Federally Qualified Health Centers (FQHC's), FQHC Look-A-Likes (LAL's), and Rural Health Clinics-Non Hospital Based (RHC's-NHB)

Provider Manual
Volume II

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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:

Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date
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, CSR, etc.).

Date Change to Manual	Effective Date	Section/Sub-Section	Change Description	Reason	Related Communication
6/19/2026	N/A	Multiple	Rebrand Document: Edits for clarity, formatting edits, edit to align standard language seen across provider manuals. Clarification on delegation and supervision. Removed appendix as it is now a standalone list. Updated rate methodology language to align with State Plan. Added Place of Service language. Added language	Update after review with stakeholders	06/19/2026 Provider Bulletin

Date Change to Manual	Effective Date	Section/Sub-Section	Change Description	Reason	Related Communication
			clarifying claiming for services provided outside of the clinic. Updated to align with allowance of telehealth services. Updated to reflect coding changes made since last publication in 2018.		
8/1/2026	N/A	11.3	Removed language stating that 96112 is not allowable when it is the only service on the encounter claim.	Fixing incorrect language from previous manual edits/release	N/A

1. NH Medicaid Provider Billing Manuals Overview

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

It is critical that the provider and the provider's staff be familiar with, and 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 General Billing Manual – Volume I Appendices section encompasses a range of supplemental materials such as Contact Information, Common Acronyms, and 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.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

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

1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

1.3 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 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.

1.4 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 email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to

providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 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.

1.6 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

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be a participating provider. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in Section 4 of the General Billing Manual – Volume I.

2.1 Eligibility to Enroll as an FQHC/FQHC-LAL/RHC

The Department and/or its associated organizations approve provider enrollment. The Department's fiscal agent, upon approval of the application, sends a notification letter to the provider. It is the responsibility of the provider to review the other provider manuals in conjunction with this one to form a complete understanding of the services, rules and regulations governing the NH Medicaid program.

To participate in the NH Medicaid program as a Federally Qualified Health Center (FQHC), FQHC Look-A-Like (LAL) or Rural Health Clinic (RHC) (non-hospital based), an entity must:

1. Be composed of licensed NH practitioners who are enrolled as individual provider types applicable to one's practice in NH Medicaid. These individual providers must be affiliated in the Medicaid Management Information System (MMIS) as a performing provider of the FQHC, FQHC-LAL, or RHC-NHB;
2. Furnish FQHC/FQHC-LAL/RHC-NHB services via practitioners authorized to provide these services, i.e., physicians (all specialties) (to include physician assistants practicing in accordance with NH RSA 328-D), nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, and visiting nurses;
3. Be certified to participate in Medicare as an FQHC/FQHC-LAL/RHC-NHB provider;
4. Provide medical care on an outpatient basis;
5. Be enrolled as a FQHC/FQHC-LAL/RHC-NHB group in NH Medicaid; and
6. Request and obtain service authorization from NH Medicaid before providing services that require service authorization.

The Department does not monitor provider compliance with scope of law or practice related to provider licensure or certification. It is the responsibility of providers to follow the laws associated with their licensure/certification.

NH Medicaid recognizes the following health clinics

- Federally Qualified Health Centers (FQHC) funded under Section 330 of the Public Health Service (PHS) Act and certified by CMS;

- FQHC "Look-A-Likes" (FQHC-LALs), that have been identified by Health Resource and Services Administration (HRSA) and certified by CMS as meeting the definition of "Health Center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330;
- Rural Health Clinics funded under Section 1905 of the Social Security Act.
- If Medicare enrolls sites individually then they need to be enrolled the same way in NH Medicaid.

2.2 Requests for Rate Changes Due to a Change of Scope in Service

A change of scope in service is recognized by the Department when there is a change in the type, intensity, duration and/or amount of services as a result of the following:

1. An increase of scope in service could result from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved FQHC/FQHC-LAL/RHC-NHB benefits that no current professional staff is licensed to perform.

2. A decrease of scope in service could result when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease of scope in service does not necessarily result from any of the following (although some of these changes may occur in conjunction with a change of scope in service):

- an increase, decrease or change in number of staff working at the clinic except as noted above
- an increase, decrease or change in office hours
- an increase, decrease or change in office space or location
- the addition of a new site that provides the same set of services
- an increase, decrease or change in equipment or supplies
- an increase, decrease or change in the number or type of patients served

FQHC/FQHC-LAL/RHC-NHB s may request a change of scope in service once a year for implementation on July 1. This will be concurrent with the effective date of the increase to the encounter rate. FQHC/FQHC-LAL/RHC-NHB's are required to submit requests in writing no later than March 31 in order to be effective July 1. The Department will review and analyze all requests to ensure compliance with the Medicare FQHC/FQHC-LAL/RHC-NHB regulations relative to a change of scope in service.

