# Substance Use Disorder (SUD) Treatment and Recovery Support Services

Provider Manual
Volume II

October 2019

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New Hampshire
Medicaid

# Table of Contents

# Change Log

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

| | |
|---|---|
| Date Change to the Manual | Date the change was physically made to the manual. |
| 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 |
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# 1. NH Medicaid Provider Billing Manuals Overview

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

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

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

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

## Intended Audience

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

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

Please note that the provider billing manual applies only to billing requirements for members who are eligible for the Fee-for-Service Medicaid Program, and not for Managed Care. Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to the General Billing Manual - Volume I for instructions on confirming member eligibility.

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

## Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media including provider bulletins, provider notices, memos, letters, website 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 the fiscal agent. Providers receive notification of manual updates through a message sent to each provider's message center inbox via the web.

## Description of Change Log

All changes made to this manual are under change control management and are approved by 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 fiscal agent's Provider Relations Unit (refer to the 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 fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

# 2. Provider Participation & Ongoing Responsibilities

All participating New Hampshire SUD providers shall be enrolled NH Medicaid providers.

SUD providers must ensure that all SUD treatment and recovery support services are provided and documented in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR 160, 45 CFR 164, Subparts A and E, and 42 CFR, Part II.

## Delegation and Supervision Requirements and Restrictions

Those practitioners who deliver services as part of Medicaid enrolled outpatient or comprehensive SUD programs shall be allowed to delegate the performance of SUD treatment and recovery support services in accordance with scope of law and practice and subject to the restrictions as outlined below. Please see the Department's rules at He-W 513 on www.nh.gov for further details. Also see "Covered Services" to determine provider requirements for the provision of each service.

1. With the exception of those licensed alcohol and drug counselors (LADC) who are permitted to engage in independent practice, LADC's shall only provide SUD treatment and recovery support services under the supervision of a master licensed alcohol and drug counselor (MLADC) who is on the staff of a Medicaid enrolled outpatient SUD or comprehensive SUD program; a LADC who is permitted to engage in independent practice who is also a licensed clinical supervisor (LCS) and who is on the staff of a Medicaid enrolled outpatient or comprehensive SUD program; or a licensed mental health provider who is on the staff of a Medicaid enrolled outpatient or comprehensive SUD program.
2. Those outpatient or comprehensive SUD program services which are delegated must be billed by the outpatient or comprehensive SUD program and are only reimbursed if the supervision requirements below are met and documented.
3. Certified recovery support workers (CRSW) must be under the supervision of one of the following who is on the staff of or under contract with a Medicaid enrolled outpatient SUD program, comprehensive SUD program, or peer recovery program:
    a. An MLADC;
    b. A LADC;
    c. A CRSW who has been certified for one year and has taken 6 hours of supervisory training and 6 hours of practical training which has been approved by the board pursuant to Alc 409.01; or
    d. A licensed mental health provider
4. LADC's delivering recovery support services must be under the supervision of an MLADC who is on the staff of or under contract with a Medicaid enrolled outpatient SUD program, comprehensive SUD program, or peer recovery program.
5. An MLADC delivering recovery support services shall not require supervision.
6. Individuals who are enrolled in a formal internship for at least a master's degree in a clinical discipline that meets the requirements for initial licensing as an MLADC pursuant to RSA 330-C:16, I shall only provide services under the supervision of an MLADC or licensed mental

health provider who is on the staff of or contracted with a Medicaid enrolled outpatient or comprehensive SUD program ,

7. Individuals who have completed at least one year of work in the field of substance use disorders treatment under the supervision of an MLADC or licensed mental health provider, have at least a master's degree in a clinical discipline that meets the requirements for initial licensing as an MLADC pursuant to RSA 330-C:16, I, and who are working to accumulate the work experience required for licensure shall only provide services under the supervision of an MLADC or licensed mental health provider who is on the staff of or contracted with a Medicaid enrolled outpatient or comprehensive SUD program.
8. Individuals who are enrolled in a formal internship for at least a master's program that meets the requirements for initial licensure by the NH Board of Mental Health Practice pursuant to RSA 330-A shall only provide services under the supervision of a psychotherapist who is on the staff of or contracted with a Medicaid enrolled outpatient or comprehensive SUD program.;
9. Individuals who have completed at least one year of work in the field of substance use disorders treatment under the supervision of a psychotherapist, who have at least a master's degree that meets the requirements for initial licensure by the NH Board of Mental Health Practice pursuant to RSA 330-A and who are working to accumulate the work experience required for licensure shall only provide services under the supervision of a psychotherapist who is on the staff of or contracted with a Medicaid enrolled outpatient or comprehensive SUD program;
10. Individuals who are enrolled in a formal internship for at least a master's program that meets the requirements for initial licensure by the NH Board of Psychologists pursuant to RSA 329-B shall only provide services under the supervision of a psychologist who is on the staff of or contracted with a Medicaid enrolled outpatient or comprehensive SUD program;
11. Individuals who have completed at least one year of work in the field of substance use disorders treatment under the supervision of a person licensed by the NH Board of Psychologists and who have at least a master's degree that meets the requirements for intial licensure by the NH Board of Psychologists pursuant to RSA 329-B, and who are working to accumulate the work experience required for licensure shall only provide services under the supervision of a psychologist who is on the staff of or contracted with a Medicaid enrolled outpatient or comprehensive SUD program;
12. Individuals who qualify via #6-11 above and who hold at least a master's degree must receive ongoing supervision of at least 2 hours per month consisting of direct, individual, or group supervision of at least one hour per month by the supervising practitioner noted above. The second hour may be peer or case review such as client-centered conferences.
13. Individuals who qualify via #6-11 above and who are enrolled in a formal internship must receive direct supervision of at least one hour per week. The supervisor must write and sign a weekly note in the intern's supervisory record stating his or her observations and recommendations relative to the intern's performance. The supervisor must write and sign a monthly note in the intern's supervisory record summarizing his or her evaluation.
14. LADC's who are permitted to engage in independent practice may not provide supervision to an MLADC for the purposes of providing SUD services under Medicaid.

