

# Adult Medical Day Program (AMDP)

Provider Manual  
Volume II

April 1, 2013

---

New Hampshire  
Medicaid



## Table of Contents

|            |   |           |
|------------|---|-----------|
| <b>1.</b>  | <b>NH MEDICAID PROVIDER BILLING MANUALS OVERVIEW .....</b>                      | <b>1</b>  |
|            | Intended Audience .....   | 1         |
|            | Provider Accountability .....   | 1         |
|            | Document Disclaimer/Policy Interpretation .....                                 | 1         |
|            | Notifications & Updates .....   | 2         |
|            | Description of Change Log .....   | 2         |
|            | Contacts for Billing Manual Inquiries .....                                     | 2         |
| <b>2.</b>  | <b>PROVIDER PARTICIPATION &amp; ONGOING RESPONSIBILITIES .....</b>              | <b>3</b>  |
|            | Care Plan .....   | 4         |
| <b>3.</b>  | <b>COVERED SERVICES &amp; REQUIREMENTS .....</b>                                | <b>6</b>  |
| <b>4.</b>  | <b>NON-COVERED SERVICES .....</b>   | <b>7</b>  |
| <b>5.</b>  | <b>SERVICE AUTHORIZATIONS (SA).....</b>   | <b>8</b>  |
| <b>6.</b>  | <b>DOCUMENTATION.....</b>   | <b>9</b>  |
| <b>7.</b>  | <b>SURVEILLANCE AND UTILIZATION REVIEW (SURS) – PROGRAM<br/>INTEGRITY .....</b> | <b>10</b> |
| <b>8.</b>  | <b>ADVERSE ACTIONS .....</b>  | <b>11</b> |
| <b>9.</b>  | <b>MEDICARE/THIRD PARTY COVERAGE .....</b>                                      | <b>12</b> |
| <b>10.</b> | <b>PAYMENT POLICIES .....</b>   | <b>13</b> |
| <b>11.</b> | <b>CLAIMS.....</b>  | <b>14</b> |
|            | Timely Filing .....   | 15        |
|            | Diagnosis & Procedure Codes .....   | 15        |
|            | Service Authorizations (SAs) .....  | 15        |
|            | Required Claim Attachments .....  | 16        |
|            | Claim Completion Requirements for AMDP.....                                     | 17        |



## 1. NH Medicaid Provider Billing Manuals Overview

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

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

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

### Intended Audience

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

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

### Provider Accountability

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

### Document Disclaimer/Policy Interpretation

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

## Notifications & Updates

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

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

## Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

## Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the Xerox Provider Relations Unit (refer to General Billing Manual – Volume I, Appendices Section for all Contact Information).

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

## 2. Provider Participation & Ongoing Responsibilities

Adult medical day programs (AMDPs) provide a protective environment for impaired or isolated program members who are at risk of institutionalization. Services include an array of social and health care and day-time respite for primary caregivers. Services are furnished on a regularly scheduled basis, for one or more days per week. Meals provided as part of this service shall not constitute a “full nutritional regimen.” Transportation services are not included in this service and are not included in the reimbursement for this service, although some AMDPs provide transportation and are reimbursed separately for that service.

The Adult Medical Day Program (AMDP) center shall be licensed pursuant to RSA 151 and He-P 818, and be enrolled as a NH Medicaid provider with the Department of Health and Human Services (DHHS).

The AMDP center shall have on staff at least one full-time registered nurse (RN), or a licensed practical nurse (LPN), or both, who shall be available at the center whenever one or more Medicaid-eligible members are present.

The AMDP center shall determine whether individuals requesting AMDP services meet the eligibility requirements and the type and frequency of services needed, in accordance with He-E 803.

