GENERAL BILLING

Provider Manual
Volume I

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New Hampshire
Medicaid

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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.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication
10/10/2023	N/A	5.0	Added that Medicaid covers telehealth services	Clarification of services added during the COVID Public Health Emergency	Provider Notice dated 10/10/2023
10/10/2023	N/A	16.2.3	Added website to the CMS1500 claim form instructions	To reference the most up to date claim form instructions	N/A
1/21/2025	N/A	15.3.1	Edited language related to backdating of provider enrollment	Edited for clarity	N/A
3/19/2025	N/A	13.1.2 and 19.2	Added language to clarify Medicaid payment when provider is not enrolled in Medicare and updated Medical Services Unit fax number	Edited for clarity	N/A
10/31/2025	10/20/2025	5.2	Updated co-pays and related exceptions	Co-pays increased per state plan changes	Provider Notice dated 9/4/2025

1.0 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 Provider Enrollment Types

Providers enrolling with NH Medicaid select a provider type during enrollment. Eligible provider types and specialties can be found on the provider page of MMIS at New Hampshire MMIS Health Enterprise Portal (nh.gov).

1.4 Document Disclaimer/Policy

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.

1.5 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.

1.6 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.

1.7 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.

2.0 NH Medicaid Program

The Medical Assistance Program (Medicaid) was established under Title XIX of the Social Security Act of 1965. Medicaid is administered in NH by the Department and encompasses the Title XIX program and the Title XXI program which is the Children's Health Insurance Program (CHIP) and will hereinafter be referred to as Medicaid. Medicaid is funded by the federal and state government and serves individuals and families who meet financial and other eligibility requirements,

The program provides direct payment to Medicaid participating providers for medical services ranging from routine preventive medical care for children to institutional care for the elderly and disabled. The Medicaid program ensures (a) access to care through enrollment of medical providers, (b) access to medical providers via coverage of transportation services, and (c) access to other services needed in order to receive medical care, such as language translation services.

Medicaid Programs are also responsible for ensuring that other sources of third party payment are used to cover health care costs and that health insurance premiums are paid for individuals who have access to other health insurance, when it is cost effective to do so. Each state's Medicaid Program is responsible for making decisions, in conjunction with regulatory requirements, regarding the type and scope of medical care to be covered by the state's Medicaid Program, keeping in mind access, quality, and cost effectiveness. New Hampshire Medicaid utilizes service authorization programs which place limits on service utilization based on medical necessity or utilization control as a tool to achieve the desired outcomes.

2.1 Federal & State Oversight Authority

At the federal level, the Title XIX and Title XXI Programs are administered by the Centers for Medicare and Medicaid Services (CMS), US Department of Health and Human Services. In order to participate in Medicaid, the state must have a Medicaid State Plan that describes the nature and scope of the state's Medicaid program, assures that the program will be administered in accordance with federal regulations, and specifies the single state agency responsible for administration of the Medicaid program. The approved State Plan serves as the basis for federal matching funds, which match funding appropriated by the state legislature. The state plan can be found at: https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-state-plan

In NH, the single state agency responsible for administering the Medicaid State Plan is the Department of Health and Human Services. As required by CMS, a Medicaid Agency must also be designated. This is the Division of Medicaid Services (DMS). There are also other agencies within the Department which administer some of the programs funded with Medicaid monies. These include the Division for Children, Youth and Families (DCYF); the Bureau of Elderly and Adult Services (BEAS); the Bureau of Developmental Services (BDS); the Division for Behavioral Health (DBH); the Bureau of Drug and Alcohol Services (BDAS) and the Maternal and Child Health (MCH) Section. Financial and categorical eligibility is determined by the Division of Economic and Housing Stability, Bureau of Family Assistance (BFA), and medical eligibility, as applicable, is determined by the Disability Determination Unit (DDU). Presumptive eligibility is determined by qualified entities authorized and trained by the Department.

2.2 NH Medicaid State Plan – Mandatory & Optional Services

The Medicaid Program reimburses participating providers for mandatory services specified in the federal regulations and the Medicaid State Plan, and for certain optional services allowed by the regulations and as elected for coverage by the Medicaid Program. The mandatory and optional services covered by each state are specified in a Medicaid State Plan that must be approved by CMS.

Information on covered services may be found in the individual Provider Specific Billing Manuals – Volume II, as well as in the Department's administrative rules. The rules serve as the legal basis for programmatic requirements and are located at http://www.gencourt.state.nh.us/rules/about_rules/listagencies.aspx. In the event that any statement in this billing manual is in conflict with an administrative rule, what is stated in the rule will override the billing manual.

2.3 Health Insurance Portability and Accountability Act - HIPAA

The U.S. Department of Health and Human Services (HHS) issued rules to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. The NH Medicaid Program requires providers to comply with all aspects of this federal regulation.

Under the Privacy Rule, a covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.

As defined in the Privacy Rule, covered entities are required to disclose protected health information as requested by the employees, agents, or contractors of the NH Medicaid Program who are authorized by law to oversee the NH Medicaid Program in which health information is necessary to determine eligibility or compliance.

The Transactions and Code Set Rules were intended to standardize and simplify health care transactions. Medical providers that file electronically must follow HIPAA standards in order to be paid. The standardized electronic transactions are outlined in the Electronic Data Interchange Section.

The Unique Identifiers Rule mandates that HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use the National Provider Identifier (NPI) to identify covered healthcare providers in standard electronic transactions to and from NH Medicaid.

2.4 Fiscal Agent Responsibilities

The Department contracts with a fiscal agent that is responsible for processing claims, adjustments, enrollment applications and revalidations. The fiscal agent is also responsible for responding to provider inquiries regarding claim status, payments and denials, third party insurance, status of applications, and related topics. The fiscal agent provides webinars, web conferencing, on-site visits and workshops for training purposes. Schedules are determined by the Department and the fiscal agent, or as needed based upon provider requests.

Information provided by the fiscal agent's Provider Relations Unit is not legally binding and is subject to change at any time.

3.0 NH MMIS Health Enterprise Portal Overview

The NH Medicaid Program is required, by federal rules and regulations, to operate a Medicaid Management Information System (MMIS). The NH MMIS Health Enterprise Portal is the web-based service that allows access to the MMIS for enrolled providers with valid user accounts. Services available via the portal include enrollment, inquiry, claims processing and management reporting for planning and control. An expected component of provider participation in the NH Medicaid Program is utilization of the NH MMIS Health Enterprise Portal.

Information is also available to the general public via the portal. The public information includes enrollment instructions and application, billing manuals, general public messages and announcements, documents and forms.

The NH MMIS Health Enterprise Portal and the MMIS comply with applicable federal rules and regulations, as well as national and state internet security regulations and policies. Government regulations stipulate that federally funded systems must comply with Section 508 Accessibility guidelines. Applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy requirements, which protects private healthcare information from unauthorized access, are supported.

3.1 Portal Features

Secure, online, real time web-based features are accessible 24/7 (with the exception of scheduled system maintenance or power failures) through use of a web browser and a standard internet connection. Some of the web-based portal features include but are not limited to:

- member eligibility verification
- service authorization status
- claim templates
- claim submissions, corrections and adjustments
- inquiry correspondence and support
- downloadable Remittance Advice, documents and forms
- enrollment
- online updates and information received via email distributions
- provider lookup

3.2 Portal Registration

Registration for the NH MMIS Health Enterprise Portal is required and must be completed as part of the enrollment process for billing providers. Providers and Trading Partners must select a User ID which permits secure web access. Providers with multiple Medicaid ID numbers must register for a User ID for each service location.

Providers must identify an individual employee as the Organization Administrator for the Provider Organization. The Organization Administrator is responsible for setting up and maintaining user accounts and resetting user passwords. After initial enrollment, the Portal Registration Form must be signed by an authorized representative and submitted to NH Medicaid Provider Relations Unit to add, change, or remove an Organization Administrator. If there is more than one Organization Administrator on an account, the remaining Organization Administrator can make these changes within the portal.

4.0 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 such as those outlined below.

4.1 Provider Participation

A participating provider is a provider who has successfully completed the NH Medicaid enrollment process, continues to meet licensure/certification requirements applicable to the specific provider type, complies with all federal and state regulations, and continues to meet all requirements listed in this manual.

By signing the Provider Participation Agreement, providers agree to abide by all rules, regulations, billing manuals, bulletins and any other types of notifications promulgated by the Department pertaining to provision of care or services provided under the NH Medicaid Program, and the claiming of payments for those services. Additionally, there are many other requirements that providers agree to upon signing the participation agreement. It is expected that providers regularly review their Provider Participation Agreement to assure themselves that they are in compliance with these requirements for which providers are held responsible by the Department.

All Medicaid enrolled providers should be aware of the requirements of the participation agreement which includes the obligation to screen all employees and contractors utilizing the List of Excluded Individuals/Entities-LEIE-website at https://oig.hhs.gov/exclusions/ and/or any other exclusion lists or instructions provided by NH Medicaid Program to determine whether any of them have been excluded from participation in Federal health care programs, and to report any such exclusions to Medicaid Program Integrity.

