

Ambulatory Surgical Center

ASC

Provider Manual
Volume II

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New Hampshire Medicaid

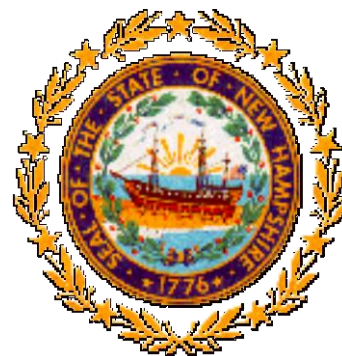


Table of Contents

1. NH MEDICAID PROVIDER BILLING MANUALS OVERVIEW	1
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
2. PROVIDER PARTICIPATION & ONGOING RESPONSIBILITIES	3
3. COVERED SERVICES & REQUIREMENTS	4
Service Limits	5
4. NON-COVERED SERVICES	6
5. SERVICE AUTHORIZATIONS.....	7
6. DOCUMENTATION.....	8
7. SURVEILLANCE AND UTILIZATION REVIEW (SURS) - PROGRAM INTEGRITY.....	9
8. ADVERSE ACTIONS	10
9. MEDICARE/THIRD PARTY COVERAGE	11
10. PAYMENT POLICIES	12
11. CLAIMS.....	13
Timely Filing.....	14
Diagnostic & Procedure Codes	14
Coding for ASC Services	14
Required Claim Attachments	16
Claims Completion Requirements for ASC Services.....	Error! Bookmark not defined.

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 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

Participating 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 service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and Xerox. Participating 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 the General Billing Manual – Volume I, Appendices Section, for all Contact Information).

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

2. Provider Participation & Ongoing Responsibilities

For the purpose of this manual, the term Ambulatory Surgical Center (ASC) refers to any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission, as defined in 42 CFR 416.2.

ASC services means the combined facility services and covered ancillary services that are furnished in an ASC in connection with covered surgical procedures, as defined in 42 CFR 416.2.

All participating ASC service providers must:

- Be licensed in accordance with He-P 812, or if outside of New Hampshire, by the state in which they practice;
- Be an enrolled NH Medicaid provider; and
- Adhere to all requirements detailed in this manual and the General Billing Manual - Volume I and He-P 812.

3. Covered Services & Requirements

Covered ASC services are surgical procedures that are separately paid under the MMIS payment system, that would not be expected to pose a significant safety risk to a patient when performed in an ASC, and for which standard medical practice dictates that the patient would not typically be expected to require active medical monitoring and care at midnight following the procedure.

Covered surgical procedures do not include those surgical procedures that:

- Generally result in extensive blood loss;
- Require major or prolonged invasion of body cavities;
- Directly involve major blood vessels;
- Are generally emergent or life threatening in nature;
- Commonly require systemic thrombolytic therapy;
- Are designated as requiring inpatient care under 42 CFR 419.22(n);
- Can only be reported using a CPT unlisted surgical procedure code; or
- Are otherwise excluded under 411.15.

NH Medicaid provides a single payment to ASCs for covered surgical procedures, which includes ASC facility services that are furnished in connection with the covered procedure including the following:

- Nursing services, services furnished by technical personnel, and other related services;
- Patient use of the ASC facility where the surgical procedure is performed;
- Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;
- Drugs and biological, for which separate payment is not allowed under the MMIS payment system,
- Surgical dressings, supplies, splints, casts, appliances, and equipment;
- Administrative, recordkeeping, and housekeeping items and services;
- Blood, blood plasma, and platelets, with the exception of those to which the blood deductible applies;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia;
- Supervision of the services of an anesthetist by the operating surgeon;
- Implantable devices and related accessories and supplies, with the exception of those devices with pass-through status under the MMIS payments system; and
- Radiology services for which payment is packaged under the payment system.

NH Medicaid also pays ASCs separately for covered ancillary services that are integral to a covered surgical procedure billed by the ASC, specifically certain services that are furnished immediately before, during, or immediately after the covered surgical procedure. Covered ancillary services include:

- Brachytherapy sources;
- Certain implantable items that have pass-through status under the MMIS payment system;
- Certain drugs and biological, for which separate payment is allowed;
- Certain radiology service for which separate payment is allowed;

- Implantable devices with payment system pass-through status; and
- Corneal tissue acquisition.

Certain services may be furnished in the ASC and billed by the appropriate NH Medicaid provider or supplier.