Additional provider requirements follow:

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| Comprehensive SUD Program | • Agency under contract or agreement with the Department whose facility is licensed as a residential treatment and rehabilitation facility in accordance with He-P 807 or a state-owned SUD residential treatment and rehabilitation facility exempt from licensure per RSA 151:2, II(i) and He-P 807 or<br>• A hospital enrolled as both a hospital per He-W 543 and as a comprehensive SUD program; or<br>• Providers enrolled in Medicaid in the state in which they practice to provide residential services per ASAM Criteria |
| Outpatient SUD Program | • Agency under contract with or agreement with the Department; or<br>• A hospital enrolled as both a hospital per He-W 543 and as an outpatient SUD program; or<br>• Providers enrolled in Medicaid in the state in which they practice to provide intensive outpatient services consistent with Level 2.1 per ASAM 2013, or partial hospitalization consistent with Level 2.5 per ASAM 2013; or<br>• Agency under current primary care services contract obligation with the Maternal and Child Health Section of the NH Division of Public Health Services; or<br>• A Medicaid enrolled community health center; or<br>• A Medicaid enrolled FQHC or RHC; or<br>• A Department-certified opioid treatment program |
| Independent LADCs | Per Chapter Law 189:2, II, Laws of 2008, and Chapter Law 249:24, V, Laws of 2010 |
| LADCs and MLADCs | Licensed by the NH Board of Licensing for Alcohol and Other Drug Use Professionals if practicing in NH.<br><br>If practicing in an out of state comprehensive or outpatient SUD program, must hold a reciprocal international certification and reciprocity consortium/alcohol and other drug abuse license. |
| Certified Recovery Support Worker | Certified by the NH Board of Licensing for Alcohol and Other Drug Use Professionals |
| Hospitals | Must be enrolled as an outpatient or comprehensive SUD program in order to provide outpatient or comprehensive SUD services |
| Peer Recovery Program | A recovery community organization or program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS), is accredited by Clubhouse International, is under contract with the Department's contracted facilitating organization, or is under contract with the Department's BDAS to provide peer recovery support services. |

# 3. Covered Services & Requirements

The covered services and requirements that make up the SUD treatment and recovery support services benefit are as described below.

## Requirements

In order for SUD treatment and recovery support services to be covered, they must be:

1. Delivered in accordance with appropriate guidelines that are consistent with generally accepted standards of care in the ASAM Criteria 2013.

2. Evidence based as demonstrated by (a) being included as an evidence-based mental health and substance abuse intervention on the SAMHSA Evidence-Based Practices Resource Center, (b) published in a peer-reviewed journal and found to have positive effects, or (c) documented as effective by the SUD provider based on (a) the service being effective based on a theoretical perspective that has a validated research, or (b) the service being supported by a documented body of knowledge generated from similar or related services that indicate effectiveness.

3. Include continuing care, transfer, and discharge plans that address all domains in ASAM 2013 as detailed in He-W 513.

When providing and billing for SUD treatment and recovery support services, it is important to follow the provider requirements for the various SUD services. The chart at the end of the covered services section contains details by service related to which provider types can provide which services, who is allowed to actually bill for the services, and who must deliver services in various settings. Additional provider requirements such as training requirements or other criteria specific to various SUD services are detailed under the applicable covered service in the covered services section below.

SUD treatment providers must ensure that all covered services are provided in accordance with ASAM 2013 criteria with the exception of SBIRT services, substance use screening, crisis intervention, and evaluations. The provider must ensure that the recipient has undergone a clinical evaluation, as described in the Covered Services section prior to the provider's delivery of other SUD treatment and recovery support services with the exception of SBIRT, screening, and crisis intervention.

All SUD providers must treat co-occurring disorders in accordance with scope of law and practice.

Hospitals that wish to provide outpatient or comprehensive SUD services in addition to acute care services must enroll as an outpatient or comprehensive SUD program in addition to hospital enrollment in accordance with He-W 543.

SUD providers that close their treatment and recovery support programs should refer to the Department's rules at He-W 513.10 for requirements regarding recipient records.

# Covered Services

Covered SUD treatment and recovery support services include:

1. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** for the purpose of identifying individuals who have an alcohol or drug use problem or who are at risk of developing one. The screening shall be conducted by evaluating responses to questions using a screening instrument listed in Appendix E of "Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment, TAP 33," 2013 edition.

SBIRT must be provided with and billed with another medical service and provided in a primary care provider's office or other health care setting not specific to the delivery of SUD services. The provider must be trained in the SBIRT model.

SBIRT provided by an FQHC is considered to be part of the encounter and cannot be billed separately.

2. **SUD Screening** for the purpose of identifying individuals who have an alcohol or drug use problem or who are at risk for developing one. The screening shall be conducted by evaluating responses to questions using a screening instrument listed in Appendix E of "Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment, TAP 33," 2013 edition.