Providers must also comply with the False Claims Act requirements of Section 1902(a)(68) of the Social Security Act regarding Employee Education About False Claims Recovery. If you, as an "entity," receive or make payments for Medicaid covered services which total at least $5,000,000 annually, then it is your responsibility, as a condition of receiving such payments, to establish and disseminate written policies to all employees, and any contractor or agent of the entity, which include detailed information about the False Claims Act and other provisions in Section 1902(a)(68)(A) of the Social Security Act. For calculation and compliance purposes, the annual time period is based upon a federal fiscal year. For example, an entity will have met the $5,000,000 annual threshold as of January 1, 2017, if it received or made payments in that amount in federal fiscal year 2016 (which ends September 30, 2016). The Department will begin regularly running reports in October 2016 which will identify those entities that have met the $5,000,000 annual threshold, and we will notify the applicable entities. Those entities that meet the $5,000,000 annual threshold will receive a targeted notification and a copy of the Proof of Compliance Form 357. Providers will have 30 days to respond. Future determinations regarding an entity's responsibilities under the DRA based on the $5,000,000 threshold amount will be made in October of each subsequent year based upon the amount of Medicaid payments an entity received or made during the preceding federal fiscal year.

However, this will not release entities from the responsibility to self identify if they have met the threshold amount. This activity should be completed annually and documented in the provider's files. For further information, please go to "messages and announcements" under the provider tab of the MMIS portal at www.nhmmis.nh.gov.

As noted in the provider participation agreement, providers agree to allow access to records as requested by the US Department of Health and Human Services, its authorized representatives, the Attorney General's (AG's) Medicaid Fraud Control Unit, and the Department. If providers do not timely comply with requests for records, the Department may choose to put a hold or partial hold on a provider's payments until such

time as the requested records are provided. If the requested records are not provided, the "held payment" will not be distributed to the provider.

All providers of care and suppliers of services who participate in the NH Medicaid Program must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be furnished to members without regard to race, color, or national origin.

Section 504 of the Rehabilitation Act provides that no handicapped individual will, solely by reason of the handicap be:

- Excluded from participation
- Denied benefits
- Subjected to discrimination under any program or activity receiving federal assistance.

Each provider, as a condition of participation, is responsible for making provisions for such handicapped members.

As an agent of the federal government in the distribution of funds, the Department is responsible for monitoring the compliance of individual providers and, in the event a discrimination complaint is lodged, is required to provide the Office of Civil Rights with any evidence regarding compliance with these requirements.

Participating providers cannot bill members the balance due after payment from NH Medicaid for covered services. Additionally, accounts receivable cannot be sold to collections agencies or similar entities for NH Medicaid members.

4.1.1 Approved Enrollment in NH Medicaid Program

Provider enrollment is approved by the Department and/or its associated organizations upon completion of all screening activities as identified in 42 CFR 455.450. A notification letter is sent to the provider by the Department's fiscal agent upon approval. (See additional enrollment information located in Provider Enrollment Process Overview Section).

4.1.2 NPI & Taxonomy Requirements for Specified Provider Types

As a result of HIPAA, the federal Department of Health and Human Services mandated the use of the National Provider Identifier (NPI), which is a standard 10-digit unique identifier for health care providers. The NPI is used nationally. It contains no "intelligence" about the provider and does not expire.

All HIPAA covered healthcare providers, whether they are individuals or organizations, must obtain an NPI for use on HIPAA standard transactions. Standard transactions are the Electronic Data Interchange (EDI) transactions that are used to transmit health care data in standard formats.

All healthcare providers are required to register an NPI number with NH Medicaid. This requirement supports the submission and exchange of HIPAA formatted claims with other payers. Atypical providers are exempt from NPI requirements.

Additionally, providers who are identified as a rendering, ordering, referring, prescribing, or other types of providers, must also have an NPI number on file as well as on the claim submission.

When applying for an NPI, providers must designate the taxonomy code(s) that best represents their provider type, classification, and area of specialization.

The taxonomy code is a federally established 10-character alphanumeric code that health care professionals use to identify their unique specialty areas. The code set is a combination of federally defined provider type and provider specialty that are self-declared by health care providers during the NPI enrollment process.

Claims processing and payment depend on being able to crosswalk a provider's NPI and taxonomy code(s) to the current NH Medicaid provider identification number(s). Providers are responsible for providing enough information to enumerate a claim which could include unique NPI, taxonomy or address. Processing of claims is impacted when multiple locations shares the same NPI, taxonomy, and billing address.

The address for obtaining an NPI is found in the Appendices Section. The taxonomy code set is available through the web address listed in the Appendices Section.

4.2 Scope of Practice

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

4.3 Bureau of Elderly and Adult Services (BEAS) State Registry

New Hampshire Statute RSA 161-F:49, VII requires that all employers of programs that are licensed, certified, or funded by the Department to provide services to individuals submit, prior to hiring, the name of prospective employees, consultants, contractors or volunteers who may have client contact, for review against the registry of founded reports of abuse, neglect, and exploitation of vulnerable adults as defined in RSA 161-F:43, VII. In addition, any person hiring or employing a paid or volunteer caregiver, consultant, or contractor directly, or through an authorized representative or fiscal intermediary, to provide personal care services, as defined in RSA 161-E or RSA 161-I, may, with the consent of the current or prospective caregiver, consultant, contractor, or volunteer, submit the prospective employee's name for review against the registry.

A Bureau of Elderly and Adult Services (BEAS) State Registry Consent Form is to be completed by the prospective employee, consultant, contractor or volunteer and used by employers to request a review of the registry. The employer is informed in writing within five business days as to whether a prospective employee, consultant, contractor or volunteer is or is not on the registry.

Individual employers with questions about their responsibilities under the Statute may wish to seek legal advice from their own legal counsel. BEAS NH State Registry contact information is located in the Appendices Section in this manual.

If providers suspect or believe in good faith that a vulnerable adult is being abused, neglected, exploited, or is self-neglecting, they must report it to the BEAS Adult Protection Central Intake Unit.

For information on reporting, see Appendices Section for Registry and Central Intake telephone numbers.

4.4 Reporting and Maintaining Accurate Provider Information

Providers are obligated to report any changes related to their practice that may impact NH Medicaid payments. Changes to a provider record may be requested via fax or mail as detailed in the following sections**.** Changes are not accepted by telephone.

Examples of changes include, but are not limited to, change of address, lapse of license, change in

ownership, and change of affiliations.

Change requests must be:

- On the provider's letterhead or on the Change of Information (CHOI) Form
- Signed by the provider or an authorized representative
- For license/certification updates, copies of the license/certification must be provided

Changes in information will not be recognized if included on a submitted claim form. Claims are processed and payment is made according to the information on the provider record. If the information on the provider record is incorrect or outdated, there may be a delay in payment of a claim.

4.4.1 Facility, Business, and Rendering Provider Name Changes

A facility, business, or rendering provider name change request must be submitted in writing. Facility or business names are entered according to how the name appears on the business license or how the business is registered with the Secretary of State. If a facility or business name changes, a new business license reflecting the new name must be submitted to the fiscal agent. If the facility or business name changes due to a change in ownership, see the following Change in Ownership section .

Rendering provider names are entered according to the name on the individual's license or certificate. If a rendering provider's name changes as a result of marriage, the marriage license cannot be used to make a name change request. The provider must change their name with the appropriate state board and submit to the fiscal agent a copy of a new license or certificate which reflects the performing provider's new name.

Providers who have incorporated must provide a legal "Certificate of Incorporation."

4.4.2 Address Change

If a provider is moving his/her entire practice to a new location this constitutes a change of address. It is imperative that providers keep their address up to date in the MMIS, as mail to the address on file is one of the primary ways that providers are contacted regarding their status as a Medicaid provider.

If the provider is adding an additional location, the action is not processed as an address change. The provider must complete a new enrollment application for the new location.

4.4.3 Provider Type Additions

Provider type additions require a new provider enrollment application for each provider type requested.

4.4.4 Specialty Code Changes/Additions

If a provider obtains a new certification to perform an additional service, beyond the standard services provided by that provider type, then the provider must submit documentation of board certification in the requested specialty in order to update the provider record. If a new license or certification has not been submitted to the fiscal agent, changes will not be made. Only once the provider has submitted this documentation will they be able to bill for that specific service.

4.4.5 Renewal of Professional License

All licensed NH Medicaid providers are required to update their license with the fiscal agent before

expiration. Failure to verify active licensure with the fiscal agent may result in termination from the Medicaid program.

4.4.6 Provider Revalidation

Provider revalidation requires providers to confirm/update the information contained in their original Medicaid application. Revalidation is done every 5 years from date of enrollment. Revalidation must be completed to ensure that a provider remains enrolled with the Medicaid program. Revalidation must be completed for both the group enrollment and for each individual provider enrollment. Providers will be notified that they must complete revalidation in advance of the date their revalidation is due with notifications at 60 and 30 days prior to the end date for the revalidation due. Once the due date has expired, providers will be notified that their enrollment will be terminated and includes language informing providers to their right to an appeal of the termination decision. Notice will be sent to any MCO's that the provider is enrolled with as well. Providers terminated for failing to revalidate will need to complete a new enrollment application. Notices will go to the provider address on file in the MMIS.