Some providers perform simple diagnostic tests just before surgery, e.g., urinalysis and blood hemoglobin or hematocrit. To the extent that such simple tests are provided by the hospital and the charges are included in the operating room or comparable revenue center, they are included in the definition of outpatient hospital facility services.

All non-physician medical and other health services furnished by the ASC that do not meet the definition of facility services are paid for in accordance with Section 1833(a)(1) of the Social Security Act (SSA) based on reasonable charges except for clinical diagnostic laboratory test which are paid based on a fee schedule.

Authorization requirements, coverage criteria (age, diagnostic, client eligibility, etc.), limitations, and related forms may be found in the appropriate program publications.

To receive service authorization for a service to be performed in an ASC, a provider must send or fax a request for authorization along with medical justification to the Department's designated service authorization agent. Please refer to the Service Authorizations section below for additional details.

Service Limits

Service limits are not applicable for the ASC facility fee, which is a one-time fee per day per visit performed at the facility.

4. Non-Covered Services

The following services are not included in the facility payment:

- Physician's professional services, including surgical procedures and all preoperative and postoperative services that are performed by a physician;
- Anesthetists' services;
- Radiology services; other than those integral to performance of a covered surgical procedure;
- Diagnostic procedures, other than those directly related to performance of a covered surgical procedure;
- The sale, lease or rental of durable medical equipment to clients for use in their homes;
- Prosthetic devices (e.g., intraocular lens¹);
- Ambulance or other transportation services;
- Leg, arm, back and neck braces, other than those that serve the function of a cast or splint;
- Artificial limbs and eyes;
- Non-implantable prosthetic devices and DME; and
- Implantable devices.

In addition the following procedures are not covered under ASC services:

- Minor surgical procedures that do not require regional or general anesthesia operating room services and are not classified by Medicare in ASC groups 1 through 9. Examples include: suturing of simple lacerations, simple incision and drainage of abscesses, manipulative reduction of simple digital fractures/dislocations with or without digital blocks.
- Surgery that requires authorization when authorization is not obtained;
- Female sterilization when Federal sterilization (Form 1146) requirements have not been met;
- Experimental and investigative surgical procedures and surgical procedures of un-proven benefit;
- Surgical procedures for which an inpatient hospital admission is medically indicated;
- Surgical procedures not designated by Medicare in ASC Groups 1 through 9; and
- Surgical procedures not covered by the Medicaid Program. Examples include: cosmetic surgery such as face-lifts, cosmetic breast augmentation, rhinoplasties.

¹ Furnishing Intraocular lenses (IOLs) is an ASC facility service that Medicaid covers separately in the Ambulatory Surgical Center Program.

5. Service Authorizations

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 agent under contract with the Department will review the service authorization request. Because the service authorization agent can vary depending on the type of service provided, the Contact information in the Appendices or on applicable SA forms should be consulted for the name and method of contact.

Generally, there are two primary elements to ASC services—the physician’s professional services for performing the procedure and the services furnished by the facility where the procedure is performed (for example, surgical supplies and equipment and nursing services). This manual is with regard to billing the latter—the costs associated with the use of the facility.

There are no SA requirements for the use of the ASC facility. However, SA requirements may be required for the physician’s professional services performed at the ASC. The Medicaid fee schedule includes an indication of which of these services require a SA. Instructions regarding SA’s for professional services can be found in the applicable provider specific billing manuals.

6. Documentation

The ASC provider must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement. See the “Record Keeping” section of the General Billing Manual – Volume I, and He-P 812.19 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 resolution of any legal action(s) commenced in the six year period, whichever is longer.

Clinical records must:

- Be legible and include records supporting the specific request;
- Be signed by the performing provider;
- Include clinical, outpatient and/or emergency room records for dates of service in chronological order;
- Include related diabetic and blood pressure flow sheets;
- Include current medication list for date of service;
- Include obstetrical record related to current pregnancy when applicable; and
- Include clinical indication for laboratory and x-ray services ordered with a copy of orders for laboratory and x-ray services signed by the physician

Laboratory and radiology reports must include:

- Clinical indication for laboratory and x-ray services ordered;
- Signed orders for laboratory and radiology services;
- Results signed by the performing provider; and
- Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

7. Surveillance and Utilization Review (SURS) - Program Integrity

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

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

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

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

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

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

8. Adverse Actions

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

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the *payer of last resort*. All third party obligations must be exhausted before claims can be submitted to 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 the 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 manual and HCPCS coding manuals as non-covered by Medicare may be billed directly to NH Medicaid who will determine whether or not the service is covered and can be reimbursed by NH Medicaid.