3. **Opioid Treatment Services** are covered when provided by medical services clinics who are certified as opioid treatment programs in accordance with He-A 304.03 and who deliver services in accordance with a treatment plan. Services are limited to treatment with methadone or buprenorphine.

Opioid treatment services are inclusive of the necessary components of the daily opioid treatment services, such as intake services, medication counseling, administration, medical supervision of vitals, observation afterwards, urine testing, and blood and lab work. Therefore, these components are not to be billed separately. However, SUD treatment and recovery support services may be provided in conjunction with opioid treatment services and billed separately. See Provider Manual, Volume II, Medical Services Clinics, and He-W 536 for further billing and service information.

4. **Pharmaceuticals** prescribed for SUD treatment services are covered and billed in accordance with Department rules at He-W 570 and the pharmacy provider manual found at https://www.dhhs.nh.gov/ombp/pharmacy/documents/providermanual02-19.pdf.

5. **Office Based Medication Assisted SUD Treatment** is covered when provided by medical professionals working within their scope of practice.

The writing of the prescription must be a component of a practitioner office visit. The practitioner must refer the recipient to clinically appropriate SUD treatment and recovery services and coordinate care with the SUD treatment and recovery provider within or external to the office based practice.

Office based MAT with buprenorphine requires the above and that the prescriber has obtained a waiver in accordance with the Drug Addiction Treatment Act of 2000, Title XXXV, Section 3502 of the Children's Health Act of 2000 and the Comprehensive Addiction and Recovery Act of 2016, to treat opioid addiction with Schedule III, IV, and V narcotic medications, and provides services in accordance with the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, Appendix F, Federation of State Medical Boards – Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office, 2004.

6. **Outpatient, Individual Treatment** consistent with ASAM Criteria 2013, Level 1, is covered when delivered in accordance with a treatment plan.

7. **Group Treatment** consistent with ASAM Criteria 2013, Level 1, is covered when delivered in accordance with a treatment plan. Additionally, services are covered only when 2 or more individuals are present for a group service. When there is only one licensed practitioner present, the group shall include no more than 12 individuals, or no more than 16 individuals when that licensed practitioner is joined by a CRSW or a second licensed practitioner. Recovery support groups shall include no more than .8 individuals with one CRSW present or no more than 12 individuals when that CRSW is joined by a second CRSW. Peer recovery support groups shall include no more than 8 individuals with one peer recovery coach present or no more than 12 individuals when that peer recovery coach is joined by a second peer recovery coach.

8. **Family Treatment** consistent with ASAM Criteria 2013, Level 1, is covered when provided to the recipient and/or the family or significant others with the recipient present if treatment is related to the recipient's SUD. Family treatment must be delivered in accordance with a treatment plan.

9. **Intensive Outpatient SUD Services** consistent with ASAM Criteria 2013, Level 2.1, are covered when delivered in accordance with a treatment plan and must be comprised of a combination of individual and group treatment services as follows:

Recipient age 21 and over: At least 9 hours per week.

Recipients under age 21: At least 6 hours per week.

Group treatment is covered only when 2 or more individuals are present for a group service. When there is only one licensed practitioner present, the group shall include no more than 12 individuals, or no more than 16 individuals when that licensed practitioner is joined by a CRSW or a second licensed practitioner. Recovery support groups shall include no more than 8 individuals with one CRSW present or no more than 12 individuals when that CRSW is joined by a second CRSW. Peer recovery support groups shall include no more than 8 individuals with one peer recovery coach present or no more than 12 individuals when that peer recovery coach is joined by a second peer recovery coach

Intensive outpatient SUD services must be comprised of a range of outpatient treatment services and other ancillary alcohol or drug treatment services to include all of the following:

- Evaluation
- Individual, group, or family treatment
- Crisis intervention
- Activity therapies
- Substance use prevention education

10. **Partial Hospitalization Services** consistent with ASAM Criteria 2013, Level 2.5, are covered when provided to recipients with moderate to severe co-occurring SUD and mental health disorders as described in DSM-5, 2013. Partial hospitalization must address both disorders and be comprised of a range of outpatient treatment services and other ancillary mental health and alcohol or drug treatment services to include all of the following:

- Evaluation
- Individual, group, or family treatment
- Crisis intervention
- Activity therapies
- Medication management, which shall include psychiatric services, including psychotropic medication management services as applicable
- Substance use prevention education

Services must be provided at least 20 hours per week. Group sessions are covered only when 2 or more individuals are present for a group service. When there is only one licensed practitioner present, the group shall include no more than 12 individuals, or no more than 16 individuals when that licensed practitioner is joined by a CRSW or a second licensed practitioner. Recovery support groups shall include no more than 8 individuals with one CRSW present or no more than 12 individuals when that CRSW is joined by a second CRSW. Peer recovery support groups shall include no more than 8 individuals with one peer recovery coach present or no more than 12 individuals when that peer recovery coach is joined by a second peer recovery coach

11. **Rehabilitative Services** are covered when provided by a Medicaid enrolled comprehensive SUD program. Services must be provided as a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for persons with SUDs.

Recipients who are being treated at an ASAM 3.5 level of care must be present in the facility at least 22 hours per day. Recipients being treated at an ASAM 3.1 level of care must receive at least 5 hours of clinical service per week.

12. **Medically Monitored Outpatient Withdrawal Management,** consistent with ASAM Criteria 2013, Level 1-WM, is covered when organized and delivered by SUD treatment and mental health personnel and other health care providers who provide a planned regimen of care in the outpatient setting, and in accordance with a treatment plan. Services must be provided in regularly scheduled sessions in accordance with defined policies and procedures consistent with ASAM 2013 standards. Services must also be provided under an integrated or collaborative service model.