To learn more about provider revalidation, please visit: NH MMMIS: Provider Revalidations and https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-provider-relations

4.4.7 Changes in Individual/Group Provider Affiliations

Individual providers who enroll as being affiliated with a group (such as physicians who are part of a group practice) must inform the fiscal agent's Provider Relations Unit immediately in writing when discontinuing affiliation with that particular group.

Group providers must notify the fiscal agent's Provider Relations Unit when their individual performing providers are no longer affiliated with their group.

4.4.8 Change of Ownership

A Change of Ownership (CHOW) requires a new provider enrollment application. The State must be notified through the fiscal agent in advance to avoid a lapse in enrollment and payment.

A change of ownership is (CHOW) is defined in 42 CFR 489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change. A current Medicaid identification number cannot be transferred to another owner it must be terminated and a new number issued to the new ownership.

The successor provider must submit a new enrollment application to become effective at the time of the change.

Any person or entity that is a provider, and any person or entity that replaces a provider, is deemed to have accepted liability, along with its predecessor, for any overpayment and/or provider fee sought to be recovered by the Department after the effective date of the successor provider's enrollment, regardless of the successor's enrollment status or lack of affiliation with its predecessor at the time the overpayment was made.

An entity is deemed to have replaced a provider if:

- Reimbursement for services rendered prior to the effective date of enrollment of a successor

provider (including any adjustments for underpayments made by the Department) is made to the provider of record at the time the payment is made or to that provider's payee as properly designated on the appropriate form(s) required by the Department.

- Any dispute or conflict legal or otherwise, arising between the currently enrolled provider and the predecessor provider concerning either apportionment of liability for any overpayment previously made by the Department or the right to additional reimbursement for any underpayments previously made by the Department are the sole responsibility of such parties and will not include the Department.

4.5 Record Keeping

Documentation Requirements and Release of Medical Records sections apply to hardcopy and electronic record keeping.

4.5.1 Documentation Requirements

Providers are required to maintain electronic and paper billing records in support of claims for at least six years from the date of service or until the resolution of any personal action(s) commenced during the six-year period, whichever is longer. If a Provider discontinues his/her practice, the State should be notified in writing of end date and where the records will be stored to be accessible during an audit situation.

Such records must be originals and must accurately and completely document the extent of the services provided. Fiscal and/or medical/clinical records relating to the provision of billed services must be furnished to the Department, or designated representatives, when such information is requested.

At a minimum, all records must:

- Be typed or legibly written
- Be dated
- Clearly identify the member
- Document the medical necessity of the service(s) billed
- Document that the service(s) provided are consistent with the diagnosis of the member's condition
- Document that the service(s) are consistent with professionally recognized standards of care
- Document the name of the performing provider
- Be complete

The clinical records, at a minimum, must document each member encounter and must include the following as appropriate:

- Complaints and symptoms, history, examination findings, diagnostic test results, assessment, clinical impression or diagnosis, plan for care, date of service, and identity of observing medical practitioner
- Specific procedures or treatments performed
- Medications administered and/or medical supplies utilized or provided
- Member's progress, response to treatment, changes in treatment, and any revision of diagnosis
- Documentation to support each item of service provided on the claim
- Physician orders
- Signature and title

Additional documentation requirements may be necessary. Reference should be made to the Provider Specific Billing Manual -Volume II related to the provider type(s) for any additional documentation requirements.

4.5.2 Release of Medical Records

Federal regulations allow for access to any member's medical records by authorized Department personnel or their agents or designees. A member authorization is not required.

In order to facilitate the processing of requests, regulations allow providers to submit the requested member information, without an additional signed authorization from the member. In accordance with HIPAA regulations, the information sought by the Department or its agents or designees is permitted disclosure of personal health information.

As noted in the provider participation agreement, and per He-W 520.04 and federal CFR 455.432, providers agree to allow access to records as requested by the US Department of Health and Human Services, its authorized representatives, the Attorney General's (AG's) Medicaid Fraud Control Unit, and the Department. If providers do not timely comply with requests for records, the Department may choose to put a hold or partial hold on a provider's payments until such time as the requested records are provided.

When members apply for medical assistance through NH Medicaid, they authorize the Department to collect records from their providers.

4.6 Verification of Member Eligibility

Members are issued NH Medicaid identification cards, which should be presented at the time of each service.

It is the responsibility of the provider to verify a member's eligibility ***and*** other insurance information for each date of service. **Prior to rendering each service**, providers should view the member's NH Medicaid ID card, verify the correct spelling of the member's name and confirm member eligibility. Member eligibility is to be verified prior to rendering each service by the provider through the use of the Automated Voice Response System (AVR) or contacting the fiscal agent's Provider Relations Unit. Providers, who are registered as Trading Partners, may also submit electronic eligibility verification via batch eligibility requests in a HIPAA-compliant format. In the absence of a NH Medicaid ID card and member identification number, eligibility may be verified by contacting the fiscal agent's Provider Relations Unit and providing all of the following:

- The member's full name
- Date of birth ***or*** Social Security number
- Date of service

In accordance with federal regulations, eligibility cannot be verified without all of the above items listed. Please note that verification cannot be done for future dates of service.

4.7 Provider Acceptance of Medicaid Member as Patient and Solicitation of Medicaid Members

It is within a provider's discretion to accept a patient as a NH Medicaid member. By accepting a patient as a NH Medicaid member, the provider is prohibited from picking and choosing specific procedures for which the provider will accept NH Medicaid payment, whereby the NH Medicaid member would be required to pay for one type of covered service and NH Medicaid to pay for another service if applicable.

The Department will deem a patient to have been accepted as a NH Medicaid member if the patient was eligible for NH Medicaid on the date of service and the provider represents or demonstrates to the member that the provider will treat the patient as a NH Medicaid member and/or the provider bills the Department for services rendered.

Medicaid members have free choice of Medicaid enrolled providers. As such, Medicaid providers are not to solicit Medicaid members nor provide incentives to Medicaid members such as gift cards.

4.8 Billing Practices and Requirements

There are various billing practices and requirements that must be followed once a provider accepts a member as a patient and agrees to bill the NH Medicaid Program. Details of preparing and submitting claims may be found in section 16: Claims & Claims Payment Section of this manual. General billing practices and requirements applicable to all providers are outlined in this section.

4.8.1 Usual and Customary Charges

Reimbursement for services provided is based on fees or rates established by the Department. The maximum reimbursement for services rendered will not exceed, and no provider (with the exception of the dispensing by a pharmacy for Medicaid reimbursement for legend and non-legend drugs) shall bill or charge the Department more than, the provider's usual and customary charges (see RSA 126-A:3, III(a)). Reimbursement will be at the Medicaid computed rate, or the provider's usual and customary charge, whichever is lower. Provider specific coverage, limitations, and reimbursement guidelines are included in the Provider Specific Billing Manual - Volume II.

4.8.2 Payment in Full

In accordance with 42 CFR 447.15, providers rendering services to eligible members agree to accept the payment made by NH Medicaid for NH Medicaid covered services as payment in full and to charge no additional fees to the members or others on the member's behalf, nor accept any additional fees that may be offered by members or any others on the member's behalf, except for NH Medicaid's co-insurance, if applicable.

4.8.3 Billing by 340 B Covered Entities

340B covered entities, except for Department approved family planning providers, shall not bill NH Medicaid for drugs purchased through the 340B Drug Program.

4.8.4 Billing Members

Providers are only allowed to bill members for services under the following limited circumstances:

- the service being provided is a non-covered service or an ancillary service related to a non-covered service
- the service would result in the member exceeding the service limit and authorization to exceed the limit has not been obtained or has been requested and denied
- the provider is no longer taking additional NH Medicaid members, but the member chooses to

receive the service as a private paying patient

Providers may only bill the member if they have informed the member in writing before the service is provided that he or she will be responsible for the bill and why. Providers must obtain member signoff and keep this documentation in their records.

A patient may become NH Medicaid eligible after a NH Medicaid reimbursable service has been rendered. If the member has already paid the provider for the service and if the provider chooses to refund the member for the service, and then bill NH Medicaid, the refund must be made to the member before NH Medicaid can be billed. The NH Medicaid Program is not allowed to make payment directly to members.

Providers may not bill members for canceled OR missed appointments. Providers may not charge a membership fee to members.

4.8.5 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.

See the Claims Timely Filing Section 16.1.6 for exceptions to the one year timely filing limit for claims that have been submitted timely, but denied.

Some other exceptions may apply. See the Claims Timely Filing Section 16.1.6 for further information.

4.9 Termination of Provider Participation

A provider's participation in the NH Medicaid Program may terminate as outlined below. Termination is defined in 42 CFR 455.101 and means that a provider's active enrollment status with the State Medicaid Agency has been terminated and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. Only providers who were in an active enrollment status qualify as terminated providers.