AMDPs that provide specialized transportation, as described in the “Covered Services” section, shall ensure that:

- All vehicles used to provide specialized transportation are registered and inspected according to the requirements of the NH Division of Motor Vehicles and insured for personal liability and medical payments.
- All drivers who provide specialized transportation are licensed to drive the vehicles being operated within the State of New Hampshire and covered under the insurance described previously.
- Employees of the AMDP or other provider of transportation, or sub-contractors or volunteers under the supervision of the AMDP center, are provided information or training from the AMDP center concerning each individual’s needs and safety concerns.

Eligibility: AMDP services are available to Medicaid-eligible members in accordance with He-E 803, as follows:

1. Who are age 18 or older;
2. Who reside in an independent living situation;
3. Whose licensed practitioner has:
  - a. Completed a physical examination on the individual within 60 days prior to the request for services; and
  - b. Referred the individual for adult medical day services, because the individual:
    - i. Has been diagnosed as having an illness or disability; and
    - ii. Requires adult medical day services; and

4. Require adult medical day services for a minimum of 4 hours per day, on a regularly occurring basis.

Adult medical day services shall not be available to anyone:

1. Who resides in a nursing facility or other licensed or certified facilities;
2. Who receives adult family care services pursuant to He-E 801;
3. Whose needs cannot met by the adult medical day program; or
4. Who is primarily seeking services to address a diagnosis of mental illness or developmental disability.

The AMDP center shall notify the member or his/her representative in writing as to whether he/she meets the eligibility requirements.

## Care Plan

An individual care plan shall be developed as required by He-P 818, based on information obtained from the physician's referral, and the clinical assessments performed by the AMDP.

Per He-P 818:

1. A care plan shall be completed within the first 30 days of attendance based upon the results of all of the member's assessments listed above and shall include:
  - a. The date any specific problem or need was identified;
  - b. A description of services to let providers know what problem(s) or need(s) was identified as a result of the assessments;
  - c. The goals for the member;
  - d. The action or approach to be taken by the ADP;
  - e. The party responsible for implementing the action or approach to be taken;
  - f. The date the next re-evaluation is to occur; and
  - g. Written documentation to verify that the member, family or caregiver were offered the opportunity to be involved in the development of the care plan and any revisions made thereafter;
2. The licensed nurse and other personnel as deemed necessary by the licensed nurse shall review the care plan at least every 6 months and revise it whenever necessary;
3. The care plan referenced shall be:
  - a. Reviewed and updated within 5 business days following the completion of each future assessment; and
  - b. Made available to personnel who assist members in the implementation of the plan;

4. If the nursing assessment, developed or the care plan is completed by an LPN, the assessment and care plan shall be reviewed and co-signed by an RN or physician that is supervising the LPN prior to the implementation of the member's care plan; and
5. The direct care personnel of the ADP shall implement the care plan.

### 3. Covered Services & Requirements

AMDP services are reimbursed on a per diem basis. The per diem rate includes the following services when provided to an eligible member in accordance with the care plan:

- Nursing care and supervision, including medication administration and wound care;
- Maintenance level therapies;
- Medical supplies that are for general purposes, or first aid;
- Nutrition services;
- Assistance with arranging for transportation; and
- Social services.

Case management services shall be coordinated with the case manager if one is assigned to the member as part of the Choices for Independence (CFI) program.

If the AMDP provides Specialized Transportation, it shall be covered as a separately billed service to ensure access to AMDP services for members. Specialized transportation shall be a covered service from the member's residence to the AMDP center or from the AMDP center to the member's residence.

When provided by the AMDP, Specialized Transportation shall be made available on all of the days that the AMDP center operates, and in a manner that will accommodate each member's attendance needs within the center's operating hours and include assistance and supervision as needed and in a manner that maintains continuity of care identified in the care plan, including, but not be limited to:

- Reminding the member, prior to leaving his/her residence, to bring items needed for the day, such as eyeglasses, medications and clothes appropriate for the weather;
- Physically assisting the member to and from the vehicle;
- Securing the member in a seatbelt and stopping to re-secure, if necessary;
- Providing reassurance as necessary and stopping to address any personal care needs that arise for the member during the trip;
- Physically assisting the member from the vehicle into the AMDP center and back to the vehicle; and
- Assisting the member from the vehicle back into his/her residence.