1. All requests should be submitted in writing to the Department by the FQHC/FQHC-LAL/RHC-NHB and should include:

- a detailed explanation of each change of scope in services provided by the FQHC/FQHC-LAL/RHC-NHB delineating how services were provided both before and after the change;
- the effective date of each change of scope in services;
- the Medicaid visits and total visits associated with each change of scope in services;
- the total number of visits for all sites for the same time period that the FQHC/FQHC-LAL/RHC-NHB submits the incremental costs;
- the incremental increase or decrease in costs by expense category for each change of scope in services; and
- the cumulative per visit dollar amount of the PPS or APM rate adjustment requested.

2. All requests should include, at a minimum, a detailed worksheet that delineates the total incremental difference in costs for each of the categories and subcategories of expenses associated with the change of scope in service.

3. A change in costs alone in and of itself will not be considered a change of scope in service unless it is a CMS approved change of scope in service (proof of CMS approval must be supplied) and all of the following apply:

- the increase or decrease in cost is attributable to an increase or decrease of the scope in the services defined above;
- the cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413;
- the change of scope in services is a change in the type, intensity, duration, or amount of services, or any combination thereof; and
- the net change in costs in the FQHC/FQHC-LAL/RHC-NHB's must meet a minimum threshold of 5%.

The FQHC/FQHC-LAL/RHC-NHB's shall submit supporting documentation for each amount included in the categories of expenses for both the prior period and the period where there is a change of scope in services following Medicare reasonable cost principles.

The Department will review the documentation submitted by the FQHC/FQHC-LAL/RHC-NHB's and will notify them as to whether the rate adjustment is approved.

The Department reserves the right to adjust the encounter rate for any change of scope in service that comes to its attention.

All requests should be submitted to dhhsratesetting@dhhs.nh.gov for review.

The following formula will be used by DHHS to determine the new rate:

$$NR = \frac{(R \times PV) + C}{(PV + CV)}$$

Where:
"NR" represents the new reimbursement rate adjusted for the increase/decrease of the scope in service;
"R" represents the present Medicaid rate;
"PV" represents the present number of total visits, which is the total number of visits for the FQHC/FQHC-LAL/RHC-NHB **during the 12-month time period prior to the change of scope in service;**
"C" represents the expected change in costs due to the change of scope in service; and
"CV" represents the expected change in the number of visits due to the change of scope in service

Example:

Assume the provider notified the department in writing of a change of scope in service offered prior to the July 1 implementation and the provider submitted the documentation and information necessary for the Department to make a determination. In addition, assume the FQHC/FQHC-LAL/RHC-NHB has a present Medicaid reimbursement rate of $100 per visit with 10,000 visits per year.

A new professional staff member is added to provide services with 1,000 additional visits per year expected at an increase in cost of $140,000.

$$NR = \frac{(Rx\ PV)+C}{(PV+CV)}$$

$$NR = \frac{(\$100 \times 10{,}000) + \$\ 140{,}000}{(10{,}000 + 1{,}000)}$$

$$NR = \frac{\$1{,}140{,}000}{11{,}000}$$

NR= $103.64

3. Covered Services & Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit these requests can be found in this Provider Specific Billing Manual - Volume II.

Services performed by FQHC's and FQHC-LAL's and covered by NH Medicaid are those defined in Section 1905(a)(2)(C) of the Social Security Act. Services performed by RHC's (NHB) are those defined in Section 1905(a)(2)(B) of the Social Security Act.

FQHC/FQHC-LAL/RHC-NHBs enrolled in NH Medicaid are authorized to perform services within the specific scope of services approved for the facility by the Health Resources and Services Administration (HRSA) and that are included as a covered service in the NH Title XIX State Plan.

FQHC/FQHC-LAL/RHC-NHB covered services can be categorized as encounter and incidental services, and other ambulatory services.