4.9.1 Voluntary

An enrolled provider may voluntarily terminate participation in the NH Medicaid program by giving 60 days written notice to the fiscal agent's Provider Relations Unit (see Appendices Section for contact information). The written notice must be on office letterhead and signed by the provider or an authorized representative.

Providers who request to voluntarily terminate participation after receipt of an issuance of notice of proposed adverse action by the Department should be aware that payment for any of he provider's outstanding claims may be held by the Department pending resolution of the matter related to the action.

4.9.2 Involuntary

Terminations are inclusive of both mandatory and discretionary terminations identified as follows: Mandatory termination is deemed a "for cause" termination whereby the denial or termination is based on the action of Medicare or another State Medicaid program where providers were terminated or had their billing privileges revoked by another program for actions including but not limited to reasons related to fraud, integrity, or quality. Each reported mandatory termination made in accordance with 42 CFR 455.416 shall include only terminations for which the provider has: exhausted appeal rights, or the

timeline for appeal has expired. It is mandatory for all State Medicaid agencies to terminate a provider in all of the following for cause circumstances: failure to comply with screening requirements, criminal conviction as defined in 42 CFR 1001.2, the provider or any person with a 5% or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP, terminated or revoked for cause under separate Medicaid or Medicare enrollment, failure to submit timely and accurate information, failure to submit fingerprints, and on site review.

Discretionary terminations for cause reasons include false or misleading information, inability to verify identity of provider, provider conduct, noncompliance with licensure standards, misuse or abuse of billing privileges, prescribing authority, improper prescribing practices, billing under suspended license, noncompliance with enrollment requirements, failed onsite review and any other reason that poses a threat of fraud, waste or abuse to the Medicaid program.

A written notice of termination is issued to the provider by the Department indicating the effective date and reason for termination. The Department also sends notice to any MCO that the provider is enrolled with.

The Department may also notify other state and federal authorities, plans or programs of the provider's enrollment status in the NH Medicaid Program, including other plans or programs within the Department. Termination under the NH Medicaid Program may result in the provider's termination under other federal and state plans or programs.

4.9.3 Inactive Status

A provider who has not submitted a claim to either fee for service through the NH MMIS or to one of the Medicaid managed care organizations for an 18-month period is considered inactive. The Department may change the participation status to inactive which effectively terminates their participation in the NH Medicaid Program. A provider whose status is inactive under this provision must complete a new enrollment application and must meet all applicable enrollment requirements.

4.10 Exclusion of Providers

Exclusions are sanctions imposed by state or federal agencies prohibiting individuals, health care practices, corporations, and/or other entities from participating in Medicaid and Medicare programs.

State and federal rules and regulations prohibit health care providers and entities from employing or entering into contracts with excluded individuals or entities to provide items or services to Medicaid members. Providers that receive state and/or federal funds may employ or contract with excluded individuals only in those situations where state and federal funds are not used to compensate the individual, and the services are provided solely to non-state/federal program members.

Under certain circumstances, healthcare providers may be held financially liable for employing or contracting with excluded individuals or entities. In addition to full restitution, providers may be subject to Civil Monetary Penalties (CMP) of up to $10,000 for each item or service furnished by the excluded individual or entity. All providers are urged to take precautionary measures to ensure that they are not employing or contracting with excluded individuals/entities.

Providers should check the Federal Department of Health and Human Services, Office of Inspector General's (OIG) web site at https://exclusions.oig.hhs.gov that provides a searchable national database of all excluded individuals and entities. This site is updated monthly and should be checked monthly for determining exclusion of current employees and contractors.

Exclusions are not limited to licensed professionals. Certified nurse assistants, volunteer drivers, personal care attendants, and corporations are all subject to exclusions. Although there are exclusions that are time limited, reinstatement into state and federal programs is not automatic. Excluded individuals/entities need to re-apply with both the state and federal agencies administering the sanctions.

In order to avoid employing or contracting with an excluded individual or entity, it is recommended that providers:

- Check all potential employees or contractors via the OIG web site noted above;
- Include a question on all applications for employment asking whether the applicant **has ever**
- been excluded from participating in Medicaid and/or Medicare,
- Include a question on all applications for employment asking whether the applicant **is currently** excluded from participating in Medicaid and/or Medicare,
- Ask the applicant to produce documentation from the federal Department of Health and Human Services and/or any state departments, as applicable, that administer Medicaid Programs indicating the applicant's reinstatement into Medicaid and/or Medicare, if an applicant indicates that their exclusion has expired; and
- Institute an ongoing process to monthly verify that all current employees and contractors are not listed on the OIG exclusion database

5.0 Covered Services: Service Limits and Co-Payments

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

Some of the specific medical services covered by the NH Medicaid Program include hospital, physician, nursing facility, home health, laboratory, radiology, family planning, rural health clinics, federally qualified health centers, prescription drugs, physical-occupational-speech therapy, wheelchair van and ambulance transportation, medical supplies, durable medical equipment, dental, psychotherapy, podiatry, advanced practice registered nurses, certified midwife, private duty nursing, newborn home visits, extended services to pregnant women, personal care attendants, vision care, audiology, community mental health centers, substance use disorder services, and services offered as part of several home and community based care waivers. Medicaid covers services delivered via telehealth, as well as remote patient monitoring and store and forward services.

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. See Provider Specific Billing Manual - Volume II for information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit theserequests.

Many of the NH Medicaid Program covered services regularly provided to members under the age of 21 are considered to be Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. (See EPSDT Section for more information).

Some NH Medicaid services may require member co-payments. There may also be limits on the number of services of any one type that a member may receive in a state fiscal year (July 1 – June 30). Additionally, some members or services may be exempt from co-payments or state fiscal year service limits.

It is important that providers access the individual Provider Specific Billing Manual - Volume II for details on covered service requirements for specific provider types.

5.1 Service Limits

There are service limits on the number of some medical services available to members per state fiscal year (July 1 through June 30). Any services provided after the service limits have been reached are not reimbursable by the NH Medicaid Program and are the responsibility of the member unless a service limit override has been requested by the provider and approved prior to the service being rendered. (See the Service Authorizations section for additional service limit override information). The Provider Specific Billing Manuals indicate service limits for specific services.

If a member is covered by other insurance, including Medicare, and that insurance pays at least half of the NH Medicaid Program rate for a covered service which is subject to a service limit, that service is not counted against the service limit maximum.

5.2 Co-Payments

Co-Payments, a type of co-insurance, is a defined amount that a member will pay out of pocket for a given service Some NH Medicaid services require a co-payment. All members are subject to co-payments

except for members:

- with income at or below 100% of the federal poverty level
- residing in a nursing facility, hospital, intermediate care facility for individuals with intellectual disabilities, or other medical institutions
- participating in the Home and Community Based Services (HCBS) waiver programs
- receiving services that relate to pregnancy, or any other medical condition that might complicate the pregnancy
- under the age of 18
- eligible through the Breast and Cervical Cancer Treatment Program, pursuant to 42 CFR 435.213
- receiving hospice care pursuant to He-W 544
- of a federally recognized Indian Tribe or Alaskan natives who have ever been served through the Indian Health Services Program, pursuant to 42 CFR 447.56

Except for the noted exceptions, members must make co-payments to the pharmacy provider for pharmaceutical products as follows:

- A co-payment in the amount of $4.00 shall be required for each prescription drugs and each refill of a prescription drug dispensed.

The pharmacy co-payments described above are NOT required for:

- family planning products
- Clozaril (Clozapine) prescriptions
- any preventive service recommended by the U.S. Preventive Services Task Force with a grade of A or B (including but not limited to medications for nicotine cessation and Pre-Exposure Prophylaxis (PrEP) for the prevention of HIV)

No provider may deny services to an eligible member on account of the member's inability to pay the co-payment.

6.0 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 a provider type (such as those listed in the Provider Specific Billing Manuals - Volume II 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 listed below.

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

Non-covered services include, but are not limited to:

- Acupuncture
- Services ancillary to, or directly related to, a non-covered service or procedure
- Biofeedback
- Experimental or investigational procedures described as such in the National Coverage Determinations (NCD), found in the Centers for Medicare and Medicaid Services "Medicare Coverage Database" at https://www.cms.gov/medicare-coverage-database/, 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
- Hypnosis, except when performed by a psychiatrist as part of an established treatment plan
- Services or items that are free to the public
- Physician care in a non-medical government or public institution
- Visual training
- Dietary services, including commercial weight loss, nutritional counseling, and exercise programs
- Homemaker services, except when provided as part of an authorized HCBC-Choices for Independence (CFI) support plan to HCBC-CFI members
- Academic performance testing not related to a medical condition
- Services provided by halfway houses
- Hospital inpatient care which is not medically necessary
- Autopsies
- Auditory training, except for auditory trainer devices which are covered
- Respite, except as a service under a home and community based care waiver
- Child care
- Chiropractic services
- Institutions for Mental Diseases, in accordance with Section 1905(a)(24)(B) of the Social Security Act, except as allowed under the 1115 Substance Use Disorder Serious Mental Illness and Serious Emotional

Disturbance Treatment and Recovery Access (SUD SMI SED TRA) demonstration Waiver and in other certain circumstances;

- Duplicative services, which are services that deliver the same functionality to the same recipient during the same period of time, regardless of whether those services are provided solely under Medicaid or by Medicaid in combination with another program or entity;
- Services provided outside the United States and its territories;
- Vaccinations for out of country travel;
- Services provided by individuals who are not licensed, certified or otherwise recognized by the provisions of He-W 500 to provide such services;
- Personal clothing or footwear except for diabetic shoes;
- Service and therapy animals;
- Equine-assisted psychotherapy;
- Any services which are not specifically listed elsewhere in administrative rules as covered, or covered with service authorization, and which do not meet Medicare, New Hampshire or New England commercial insurance coverage criteria. See Provider Specific Billing Manual - Volume II for information about specific non-covered services which may apply to a given provider type.

