

HOSPITALS,  
HOSPITAL-BASED  
RURAL HEALTH CLINICS  
(RHC-HB), and SWING  
BED HOSPITALS\*

Provider Manual  
Volume II

March 3, 2026

\*Swing Bed Hospitals should also reference the Nursing Facility Billing Manual for information regarding provider participation requirements, service authorizations, and utilization review

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Department of  
**HEALTH &  
HUMAN SERVICES**

Division of  
Medicaid  
Services

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## Change Log

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

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
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.).

<b>Date Change to Manual</b>	<b>Effective Date</b>	<b>Section</b>	<b>Change Description</b>	<b>Reason</b>	<b>Related Communication</b>
2/24/2026	9/18/2025	Sections 2, 4, and 5	Updated authorization requirements as well as in-state, out-of-state, and border designations	To align with newly adopted administrative rules	He-W 543 Adopted 9/18/2025
2/24/2026	N/A	Various	Updated all sections of the manual to align with updates that have been made to the General Billing Manual- Volume I	To update manual to align with current General Billing Manual	Provider Notice dated 10/25/2022
2/24/2026	N/A	3.5	Updated reference to Abortion, Sterilization, and Hysterectomy Provider Manual – Volume II	This manual is no longer published	N/A

2/24/2026	09/01/2024	10.1	Updated Peer Group descriptions and information	Updated to align with the NH Medicaid State Plan	State Plan Public Comment Period Notice from July 5, 2024
2/24/2026	N/A	10.1.3	Added language about responsible payor when member switches from FFS to MCO coverage during an inpatient stay	Long-standing policy that was not documented in this manual	N/A
2/24/2026		10.4	Added clarifying language related to hospital-based RHC reviews for cost-settlement	Clarification not in manual	N/A
2/24/2026	1/1/2018	10.4 and 11.3.1	Added detail on payment for Long Acting Reversible Contraceptives	Clarification not in manual	Postpartum Long-Acting Reversible Contraception Reimbursement Update

# 1. NH Medicaid Provider Billing Manuals Overview

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

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

## 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 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 participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

### 2.1 Hospitals

To participate in the NH Medicaid Program, all in-state and out-of-state hospital providers must:

1. Be licensed by the Department in accordance with RSA 151, or the same state licensing authority in the state within which the provider operates;
2. Meet Medicare participation requirements; and
3. Be an enrolled New Hampshire Medicaid provider in accordance with the following:
  - a) In-state hospitals will be enrolled as in-state hospital providers;
  - b) Out-of-state hospitals will be enrolled as out-of-state hospital providers.

### 2.2 Distinct Part Units (DPU) of Medicaid Enrolled Hospitals

To participate in the NH Medicaid Program, a DPU must be certified by Medicare as a distinct part unit.

### 2.3 Swing Bed Hospitals

Nursing facility services for individuals age 21 or over may be provided by hospitals that have an approval from CMS to furnish skilled nursing services in the Medicare program. Please refer to the Nursing Home Provider Specific Billing Manual – Volume II for program details and

requirements such as provider participation, service authorizations and utilization review. Please refer to the appropriate sections in *this* manual for swing bed billing instructions.

## 2.4 Hospital Based Rural Health Clinics

To participate in the NH Medicaid Program, all entities seeking to enroll as a hospital-based rural health clinic provider type must be:

- a) Certified as a Hospital Based Rural Health Clinic by Medicare;
- b) Enrolled in the NH Medicaid program;
- c) Composed of licensed and NH Board-certified practitioners; and
- d) Able to provide medical care on an outpatient basis.

## 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.

Covered services include those services provided in a hospital setting as either an inpatient or outpatient hospital service. A hospital means any hospital providing acute care services, to include acute care rehabilitation services, not operating as a psychiatric hospital or an institution for mental diseases (IMD) and which meets the requirements of 42 CFR 440.10.

### 3.1 Inpatient Hospital Service

Medicaid covers inpatient hospital services for members when those services are rendered:

- Under the direction of a physician or dentist per 42 CFR 440.10;
- To a member who has been admitted to a hospital as an inpatient;

- For a continuous period of 24 hours or longer;
- By a hospital offering room, board and professional services;
- By a NH Medicaid participating hospital which meets the requirements described in the “Provider Participation and Ongoing Responsibilities” section above; and
- As psychiatric services to members who are admitted to a distinct part psychiatric unit of a general hospital. Members must have a DSM IV diagnosis as the primary diagnosis.

Payment for inpatient care is made for medically necessary in patient days only as approved by the Department. For inpatient hospital services, the Program Integrity unit Medical Nurse Reviewers perform retrospective utilization and quality control reviews in accordance with 42 CFR 476, determines the quality, necessity, and appropriateness of care and length of stay.

## 3.2 Outpatient Hospital and Observation Bed Services

Members are eligible to receive outpatient hospital and observation bed services when those services are rendered:

- As preventive, diagnostic, therapeutic, rehabilitative, emergency, or palliative outpatient services;
- By or under the direction of a physician or dentist per 42 CFR 440.20;
- To a member who has not been admitted as an inpatient;
- For a period of time not to exceed 24 hours;
- By a NH Medicaid participating hospital which meets the requirements described in the “Provider Participation and Ongoing Responsibilities” section above; and
- In accordance with the service limit requirements detailed in the “Service Limits” section below.

Observation bed services are defined as those services furnished by a hospital on the hospital’s premises, including the use of a bed and periodic monitoring by a hospital’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the hospital as an inpatient. This period of time is not to exceed 24 hrs. It may span 2 calendar days.