## 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 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 s/he understands that the service is non-covered and that s/he agrees to pay for this service.

## 5. Service Authorizations (SA)

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

Service Authorizations are not required for AMDP services at this time.

## 6. Documentation

AMDP providers must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement. Please see the “Record Keeping” section of the General Billing Manual – Volume I, for documentation requirements.

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer.

AMDP providers shall maintain a service record and care plan for each member, which includes the documentation requirements in He-P 818.

The provider of specialized transportation shall maintain documentation of the transportation services they provide to the member, including but not limited to:

- The dates of service;
- The starting and ending locations;
- The name(s) of the driver(s); and
- The type(s) of assistance provided to each individual on each date of service.

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

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

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

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

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

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

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

## 8. Adverse Actions

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

## 9. Medicare/Third Party Coverage

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

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

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

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

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

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

This does not apply to QMB-Only members whose benefits are limited to the Medicare premiums and payment toward the Medicare deductible and coinsurance. Therefore, if Medicare does not cover the service, there is no NH Medicaid payment available for QMB members.

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

## 10. Payment Policies

The per diem rate for AMDP services shall be all-inclusive, provided that therapy services are at the maintenance level.

Members receiving the services described in “Covered Services” shall attend the AMDP center for a minimum of 4 hours per day, on a regularly occurring basis, which shall not include time spent in transit or on services not included in the per diem rate.

Reimbursement for specialized transportation under AMDP care services shall be all inclusive, and shall not be in addition to any other reimbursement for transportation. Specialized transportation shall be reimbursed at a per-person, per-trip rate.

Medicaid reimbursement for general medical transportation shall be made as stipulated in He-W 574.

Reimbursement for wheelchair van transportation shall be made as stipulated in He-W 573, when provided instead of specialized transportation.

## 11. Claims

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

Providers participating in the NH Medicaid Program are responsible for timely and accurate billing. If NH Medicaid does not pay due to billing practices of the provider which result in non-payment, the provider cannot bill the member.

Claim completion guidelines in this manual should be followed for instructions on specific fields. The NH Specific Companion Guide, which can be found at [www.nhmmis.nh.gov](http://www.nhmmis.nh.gov) (see provider manuals under the provider tab), should be used for electronic claim filing instructions. While field-by-field requirements are shown for paper claims; the same required data is captured through web portal claim entry and through electronic submissions to EDI. Web portal submissions feature step-by-step claim completion instructions as well as tools such as Online Help to assist providers in correct claim completion.

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

The following claim-related topics are found in the General Billing Manual – Volume I:

- Claims Submission via EDI, web portal, paper
- Claims processing – edits & audits, transaction control numbers, line item vs. header processing, claim status, remark/EOB codes
- Claim Resubmission
- Claim adjustments and voids
- Medicare cross-overs
- Claims payment
- Remittance Advice

Providers will be notified of payment or denial via a Remittance Advice, usually received in electronic format or via the web portal.

Denied claims should be resubmitted only if the reason for the denial has been corrected.

Paid claims cannot be resubmitted; resubmission of a paid claim will result in a denial as a duplicate. Paid claim corrections must be made through the adjustment process. If a paid claim has a line item denial, the individual line charge can be resubmitted.

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information which is now corrected. Providers should never resubmit claims that are currently in process (suspended).

Any claim denied for failure to be submitted or resubmitted in accordance with timely filing standards will not be paid. Denied claims that have been corrected must be resubmitted as a new claims transaction on paper, via the web portal, or electronically via EDI.

## Timely Filing

In accordance with federal and state requirements, all providers must submit all initial claims within one year following the earliest date of service on the claim.

Except as noted below, NH Medicaid will **not** pay claims that are **not** submitted within the one-year time frame.

Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper, along with Form 957x, "Override Request" located on the NH MMIS Health Enterprise Portal web site at [www.nhmmis.nh.gov](http://www.nhmmis.nh.gov). A copy of the RA with the original billing date and the denial circled must also be attached. This resubmission **must** be received **within 15 months** of the date of service. If this time frame is not met, the claim will be denied.

The only other circumstance eligible for consideration under the one-year override process is for claims for NH Medicaid covered services for members whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above.

## Diagnosis & Procedure Codes

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

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

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

## Service Authorizations (SAs)

For some services, providers must obtain pre-approval and a corresponding service authorization number. The claim form allows the entry of a service authorization number. However, the NH Medicaid Program does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

Service Authorizations are not required for AMDP services at this time.

## Required Claim Attachments

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

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

| Type Attachment | Delivery Method | Attachment Control # |
|-----------------|-----------------|----------------------|
| No Data         |                 |                      |

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

- **Please mail claim attachments to:**  
Xerox Claims Unit  
PO Box 2003  
Concord, NH 03302
- **Please fax claim attachments to:**  
(888) 495-8169

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

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

## Claim Completion Requirements for AMDP

AMDP providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P. Unless you are submitting a claim after Medicare has paid or allowed the charge, this claim would be a crossover and you would submit the same claim type you submitted to Medicare.

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

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted areas show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
4. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
5. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
6. DO use only black ink on ALL claims or adjustments that you submit to Xerox. The Xerox imaging/OCR system reads blue and black ink.
7. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
8. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

Paper claims and other documents can be mailed to:

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

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. An actual signature or signature stamp is required – typed provider name or signature on file will not be adequate. Please note that anyone authorized by the provider or company is allowed to sign the form based on the company's own policy for authorized signers.

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

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

The format is: YYDDD M BBBB NNNNNN T, where

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

- T is the transaction type.

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

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

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

The list of Carrier IDs for other insurance companies can be accessed on [nhmmis.nh.gov](http://nhmmis.nh.gov) Web Site

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

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

## CMS-1500 Claim Form Instructions

| Item # | Description   | Instructions   |
|--------|---|--|
| 1      |   | Check Medicaid   |
| 1a.    | Insured's ID Number   | <b>Required</b> - Enter the NH Title XIX ID number (11 characters) shown on the ID card.       |
| 2      | Patient's Name  | <b>Required</b> - Enter the last name, first name, and middle initial as shown on the ID card. |
| 3      | Patient's Birth Date (8 digits), Sex                            | <b>Required</b><br>Must be valid date mm/dd/ccyy   |
| 4      | Insured's Name  | Last Name, First Name, MI  |
| 5      | Patient's Address (Multiple Fields)<br>Member's mailing address | City, State, Zip Code  |
| 6      | Patient Relationship to Insured                                 | N/A  |
| 7      | Insured's Address   | If selected, city, state, zip code, and telephone. If not selected default to "self".          |
| 8      | Patient Status  | N/A  |

| Item # | Description   | Instructions   |
|--------|---|--|
| 9      | Other Insured's Name  | When additional group health coverage exists, enter other insured's full name if it is different from that shown in Item Number 2. Last Name, First Name, MI<br><br>If Item # 11d is marked, complete fields #9 and #9a-d, otherwise leave blank.                        |
| 9 a.   | Other Insured's Policy or Group Number  | <b>Situational</b> – provide policy number if applicable. Must be 12 or less alpha-numeric characters.   |
| 9 b.   | Other Insured's Date of Birth   | N/A  |
| 9 c.   | Employer's Name or School Name  | N/A  |
| 9 d.   | Insurance Plan Name or Program Name   | <b>Required</b> – if other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code<br>Codes can located on the NH MMIS Health Enterprise Portal under documents section  |
| 10 a-c | Is Patient's Condition Related To?  | <b>Required</b><br>Enter an X in the correct box to indicate whether one or more of the services described in Item # 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Mark <u>one</u> box only on each line. |
| 10 d.  | Reserved for Local Use  |  |
| 11     | Insured's Policy, Group or FECA Number  | <b>Situational</b> – Enter the insured's policy or group number as it appears on the insured's health care identification card.  |
| 11 a.  | Insured's Date of Birth (8 digits)  | Must be valid date mmddccyy  |
| 11 b.  | Insured's Employer's Name or School Number<br><br>The name of the insured's employer or school. | N/A  |