7.0 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Under Age 21) Services

All state Medicaid Programs are required to have an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for categorically needy individuals under age 21. In NH, the EPSDT Program is available to all categorically and medically needy members under age 21.

Through the EPSDT Program, the Department is federally required to provide an extensive package of preventative, screening, diagnostic, and treatment services to members under the age of 21. The Department must also effectively inform all EPSDT eligible individuals about the EPSDT program, the benefits of preventive health care, and provide assistance with transportation and scheduling of appointments as needed.

Many of the NH Medicaid covered services regularly provided to members under the age of 21 are considered to be EPSDT services. For example, health care examinations, screenings, immunizations, and dental checkups provided in accordance with Department specified periodicity schedules are considered to be EPSDT services. The Department tracks EPSDT services through the use of modifiers on claims submitted by providers. (See the Provider Specific Billing Manual - Volume II to determine if and when such modifiers are required).

Although EPSDT members are eligible to receive all NH Medicaid covered services, the Omnibus Budget Reconciliation Act of 1989 (OBRA) directed states to also provide non-covered services to members under the age of 21 if the services are coverable (i.e., the state could have elected to cover the optional service, but chose not to), and medically necessary. States have the authority to determine if medical necessity is demonstrated. In NH, this is done via service authorization.

Providers who are treating members under the age of 21 should be aware that if the provider feels that it is medically necessary for a member under age 21 to receive a NH Medicaid **non-covered service**, including services in excess of the service limits, the provider may request coverage via submission of a service authorization request to the Department. The Department will review the service authorization request and any accompanying documentation to determine if medical necessity has been substantiated and whether or not the service authorization request will be approved. Providers must submit a service authorization request in advance for such services (See Service Authorizations section for more information).

8.0 Service Authorizations

Service authorizations related to covered services are described in the Provider Specific Billing Manual - Volume II. There are two instances in which a provider will need to request a service authorization: for approval of medically necessary services for members under 21 (as described in the section above) and for service limit overrides, which vary depending upon whether the member is (a) under age 21 or (b) age 21 and over, are described in this section.

8.1 Service Authorizations For Service Limit Overrides & Medically Necessary Services for Members Under Age 21

Service authorization is required ***in advance*** for services not listed as NH Medicaid covered services in the New Hampshire Medicaid State Plan and for services in excess of the service limits when such services are to be provided to members under age 21. These services are considered for coverage under the EPSDT medical necessity provisions of Medicaid (OBRA 1989) which requires that any medically necessary coverable service provided to EPSDT members even if that service is not in the State Plan. If the service being requested is a ***covered*** service, but requires service authorization, the provider must refer to the appropriate service authorization section of the Provider Specific Billing Manual - Volume II for instructions.

Requests for service authorization must include all of the following:

- The member's name, address, and NH Medicaid identification number
- The member's diagnosis and prognosis, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition
- An estimation of the effect on the member if the requested service(s) is not provided
- The medical justification for the service(s) or equipment being requested
- The recommended timetable of the prescribed treatment
- A discussion of why the service is medically necessary as it relates to the following medically necessary definition
- The expected outcome of providing the requested service
- The recommended timeframe to achieve the expected outcome
- A summary of any previous treatment plans, including outcomes, which were used to treat the diagnosed condition for which the requested service is being recommended
- Listings of individuals or agencies to whom the member is being referred
- Assurance that the requested service is the least restrictive, cost-effective service available to meet the member's needs
- A statement, signed by at least one of the following, indicating that they concur with the request:
    a) Treating physician or primary care provider
    b) Treating advanced practice registered nurse
    c) Primary treating psychotherapist

In accordance with federal law, it is the Department that has the decision-making power as to whether or not a service request meets the definition of medical necessity.

"***Medically necessary***," as defined by the Department for EPSDT services provided to members under the age of 21, and in accordance with federal regulations, means "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 EPSDT member requesting a medically necessary service."

Service authorizations requesting service limit overrides and coverage of non-covered, but medically necessary, services for members under age 21 are approved by the Department if the Department determines that the information provided demonstrates medical necessity.

A written service authorization approval form is sent to the listed billing office of the provider.

An approved service authorization does not guarantee payment. Claims must be completed correctly, the NH Medicaid provider must be actively enrolled, and the individual must be Medicaid eligible on the date(s) of service. All third party liability must be exhausted for these claims to be paid.

The provider is responsible for determining that the individual is NH 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.

If a service limit override request is denied, notification will be sent to the member and the provider on the Department's Form 272a, "Medical Assistance Program Denial for Prior Authorized Services." The denial will describe the service(s) being denied, the legal basis for the denial, and the member's appeal rights. Requests for appeals must be made within 30 calendar days of the date on the notice of denial.

8.2 Service Authorization for Service Limit Overrides for Members Age 21 & Older

When the individual medical care plan of a member 21 years of age or older indicates the need for services in excess of the service limits, the provider may request that the Department approve additional units of covered services. The service authorization for a service limit override must be submitted and approved in advance of the additional units of service being provided. Otherwise the claim may be denied. Requests for additional units of covered services may be signed off on **only** by the following providers:

- Advanced Practice Registered Nurses
- Associate Psychologists
- Occupational Therapists
- Optometrists
- Osteopathic Physicians
- Physical Therapists
- Physicians
- Physician Assistants
- Podiatrists
- Psychologists
- Psychotherapists Licensed by the Board of Mental Health Practice
- Speech and Language Therapists

Requests for authorization of covered services in excess of the limits must be:

- Submitted in writing on the Department's Form 272E to the Department via mail, e-mail, or fax;
- Signed by one of the licensed providers noted above;
- Based on the provider's medical care plan developed for the member

- Submitted in advance of rendering the additional services (with the exception of services provided during a retroactive eligibility period)

Requests are authorized if the Department determines, after an evaluation of the information on the Department's Form 272E, that coverage is medically necessary or is supported by clinical documentation provided.

A written service authorization approval form is sent to the listed billing office of the provider.

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.

If a service limit override request is denied, notification will be sent to the member and the provider on the Department's Form 272a, "Medical Assistance Program Denial for Prior Authorized Services." The denial will describe the service being denied, the legal basis for the denial, and the member's appeal rights.

9.0 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.

9.1 Authority

Federal regulations at 42 CFR 455 and 42 CFR 456 require that the Department perform a comprehensive review of services billed to, and paid for by, the NH Medicaid Program.

9.2 Program Integrity Review

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; or
- 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.

9.3 Fraud, Waste and Abuse

A component part of the reviews conducted within the NH Medicaid Program is to determine if possible fraud, waste, or abuse exists.

Abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to a Medicaid Program, or in reimbursement for services that are above those actually rendered, that are not medically necessary, or that fail to meet professionally recognized

standards for healthcare.

Waste means over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered to be caused by reckless actions but rather the misuse of services.

Fraud is an intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to oneself or some other person. It includes any act that constitutes fraud under New Hampshire criminal code, RSA Title LXII.

Examples of fraud include:

- **Billing for services not rendered:** A provider bills the NH Medicaid Program for a procedure or service that was not actually provided.
- **Double Billing:** A provider bills the NH Medicaid Program twice for the same procedure or service.
- **Billing for unnecessary services:** A provider misrepresents the diagnosis and symptoms on patient records and billing invoices in order to obtain payment for unnecessary services.
- **Drug Substitution:** A pharmacist fills a member's prescription with a generic drug, but bills the NH Medicaid Program for a higher cost, brand name drug.
- **Kickbacks:** A provider offers or pays a kickback to induce someone to refer members to that provider as patients or clients. Examples of kickbacks include cash, vacations, and gifts.
- **Supplemental Charges:** A provider charges a member for a service which is covered by, and should be billed to, the NH Medicaid Program, and then charges the member the difference between the provider's usual fee and what the NH Medicaid Program pays.
- **Inflating the Usual and Customary Charges:** A provider charges the NH Medicaid Program more than their usual and customary charge for the same product or service billed to other insurers and the public. A provider might inflate the cost of the procedure, service or goods provided.