## 3.3 Hospital-Based Rural Health Clinic Services

Hospital-Based Rural Health Clinic encounters include:

- The services of a physician (to include physician assistants under the supervision and direction of a physician in accordance with NH RSA 328-D:1), when the physician has an agreement to be paid by the clinic for such services;
- The services of a nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker, visiting nurse, provided within the scope of his/her training and/or certification; and
- The services and supplies that are furnished as incidental to the professional services of a physician, physician assistant, nurse practitioner, or certified nurse midwife; as well as medical supplies, other than drugs and biologicals, for visiting nurse care.

### 3.4 Organ Transplants

Organ transplant procedures and procurements will be covered when performed as an inpatient service at an organ transplant facility approved by Centers for Medicare and Medicaid Services (CMS). The following organ transplants from a human donor to a member shall be covered subject to service authorization and in accordance with the applicable coverage criteria in Interqual Connect Clinical Guidelines, 2019 Edition.

- (1) Kidney transplants;
- (2) Heart transplants;
- (3) Heart and lung transplants;
- (4) Lung transplants;
- (5) Allogeneic bone marrow transplants;
- (6) Autologous bone marrow transplants;
- (7) Liver transplants;
- (8) Pancreas transplants; and
- (9) Pancreas and kidney transplants.

### 3.5 Abortions, Sterilizations, Hysterectomies

Abortion procedures must be done in accordance with 42 CFR 441 Subpart E and claims for the procedure must be submitted with Form 904, Certification of The Decision to Terminate Pregnancy.

Sterilization and hysterectomy procedures must be done in accordance with 42 CFR 50 Subpart B and/or 42 CFR 441 Subpart F. Claims for these procedures must be submitted with form 687, Consent for Sterilization.

## 3.6 Service Limits

Service limits are counted based on the state fiscal year beginning July 1 and ending June 30. The following hospital related service limits apply:

- Outpatient hospital services are limited as follows:
  - Outpatient hospital services are limited to 12 visits per member per state fiscal year;
  - Services provided in an emergency department (ED) or urgent care setting shall not count toward the 12 visit limit;
  - Observation bed services shall not count toward the 12 visit limit; and
  - Services that are described individually in component parts of the Medicaid He-W 500 chapter rules, such as physical, occupational and speech therapy services or radiology services (see below), and provided in outpatient departments of hospitals, will be subject to the limits which apply to that individual service;
- Physician and APRN services will be limited as follows:
  - Services performed in the inpatient hospital setting will be limited to one visit per Department approved day of stay;
- Therapy services provided as part of an inpatient hospital stay will not be counted under the therapy limitations of physical, occupational and speech therapy per member.
  - X-ray services for diagnostic purposes will be limited to 15 x-rays;
  - X-ray services provided for radiation therapy will not be limited;
- For hospital based rural health clinic services, the only services that are counted toward the various service limits associated with individual services are those “other ambulatory services” that have service limits. See the various Provider Billing Manuals - Volume II and the Service Limits Section of the Provider Billing Manual – Volume I.

## 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.

Hospital providers should also review the covered and non-covered services sections of the other provider specific billing manuals – Volume II – because services that are not described as covered or that are described as non-covered in the various billing manuals or in the Medicaid He-W Chapter 500 service rules are also non-covered if provided in the inpatient or outpatient hospital setting.

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. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

In addition to any listings referenced above, other specific non-covered hospital and hospital based rural health clinic services include:

- Services ancillary to, or directly related to, or a complication as the result of, a non-covered service or procedure;
- Experimental or investigational procedures, or admissions for such procedures, described as such in the current edition of the “Medicare National Coverage Determination Manual,” including thermogenic therapy and electrosleep therapy;
- Reversal of voluntary sterilization;
- Operations for impotency;
- Operations, devices, and procedures for the purpose of contributing to or enhancing fertility or procreation;
- Plastic surgery, to include cosmetic surgery, for the purpose of preserving or improving appearance or disfigurement, except when required for the prompt repair of accidental injury or for the improvement in functioning of a malformed body part such as post-mastectomy performed for medically necessary reasons;
- Services or items that are free to the public;

- Hospital inpatient care which is not medically necessary, to include days not approved by the Department;
- Autopsies;
- Admissions that have not received a service authorization in accordance with NH Medicaid program policy;
- Admissions and/or continued stays which are strictly for member convenience and not related to the care and treatment of the member;
- Inpatient admissions for services that could be performed in an outpatient setting.

## 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.

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 or on the SA form itself should be consulted for the name and method of contact.

## 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 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 manuals, 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.

Inpatient hospital services provided by in-state hospitals are also subject to utilization review carried out by the Medicaid Program Integrity Unit. The Medicaid Program Integrity Unit reviews and determines medical necessity and appropriateness of admissions, treatment, and transfers, as well as appropriateness of setting (inpatient or outpatient). The Medicaid program Integrity Unit applies quality of care screens to all cases reviewed and issues notifications and recommendations when problems involving patient care, erroneous billing, or documentation are identified. Reviews of specific cases are conducted following the payment of hospital claims. A provider's failure to provide the complete medical record within the time frame specified may result in recovery of payment for that case.

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

## 8. Adverse Actions

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

## 9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the **payer of last resort**. All third party obligations must be exhausted before claims can be submitted to 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 1.

For Medicare recipients, the 60-day “lifetime reserve” for Medicare inpatient hospital benefits must be used before NH Medicaid will pay for inpatient hospital services. (Note: The 60-day “lifetime reserve” does not affect Part B Medicare coverage.)

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 hospital services will be made at rates established by the department in accordance with RSA 161:4, VI(a).