13. **Medically Monitored Residential Withdrawal Management,** consistent with ASAM Criteria 2013, Level 3.7-WM, is covered when organized and delivered by SUD treatment and mental health personnel and other health care providers who provide a planned regimen of care in a 24-hour live-in setting.

14. **Medically Managed Withdrawal in an Acute Care Setting** is covered by hospitals in accordance with Provider Volume II, "Hospitals," and the Department's rules at He-W 543.

15. **Crisis Intervention** is covered when a recipient, family member, or significant other is facing a crisis or emergency situation and the crisis intervention is provided with the recipient present and is related to the recipient's SUD.

16. **Peer Recovery Support Services** are delivered by a peer recovery coach and are covered for the purpose of helping recipients age 12 and above and families identify and work toward strategies and goals around stabilizing and sustaining recovery and, as applicable, providing links to professional treatment and community supports. Peer recovery coaches must have at least 30 contact hours of recovery coach training approved by (a) the NH Training Institute on Addictive Disorders, (b) NAADAC, the Association for Addiction Professionals, (c) the NH Board of Licensing for Alcohol and Other Drug Use Professionals, (d) The Addiction Technology Transfer Center, (e) AdCare Education Institute, Inc., of New England, or (f) the Connecticut Communities for Addiction Recovery (CCAR) Recovery Coach Academy (RCA). Peer recovery coaches must also have completed at least 16 contact hours of training in ethics and at least 6 contact hours of training in suicide prevention, and at least 3 contact hours of training on co-occurring mental health and substance use disorders approved by the above.

17. **Recovery Support Services** are covered and include non-clinical group or individual services consistent with a recipient's treatment plan that help to prevent relapse and promote recovery and community integration.

18. **Continuous Recovery Monitoring** is covered and must include recovery check-ups with recipients on a regular basis, evaluations of the status of the recipient's recovery, consideration of a broad array of recipient needs, and provision of active referral to community resources as applicable.

19. **Evaluations** to determine the existence and severity of the SUD and appropriate level of care for the recipient are covered. The results of the evaluation must be maintained in the recipient's file and must include the following:

- Client identified problem(s)
- Summary of data gathered
- Diagnostic evaluation interpretive summary, including signs, symptoms, and progression of the recipient's involvement with alcohol and other drugs
- Statement regarding provision of an HIV/AIDS screening and referrals made
- Documentation of the level of care recommended in accordance with ASAM Criteria 2013

Evaluations must be completed within 3 sessions or within 3 days of client admission to services, whichever is longer.

Additional provider requirements for the provision of each service:

| Service | Provided by: | Billed by (individual or group): | Comments: |
|---|---|---|---|
| SBIRT | Medicaid enrolled practitioner working within their scope of practice. | Practitioner or supervising physician | Must be provided and billed with another medical service and in a location not specific to the delivery of SUD treatment and recovery support services. Provider must be trained in SBIRT model |
| SUD Screening | Medicaid Enrolled:<br>Psychotherapy providers<br>MLADCs<br>Independent LADCs<br>Outpatient SUD programs<br>Comprehensive SUD programs<br>_____<br>Individuals under supervision of the above | Psychotherapy provider<br>MLADC<br>Independent LADC<br>Outpatient SUD<br>Comprehensive SUD<br>_____<br>Supervising practitioner or outpatient or comprehensive SUD | "delegation and supervision restrictions" do not apply; see He-W 513.05(d) (4) and (5) for service delivery and supervision requirements |
| MAT in an Opioid Treatment Program | Medicaid Enrolled:<br>Medical services clinics | Medical services clinics | Services must be delivered by Department approved opioid treatment programs |
| Pharma-ceuticals | Medicaid Enrolled Pharmacies | Pharmacies | |

| Service | Provided by: | Billed by (individual or group): | Comments: |
|---|---|---|---|
| Office Based Medication Assisted SUD Treatment | Medicaid Enrolled practitioners working within scope of practice | Supervising practitioner or supervising physician<br>OP SUD<br>Comprehensive SUD | Prescription writing must be component of practitioner office visit |
| Outpatient Individual Treatment | Medicaid Enrolled:<br>Psychotherapy providers<br>MLADCs<br>Independent LADCs<br>Physicians<br>APRN's<br>Outpatient SUD Programs<br>Comprehensive SUD Programs | Psychotherapy provider<br>MLADC<br>Independent LADC<br>Physician<br>APRN<br>Outpatient SUD<br>Comprehensive SUD | |
| Group Treatment | Medicaid Enrolled:<br>Psychotherapy providers<br>MLADCs<br>Independent LADCs<br>Physicians<br>APRN's<br>Outpatient SUD Programs<br>Comprehensive SUD Programs | Psychotherapy provider<br>MLADC<br>Independent LADC<br>Physician<br>APRN<br>Outpatient SUD<br>Comprehensive SUD | |
| Family Treatment | Medicaid Enrolled:<br>Psychotherapy providers<br>MLADCs<br>Independent LADCs<br>Physicians<br>APRN's<br>Outpatient SUD Programs<br>Comprehensive SUD Programs | Psychotherapy provider<br>MLADC<br>Independent LADC<br>Physician<br>APRN<br>Outpatient SUD<br>Comprehensive SUD | |
| Intensive Outpatient SUD, 2.1 | Medicaid Enrolled:<br>Outpatient SUD Programs<br>Comprehensive SUD Programs | Outpatient SUD<br>Comprehensive SUD | |
| Partial Hospitaliza-tion | Medicaid Enrolled:<br>Outpatient SUD Programs<br>Comprehensive SUD Programs | Outpatient SUD<br>Comprehensive SUD | |
| Rehabilita-tive Services | Medicaid Enrolled:<br>Comprehensive SUD program | Comprehensive SUD | |
| Medically Monitored Outpatient Withdrawal Manage-ment (WM), Level 1 | Medicaid Enrolled:<br>Outpatient SUD Programs<br>Comprehensive SUD Programs (and supervised by a licensed physician or APRN on staff of, or under contract with, such programs) | Outpatient SUD<br>Comprehensive SUD | |
| Medically | Medicaid Enrolled: | | |