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

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

10. Payment Policies

Generally, there are two primary elements in the total cost of performing a surgical procedure—the cost of the physician’s professional services for performing the procedure and the cost of services furnished by the facility where the procedure is performed (for example, surgical supplies and equipment and nursing services). This manual is with regard to billing the latter--the costs associated with the use of the facility.

When billing for ASC services, ASC providers must use the code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that all local codes be replaced with national standard procedure codes from either the Level 1 Common Procedure Terminology (CPT) or Level II of the Healthcare Common Procedure Coding System (HCPCS).

Medicaid pays ASC a facility fee of \$225.80 to \$495.00 per surgery, depending on the level of service. NH Medicaid Levels 1, 2, 3 and 4 correspond to the first four Medicare groups for such services. Medicaid Level 5 is for anything falling in the Medicare groups 5-8.

Payments to ASCs for covered ASC procedures are made on the basis of prospectively set rates known as the standard overhead amount, as provided in regulations at 42 CFR 416.125. The Xerox facility services covered by the standard overhead amounts are generally described in 42 CFR 416.61 and 424 of the *Hospital Manual*. Covered ASC procedures are classified into four standard overhead amounts or payment groups. The rates applicable to the payment groups are as follows:

- Group 1 Procedures \$274.00
- Group 2 Procedures \$326.00
- Group 3 Procedures \$351.00
- Group 4 Procedures \$399.00
- Group 5 Procedures \$495.00

Medicaid has established a maximum allowable fee for each surgical group. The maximum allowable fees are global fees that include all of the covered ASC facility services. Reimbursement is the lesser of the billed charge or the maximum allowable fee for the applicable surgical group.

Lab, X-ray and machine tests that are not directly related to the surgery are covered separately.

Claims for surgical procedures that have not been assigned to a surgical group are reviewed and manually priced by the Department or the Department’s fiscal agent.

When multiple surgical procedures are performed on the same date of service, all charges except lab, x-ray and machine tests must be billed using the most complex applicable procedure code.

For providers performing multiple surgical procedures in a single operative session, the Department reimburses the lesser of the billed amounts, or up to 100 percent of the Department’s maximum allowable for the procedure with the highest group number. For the second procedure, reimbursement is the lesser of the billed amount or up to 50 percent of the Department’s maximum allowable. The Department does not make additional reimbursement for subsequent surgical procedures.

11. Claims

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

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

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

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

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

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

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

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

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

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

Timely Filing

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

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

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

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

Diagnostic & Procedure Codes

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

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

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

Coding for ASC Services

Free standing ASCs:

- Claims for procedures classified in ASC groups 1 through 9 by Medicare must be submitted on CMS (formerly HCFA) 1500 claim forms.
- Procedures must be coded with the most appropriate CPT-4 procedure code. Allowable prosthetic devices such as intraocular lenses and cochlear implants must be coded with appropriate HCPCS codes.

Hospital based ASCs and outpatient hospital surgery:

- Claims for ASC or outpatient hospital services are submitted on UB-04 claim forms.

- Revenue Codes 49X or 36X should be used for procedures that have been assigned to ASC payment groups 1 through 9 by Medicare. The CPT-4 code that best describes the procedure is required and must be entered in form locator (FL) block 44.
- Revenue Code 0929 should be used for outpatient procedures that are not recognized by Medicare as an ASC service but were provided under general anesthesia and required a recovery room stay may be billed with revenue code 0929. Claims billed with revenue code 0929 will be reviewed. CPT codes in the range 10000 to 69999 must be included on the 0929 claim line.

Although Medicare allows payment to ASC for certain surgical procedures not in ASC groups 1 through 9, for payment purposes, Medicaid acknowledges only ASC Groups 1, 2, 3, and 4. Payments for Medicare ASC groups 5 and above are paid at the ASC group 4 rates.

Multiple codes:

If more than one (1) CPT-4 code is listed, the following guidelines are followed:

- If one (1) CPT-4 code is designated by Medicare in ASC Groups 1 through 9, and the other(s) is/are not, payment at the appropriate Medicare-covered ASC group of the code will be extended.
- If two (2) or more CPT codes are in Medicare ASC groups 1 through 9, but the procedures are related, one payment is extended for the ASC Group listed first on the claim. Example: esophagoscopy for diagnosis with biopsy, esophago-scopy with removal of polyp(s) by hot biopsy forceps/cautery, esophagoscopy with removal of polyp(s) by snare technique.
- If two (2) or more CPT codes are in Medicare ASC groups 1 through 9, and the procedures are not directly related, payment for the first surgical procedure listed on the claim is extended at 100% of Medicaid's payment rate for the Xerox group and at 50% of Medicaid's payment rate(s) for the other procedure(s).