- Hospital providers should submit claims for payment to the department's fiscal agent using the paper form or electronic format currently designated and approved by the Centers for Medicare and Medicaid Services for this purpose.
- For newborn billings, the fiscal agent will help facilitate the process of obtaining a NH Medicaid identification number for the newborn. If hospital providers need to bill for newborns who do not have their own NH Medicaid identification number (payment is guaranteed for the first 30 days), hospitals should complete the paper claim form as follows:
  - The newborn's name will be entered in the patient field;
  - The NH Medicaid identification number field will be left blank; and

- The mother's name and NH Medicaid identification number will be entered in the remarks section.
- Mail paper claim form to:
  - Attention: Newborn Claims
  - PO Box 2003
  - Concord NH 03302-2003
- Payment for inpatient hospital services will be made for Department-approved acute care days of stay only.
- All outpatient hospital services rendered to a member within 3 calendar days prior to his/her inpatient admission, with a calendar day beginning at 12:00 AM and ending at 11:59 PM, will be inclusive of the inpatient payment and not be billed separately, with the exception of:
  - Prenatal outpatient services; and
  - Diagnostic and non-diagnostic outpatient services which are unrelated to the member's inpatient hospital admission.

## 10.1 Inpatient Hospital Payment

The NH Medicaid Program reimburses by a prospective payment system based on diagnostic related groups (DRG) for inpatient hospital services.

The DRG system for inpatient hospital services includes the following provisions and components:

- The Medicare table of MS-DRG coding and the Medicare grouper used to assign DRG's.
- Medicare relative weights are utilized, except where otherwise specified.
- Generally, the table of DRG's relative weights is updated concurrently with Medicare changes.
- A Price-per-Point is determined by NH Medicaid taking into account available NH Medicaid funds and other economic indicators.
- DRG reimbursement is calculated by multiplying the Price-per-Point times the relative weight assigned to the DRG.
- Pricing is prospective; actual payments will be retrospective upon discharge.

Hospitals are paid a rate per DRG point based on various groupings, as follows:

- In-State General Acute Care
- Out-of-State General Acute Care
- In-State Critical Access Hospitals
- Maternity and Newborn Services for In-State Critical Access Hospitals

- Psychiatric DRG's with a relative weight less than 1.2 in Medicare certified Distinct Part Units (DPU's) of in-state hospitals only, are paid a higher peer group rate regardless of voluntary or involuntary admission status
- Psychiatric DRG's with a relative weight of 1.2 or greater in Medicare certified Distinct Part Units (DPU's) of in-state hospitals only, are paid a higher peer group rate regardless of voluntary or involuntary admission status  
Psychiatric DRG's in Designated Receiving Facilities (DRF's) approved by the Bureau of Behavioral Health and in good standing of are paid a higher peer group rate
- Rehabilitation physical rehabilitation specialty hospitals and of Medicare certified Distinct Part Units enrolled as NH Medicaid Rehab hospitals are paid at a flat rate per discharge with NO outlier payments allowed. Refer to the annual DRG provider notice for details.

NH Medicaid does not allow interim billing and/or periodic interim payments (PIP's).

Specific maternity-related DRGs identified in the NH Medicaid State Plan include an add-on percentage to their rate. The In-State General Acute Care and Out-of-State General Acute Care peer groups receive a 24% add on to the identified DRG rates and In-State Critical Access Hospitals receive a 34% add on to the identified DRG rates.

In-state hospitals receive a \$75 payment for each live birth to support genetic testing conducted after a live birth.

Direct medical education (DME) costs are allowed as pass-through payments for in-state facilities only. Payments are made semi-annually when funded.

Indirect medical education costs (IME) for in-state teaching hospitals only, are recognized and paid per discharge, as an addition to the DRG/outlier amount when funded.

Day outliers only for children under the age of 6 years, except where otherwise specified, are allowed and reimbursed on a per diem basis, at 60% of the full per diem amount.

Cost outliers are neither recognized nor reimbursed.

Observation room services may not be billed separately if the member is subsequently admitted. These services are covered as part of the inpatient stay. Any outpatient services rendered to a NH Medicaid recipient within 3 calendar days prior to the date of his/her inpatient admission, with a calendar day beginning 12:00 a.m. and ending 11:59 p.m., are included in the inpatient payment and should not be billed separately. The only exceptions are prenatal outpatient services and diagnostic and non-diagnostic services which are unrelated to the recipient's inpatient hospital admission.

The DRG payment is considered to be all inclusive of necessary diagnostic testing, treatment, and transportation rendered to a member by another acute care hospital while an inpatient of the billing hospital. If a member obtains necessary treatment or diagnostic testing at another acute care hospital while still an inpatient at the originating hospital, the originating hospital is considered to have received payment for such testing and treatment, as well as for any necessary transportation, as part of the DRG. No other hospital or transportation provider (e.g., ambulance providers) may bill for these services.

**Please Note:** If the patient was admitted through the Emergency Room, Urgent Care, or Outpatient Department, the admission date should be the date the inpatient order was written, and the charges for the 72 hours prior to the admission are rolled into the inpatient admission.

### 10.1.1 Payment for Transfer Services

#### ACUTE FACILITY TO ACUTE FACILITY

Hospitals that transfer patients to the same type of provider/sub provider are paid at the outlier per diem basis (100% of the full per diem) not to exceed the DRG rate allowed. When the hospital bills, the UB 04 must indicate a patient status code 02 in form locator 17.

Hospitals that transfer patients to a different type of provider/sub provider are paid according to the straight DRG payment (plus an outlier payment when appropriate). When the hospital bills, the UB 04 must indicate a patient status code 05 in form locator 17.

For Psychiatric Units, a transfer to NH Acute Psychiatric Service (APS) State Hospital is considered the same type of facility. Receiving acute hospitals and distinct part units will continue to be paid the DRG rate plus an outlier payment when appropriate.

