The following qualifiers are to be used when reporting NDC unit/basis of measurement: F2 International Unit ME Milligram UN Unit GR Gram ML Milliliter
24B	Place of Service lines(1–6)	**Required -** In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The "Place of Service" Code identifies the location where the service was rendered. The Place of Service Codes are available at: www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf.
24C	EMG (lines 1–6)	**N/A**
24D	Procedures, Services or Supplies (Lines 1-6)	**Required-**Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description.
24E	Diagnosis Pointer (Lines 1-6)	**Required -** In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. This field allows for the entry of 4 characters in the unshaded area
Item #	**Description**	**Instructions**
24F	$ Charges (Lines 1-6)	**Required -** Enter the charge for each listed service. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole

		number. "Charges" is the total billed amount for each service line.
24G	Days or Units (Lines 1-6)	**Required -** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers left justified in the field. No leading zeroes are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management"). "Days or Units" is the number of days corresponding to the dates entered in 24A
24H.	EPSDT/Family Plan (Lines 1-6)	**Situational-**For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only. If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is right justified in the shaded area of the field. The following codes for EPSDT are used in 5010A1: AV- Available – Not Used (Patient refused referral.) S2- Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) ST- New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) NU- Not Used (Used when no EPSDT patient referral was given.) If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field.

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

Item #	Description	Instructions
28	Total Charge	**Required –** Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. The "Total Charge" is the total billed amount for all services entered in 24F (lines 1–6).
29	Amount Paid	**Required**- Enter total amount the patient and/or other payers paid on the covered services only. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. The "Amount Paid" is the payment received from the patient or other payers.
30	Reserved for NUCC Use	**N/A** -This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.
31	Signature of Physician or Supplier Including Degrees or Credentials	**Required –** "Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1. Enter the legal signature of the practitioner or supplier, or signature stamp Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY) the form was signed. This date must be on or after the last date of service on the claim. The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title.
32	Service Facility Location Information	**Situational-**The name and address of facility where services were rendered identifies the site where service(s) were provided. Enter the name, address, city, state, and ZIP code of the location where the services were rendered. NH Medicaid utilizes this information to assist with the NPI crosswalk.
32A	NPI #	**Situational** -Enter the NPI number of the service facility location in 32a. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.
32B	Other ID#	**Optional**- Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number LU Location Number The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

Item #	Description	Instructions
33	Billing Provider Info & Ph #	**Required –** Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP Code Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code, including the hyphen. Do not use a hyphen or space as a separator within the telephone number. 5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here. The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.
33A.	NPI#	**Required -** Enter the NPI number of the billing provider in 33A. **Not required for Atypical providers.**
33B	Other ID#	**Required –** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.) The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field. The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional.

12. Terminology

Acute Care Hospital: A hospital that provides short-term medical treatment for patients who have an acute illness or injury, or who are recovering from surgery.

Air Ambulance: A fixed-wing or rotary-wing aircraft that is certified by the Federal Aviation Administration as an air ambulance and which is designed and equipped for the provision of medically necessary supplies and services.

Ambulance: Any vehicle designed, equipped, and used for the transport of sick or injured individuals and which are licensed to do so in the state in which they operate.

Advanced Life Support (ALS) Services: Medical procedures and the scope of practice rendered by advanced emergency medical care providers in accordance with RSA 153-A:12.

Basic Life Support (BLS) Services: Fundamental medical procedures and the scope of practice in which emergency medical care providers at the first responder or emergency medical technician-basic levels are trained.

Emergency medical condition: Means either of the following conditions:

(1) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions:

a That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer may pose a threat to the health or safety of the woman or unborn child.

Scheduled and routine ambulance transportation: Transportation by an ambulance for the purpose of attending an appointment to obtain a Medicaid covered service from a Medicaid enrolled provider when the use of any other mode of transportation would likely endanger the health and safety of the member and when the Medicaid covered service is not to treat an emergency medical condition.