| Service | Provided by: | Billed by (individual or group): | Comments: |
|---|---|---|---|
| Monitored Residential Withdrawal Manage-ment, Level 3.7 | Comprehensive SUD program | | |
| Medically Managed Withdrawal in Acute Care Setting | Medicaid Enrolled:<br>Hospitals meeting requirements of He-W 543 | Hospitals | |
| Crisis Intervention | Medicaid Enrolled:<br>Psychotherapy providers<br>MLADCs<br>Independent LADCs<br>Physicians<br>APRNs<br>Outpatient SUD Programs<br>Comprehensive SUD Programs | Psychotherapy provider<br>MLADC<br>Independent LADC<br>Physician<br>APRN<br>Outpatient SUD<br>Comprehensive SUD | |
| Peer Recovery Support | Medicaid Enrolled Peer Recovery Program | Peer Recovery Program<br><br>Supervising practitioner must be listed as rendering | Must be delivered by:<br>Peer Recovery Coach<br>(see He-W 513 for details |
| Recovery Support Services | Medicaid Enrolled:<br>Outpatient SUD Programs<br>Comprehensive SUD Programs<br>Peer Recovery Programs | Outpatient SUD<br>Comprehensive SUD<br>Peer Recovery Program<br><br>Supervising practitioner must be listed as rendering | Must be delivered by:<br>CRSW<br>LADC<br>MLADC<br>(See He-W 513 for supervision requirements.) |
| Continuous Recovery Monitoring | Medicaid Enrolled:<br>Outpatient SUD Programs<br>Comprehensive SUD Programs<br>Peer Recovery Programs | Outpatient SUD<br>Comprehensive SUD<br>Peer Recovery Programs | Must be delivered by:<br>CRSW<br>LADC<br>MLADC<br>(See He-W 513 for supervision requirements) |

| Service | Provided by: | Billed by (individual or group): | Comments: |
|---|---|---|---|
| Evaluations | Medicaid Enrolled:<br>Psychotherapists<br>MLADCs<br>Independent LADCs<br>Outpatient SUD Programs<br>Comprehensive SUD Programs | <br>Psychotherapists<br>MLADC<br>Independent LADC<br>Outpatient SUD<br>Comprehensive SUD | |

## Service Limits

There are no service limits on SUD treatment and recovery support services.

# 4. Non-Covered Services

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

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

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

Non-covered SUD treatment and recovery support services include:

- Services that are delivered at a higher level than the recipient's level of care as described in ASAM 2013
- Services that are non-evidence based per He-W 513.05(b)
- Services that are not specified as covered in this billing manual or in He-W 513.05

# 5. Service Authorizations (SA)

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

Service authorizations do not apply to SUD treatment and recovery support services at this time.

However, prior authorization may be required before a pharmacy provider can bill for medications used for Medication Assisted Treatment (MAT). Prior authorization is not required for the preferred product on the Medicaid preferred drug list (PDL) at the standard dose. Prior authorization is required for non-preferred products. The PDL and fax form can be found at: http://www.dhhs.nh.gov/ombp/pharmacy/

# 6. Documentation

SUD providers must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement. Refer to 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 the resolution of any legal action(s) commenced in the six year period, whichever is longer.

Supporting documentation that must be maintained includes:

- A complete record of all physical examinations, laboratory tests, and treatments including drug and counseling therapies, whether provided directly or by referral;
- Progress notes for each treatment session including (a) the treatment modality and duration, (b) the signature of the primary therapist for each entry, (c) the primary therapist's professional discipline, and (d) the date of each treatment session;
- A copy of the treatment plan that is (a) updated at least every 4 sessions or 4 weeks, whichever is less frequent, (b) signed by the provider and the recipient prior to treatment being rendered, and (c) signed by the clinical supervisor prior to treatment being rendered if the service is an outpatient or comprehensive SUD program

The recipient's individual record shall include at a minimum (a) the recipient's name, date of birth, address, and phone number and (b) a copy of the evaluation described under "Covered Services."

SUD providers must ensure that all SUD treatment and recovery support services are provided and documented in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR 160, 45 CFR 164, Subparts A and E, and 42 CFR, Part II.

SUD providers that close their treatment and recovery support programs should refer to the Department's rules at He-W 513 for requirements regarding recipient records.

All electronic or written documentation must be legible and written in English and in the recipient's primary language as applicable.

SUD treatment and recovery support services providers shall provide documentation to the Department upon request.

# 7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse. These utilization review activities are required and carried out in accordance with Federal regulations at 42 CFR 455 and 42 CFR 456, and they are done to ensure that accurate and proper reimbursement has been made for care, services and/or supplies that have been provided to a member, and for which a provider has received payment.