#### TRANSFER FROM AND RETURN TO ACUTE INPATIENT HOSPITAL

If the patient is Medicaid eligible for the entire hospital stay, and the patient has been transferred to different levels of care, i.e. acute care to psychiatric care and then returned to acute care, please use the following guidelines:

If the member is transferred back to the original facility, the claim should be continued on the original care claim started from the first stay. This one claim should be submitted as follows:

1. Dates of Service: Must include the actual date of admit and the actual final discharge date for the first facility. Must also include the admit date and final or second discharge date.
2. Billed Amount: Must include the total billed amount minus the non-covered service days (inclusive in non-covered days, all ancillary charges) the patient was at the other facility.
3. Patient Status: Patient status code will be the actual disposition at the time of the final discharge.
4. Accommodation Days: Use appropriate revenue code for accommodation days. The total units must include ALL days from the first through the last day of the patient stay.
5. Revenue Codes: For ALL non-covered days, use Revenue Code 0180 or 0182 for the days the member was at the other type of facility.
6. Value Codes:
  - a) Covered Days
    - a) Use value code 80 to indicate the number of covered days:
      - i. Enter the total number of covered days
    - b) Non-covered days
  - c) Use value code of 81 or 82 to indicate the number of non-covered days:
    - i. Enter the total number of non-covered days (those days associated with the use of revenue codes 0180 or 0182)

### 10.1.2 Payment for Readmissions

A separate payment shall not be made for readmission to any hospital for the same diagnosis if the readmission occurs within 30 days of discharge, except for those cases where the department has given medical necessity approval.

### 10.1.3 Payment for Split Eligibility

Split billing is necessary when the patient is NOT NH Medicaid eligible for the entire length of the acute, inpatient hospital stay. When a NH Medicaid patient is eligible for only a part of the hospital stay, the NH Medicaid reimbursement shall be paid at the outlier per diem, not to exceed the DRG allowed amount. The DRG rate shall be considered payment in full for all services rendered on those days for which the patient was eligible for NH Medicaid.

The claim should be submitted as follows:

1. Dates of service: must reflect only the dates for which the member was eligible.

- a) When submitting a split claim for payment, if the member is eligible for only a portion of the hospital stay, NOT including the date of discharge, bill with patient status code 14 in field 17 on the UB04. The covered days must align with the dates of service on the claim.
  - b) When submitting a split claim for payment, if the member is eligible for only a portion of the hospital stay, which INCLUDES the date of discharge, bill with patient status code 15 in field 17 on the UB04. The covered days must align with the dates of service on the claim, not including the date of discharge, which is never covered.
2. Patient Status:
- a) Patient Status is 14 - When the member is eligible for only a portion of hospital stay, not including day of discharge
  - b) Patient Status is 15 - When the member is eligible for only a portion of hospital stay, including day of discharge
3. Revenue Code:
- a. Use value code 80 for the number of covered days:
    - i. Enter the number of covered days
  - b. Non-covered days – use value code of 81 or 82:
    - i. Enter the number of non-covered days (days reflected with the use of revenue codes 0180 or 0182)

When a member is eligible for Medicaid but transitions to or from NH Medicaid MCO coverage during the inpatient stay, the payor as of the start date of the inpatient stay should be billed for the entire stay.

#### 10.1.4 Acute Facility Billing a Stay Which Includes Non-Acute Days

If the patient is Medicaid eligible for the entire hospital stay, but a portion of the patient's stay was deemed to not be medically necessary by the Department, the claim needs to be rebilled with the non-acute days as non-covered days using Revenue Code 0180 (leave days) in order for the claim to reflect the admit and discharge dates.

If a claim is submitted when a portion of the member's stay was deemed not medically necessary, the claim should be rebilled as follows:

1. Date of Service - Must include the actual date of admit through to actual discharge date.

2. Billed Amount - Must include the total billed amount minus the non-covered service days the patient was treated at the Acute Facility.
3. Patient Status - Patient status code will be the actual disposition at the time of the final discharge field 17.
4. Use appropriate revenue code for medically necessary accommodation days. For non-covered days, use Revenue Code 0180.
5. Non-covered days – use value code of 81 or 82:
  - o Enter the number of non-covered days (days reflected with the use of revenue codes 0180 or 0182)

**Note:** Any claim which includes Revenue Code 0180 must be submitted on a paper UB 04 claim form.

## 10.2 Outpatient Hospital Payment

The Department will reimburse outpatient services as an interim payment based on a percent of charges. Final payment is made in accordance with a percent of costs. A review of each hospital's actual costs eligible for reimbursement shall be performed by the Department's third party contractor in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data reviewed by the Department's third party contractor.

Laboratory services provided as part of an outpatient hospital or RHC-HB visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit. In order for the add-on payment to be made, laboratory services, revenue codes 0300 through 0319, MUST be billed with the corresponding HCPC code identified in Field 44. Reimbursement will be according to fee for service rates established for the HCPC procedure codes, and are final and not subject to cost settlement.

Hospitals are required to bill for outpatient services on the UB-04 claim form using the appropriate Revenue Codes and descriptive HCPC codes for the services rendered.

### **Payment for Observation Room Services**

Observation room services may be billed as outpatient hospital services if the member is not subsequently admitted, but must be for a period of time not to exceed 24 hours.

## 10.3 Swing Bed Care Billing

Billing for swing bed care is as detailed below.

**When member is Medicaid prime (non-crossover)**

1. Submit a claim with TOB 018X (indicating inpatient)
2. Revenue Code 0101 (Room and Board), 0182 (Other LOA), or 0185 (LOA). This covers the room and board. Swing Bed providers are paid a per diem rate based on the appropriate LTC span for the member’s care. The claim processes and prices as a Nursing Home claim.
3. Use form locator 39-41 to indicate non-medically necessary dates.

**Form Locator 39-41**

**Required**

Use value code 80 for the number of covered days:

- Enter the number of covered days

For non-covered days use value codes of 81:

- Enter the number of non-covered days

4. Ancillary charges are submitted on a second claim with TOB 023X (Skilled Nursing Outpatient-to indicate SNF level of care), or TOB 089X (Specialty Facility-Other-to indicative ICF level of care). The claim processes and prices as an Outpatient claim.