The Department's procedures for reviewing providers may involve the use of sampling. If sampling is used, the Department or its agents utilize a generally accepted, statistically valid sampling methodology for selecting the sample of claims to be reviewed. Overpayments identified by the Department may be calculated through the use of all paid claim analysis based on such sampling.

9.4 Request Appeal

The Provider Grievances and Appeals Section should be referenced for information regarding appeal requests.

9.5 Pharmacy Lock-In

Pursuant to Departmental rules at He-W 570, if the Medicaid agency finds that a member has utilized NH Medicaid Program pharmacy services at a frequency or amount that is ***not*** medically necessary, as determined in accordance with utilization guidelines established by the Department, the member may be restricted (locked-in) to obtaining NH Medicaid services from a designated pharmacy. Lock- in programs are recommended at 42 CFR 431.54(e). At the conclusion of the lock-in period, the member's pharmacy utilization is reevaluated to determine whether or not the restriction(s) should continue.

9.6 Provider Pend

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.

Before the Department imposes any restriction, the following conditions will be met:

1. The provider will be given notice and opportunity for a hearing, in accordance with procedures established by the Department.
2. The Department will have found in a significant number or proportion of cases, that the provider has furnished NH Medicaid services:
    - at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the Department; and
    - of a quality that does not meet professionally recognized standards of health care
3. The Department will ensure that the restrictions do not result in denying members reasonable access (taking into account geographic location: and reasonable travel time) to NH Medicaid services of adequate quality, including emergency services.

After a restriction has been imposed in accordance with the above, the Department will notify the Centers for Medicare and Medicaid Services (CMS) and the general public of the restriction and its duration.

9.7 Medicaid Fraud Control Unit (MFCU) of the AG's Office

The Medicaid Fraud Control Unit (MFCU) investigates and prosecutes Medicaid provider fraud as well as patient abuse and neglect in health care facilities and board and care facilities. The MFCU is part of the NH Attorney General's office and employs attorneys, investigators, and auditors. The MFCU is constituted as a single, identifiable entity and must be separate and distinct from the State Medicaid agency.

In accordance with the provisions of Section 1909 of the Social Security Act, and State Laws RSA 167:17-B and 167:58, any false statements or inappropriate billing practices may be considered a felony and prosecutable to the fullest extent of the law.

10.0 Adverse Actions

A provider's non-compliance with Federal regulations, State laws, and/or the Department's rules, policies and procedures may result in the Department taking an adverse action against the provider. 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.

10.1 Denials of Provider Enrollment Application, Non-Renewal of Provider Participation, Suspension & Termination of a Provider's Enrollment

The Department may deny an application for enrollment or reenrollment in the NH Medicaid Program, suspend a provider's participation in the NH Medicaid Program, or terminate a provider's participation in the NH Medicaid Program for any of the following reasons:

1. Revocation, suspension, probation, or restriction of the provider's license, permit, or contract with the NH Medicaid Program;
2. A determination by the Department of Human Resources, the U.S. Department of Health and Human Services, the US Office of Civil Rights, or other federal or state regulatory agencies that the provider's practice is conducted in violation of federal or state laws or regulations including, but not limited to, Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, or the Age Discrimination Act of 1975;
3. A determination by the Department that a provider has violated the terms of the Provider Participation Agreement;
4. Making a false representation or omission of any material fact on the provider enrollment application;
5. Any criminal conviction or admission in a court of law, State Board proceeding, criminal investigation, or administrative proceeding relating to:
    a. The provision of services under Medicare, the NH Medicaid Program, or other health insurance program;
    b. Neglect or abuse of a member;
    c. The unlawful manufacture, distribution, prescribing, or dispensing of a controlled substance;
    d. Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
6. Exclusion, sanction, suspension, termination, or involuntary withdrawal from participation in any other state's Medicaid or State Children's Health Insurance Program (SCHIP) or from participation in any other governmental or publicly funded federal or state health care, private health care or health insurance program;
7. Determination by a licensing, certifying or professional standards board or agency that the provider has violated the standards or conditions relating to licensure or certification or the quality of services provided.
8. Failure to revalidate within 5 years per federal regulation under 455 Subparts B and E

10.2 Other Sanctions

The Department is authorized to take additional adverse action not previously stated, which it finds necessary to secure compliance with federal and state laws and regulations.

11.0 Provider Grievances & Appeals

Any individual or organization dissatisfied with a decision made by any office within the Department or any MMIS claim action has several grievance and appeal options available. The first is to request a review by the fiscal agent. The second is to request a review by the Department. The third is to request an appeal of the unfavorable decision through the Department's Administrative Appeals Unit (AAU). For more details on appeals through the Administrative Appeals Unit, please see the Department's rules at He-C 200 at http://gencourt.state.nh.us/rules/state_agencies/he-c200.html and RSA 126-A:5, VIII and RSA 541-A.

MCO-enrolled providers and members must first exhaust any MCO grievance and appeals processes before going through the steps outlined above.

11.1 Initial Review by the Fiscal Agent

A provider who is dissatisfied with a claim action or Department decision may request an initial review via the Provider Inquiry function of the NH Health Enterprise Portal or by submitting a request to the fiscal agent's Provider Relations Unit. The fiscal agent ensures that all claims policies were followed during the adjudication process.

If the provider has exhausted all administrative options available through the fiscal agent, a claim denial may be appealed by filing a written grievance with the Department (see below).

11.2 Review by the Department

If the fiscal agent has determined that the claims policies have been followed, but the provider still disagrees with the fiscal agent, the fiscal agent can advise the provider to submit a letter stating the issue and to include any medical records for review by the appropriate Department staff. The Department will review the claim and will advise the fiscal agent on the appropriate action to take either to reprocess the claim or to send the provider a letter as to why the claim will remain denied, including legal basis for the denial, if applicable. All actions are logged.

11.3 Administrative Appeal

In the event the provider's issue cannot be resolved by the fiscal agent or the Department, the provider may submit a request for an administrative appeal through the Administrative Appeals Unit (AAU). This request must be submitted within 30 days of the date of the letter in 11.2 above regarding continued claim denial.

The AAU's mission is to conduct impartial hearings and render decisions in accordance with state and federal laws, administrative rules and policies. While these hearings are formal legal proceedings, they are conducted in an informal manner allowing those who challenge a Department decision to present their case to an impartial hearing officer. The hearing officer reviews documentary evidence, hears testimony under oath from individuals, and issues written, final Departmental legal decisions that may confirm or reverse the original determinations made by a program within the Department.

The Department encourages settlement of issues under appeal prior to a hearing being held. Either the provider or the Department may request a meeting for this purpose at any time. Such meetings are desirable, but in no way limit a provider's right to a hearing as long as the appeal has been requested in accordance with the time limit for requesting an appeal.

After the hearing is conducted, the presiding officer will issue a written decision. The decision is based on the facts of the case and applicable laws, rules and policies.

No entitlement to interest will accrue regarding any amount claimed by a provider, regardless of whether or not the amount is the subject of a demand upon the Department which is adjudicated through administrative review, hearing, or other methods.

11.3.1 Notification of Appeal Rights

When a written notice of decision or action is issued by the Department, the Department will notify any person aggrieved by the decision or action that the person is entitled to request a hearing, in accordance with the statutes or rules which govern the decision or action which is being appealed.

11.3.2 Time Limit for Requesting an Appeal

Unless otherwise specifically provided in applicable federal or state law, or other Department administrative rules which set a different time limit, appeals must be submitted within 30 days after the date the Department's notice of decision was issued, if applicable; or of the Department's notice to the appellant of its action if a notice of decision was not issued.

Pursuant to He-C 200, the time limits for filing appeals shall not be waived unless the appellant establishes good cause for the non-compliance. Appeals received by the Department beyond the time limits will be denied, except as otherwise provided by He-C 200.

All time periods referenced in this section are calendar days. Computation of any period of time referred to in this section begins with the day after the action which sets the time period in effect, and includes the last day of the period so computed.

If the last day of the period so computed falls on a Saturday, Sunday or legal holiday, the time period is extended to include the first business day following the Saturday, Sunday or legal holiday.

11.3.3 Appeal Requests

Appeals shall be filed in writing with the Department. All appeals must identify the specific decision or action by the Department that forms the basis for the appeal. A copy of the notice of decision being appealed should be filed with the appeal. The scheduling process will be delayed if you do not produce a copy of your notice/decision. Appeal request forms may be obtained from any district office or directly from the Administrative Appeals Unit by calling 603-271-4292.

If an appeal is filed in one of the Department's district offices or a state office, it will be promptly forwarded to the AAU.

The appealing party will identify, in the appeal, any known specific needs or circumstances that relate to appellant's ability to attend or participate in a hearing, including, but not limited to, the need for interpreters, signers, or locations accessible by the disabled.

An appeal request shall be denied, or the appeal dismissed, without a hearing on the merits for any of the following reasons:

- Lack of jurisdiction
- Lack of available relief
- Lack of standing
- The appeal request is untimely
- The issue is not ripe for an appeal
- As a result of the AAU's repeated inability to communicate with appellant, as evidenced by

returned mail, disconnected phone line, blocked phone number or repeated, unreturned telephone messages.