Utilization review activities may be conducted prior to payment, following payment, or both. These activities include, but are not limited to, conducting provider reviews. These reviews may be selected at random, generated from member complaints, other providers, anonymous calls, or from the SURS reporting system.

There are various outcomes that may result from Program Integrity review activities. They include, but are not limited to:

- Recovery of erroneous and improper provider payments
- Provider education regarding appropriate documentation to support the submission and payment of claims
- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid Program
- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG)
- Potential termination from the NH Medicaid Program
- Other administrative actions

If a provider is found to have abused the NH Medicaid Program requirements, the provider may be restricted, through suspension or otherwise, from participating in the NH Medicaid Program for a reasonable period of time. In addition, the provider may also have their claims placed on a prepayment pend or hold status for additional review by the Program Integrity Unit.

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

# 8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. 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 the fiscal agent in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume I. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

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

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

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

When a member is also covered by Medicare, the provider must bill Medicare for all services before billing NH Medicaid. The provider must accept assignment of Medicare benefits in order for the claim to "***cross over***" to NH Medicaid. The crossover process works only for Medicare approved services; Medicare denied services and Medicare non-covered services are addressed in this section. NH Medicaid pays crossover claims only if the service is covered by NH Medicaid.

Certain services that are not covered by Medicare *may* be covered by NH Medicaid for dually eligible members. Services identified in the Medicare billing manual and the HCPCS coding manuals as non-covered by Medicare may be billed directly to NH Medicaid who will determine whether or not the service is covered and can be reimbursed by NH Medicaid.

This does not apply to Qualified Medicare Beneficiaries (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 services to SUD treatment and recovery support services shall be made in accordance with rates of reimbursement established by the Department pursuant to RSA 161:4, VI(a).

Reimbursement for rehabilitative services in a comprehensive SUD program shall be on a per diem basis that takes into account the ASAM level of care and does not include room and board.

Reimbursement for partial hospitalization, medically monitored residential withdrawal management, and intensive outpatient SUD services shall be on a per diem basis and inclusive of all component services rendered with the exception of interpreter services which can be billed separately by the interpreter provider.

Reimbursement for medically monitored outpatient withdrawal management shall be on a per visit basis inclusive of all component services rendered with the exception of interpreter services which can be billed separately by the interpreter provider.

SUD providers may bill separately for drug testing utilizing rapid read tests, except when done in conjunction with opioid treatment services.

## Opioid Treatment/Methadone Clinics, Hospitals, and FQHC's

Opioid Treatment/Methadone Clinics:

Payment for opioid treatment services is inclusive of the necessary components of the daily opioid treatment services, such as intake services, medication, counseling, administration, medical supervision of vitals, observation afterwards, urine testing, and blood and lab work. Therefore, these components are not to be billed separately. However, SUD treatment and recovery support services may be provided in conjunction with opioid treatment services and billed separately. Details regarding the billing of opioid treatment services are found in the "Provider Billing Manual-Volume II, Medical Services Clinics."

Inpatient Hospitals:

Hospitals may provide and bill for medically necessary, acute care hospital services described in Department rules at He-W 543 and "Provider Billing Manual-Volume II, Hospital Services, and must be enrolled as Medicaid hospital providers in order to do so. If hospitals wish to provide and bill for SUD treatment and recovery support services as an outpatient or comprehensive SUD provider, the hospital must be enrolled as an outpatient or comprehensive SUD program in order to provide such services.

Federally Qualified Health Centers (FQHC's), FQHC Look-A-Likes, and RHC-Non-Hospital Based:

FQHC's, FQHC Look-A-Likes and RHC-Non-Hospital Based must follow the billing requirements detailed in the "Provider Billing Manual-Volume II, FQHC's, FQHC Look-A-Likes, RHC-Non-Hospital Based." These providers are allowed to provide the covered services specified as billable by outpatient SUD providers.

In accordance with the FQHC billing manual, FQHC's are allowed to bill one medical encounter and one behavioral health encounter per day. The specific behavioral health codes that qualify for an encounter payment are specified in the FQHC billing manual and do not include any SUD treatment and recovery support services codes. FQHC providers should bill only those SUD services allowed to be billed by outpatient SUD programs and should bill those services in the same manner that FQHC ambulatory services are billed.

SBIRT services that are provided by the FQHC must be performed in conjunction with a physician visit and are considered to be part of the encounter. They should not be separately billed as fee for service. If a screening results in a positive screen and a referral, the SBIRT is still considered to be part of the encounter. If a clinician is pulled into the visit when the SBIRT is taking place, this is also part of the encounter and cannot be billed separately.

See the provider bulletin of December 1, 2017 in Appendix I for detailed billing instructions.

# 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. One procedure code must be provided for each charge billed.

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

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.

## 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.

For some services, providers must obtain pre-approval and a corresponding service authorization number. The claim form allows the entry of a service authorization number. However, the NH Medicaid Program does not require the service authorization number on the claim form. If providers

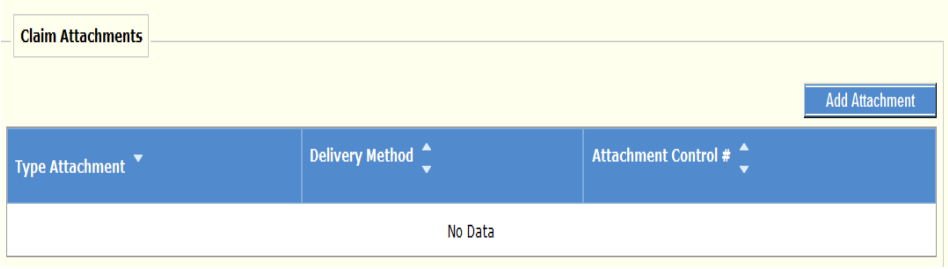
choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

Service authorizations are not required for SUD treatment and recovery support services.