3.1 Encounter and Incidental Services

FQHC/FQHC-LAL/RHC-NHB encounter and incidental services generally include:

- Physician services (to include physician assistants practicing in accordance with NH RSA 328-D, nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, visiting nurses;
- Services and supplies furnished as "incident to" professional services furnished by a physician (to include a physician assistant practicing in accordance with NH RSA 328-D), nurse practitioner or certified nurse midwife; and, for visiting nurse care, related medical supplies, other than drugs and biologicals;

Services and supplies "incident to" the professional services of health care practitioners are those commonly furnished in connection with these professional services, generally furnished in a practitioner's office, and ordinarily rendered without charge, or included in the practice bill such as ordinary medications, and other services and supplies used in patient primary care services. "Incident to" services must be furnished by a clinic employee and must be furnished under the direct, personal supervision of the health care practitioner, meaning that the health

care practitioner must be physically present in the building and immediately available for consultation.
The ability to delegate and supervise services varies by provider type. It is the responsibility of providers to understand and follow the delegation and supervision laws associated with their licensure/certification.

3.2 Other Ambulatory Services

Other ambulatory services are also covered as FQHC/FQHC-LAL/RHC-NHB services. These include non-primary care services, such as dental services and pharmaceuticals, and all other services covered under the NH Title XIX State Plan. These services are covered according to the applicable descriptions and service limits described for each individual service in the Title XIX State Plan, the applicable departmental administrative rules, and in the applicable Provider Billing Manuals – Volume II. With the exception of behavioral health visits which are paid a separate encounter, other ambulatory services are reimbursed according to the Medicaid fee schedule as described in the Title XIX State Plan and applicable provider billing manuals, as these services are not included in the encounter rate. Examples of other ambulatory services include:

- Inpatient and outpatient hospital services
- Radiology services
- Pharmacy services
- Vision services (other than routine screenings)
- Dental services
- Podiatry services
- Hearing services (other than routine screenings)
- Non-routine laboratory services
- Family planning devices such as implants and IUD's
- Occupational, speech, and physical therapy services
- Substance Use Disorder (SUD) Treatment and Recovery Support Services
- Medication Assisted Treatment (MAT)
- Medical transportation services
- Vaccine administration for adults and children if not part of or incidental to an encounter
- Actual cost to acquire the vaccine for adults age 19 and over regardless of whether the administration of such vaccine is part of the encounter or reimbursed separately
- Behavioral health/psychotherapy services

See the "Payment Policies" and "Claims" Sections of this billing manual for information on how encounter and ambulatory services are reimbursed.

3.3 Service Limits

Only the "other ambulatory services" provided by FQHC/FQHC-LAL/RHC-NHBs are subject to service limits. Service limits for other ambulatory services are the same limits that are applicable to the individual ambulatory services as described in the various departmental administrative rules, fee schedules, and Provider Specific Billing Manuals – Volume II.

3.4 Encounter Limits

An encounter is comprised of all recipient visits with more than one health care practitioner or multiple visits with the same health care practitioner which take place on the same day and at a single location, for the same diagnosis or treatment. A recipient may have one medical and one behavioral encounter on the same day.

Providers may submit only one medical encounter and one behavioral health encounter per date of service unless a service authorization has been approved for two specific exceptions as follows:

1) Subsequent to the first encounter, the recipient suffers an illness or injury with a different diagnosis; or
2) Subsequent to the first encounter, the patient received a different treatment at a different time of the same day

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

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

FQHC/FQHC-LAL/RHC-NHB providers should particularly note that medical nutrition therapy/diabetes education are not stand-alone services under the NH Title XIX State Plan and, therefore, will not be paid as a separate encounter payment amount but as part of the established medical encounter rate.

5. Service Authorizations

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

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The Contact information in the Appendices of the General Billing Manual – Volume I or on the SA form itself should be consulted for the name and method of contact.

Medical and behavioral encounters in and of themselves are not subject to service authorizations. Service authorizations are applicable to "Other Ambulatory Services". Please see the appropriate Provider Billing Manual – Volume II for service authorization requirements for each individual service.

Please note that multiple encounters in the same day may require a service authorization.

Providers may submit only one medical encounter and one behavioral health encounter per date of service unless a service authorization has been approved for two specific exceptions as follows:

1) Subsequent to the first encounter, the recipient suffers an illness or injury with a different diagnosis; or
2) Subsequent to the first encounter, the patient received a different treatment at a different time of the same day

See the "Service Authorizations" Section (8) of the General Billing Manual for additional information.

6. Documentation

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. See the "Record Keeping" section of the General Billing Manual – Volume I, for more detailed documentation requirements.