11.3.4 Notice of Hearing

The initial notice of a hearing or prehearing conference will be issued by the AAU and contain the information required by RSA 541-A:31, III; and a list of the organizations in New Hampshire which provide free or reduced cost legal services.

Subsequent notices of hearings will be included in an order issued by a presiding officer, or as a separate hearing notice issued by the AAU.

The initial and any subsequent notices of a hearing will be sent to all parties in accordance with the service requirements of He-C 202.03.

If a party has a representative who has filed an appearance in accordance with He-C 203.05, the hearing notice shall be sent to the representative as well as the party.

11.3.5 Prehearing Conference

Any party or intervener may request, or the presiding officer may schedule on individual initiative, a prehearing conference in accordance with RSA 541-A:31, V.

Failure to attend a prehearing conference shall be considered a failure to attend a hearing under He-C 203.12.

12.0 Member Eligibility

The Department is responsible for establishing financial eligibility criteria based on federal regulations for individuals residing in New Hampshire. A NH Medicaid member is issued a permanent NH Medicaid ID card when eligibility is first determined.

Most Medicaid members will become eligible for same day managed care eligibility, but will not immediately have managed care ID cards. Therefore, it is **very important that providers check member eligibility electronically before serving Medicaid members.**

12.1 Eligibility Determination

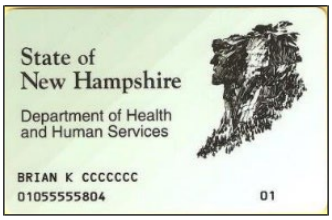
The Bureau of Family Assistance (BFA) determines financial eligibility and all non-financial eligibility for individuals applying for Medicaid.

There are three basic areas that BFA evaluates to make an eligibility determination for Medicaid: financial, non-financial (which includes citizenship, residency, SSN), and medical criteria (e.g., disability for APTD, ANB, MEAD & HC-CSD). BFA also coordinates with the Division of Long Term Supports and Services, who determine the level of care for nursing facility and Home and Community Based Services.

Individuals who wish to apply for Medicaid may apply at one of the Department's statewide District Offices, online via NH EASY or via HealthCare.gov, or by phone (1-844-275-3447).

12.2 Member ID Card

Members are issued a State of New Hampshire Department of Health and Human Services Medicaid ID card when eligibility is first determined. Dates of eligibility are ***not*** shown on the card. Therefore, it is very important that providers check member eligibility electronically before serving Medicaid members.



12.3 Member Responsibilities

It is important for providers to understand the responsibilities of Medicaid members and to assist if possible. Members should:

- Show their NH Medicaid identification card to each provider, at each visit, **before** receiving any service
- Show all other private insurance, Medicare, or Medicaid managed care plan cards
- Follow the rules of their other insurance, including use of in-network or participating providers, obtaining referrals, etc.
- Ask medical providers if they are participating with the member's other insurance plan(s) and if they are enrolled with the NH Medicaid Program

- Ask medical providers if the service(s) to be provided are covered by their other insurance and the NH Medicaid Program
- Keep records of all services received
- Inform the Family Services Specialist at the Department's District Office (DO) immediately if their name or address changes
- Keep every appointment and follow the treatment plan recommended by the provider or give advance notice of a need to cancel or reschedule an appointment. Failure to keep appointments may jeopardize the outcome of the member's care and/or result in member's dismissal from the provider's practice.

The member is responsible for payment of the entire cost of a service if the individual is not eligible for the NH Medicaid Program on the date of service, the service is ***not*** covered by the NH Medicaid program, the service would have been covered by other insurance if the rules of the insurance plan had been followed, the provider is not a NH enrolled Medicaid provider or the provider is no longer taking additional Medicaid members but the member chooses to receive the service as a private pay patient.

The member is also responsible for payment if the services received exceed service limits and service authorization to exceed service limits has not been received.

12.4 Newborn Eligibility

A newborn, whose mother is NH Medicaid eligible, will be covered for a period of one year. The child is covered under the mother's Medicaid eligibility from date of birth until the child is reported to Medicaid. After the child's birth is reported to the Department's District Office, eligibility is established for the child. Once eligibility is established, the child will receive a permanent card and identification number. If the mother is enrolled with an MCO, the newborn will be enrolled with the same MCO as the mother unless another selection is made.

12.5 Presumptive Eligibility

When an individual is in need of immediate care, but not yet enrolled in Medicaid, Providers who have been certified by the Department can determine Medicaid eligibility for individuals in their care while a full Medicaid application is pending. Presumptive eligibility is a means of offering immediate access to Medicaid coverage for individuals presumed to be eligible. Services will be covered for the individual based on this process. The presumptive eligibility period ends the earlier of the date the eligibility determination for full Medicaid is made, if the application for Medicaid is filed by the last day of the month following the month in which the presumptive eligibility determination is made; or the last day of the month following the month in which the presumptive eligibility determination is made, if the individual does not file a full application.

Claims for individuals covered under presumptive eligibility are covered by Medicaid Fee-for-Service. These individuals should complete their Medicaid application while covered under presumptive eligibility, or complete the Medicaid application on the same day that their presumptive eligibility application is submitted. When completing the full Medicaid application, individuals will be asked to select a health plan or to have one assigned. The member is not enrolled in this health plan, however, until their Medicaid application is approved and the individual is enrolled in Medicaid. While covered under presumptive eligibility, prior to receiving a determination on the Medicaid application, this individual is covered under Medicaid Fee-for-Service. Claims for services delivered during the presumptive eligibility period will be billed directly to the fiscal agent as a fee-for-service claim.

Presumptive eligibility is limited to no more than one period within a calendar year, and once per pregnancy, for pregnant women. Once full eligibility determination is complete (not to exceed 45 days) an identification

number is issued, at which time providers may bill the NH Medicaid Program as usual. If the patient is not approved for NH Medicaid, the date(s) of service from the time of application to the time of full determination is covered and a card/number issued for that limited period of time. Any claims for services rendered during that period of time will be submitted to Medicaid Fee-for-Service.

Providers who are interested in becoming certified to make eligibility determinations should contact the Department's Provider Relations Unit. All staff who wish to become certified will be required to take part in a presumptive eligibility training.

12.6 Qualified Medicare Beneficiaries (QMB) Eligibility

Congress passed the Medicare Catastrophic Coverage Act (MCCA) in 1988. This act contained provisions for a new group of persons to be eligible for payment by Medicaid for their Medicare Part A (hospital insurance) and Part B (supplemental insurance) premiums, premium penalties for late enrollment, Medicare deductibles, and Medicare co-insurance expenses not paid by Medicare. This group of members is known as Qualified Medicare Beneficiaries (QMB).

For QMB members, payment will be made by NH Medicaid for the deductible and co-insurance amount for ***only*** those services that are covered by Medicare.

Some members are eligible for both QMB and Medicaid. Refer to Section 13: Medicare for more information on Medicare and how it relates to Medicaid.

12.7 Specified Low Income Medicare Beneficiaries (SLMB)

The Specified Low-Income Medicare Beneficiary programs (SLMB & SLMB135) provide limited medical assistance coverage to help certain individuals pay their Medicare Part B (supplemental insurance) premium and premium penalties for late enrollment.

Some SLMB individuals are also eligible for Medicaid coverage. However, individuals eligible under SLMB135 are not eligible for Medicaid coverage, including Medicaid In and Out.

To be eligible for SLMB, an individual must be entitled to Medicare Part B insurance as determined by the Social Security Administration (SSA).

12.8 Medically Needy ~ Spenddown ~ In and Out

Medical assistance is available on an "In and Out" basis to a member who meets all eligibility requirements for medical assistance, except countable income exceeds the medically needy income limits. In and Out medical assistance is helpful to individuals whose income is insufficient to meet incurred medical costs or unpaid prior medical debts.

This program provides medical coverage when an individual's countable income exceeds the medically-needy MA income limit.

People who meet all eligibility factors for the Medically Needy program except for income are allowed to reduce their excess income through incurred medical expenses. This process is called spenddown.

Eligibility for Medically Needy In and Out is available on either a one-month spenddown or a six month spenddown.

12.9 Retroactive Eligibility

Retroactive Eligibility applies to an individual who is not a NH Medicaid member on the date of service but later applies for and is determined to be eligible for up to 90 days prior to the application date. The Department does not provide retroactive Medicaid coverage to adults aged 19 through 64 in the new adult group who are eligible consistent with section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR 435.119.

If a provider learns that the patient subsequently qualified for NH Medicaid eligibility for the date of service rendered, the provider may:

- Continue to bill the patient as private pay because the patient had not been accepted as a NH Medicaid member on the date of service, or
- Accept the patient as a NH Medicaid member after the fact and bill accordingly after reimbursing the member for any amounts s/he may have paid for the service.