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided during surgical procedures performed in the ASC are not separately reimbursable unless the items are not part of the ASC group rate. Examples of items not included in the ASC group rate are intra-ocular and cochlear implants.

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.

Claims Completion Requirements for ASC Services

Ambulatory Surgical Center services can be submitted on either a CMS1500 paper form or the UB04 depending on whether the center is free-standing or hospital based. The electronic versions are 837P or 837I.

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

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

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.
- UB-04 (or institutional claim), it is Locator box 50.

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

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

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

If the insurance company is not listed, contact the Third Party Liability Call Center at (603) 223-4774 or 1 (866) 291-1674 for the correct code to use. **CMS-1500 Claim Form Instructions**

Item #	Description	Instructions
1		Check Medicaid
1a.	Insured's ID Number	Required - Enter the NH Medicaid number (11 characters) shown on the ID card.
2	Patient's Name	Required - Enter the last name, first name, and middle initial as shown on the ID card.
3	Patient's Birth Date (8 digits), Sex	Required Must be valid date mm/dd/ccyy
4	Insured's Name	Last Name, First Name, MI
5	Patient's Address (Multiple Fields) 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
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 If Item # 11d is marked, complete fields #9 and #9a-d, otherwise leave blank.

Item #	Description	Instructions
9 a.	Other Insured's Policy or Group Number	Situational – 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	Required - Required - Required - if other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code Codes can located on the NH MMIS Health Enterprise Portal under documents section
10 a-c	Is Patient's Condition Related To?	Required 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	Situational - 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 The name of the insured's employer or school.	N/A
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	N/A

Item #	Description	Instructions
	Person's Signature	
13	Insured's or Authorized Person's Signature	N/A
14	Date of Current Illness, Injury, Pregnancy	Situational – Enter if “YES” is present in Item #10 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	Required – when billing radiology, Lab , DME Last name, First Name, and MI If multiple providers are involved, enter one provider using the priority order: #\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	Optional 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 Illness or Injury	Required – Relate Items #1, #2, #3 or #4 to #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.

Item #	Description	Instructions
23	Service Authorization Number (12 characters)	Required- if applicable enter Service Authorization Number. Must be 12 characters **Not being used at this time**

24 a.	Date(s) of Service (Lines 1-6)	Required - 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 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)	Required - 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)	Required - Enter CPT/HCPCS and modifier(s) if applicable. This field accommodates the entry of up to four two-digit modifiers.
24 e.	Diagnosis Pointer (Lines 1-6) The diagnosis code reference number (pointer) as shown in Item 21 to relate the date of service and the procedures performed for the primary diagnosis.	Required ICD-9-CM diagnosis codes must be entered in Item #21 <u>only</u> . Do <u>not</u> enter them in #24E. 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 justified in the field. Do <u>not</u> use commas between the numbers.
24 f.	\$ Charges (Lines 1-6)	Required -Enter the total billed amount for each service. 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)	Required - 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)	<p>Required</p> <p>The Rendering Provider is the provider who rendered or supervised the care.</p> <p>Report the Identification Number in Items #24I and #24J only when different from data recorded in Items #33a and #33b.</p> <p>In the shaded area of #24I, enter the qualifier identifying if the number is a non-NPI.</p> <p>Providers can bill with ZZ for taxonomy (with NPI) or a Medicaid ID qualifier. Must be 2 characters long.</p>
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	<p>Required</p> <p>Enter patient account number</p>
27	Accept Assignment	Only one box may be checked.
28	Total Charge Total charges for the services (i.e., total of all charges in 24F)	<p>Required – Enter total charges for the services (i.e., total of all charges in #24F)</p> <p>Must be 9 digits or less.</p>
29	Amount Paid	Total amount the patient or other payers paid on the covered services only. IPL Only. Must be 9 digits or less
30	Balance Due	Required – 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	Required – legal signature of provider or provider's authorized representative. Include date. Must be an

	Degrees or Credentials	actual signature or signature stamp or signature on file. Date format mm/dd/ccyy
32	Service Facility Location Information	Required if applicable - 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	Required – Enter the provider's or supplier's billing name, address, zip code and phone number.
33 a.	NPI Number	Required – except for Atypical providers. Must be 10 numeric digits.
33 b.	Other ID Number	Required – the two-digit qualifier identifying the non-NPI number followed by the ID number.