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 Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations CMS transmittals, provider fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

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

8. Adverse Actions

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

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for exclusions as outlined in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume I.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

Payment for NH Medicaid services is made in accordance with rates of reimbursement established by the Department pursuant to RSA 161:4, VI (a).

10.1 Payment Methodology

There are two methods of payment for FQHC/FQHC-LAL/RHC-NHBs:

- A fixed encounter rate for certain medical and behavioral services; and
- Fee schedules for "other ambulatory services" that are consistent with the standard NH Medicaid fee schedules for each of these services.

10.2 Encounter Rate and Incidentals Reimbursement

FQHC/FQHC-LAL/RHC-NHB services as defined in Section 1905(a)(2)(B) and (C) of the Social Security Act, as well as behavioral health services that are part of "other ambulatory services," are reimbursed at all-inclusive encounter rates.

In order to bill the all-inclusive encounter rate, services must be billed using the encounter code **T1015, along with one or more pertinent procedure codes that identify each**

specific service provided during the visit. Claims submitted with only the medical encounter code will be denied payment.

Only one medical and one behavioral health encounter claim may be submitted per date of service unless a service authorization has been approved (see the "Service Authorizations" section) for either of the following exceptions:

1. subsequent to the first encounter, the patient suffers an illness or injury with a different diagnosis; or
2. subsequent to the first encounter, the patient received a different treatment at a different time of the same day.

The Department establishes facility-specific encounter rates for each FQHC/FQHC-LAL/RHC-NHB enrolled in NH Medicaid. Facility-specific encounter rates take into account, but are not entirely based on, the scope of services each clinic is authorized to provide as determined by CMS. NH Medicaid sets the behavioral health encounter rate equal to the medical encounter rate.

Payment for RHC-NHB's, FQHC's, and FQHC-LAL's is based on Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. The NH Department of Health and Human Services (the Department) determines an encounter rate for primary, preventive care services using an Alternative Payment Methodology (APM) under SSA 1902(bb)(6). The encounter rate is an all-inclusive rate of payment for primary, preventive care covered services defined in 1905(a)(2)(B) and (C) of the Social Security Act and included in the NH Title XIX State Plan to eligible Medicaid recipients.

The Alternative Payment Methodology (APM) is calculated using the providers' fiscal year 2022 cost-settled rates as the baseline for all subsequent years' encounter rates trending forward using the Federally Qualified Health Center PPS published annually for each of those years. The cost settlement process applied to the 2022 baseline limited each provider to the greater of their actual costs or 133% of the Medicare rate.

The Department also calculates an encounter rate using a Prospective Payment Methodology (PPS) and the formula established by BIPA 2000, using the average cost based rate per visit for provider fiscal years of 1999 and 2000, trended forward by the MEI.

The baseline rates for RHC-NHB's, FQHC's, and FQHC-LAL's that did not have any reported costs in either the APM or PPS baseline will be set as an average of the rates for similar clinics or centers. The effective date for such rates is the effective Medicaid enrollment date for the provider.

Effective October 1, 2023, each provider will receive an encounter rate that is the greater of the APM or PPS. Only those providers that agree in writing to the proposed APM will receive the proposed APM. Thereafter, annually on July 1, each provider's encounter rate will be

trended forward by using the MEI for the PPS and the FQHC PPS for the APM and adjusted for any approved change in scope of services.

Services considered "incidental" to a medical or behavioral encounter visit will be reimbursed as part of the service encounter rate and shall not be reimbursed separately. For example:

- Administration of vaccines;
- Routine laboratory and radiology services inherently integrated with the medical/behavioral purpose of the visit;
- Oral health exam, application of fluoride varnish, anticipatory guidance and referral to a dental home are services considered part of the medical encounter and will not be reimbursed separately.

10.3 Fee-for-Service Reimbursement

Other ambulatory services provided by an FQHC/FQHC-LAL/RHC-NHB will be reimbursed at the Medicaid fee schedule rate for the appropriate CPT codes. For example:

- Dental
  Payment for face-to-face dental visits with a clinic's dentist or a dentist subcontracted by the FQHC/FQHC-LAL/RHC-NHB for patients who are enrolled as primary care patients of the practice will be reimbursed at the Medicaid fee schedule, subject to standard service limitations. Dental services will continue to be billed FFS by NH Medicaid enrolled providers using the appropriate CDT codes.