| Item # | Description  | Instructions  |
|--------|--|---|
| 11 c.  | Insurance Plan or Program Name                     | N/A   |
| 11 d.  | Is There Another Health Benefit Plan?              | Enter an X in the correct box. If marked "YES," complete #9 and #9a-d and list denial in #19 or payment in #29. Mark <u>one</u> box only.   |
| 12     | Patient's or Authorized Person's Signature         | N/A   |
| 13     | Insured's or Authorized Person's Signature         | N/A   |
| 14     | Date of Current Illness, Injury, Pregnancy         | <b>Situational</b> – Enter if "YES" is present in Item #10<br>Must be a valid format mmddccyy   |
| 15     | If Patient Has Had Same or Similar Illness         | Date format mm/dd/ccyy  |
| 16     | Dates Patient Unable to Work in Current Occupation | Date format mm/dd/ccyy  |
| 17     | Name of Referring Provider                         | <b>Required</b> – when billing radiology, Lab, DME<br>Last name, First Name, and MI<br>If multiple providers are involved, enter one provider using the priority order:<br>#\1. Referring Provider, 2. Ordering Provider, 3. Supervising Provider |
| 17 a.  | Other ID Number (2 digits)                         | Use two digit qualifier ZZ and the appropriate Taxonomy Code. Enter up to 9 characters.   |
| 17 b.  | NPI Number   | Enter the NPI number of the referring, ordering, or supervising provider. Entry must be 10 numeric digits.  |
| 18     | Hospitalization Dates Related to Current Service   | <b>Optional</b><br>Date format mmddccyy   |
| 19     | Reserved for Local Use                             |   |
| 20     | Outside Lab? \$ Charges                            | "Y" or "N" or Blank. Amount must be between 0 and 999999.   |
| 21     | Diagnoses or Nature of                             | <b>Required</b> – Relate Items #1, #2, #3 or #4 to  |

| Item # | Description   | Instructions   |
|--------|---|--|
|        | Illness or Injury   | #24E by line Enter the patient's diagnosis/condition. List up to four ICD-9-CM diagnosis codes. Do <u>not</u> provide narrative description in this field. Must be a valid diagnosis.  |
| 22     | Medicaid Resubmission Code  | List the original Transaction Control Number (TCN) for resubmitted claims.   |
| 23     | Service Authorization Number<br>(12 characters)   | <b>Required</b> - if applicable enter Service Authorization Number.<br>Must be 12 characters <b>**Not being used at this time**</b>  |
| 24 a.  | Date(s) of Service<br>(Lines 1-6)   | <b>Required</b> - Enter dates of service, from and to. If one date of service only, enter that date under "from." Leave "to" blank or re-enter "from" date. Date format: mmddccyy<br><br>If services are grouped on the same line they must have the same place of service, procedure code, charge and individual provider. The number of days must correspond to the number of units in #24G. |
| 24 a.  | Shaded Area   | Required if Applicable-Enter the NDC code, if required, N4, the NDC qualifier should be entered in the first two positions, then the NDC. The NDC units of measure qualifier and NDC quantity should follow:   |
| 24 b.  | Place of Service (Lines 1-6)  | <b>Required</b> - Enter the two-digit code for each item or service. VV Must be numeric characters   |
| 24 c.  | EMG (Lines 1-6)   | N/A  |
| 24 d.  | Procedures, Services or Supplies (Lines 1-6)  | <b>Required</b> - Enter CPT/HCPCS and modifier(s) if applicable. This field accommodates the entry of up to four two-digit modifiers.  |
| 24 e.  | Diagnosis Pointer<br>(Lines 1-6)<br>The diagnosis code reference number ( <b>pointer</b> ) as shown in Item 21 to relate the date of service and the procedures performed | <b>Required</b><br>ICD-9-CM diagnosis codes must be entered in Item #21 <u>only</u> . Do <u>not</u> enter them in #24E.<br>When multiple services are performed, the primary diagnosis pointer for each service should be listed first, other applicable pointers should follow. The diagnosis pointers(s) should be #1, or #2, or #3, or #4; or multiple numbers. Enter numbers left          |