## Required Claim Attachments

All attachments must be submitted in hardcopy format or via fax. Providers that submit claims on paper 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 on the claim form if there is an attachment to support the claim. Providers should answer yes to the question "Does this claim have attachments?" and click "Add Attachment" **Note:** Please select Delivery Method "by Mail" or "by Fax" to submit attachments.




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

- **Please mail claim attachments to:**
  NH Medicaid Claims Unit
  PO Box 2003
  Concord, NH 03302

- **Please fax claim attachments to:**
  (888) 495-8169

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

Examples of, but not inclusive of, when a claim attachment is required are when another insurer is primary and has denied coverage for the service or a 957x form is required because the filing limit was not met.

# Claims Completion Requirements for SUD Treatment and Recovery Support Services

SUD services must be submitted on a CMS 1500 claim form. The electronic version is an 837P.

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 areas 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 the fiscal agent. The fiscal agent imaging/OCR system reads only black ink.
7. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
8. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

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

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

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

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

The format is: YYDDD M BBBB NNNNNN T, where

- YYDDD is the Julian date when the batch was created.

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

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

- CMS-1500 (or professional claim), it is box 9D.
- UB-04 (or institutional claim), it is Locator box 50.

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.

# 12. CMS-1500 Claim Form Instructions

| Item # | Description | Instructions |
|---|---|---|
| 1 | | **Required**-Indicate NH Medicaid coverage by placing an X in the appropriate box. Only one box can be marked. |
| 1A | Insured's ID Number | **Required** - Enter the NH Medicaid ID number (11 characters) shown on the ID card. |
| 2 | Patient's Name | **Required -** Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. |
| 3 | Patient's Birth Date, Sex | **Required-**Enter the patient's 8-digit birth date (MM ǀ DD ǀ YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave blank. |
| 4 | Insured's Name | **Optional-** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. |
| 5 | Patient's Address (Multiple | **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. |

| Item # | Description | Instructions |
|---|---|---|
| | Fields) | 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.<br>This field allows for the entry of 28 characters, alpha or numeric |
| 9B | Reserved for NUCC Use | **N/A** -This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated. |
| 9C. | Reserved for NUCC Use | **N/A** -This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated. |
| 9D | Insurance Plan Name or Program Name | **Required -** If other insurance and 11D= yes<br>enter the NH Medicaid specific 10-digit carrier code<br>Codes can be located on the NH MMIS Health Enterprise Portal under documents section<br>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.<br>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 | **N/A** -When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current |

| Item # | Description | Instructions |
|---|---|---|
| | NUCC) | 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. |
| 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.<br>Enter the applicable qualifier to identify which date is being reported.<br>431 Onset of Current Symptoms or Illness<br>484 Last Menstrual Period<br>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.<br>Enter the applicable qualifier to identify which date is being reported.<br>454 Initial Treatment |

| Item # | Description | Instructions |
|---|---|---|
| | | 304 Latest Visit or Consultation<br>453 Acute Manifestation of a Chronic Condition<br>439 Accident<br>455 Last X-ray<br>471 Prescription<br>090 Report Start (Assumed Care Date)<br>091 Report End (Relinquished Care Date)<br>444 First Visit or Consultation<br>Enter the qualifier between the left-hand set of vertical, dotted lines. |
| 16 | Dates Patient Unable to Work in Current Occupation | Optional-If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage. |
| 17 | Name of Referring Provider or Other Source | Situational – Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:<br>1. Referring Provider<br>2. Ordering Provider<br>3. Supervising Provider<br>Enter the applicable qualifier to identify which provider is being reported.<br>DN Referring Provider<br>DK Ordering Provider<br>DQ Supervising Provider<br>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.<br>The NUCC defines the following qualifiers used in 5010A1:<br>0B State License Number<br>1G Provider UPIN Number<br>G2 Provider Commercial Number<br>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 |

| Item # | Description | Instructions |
|---|---|---|
| | | 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.<br>NH Medicaid-Used for providers to communicate information particular to this claim, not a duplicate or not covered by other insurance and why. |
| 20 | Outside Lab? $ Charges | Optional -Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. |
| 21 | Diagnoses or Nature of Illness or Injury | Required - Enter the applicable ICD indicator to identify which version of ICD codes is being reported.<br>9 ICD-9-CM<br>0 ICD-10-CM<br>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.<br>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).<br>When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.<br>7 Replacement of prior claim<br>8 Void/cancel of prior claim<br>This Item Number is not intended for use for original claim submissions. |
| 23 | Prior Authorization Number<br>( Service | **Not being used at this time**<br>Situational- Enter any of the following: prior authorization number, as assigned by the payer for the current service. The "Prior Authorization |

| Item # | Description | Instructions |
|---|---|---|
| | Authorization) | Number" is the payer assigned number authorizing service(s) |
| 24A | Date(s) of Service<br>(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.<br>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.<br><br>The following qualifiers are to be used when reporting NDC unit/basis of measurement:<br>F2 International Unit<br>ME Milligram<br>UN Unit<br>GR Gram<br>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.<br>The Place of Service Codes are available at: www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf. |
| 24C | EMG<br>(lines 1–6) | N/A |
| 24D | Procedures, Services or Supplies<br>(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<br>(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. |