**When member is Medicare prime (crossover)**

1. Submit a claim with TOB 018X (indicating inpatient)
2. Revenue code 012X (Room and Board), 0182 (Other LOA), or 0185 (LOA). This covers the room and board. The claim processes and prices as an inpatient Crossover Claim.
3. Use form locator 39-41 to indicate non-medically necessary dates.

**Form Locator 39-41**

**Required**

Use value code 80 for the number of covered days:

- Enter the number of covered days

For non-covered days use value codes of 81:

- Enter the number of non-covered days

4. Ancillary charges are submitted on a second claim to TOB 023X (Skilled Nursing Outpatient-to indicate SNF level of care), or TOB 089X (Specialty Facility-Other-to indicate ICF level of care). The claim processes and prices as an Outpatient Crossover Claim.

NH MEDICAID SWING ANCILLARY ACCEPTABLE REVENUE CODES TOB 023X OR 089X	
Revenue Code	Description
0250	PHARMACY GENERAL
0251	PHARMACY GENERAL

0252	PHARMACY NON-GENERIC
0253	TAKE HOME DRUGS
0254	LESS THAN EFFECTIVE DRUGS
0255	PHARMACY - RADIOLOGY
0256	DRUGS
0257	PHARMACY NON-PRESCRIPTION
0258	PHAMACY IV SOLUTION
0259	PHARMACY OTHER
0270	MEDICAL SURGICAL SUPPLIES GENERAL
0272	MEDICAL SURGICAL SUPPLIES STERILE SUPPLY
0273	MEDICAL SURGICAL SUPPLIES TAKE HOME
0274	MEDICAL SURGICAL SUPPLIES PROSTHETIC DEVICE
0275	MEDICAL SURGICAL SUPPLIES PACEMAKER
0276	INTRAOCULAR LENS
0277	OXYGEN TAKE HOME
0278	MEDICAL SURGICAL SUPPLIES OTHER IMPLANTS
0279	MEDICAL SURGICAL SUPPLIES OTHER
0300	LABORATORY GENERAL
0301	LABORATORY CHEMISTRY
0302	LABORATORY IMMUNOLOGY
0303	LABORATORY RENAL
0304	LABORATORY NON ROUTINE DIALYSIS
0305	LABORATORY HEMATOLOGY
0306	LABORATORY BACTERIOLOGY MICROBIOLOGY
0307	LABORATORY UROLOGY
0309	LABORATORY OTHER
0310	PATHOLOGICAL GENERAL
0311	PATHOLOGICAL CYTOLOGY
0312	PATHOLOGICAL HISTOLOGY
0314	PATHOLOGICAL BIOPSY
0319	PATHOLOGICAL OTHER
0320	RADIOLOGY DIAGNOSTIC GENERAL
0321	RADIOLOGY DIAGNOSTIC ANGIOCARDIOGRAPHY
0324	RADIOLOGY DIAGNOSTIC CHEST X-RAY
0329	RADIOLOGY DIAGNOSTIC OTHER
0350	CT SCAN GENERAL
0351	CT SCAN HEAD
0352	CT SCAN BODY
0359	CT SCAN OTHER
0360	OPERATING ROOM GENERAL
0370	ANESTHESIA GENERAL
0391	BLOOD STORAGE PROCESSING ADMINISTRATION

0402	X-RAY OTHER IMAGING SERVICE ULTRASONIC
0410	RESPIRATORY SERVICES GENERAL
0412	RESPIRATORY SERVICES INHALATION
0413	RESPIRATORY SERVICES HYPERBONIC OXYGEN
0419	RESPIRATORY SERVICES OTHER
0420	PHYSICAL THERAPY GENERAL
0421	PHYSICAL THERAPY VISIT CHARGE
0422	PHYSICAL THERAPY HOURLY CHARGE
0423	PHYSICAL THERAPY GROUP RATE
0424	PHYSICAL THERAPY EVALUATION RE-EVALUATION
0429	PHYSICAL THERAPY OTHER
0430	OCCUPATION THERAPY GENERAL
0431	OCCUPATION THERAPY VISIT CHARGE
0432	OCCUPATION THERAPY HOURLY CHARGE
0433	OCCUPATION THERAPY GROUP RATE
0434	OCCUPATION THERAPY EVALUATION RE-EVALUATION
0439	OCCUPATIONAL THERAPY OTHER
0440	SPEECH THERAPY GENERAL
0441	SPEECH THERAPY VISIT CHARGE
0442	SPEECH THERAPY HOURLY CHARGE
0443	SPEECH THERAPY GROUP RATE
0444	SPEECH THERAPY EVALUATION RE-EVALUATIO
0449	SPEECH THERAPY OTHER
0460	PULMONARY FUNCTION GENERAL
0730	EKG/ECG GENERAL
0801	INPATIENT RENAL DIALYSIS INP HEMODIALYSIS
0946	COMPLEX MEDICAL EQUIPMENT - ROUTINE

## 10.4 Hospital-Based Rural Health Clinic Payment

Payment for hospital based rural health clinic services shall be made as an interim payment based on a percentage of charges. Final payment is made in accordance with a percent of costs. A review of each hospital's actual costs eligible for reimbursement shall be performed by the Department's third party contractor in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data reviewed by the Department's third party contractor. The Department may forego the review if the aggregate Medicaid FFS outpatient charges from the provider are below \$25,000 annually.

Laboratory services provided as part of a health clinic visit are paid a fee in addition to the percentage of cost payment and are final and not subject to cost settlement. When billing lab services, revenue codes 0300 through 0319 MUST be billed with the corresponding HCPC code identified in Field 44.