|       |  |  |
|-------|--|--|
|       | for the primary diagnosis.               | justified in the field. Do <u>not</u> use commas between the numbers.  |
| 24 f. | \$ Charges (Lines 1-6)                   | <b>Required</b> -Enter the total billed amount for each service.<br>Do <u>not</u> use commas or dollar signs. Negative dollar amounts are <u>not</u> allowed.  |
| 24 g. | Days or Units (Lines 1-6)                | <b>Required</b> - Enter the number of days or units. If only one service is performed, enter #1.   |
| 24 h. | EPSDT/Family Plan (Lines 1-6)            | Must be "AV", "ST", "S2", "NU", "Y", "N" or Blank  |
| 24 i. | ID Qualifier (Lines 1-6)                 | <b>Required</b><br><br>The Rendering Provider is the provider who rendered or supervised the care.<br><br>Report the Identification Number in Items #24I and #24J only when different from data recorded in Items #33a and #33b.<br><br>In the shaded area of #24I, enter the qualifier identifying if the number is a non-NPI.<br><br>Providers can bill with ZZ for taxonomy (with NPI) or a Medicaid ID qualifier. Must be 2 characters long. |
| 24 j. | Rendering Provider ID Number (Lines 1-6) | If provider has NPI please indicate in the unshaded area. If the provider cannot be assigned an NPI(atypical provider) the Medicaid ID number should be entered in the shaded portion of the field   |
| 25    | Federal Tax ID Number                    | Must be 9 characters or less.  |
| 26    | Patient's Account Number                 | <b>Required</b><br>Enter patient account number  |
| 27    | Accept Assignment                        | Only one box may be checked.   |
| 28    | Total Charge<br>Total charges for the    | <b>Required</b> – Enter total charges for the services (i.e., total of all charges in #24F)  |

|       |   |   |
|-------|---|---|
|       | services (i.e., total of all charges in 24F)                        | Must be 9 digits or less.   |
| 29    | Amount Paid   | Total amount the patient or other payers paid on the covered services only. TPL Only.<br>Must be 9 digits or less   |
| 30    | Balance Due   | <b>Required</b> – Enter total amount due (subtract Amount Paid Item #29 from Total Charge Item #28. Must be 9 digits or less.   |
| 31    | Signature of Physician or Supplier Including Degrees or Credentials | <b>Required</b> – legal signature of provider or provider's authorized representative. Include date. Must be an actual signature or signature stamp or signature on file.<br>Date format mm/dd/ccyy |
| 32    | Service Facility Location Information                               | <b>Required if applicable</b> - if different than Box #33.  |
| 32 a. | NPI Number  | Must be 10 characters long, numeric only.   |
| 32 b. | Other ID Number   | N/A   |
| 33    | Billing Provider Info & Phone Number                                | <b>Required</b> – Enter the provider's or supplier's billing name, address, zip code and phone number.  |
| 33 a. | NPI Number  | <b>Required</b> – except for Atypical providers.<br>Must be 10 numeric digits.  |
| 33 b. | Other ID Number   | <b>Required</b> – the two-digit qualifier identifying the non-NPI number followed by the ID number.   |