| Item # | Description | Instructions |
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| | | This field allows for the entry of 4 characters in the unshaded area |
| 24F | $ Charges<br>(Lines 1-6) | Required - Enter the charge for each listed service.<br>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.<br>"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.<br>Enter numbers left justified in the field. No leading zeroes are required. If reporting a fraction of a unit, use the decimal point.<br>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").<br>"Days or Units" is the number of days corresponding to the dates entered in 24A |
| 24H. | EPSDT/Family Plan<br>(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:<br>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.<br>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.<br>The following codes for EPSDT are used in 5010A1:<br>AV- Available – Not Used (Patient refused referral.)<br>S2- Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)<br>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.)<br>NU- Not Used (Used when no EPSDT patient referral was given.)<br>If the service is Family Planning, enter Y ("YES") or N ("NO") in the |

| Item # | Description | Instructions |
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| | | bottom, unshaded area of the field. |
| 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.<br>The NUCC defines the following qualifiers used in 5010A1:<br>0B State License Number<br>1G Provider UPIN Number<br>G2 Provider Commercial Number<br>LU Location Number<br>ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)<br>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.<br>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<br>(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.<br>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.<br>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.<br>Report "Accept Assignment?" for all payers. |

| Item # | Description | Instructions |
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| | | The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program. |
| 28 | Total Charge | Required – Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>The NUCC defines the following qualifiers used in 5010A1:<br>0B State License Number |

| Item # | Description | Instructions |
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| | | G2 Provider Commercial Number<br>LU Location Number<br>The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility. |
| 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:<br>1st Line – Name<br>2nd Line – Address<br>3rd Line – City, State and ZIP Code<br>Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.<br>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.<br>5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here.<br>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.<br>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.<br>The NUCC defines the following qualifiers used in 5010A1:<br>0B State License Number<br>G2 Provider Commercial Number<br>ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider<br>Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)<br>The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either |

| Item # | Description | Instructions |
|---|---|---|
| | | 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.<br><br>The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional. |

# Appendix I - December 2017 Provider Bulletin

TO: **All FQHC's, FQHC Look-A-Likes, and Non-Hospital Based Rural Health Centers**
FROM: **NH Medicaid**
DATE: **December 1, 2017**
SUBJECT: **FQHC BILLING OF SUD SERVICES**

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Effective January 1, 2018, FQHCs are to bill SUD services, except for SBIRT*, on a separate claim form and will be reimbursed at the SUD service's Fee-for-Service (FFS) rate. FQHCs cannot bill SUD services as a medical or behavioral health encounter. (SBIRT* services are included in the encounter rate, as clarified in the October 2016 Provider Bulletin.)

The following SUD codes are to be billed separately and will be reimbursed at the rates listed on the SUD fee schedule: https://www.dhhs.nh.gov/ombp/sud/documents/sud-billable-services.pdf

| | |
|---|---|
| H0001 | Alcohol and/or Drug Assessment |
| H0004, U1 | Behavioral Health Counseling and Therapy (30 minute session) |
| H0004, U2 | Behavioral Health Counseling and Therapy (45 minute session) |
| H0004, U3 | Behavioral Health Counseling and Therapy (60 minute session) |
| H0007, U1 | Crisis Intervention (OP) - In Provider Office or Community (first 60 minutes) |
| H0007, U2 | Crisis Intervention (OP) - In Provider Office or Community (each additional 30 minutes) |
| H0005 | Alcohol and/or Drug Services; group counseling by a clinician per person, per session |
| H0047, HS, HQ | Counseling, Family-Multi Family Group |
| H0047, HR, HQ | Family/couple with client present Group setting |
| H0015 | Intensive Outpatient Services |
| H2036 | Partial Hospitalization Services |
| H0014 | Medically Monitored Withdrawal Management |
| T1012 | Non Peer Recovery Support, Individual |
| T1012, HQ, FS | Non Peer Recovery Support, Group |
| H0038 | Peer Recovery Support, Individual |
| H0038, HQ | Peer Recovery Support, Group |
| H0006 | Case Management (Continuous Recovery Monitoring-CRM) |

With the exception of SBIRT codes, if the FQHCs bill the encounter code, T1015, along with a SUD code, the claim will be denied. The provider will have to resubmit the claim only using the SUD code and will be paid the FFS rate. If the provider bills T1015 along with a SUD code and another non-SUD code, the claim will be denied. The provider will have to resubmit two claims: one with the T1015 code and the non-SUD code and another claim with the SUD code.

If Medication Assisted Treatment (MAT) is rendered on the same day of a medical visit, the provider can bill T1015 for the medical visit and then on a separate claim bill one of the below E&M codes with modifier HF for the MAT office visit:

| |
|---|
| 99201 |
| 99202 |
| 99203 |
| 99204 |
| 99205 |
| 99211 |
| 99212 |
| 99213 |
| 99214 |
| 99215 |

Other SUD services rendered on the same day as a MAT visit can be billed on the same claim as the MAT office visit.

New Hampshire Healthy Families and the Well Sense Health Plan are also implementing these SUD billing changes, in partnership with DHHS.

If you have questions about billing, please contact NH Medicaid Provider Services at 866-291-1674. If you have questions about the above billing policy, please contact Betsy Hippensteel, Provider Relations Manager, at 603-271-9414.

We thank you for your participation in the NH Medicaid Program.