Payment for long-acting reversible contraception (LARC) devices and some vaccine services are paid a fee in addition to the percentage of cost payment and are final and not subject to cost settlement. see section 11.3.1 for additional detail.

Member encounters with more than one health professional, or multiple encounters with the same health professional, which take place on the same day for the same diagnosis or treatment, are counted as one encounter. In instances in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment on the same day, the additional encounter may be billed as a separate encounter.

## 10.5 Denial of Payment for Provider Preventable Conditions

The Department does not make payment for health care acquired conditions (HCAC) and other provider preventable conditions which includes three erroneous surgeries (never events). Claims with a present on admission code of "N" or "U" will receive a reduced payment for treatment of the HCAC, but not for the procedure itself.

See the "Claims" section below for claim submittal requirements.

## 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.

Please see "Timely Filing" below for claims resubmitted as a result of a utilization review.

### **Erroneous Surgeries and Provider Preventable Conditions**

Note that federal reporting requirements require that providers submit claims for erroneous surgeries and related services. Claims indicating any one of three erroneous surgeries and related services will be reviewed and denied if appropriate. This includes hospitalizations, services in the operating room, and services of any providers who could bill for operating room services such as hospitals, practitioners, ambulatory surgical centers, and other appropriate types of providers.

Claims for erroneous surgeries are identified by diagnosis E codes or CPT/HCPCS modifiers and include:

#### **E-codes:**

- a. E876.5 Performance of wrong operation (procedure) on correct patient
- b. E876.6 Performance of operation (procedure) on patient not scheduled for surgery
- c. E876.7 Performance of correct operation (procedure) on wrong side/body part

#### **CPT/HCPCS Modifiers:**

- a. PA: Surgical or other invasive procedure on wrong body part
- b. PB: Surgical or other invasive procedure on wrong patient
- c. PC: Wrong surgery or other invasive procedure on patient

### 11.1 Timely Filing

For hospitals that are under utilization review and who resubmit a claim as directed by the Department, if the claim is over the timely filing limit, claim submission should be made on a regular UB 04 claim form using a C1 indicator in the condition code field, form locator 18. This will allow the system to override the timely filing limit for that claim.

## 11.2 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.

Hospitals are required to bill for outpatient services on the UB-04 claim form using the appropriate Revenue Codes and descriptive HCPC codes for the services rendered.

Laboratory services provided as part of an outpatient hospital or RHC-HB visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit. In order for the add-on payment to be made, laboratory services, revenue codes 0300 through 0319, MUST be billed with the corresponding HCPC code identified in Field 44. Reimbursement will be according to fee for service rates established for the HCPC procedure codes.

## 11.3 RHC-HB Encounter Code Billing

New Hampshire Medicaid requires that Hospital Based Rural Health Clinics bill their encounters using the revenue code 0521 and the appropriate descriptive HCPC codes on the UB-04 claim form.

### 11.3.1 Additional Services Billing

Certain procedures performed in a Hospital Based Rural Health Clinic can be billed in addition to the encounter code. Below is a listing of revenue codes which may be billed.

Revenue Code	Description
0300	Laboratory, General
0301	Laboratory, Chemistry
0302	Laboratory, Immunology
0304	Laboratory, Non-Routine Dialysis
0305	Laboratory, Hematology
0306	Laboratory, Bacteriology & Microbiology
0307	Laboratory, Urology
0309	Laboratory, Other Laboratory
0310	Laboratory Pathology, General Classification
0311	Laboratory Pathology, Cytology
0312	Laboratory Pathology, Histology
0314	Laboratory, Biopsy
0319	Laboratory, Other Laboratory Pathology

### **VACCINES**

If vaccinations are given as part of or incidental to a medical or behavioral encounter visit at an RHC-HB, the vaccine administration is considered to be part of the service encounter and is not reimbursed separately by NH Medicaid.

If the vaccine administration is the only service performed, the administration can be billed separately using the clinic visit revenue code 0521 and will be reimbursed at the interim rate at a percent of charges which is subsequently cost settled.

For adults age 19 and over, RHC-HB providers may bill for the vaccine itself using the pharmacy revenue code 0250 and will be paid at an interim rate which is subsequently cost settled.

### **LONG ACTING REVERSIBLE CONTRACEPTION**

The procedure codes for long-acting reversible contraception (LARC) devices are as follows (include NDC code with procedure code where applicable):

- J7296
- J7297
- J7298
- J7296
- J7300
- J7301
- J7306

- J7307

**Fee for Service Medicaid**

- Hospitals will submit claims for the LARC device on an outpatient claim
- Payment for the device will be made in accordance with the NH Medicaid Fee Schedule
- ICD-10 family planning code(s) must be included on the claim.

## 11.4 Service Authorizations (SAs)

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

## 11.5 Claim Completion Requirements for Hospital

Hospital providers are required to submit claims to NH Medicaid using the UB04 form or the electronic version, an 837I. Unless you are submitting a claim after Medicare has paid or allowed the charge, this claim would be a crossover and you would submit the same claim type you submitted to Medicare.

Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted areas 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 adjustments 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 UB-04 form must be both signed and dated. 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

## 11.6 UB04 Paper Completion Instructions – Hospital Only

### **Form Locator 01**

Provider name, address and telephone number

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

### **Form Locator 02**

Billing Provider's Designated Pay-to Address

- **Optional**

### **Form Locator 03a**

Patient control number

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

### **Form Locator 03b**

Medical/Health Record Number

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

### **Form Locator 04**

Type of Bill (TOB)

- **Required**

- Up to 4 characters with leading 0
- NH Medicaid does not accept interim claims
- Frequency codes 7 and 8 are **only** accepted electronically (X12/web portal) to void a or submit a replacement claim
- Inpatient, TOB=(0)111
- Outpatient, TOB= (0)131

**Form Locator 05**

Federal Tax Number

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

**Form Locator 06**

Statement Covers Period – From/Through

- **Required**
- For services performed on one day, use the same date “From” and “Through”
- Valid date format as month, date and year (MMDDCCYY)
- Inpatient
  - Include all acute and non-acute days in the span
- Outpatient
  - Span dates are **not** allowed
  - “From” and “through” dates **must be** the same date

**Form Locator 07**

Reserved for Assignment by the NUBC

- N/A

**Form Locator 08a –**

Patient ID

- **Optional**
- Enter the patient’s NH Title XIX ID
- NH Medicaid ID numbers are 11 characters

**Form Locator 08b**

Patient Name

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

**Form Locator 09**

Patient Address

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

**Form Locator 10**

Patient Birth Date

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

**Form Locator 11**

Patient Sex

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

**Form Locator 12**

Admission Date

- **Required**
- For inpatient claims-begin date is the day of admission
- Outpatient claims- the date the episode of care began
- Record the date as month, date, and year (MMDDCCYY)

**Form Locator 13**

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

- **Required**
- Inpatient claims
- Enter the applicable code which corresponds with the time

**Form Locator 14**

Priority (Type) of Admission or Visit

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

Code	Description	Code	Description
1	Emergency	5	Trauma
2	Urgent	6-8	Reserved
3	Elective	9	Information not available
4	Newborn		

**Form Locator 15**

Point of Origin for Admission or Visit

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

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

**Form Locator 16**

Discharge Hour

- **Required**
- Inpatient claims
- Record discharge hour code for when the patient was discharged from inpatient claims
- Use Table from Form Locator13
- 4 characters HHMM

**Form Locator 17**

Patient Discharge Status

- **Required**
- All inpatient claims
- Record the disposition or discharge status of the patient at the end of the service for the period covered as reported in FL 6, Statement Covers Period

01	Discharge to Home	05	Discharge Transfer to Other Type of Institution
02	Discharge Transfer to Short Term Hospital	06	Discharge Transfer to Home Under Home Health Care
03	Discharge Transfer to SNF	07	Left Against Medical Advice
04	Discharge Transfer to ICF	20	Expired

**Form Locator 18 - 28**

Condition Codes

- **Situational**
- Record the code used to identify the conditions or events that may affect processing as related to this bill

**Form Locator 29**

Accident State

- **Optional**

**Form Locator 30**

Reserved for Assignment by NUBC

- **N/A**

**Form Locator 31-34**

Occurrence Codes and Dates

- **Required**
- Use 11- "onset of illness"
- Record all dates as month, date, and year (MMDDCCYY)

**Form Locator 35-36**

Occurrence Span Codes and Dates

- **Situational**
- Record a code and the related dates that signify an event that relates to the payment of this claim.

**Form Locator 37**

Reserved for Assignment by NUBC

- **N/A**

**Form Locator 38**

Responsible Party Name and Address

- **Optional**
- Enter the name and address of the party being billed

**Form Locator 39-41**

Value Codes and Amounts

- **Required- inpatient**
- Use value code 80 to determine number of days

- Non-covered days use value code of 81 or 82
- Enter the number of non-covered days

### **Form Locator 42**

#### Revenue Code

- **Required**
- Identify specific accommodations, ancillary service or unique billing circumstances
- 4 digits
- Inpatient services involving more than one service for the same item should combine the services under the applicable revenue code and record the total number of units that correspond to those services.
- Outpatient services enter the applicable HCPCs for the services in conjunction with the date of the service and revenue code.
- If more than one service is performed on the same day for related services with the same HCPCs, the provider should combine the related services for each date and enter the date along with the number of units, as well as the revenue code.

### **Form Locator 43**

#### Revenue Description/IDE Number/Medicaid Drug Rebate

- **Required**
- Enter narrative description of the revenue codes
- Outpatient claims that need a NDC the following information is to be recorded
  - Record the NDC qualifier of N4 in the first 2 positions on the left side of the field
  - Record the NDC 11-digit numeric code which is given in a "5-4-2" format – **no** hyphens are to be used.
  - Record the NDC Units of Measurement Qualifier
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN – Unit
  - Record the NDC quantity, up to 3 decimal places, ex. 1234.567

### **Form Locator 44**

#### HCPCS/Accommodation Rates

- **Situational**

- Accommodation revenue codes must have a corresponding accommodation rate; for the following revenue codes, (**outpatient services only**) you must enter a corresponding HCPCS code
  - 0260-0269
  - 0273-0277
  - 0280-0290
  - 0300-0369
  - 0380-0620
  - 0622-0637
  - 0681-0709
  - 0721-0729
  - 0730-0799
  - 0820-0821
  - 0900-0989
  
- When billing with a NDC enter the appropriate HCPCS related with the NDC

**Form Locator 45**

## Service Date

- **Required**
- Record the service date in valid format (MMDDCCYY) for any accommodation revenue code
- Line one must correlate with FL 6 "From" date

**Form Locator 46**

## Service Units

- **Required**
- Record units of service for all accommodation days
- Must correlate with each detail
- The sum of all units for all accommodation details need to correspond with the covered days listed in FL 7.
- If using an NDC code, enter the number of HCPCS units provided

**Form Locator 47**

## Total Charges

- **Required**
- Record the sum of all charges related to the applicable revenue codes for each detail line
- Record in appropriate currency format DD.CC

- Record revenue code 0001 for a total charge for the claim
- **OR**...enter the total charges in the "TOTALS" of line 23. Total line must be the sum of all individual line items in FL 47

**Form Locator 48**

Non-Covered Charges

- **Situational**
- Line item non-covered charges
- Record the sum of the non-covered charges on Line 23 of the final claim page using Revenue Code 0001
- Valid currency format DD.CC