- Vaccine Administration
  If vaccine is not administered as part of or incidental to an encounter, the vaccine administration for both adults and children should be billed separately and will be reimbursed based on the Medicaid fee schedule. The FQHC/FQHC-LAL/RHC-NHB will not be reimbursed at the encounter rate.

- The Actual Vaccine
  The cost of the actual vaccine for adults age 19 and over will be paid at the fee for service rate, regardless of whether the administration of such vaccine is part of the encounter or reimbursed separately. The cost of the actual vaccine, if received through the Vaccine for Children (VFC) or distributed by the State/federal government, will not be reimbursed.

- Obstetric Services
  Vaginal and Cesarean section delivery services will be reimbursed at the Fee for Service rate.

- SUD Services
  With the exception of Screening, Brief Intervention, and Referral to Treatment Services (SBIRT) which is included as part of the encounter, SUD services will be reimbursed based on the Medicaid SUD fee schedule.

11. Claims

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

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis & Procedure Codes

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

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

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.

11.2 Medical Services Encounters

Claims for medical services must be billed using the encounter code T1015, along with one or more pertinent procedure codes that identify each specific service provided during the visit. Claims submitted with only the medical encounter code will be denied payment.

Only one medical and one behavioral encounter may be submitted per date of service, unless a service authorization has been approved. Multiple claims for medical encounter visits on a single date of service must contain different diagnosis/procedure combinations to signify the patient is receiving treatment for a different diagnosis that was acquired subsequent to the first visit.

11.3 Behavioral Health Services Encounters

Claims for behavioral health visits must be billed using the encounter code T1015, along with one or more pertinent procedure codes that identify each specific service provided during the visit. Claims submitted with only the encounter code will be denied payment.

The type of practitioner allowed to bill for specific codes and services are those psychotherapy providers that are allowed to enroll in the Medicaid fee for service program. Primary care providers cannot bill a behavioral health encounter code. Services may be delegated to supervised professionals as allowed by the providers scope of practice.

Valid CPT codes for behavioral health encounters at an FQHC/FQHC-LAL/RHC-NHB include:

- 90785: Psychiatric services complicated by communication factor
- 90791: Diagnostic evaluation
- 90792: Diagnostic evaluation with medical services
- 90832: 30 minute psychotherapy with patient and/or family member
- 90833: Psychotherapy with evaluation and management visit, 30 minutes
- 90834: 45 minute psychotherapy with patient and/or family member
- 90836: Psychotherapy with evaluation and management visit, 45 minutes
- 90837: 60 minute psychotherapy with patient and/or family member
- 90838: Psychotherapy with evaluation and management visit, 1 hour
- 90839: Psychotherapy - Crisis first 60 minutes
- 90846: Family psychotherapy without patient present
- 90847: Family psychotherapy with patient present
- 90853 Group psychotherapy with patient present

Developmental assessment (CPT code 96110) is considered part of the behavioral health or well-child visit and is not reimbursable at the encounter rate if it is the sole service on a claim. FQHC/FQHC-LAL/RHC-NHBs shall list these services along with other appropriate procedure codes when submitting encounter claims for a well-child or other medical/behavioral visit.

Cognitive testing services provided by an FQHC/FQHC-LAL/RHC-NHB for a patient enrolled as a primary care patient shall only be billed as FFS using the appropriate CPT code and are subject to service limits when not performed by a psychiatrist. The types of providers that may provide the services is limited to psychotherapy providers enrolled by the Board of Mental Health Practice, psychologists enrolled by the Board of Psychology, and psychiatrists. The codes that may be billed include:

96130: Evaluation of psychological test, first hour
96131: Evaluation of psychological test, each additional hour
96132: Evaluation of neuropsychological test, first hour
96133: Evaluation of neuropsychological test, each additional hour
96136: Administration of psychological or neuropsychological test, first 30 minutes
96137: Administration of psychological or neuropsychological test, each additional 30 minutes
96138: Administration of psychological or neuropsychological test by technician, first 30 minutes
96139: Administration of psychological or neuropsychological test by technician, each additional 30 minutes
96146: Administration of psychological or neuropsychological test by single standardized instrument via electronic platform with automated result

Only one behavioral health encounter claim may be submitted per date of service unless a service authorization has been approved. Multiple claims for behavioral health encounter visits on a single date of service must contain different diagnosis/procedure combinations to signify the patient is receiving treatment for a different diagnosis that was acquired subsequent to the first visit.