**Form Locator 49**

Reserved for Assignment by NUBC

- N/A

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

Payer Name

- **Situational**
- Record the NH Title XIX carrier code and carrier name if member has other insurance
- Carrier code- 10 digits. The original 4-digits with 6 preceding zeros.
- Carrier Codes can be found by:
- Viewing the provider website and quarterly bulletins for the most up-to-date list or
- Contact the provider relations unit at 1-866-291-1674

**Form Locator 51**

Health Plan Identification Number

- **N/A**

**Form Locator 52**

Release of Information Certification Indicator

- N/A

**Form Locator 53**

Assignment of Benefits Certification Indicator

- N/A

**Form Locator 54**

Prior Payments

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

**Form Locator 55**

Estimated Amount Due- Payer

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

**Form Locator 56**

National Provider Identifier – Billing Provider

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

**Form Locator 57**

Other (Billing) Provider Number

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

**Form Locator 58 –**

Insured's Name

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

**Form Locator 59**

Patient's Relationship to Insured

- N/A

**Form Locator 60**

Insured's Unique Identifier

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

**Form Locator 61**

Insured's Group Name

- **Situational**

**Form Locator 62**

Insured's Group Number

- **Situational**

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

Treatment Authorization Code

- **Not Required, at this time**

**Form Locator 64**

Document Control Number (DCN)

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

**Form Locator 65**

Employer Name

- **Optional**

**Form Locator 66**

Diagnosis and Procedure Code Qualifier

- N/A

**Form Locator 67**

Principal Diagnosis Code and Present on Admission Indicator

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

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

Other Diagnosis Codes and Present on Admission (POA) Indicator

- **Situational, inpatient claims**
- Record the POA code(s) when other conditions are present or develop during the member's treatment.

POA Indicator	Description
Y	Dx Present at time of inpatient admission
N	Dx Not present at time of inpatient admission
U	Documentation insufficient to determine
W	Clinically undetermined
1	Unreported/not used; exempt from POA

**Form Locator 68**

Reserved for Assignment by NUBC

- N/A

**Form Locator 69 –**

Admitting Diagnosis Code

- **Required for inpatient claims**

**Form Locator 70 (A-C)**

Patient's Reason for Visit

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

**Form Locator 71**

Prospective Payment System (PPS) Code

- N/A

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

External Cause of Injury (ECI) Code and Present on Admission (POA) Indicator

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

**Form Locator 73**

Reserved for Assignment by the NUBC

- N/A

**Form Locator 74 –**

Principal Procedure Code and Date

- **Required for inpatient claims**
- Valid date form, month, date, and year (MMDDCCYY)
- Record the ICD-9-CM code that names the primary procedure performed

**Form Locator 75**

Reserved for Assignment by NUBC

- N/A

**Form Locator 76 –**

Attending Provider Name and Identifiers (Attending Physician ID)

- **Situational**
- Record provider's 10 digit NPI in the correct field
- **OR**, record the NH Title XIX provider ID for the physician that was principally responsible for the care of the patient upon admission
- Record the last name, first name of the Principal physician

**Form Locator 77 –**

Operating Physician's Name and Identifiers

- **Situational**
- Record if procedure is billed
- Record the name and ID number of the physician who performed the surgical procedure(primary)

**Form Locator 78 – 79**

Other Provider (Individual) Names and Identifiers

- **Situational**
- Record information if the provider is eligible for an NPI

**Form Locator 80**

Remarks Field

- **Situational**
- Add any additional information needed for processing this claim

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

Code Field

- **Situational**
- Utilizing Field a-b enter a qualifier code of "B3" in two-digit field
- Enter the taxonomy code associated to the billing provider's NPI number used in Form Locator 56
- Enter on the same line as the "B3"
- Strongly suggested that a taxonomy code be provided when an NPI is in Form Locator 56

- The NPI number and corresponding taxonomy code must be on file with the fiscal agent

## 12. Terminology

“Acute care” means those services provided to recipients, other than swing bed patients, in a hospital.

“Budget neutrality factors” means adjustments applied to rate-setting methodology to reduce spending growth.

“Centers for Medicare and Medicaid Services (CMS)” means the division of the federal Department of Health and Human Services that administers medicare, medicaid, the children’s health insurance program, and the health insurance marketplace.

“Day outlier” means those cases for which the actual length of stay exceeds the trim point per diagnosis related group.

“Department” means the New Hampshire (NH) department of health and human services.

“Diagnosis related group (DRG)” means the taxonomy of diagnoses as classified in the medicare DRG classification system which groups hospital inpatient cases according to factors such as principal diagnosis, age, and sex, and assigns a relative weight which represents hospital resource use associated with treatment for the diagnosis, pursuant to 42 CFR 412.60.

“Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or the recommendations of physician specialists practicing in relevant clinical areas or of various physician specialty societies.

“Hospital” means any facility providing acute care services, to include acute care rehabilitation services, not operating as a psychiatric hospital or an institution for mental diseases and which provides the inpatient hospital services defined in 42 CFR 440.10.

“In-state hospital” means a hospital which is located within the physical boundaries of NH.

“Medicaid” means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

“Medically necessary” means:

- (1) For individuals under age 21, reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the

early and periodic screening, diagnosis, and treatment services (EPSDT) recipient requesting a medically necessary service; and

(2) For individuals age 21 and over, health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

- a. Clinically appropriate in extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;
- b. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;
- c. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and
- d. Not experimental, investigative, cosmetic, or duplicative in nature.

"Observation services" means services furnished by a hospital on the hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

"Out-of-state hospital" means a hospital located outside of NH.

"Recipient" means an individual who is eligible for and receiving medical assistance under the medicaid program.

"Title XIX" means the joint federal-state program described in Title XIX of the Social Security Act and administered in NH by the department under the medicaid program.

"Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in NH by the department under the medicaid program.