11.4 Other Ambulatory Services

Other ambulatory services provided by an FQHC/FQHC-LAL/RHC-NHB are to be listed on the encounter claim using only the applicable standard procedure code.

Family Planning Services must be billed with the appropriate family planning diagnostic and procedure codes, and with the family planning indicator checked on the claim form.

11.5 Additional Claim Instructions for Certain Services

11.5.1 Maternity Related (Pre-natal, Obstetric Delivery and Post-Partum) Services

Payment for maternity related services (prenatal, obstetric delivery and post-partum services) for female patients enrolled as a primary care patient of an FQHC/FQHC-LAL/RHC-NHB shall be made as follows:

- Prenatal encounter claims must include the "TH" modifier and must include one or more procedure codes that identify the specific services performed during the visit. Prenatal encounter claims with no other procedure code(s) will be denied payment.
  - Prenatal visit, defined as a face-to-face office visit, will be paid at the FQHC/FQHC-LAL/RHC-NHB encounter rate, using the following codes:
    - 99214 shall be used for the first pre-natal visit with the "TH" modifier; and
    - 99213 shall be used for all other pre-natal visits with the "TH" modifier.
- Obstetric Delivery provided in an inpatient hospital setting shall be billed and reimbursed as FFS using the appropriate CPT code for the service provided.
- An inpatient visit post-delivery, and prior to discharge shall be reimbursed at the FFS rate using the following CPT code:
  - 99231: Inpatient subsequent care, 15 minutes
- Post-partum visit, which is defined as an in-office, face–to-face visit within 60 days post-partum, is reimbursed at the FQHC/FQHC-LAL/RHC-NHB encounter rate using the following CPT code:
  - 59430: Office or outpatient visit following vaginal or C-Section delivery.

Prenatal and child/family health care support services (CPT code T1027 TH) is not reimbursable at the encounter rate if it is the *sole* service on the claim nor is it reimbursable at the (15 minute units) FFS rate at FQHC/FQHC-LAL/RHC-NHBs; prenatal and child health care are reimbursed at the all-inclusive encounter rate, and as such, this code will only pay if it is "bundled" with other CPT codes/services. FQHCs that are also approved home visiting providers are paid for this service at a provider specific rate separate from any encounter services.

11.5.2 Substance Use Disorder & Medication Assisted Treatment Services

With the exception of Screening, Brief Intervention, and Referral to Treatment (SBIRT) codes, if the FQHCs bill the encounter code, T1015, along with a Substance Use Disorder (SUD) code, the claim will be denied.

Substance Use Disorder services should be billed 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.

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

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.

11.5.3 Immunizations

- Vaccine Administration
  If vaccine is not administered as part of or incidental to an encounter, the vaccine administration for both adults and children should be billed separately and will be reimbursed based on the Medicaid fee schedule. The FQHC/FQHC-LAL/RHC-NHB will not be reimbursed at the encounter rate.

- The Actual Vaccine
  The cost of the actual vaccine for adults age 19 and over will be paid at the fee for service rate, regardless of whether the administration of such vaccine is part of the encounter or reimbursed separately. The cost of the actual vaccine, if received through the Vaccine for Children (VFC) or distributed by the State/federal government, will not be reimbursed.

11.5.4 Services Rendered Outside of the Clinic Setting

Services rendered outside of the clinic setting, such as inpatient and outpatient hospital services, should be billed separately and will be reimbursed based on the Medicaid fee schedule. The FQHC/FQHC-LAL/RHC-NHB will not be reimbursed at the encounter rate.

11.6 Claim Completion Requirements for FQHC's, FQHC-LALs, and RHC-NHB

FQHC, FQHC-LALs, and RHC-NHB providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P.

Claims should be submitted with the appropriate place of service (POS) code to indicate the location where the service was provided.

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 NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. 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.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. 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

For additional guidance on how to complete a CMS1500 claim form please refer to the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

12. Terminology

APM – Alternative Payment Methodology

BIPA – Benefits and Improvement Protection Act

CPT – Current Procedural Terminology

FFS – Fee For Service

FQHC – Federally Qualified Health Center

FQHC-LAL – Federally Qualified Health Center Look A Like

MMIS – Medicaid Management Information System

OMBP – Office of Medicaid Business and Policy

PPS – Prospective Payment System

RHC – Rural Health Clinic

RHC-NHB – Rural Health Clinic-Non Hospital Based