12.10 Disability Determination

The Disability Determination Unit (DDU) is responsible for determining the medical component for those pathways to eligibility in which the applicant must meet disability requirements in order to receive Medicaid benefits. The DDU is authorized to evaluate applicants for Aid to the Permanently and Totally Disabled (APTD), Aid to the Needy Blind (ANB), Medicaid for Employed Adults with Disabilities (MEAD), Medicaid for Employed Older Adults with Disablities (MOAD), and Home Care for Children with Severe Disabilities (HC-CSD).

13.0 Medicare/Third Party Insurance Coverage

This section describes how claims should be submitted when a member is also covered by other public or private insurance. It defines other insurance resources as they apply to NH Medicaid and outlines provider responsibility related to these resources. In most cases, except as noted in Section 13.2.4, NH Medicaid is required to be payer of last resort, i.e., all other third party coverage must be pursued before NH Medicaid makes payment.

13.1 Medicare

If a member is eligible for both Medicare and Medicaid, and Medicare covers the service, the provider must accept assignment of Medicare benefits and submit a claim to Medicare within Medicare's time limitations.

This section addresses the relationship between Medicare and the Medicaid Program and provides a general overview as to what is covered and how claims for dual eligible members are processed. For more information on QMB benefits and eligibility refer to Section 12.6: Qualified Medicare Beneficiaries (QMB) Eligibility.

What the Medicaid Program covers for Medicare participants:

Individuals may qualify for the following benefits, as outlined in the chart below:

- Medicare benefits and NH Medicaid benefits
- QMB Medicare benefits and NH Medicaid benefits (QMB-Plus)
- QMB-only benefits without NH Medicaid benefits

Medicare & NH Medicaid Benefits (no QMB eligibility)	QMB & NH Medicaid Benefits (QMB-Plus)	QMB-only Benefits
The NH Medicaid Program pays coinsurance and deductible on Medicare crossover claims for services that are both Medicare and Medicaid benefits and pays for all regular Medicaid Program benefits not covered by Medicare. "Crossover" and the calculation of benefits are described below.	The NH Medicaid Program pays coinsurance and deductible on Medicare crossover claims for services that are both Medicare and Medicaid benefits and pays for all regular Medicaid Program benefits not covered by Medicare. The NH Medicaid Program also pays the monthly Medicare premiums for the Medicare beneficiary.	The NH Medicaid Program pays monthly Medicare premiums, coinsurance and deductibles on crossover claims for Medicare covered benefits. ◆ There is no coverage for NH Medicaid Program benefits that are not covered by Medicare. ◆ QMB-only clients may not be billed for crossover balances (i.e., the costs remaining for a Medicare-covered service after Medicare makes a payment). ◆ QMB-only members are financially responsible for services that are not covered by Medicare.

13.1.1 Medicare Coverage

Medicare provides benefits through the following plans:

- Part A (Hospital Insurance)
- Part B (Medical Insurance)
- Part C (Medicare Advantage Plans, like an HMO or PPO)
- Part D (Medicare prescription drug coverage)

Medicare Part A helps cover inpatient care in hospitals. This includes critical access hospitals and inpatient rehabilitation facilities. It also helps cover hospice care, home health care, and skilled nursing facilities (not custodial or long-term care).

Medicare B helps cover medically-necessary services like doctors services, outpatient care, and other medical services.

Medicare C, Medicare Advantage Plans are health plan options that are approved by Medicare and run by private insurance companies. Medicare C is a combination of Medicare A and B, and sometimes Medicare D. These plans may also offer other coverage at additional cost, such as dental services.

Medicare D helps cover prescription drug coverage based on the level of plan purchased by the Medicare beneficiary.

NH Medicaid Program members may have the following Medicare coverage:

- Part A Medicare coverage only
- Part B Medicare coverage only
- Both Part A and Part B coverage
- Part D coverage when covered by Part A and/or Part B, or Part C (provided that Part C plan does not cover drugs)
- Part C coverage instead of coverage by Part A and/or Part B

Medicare Part A Crossover Payments

Hospital Inpatient & Outpatient Charges	Nursing Facility Services	Clinic & Facility Services
Provider payment is the Medicare determined deductible and/or coinsurance, less the Medicaid coinsurance, if applicable.	Provider payment is the NH Medicaid Program per diem minus the Medicare payment For Part B services rendered by the Nursing Facility, the NH Medicaid Program pays the NH Medicaid Program's allowable minus the Medicare payment or Medicare deductible and/or coinsurance, whichever is less.	The NH Medicaid Program pays the NH Medicaid Program's allowable minus the Medicare payment or Medicare deductible and/or coinsurance, whichever is less, less the Medicaid coinsurance, if applicable.

Medicare Part B Crossover Payments
The NH Medicaid Program pays the deductible and coinsurance or the Medicare Program's allowed amount minus the Medicare payment for the benefit, whichever is less. If Medicare's payment equals or is more than the NH Medicaid Program's allowed amount, crossover claims are paid zero. Certain non-covered services are payable subject to NH Medicaid policy.

Medicare Part C Payments
Medicare Part C plans are health plan options approved by CMS, and offered by commercial insurers. These plans must provide all Part A and Part B services, and may offer additional services including Part D drug coverage. These plans include Medicare Preferred Provider Organizations (PPO), Medicare Health Maintenance Organizations (HMO), Medicare Private Fee-for-Service (PFFS) plans, Medicare Medical Savings Account (MSA) and similar entities.

Because Part C plans can vary in their coverage, providers need to submit Medicare Part C plans on paper and designate in the other insurance that the claim is a Medicare crossover claim. The NH Medicaid program will pay these claims in the same manner they would pay Medicare part A or Medicare part B claims

Medicare Part D Payments
Medicare Part D plans are commercial insurance plans that provide coverage for pharmaceuticals utilizing pharmacy networks approved by CMS. Part D provides prescription drug coverage to those enrolled in Part A and/or Part B. All Medicare beneficiaries who are also members of the NH Medicaid Program must receive their medications through Part D, even if the member is not enrolled in a Medicare Part D plan. The NH Medicaid Program will not reimburse members for pharmaceuticals covered under Part D. The only medications the NH Medicaid Program will continue to cover for members enrolled in Medicare and NH Medicaid are those "excluded" under Part D (including drugs for anorexia, weight loss, or weight gain; prescription vitamins and minerals; and certain over-the-counter medications. Drugs covered by Medicare must be billed to Medicare.

13.1.2 Medicare Crossover Claims

When a NH Medicaid member is also covered by Medicare, and the provider is an active Medicare provider, the provider must bill Medicare for all services before billing the NH Medicaid Program. The provider must accept assignment of Medicare benefits in order for the claim to "***cross over***" to the NH Medicaid Program directly from Medicare unless the:

- Individual is not eligible for the NH Medicaid Program on date of service but is determined retroactively eligible for the month of service
- Provider fails to accept assignment through an administrative or clerical error
- Fiscal intermediary erroneously processes an assigned claim as non-assigned
- The person has a Medicare Part C plan

If any of these conditions exist and the provider elects to submit a claim for the NH Medicaid Program secondary payment, the provider must:

- Complete the appropriate claim form if billing hard copy
- Attach a copy of the Medicare remittance advice/Explanation of Medicare Benefits

Providers may also bill electronically through the web site or through an X12 transaction as long as

the processes regarding claim attachments are followed.

13.1.2 Non-Covered Medicare Services or Non-enrolled Medicare Provider

Certain services that are not covered by Medicare may be covered by the NH Medicaid Program for dually eligible members. The Provider Specific Billing Manual - Volume II contains information on the scope of the NH Medicaid Program covered services; some of these services may not be covered by Medicare and can be billed directly to the NH Medicaid Program.

Providers that are not active Medicare providers at time of service, bur are active NH Medicaid providers, can bill NH Medicaid as primary and are not required to bill Medicare for denial. NH Medicaid will process claims for services delivered to dually eligible members by NH Medicaid-enrolled providers, to the extent that the services are covered by the NH Medicaid state plan.

This does not apply to members who are only receiving QMB coverage, their benefits are limited to the Medicare premiums and payment toward the Medicare deductible and/or coinsurance. Therefore, if Medicare does not cover the service, there is no NH Medicaid payment available for QMB members.

Members are required to pay NH Medicaid coinsurance, if applicable, even if the member has Medicare.

13.1.3 Inaccurate Medicare Payments

If a Medicare cross-over payment is made to an incorrect provider or is above the amount due, the provider must return the erroneous checks or issue a refund to Medicare and to the NH Medicaid Program for their respective shares. Any erroneous NH Medicaid Program payments or refunds due the Department should be made payable to the Department at the address listed for the Medicaid fiscal agent in the Appendices Section.

Adjustments to Medicare payments may be processed by the NH Medicaid Program as a cross-over claim if Medicare has increased or decreased reimbursement and issued an Explanation of Medicare Benefits or Medicare Remittance Advice accordingly.

13.2 Third Party Liability (TPL)

A “third party” means a health carrier that is or may be liable to pay all or part of the expenses for medical care furnished to a member. Under state law, "health carrier" means any entity subject to the insurance laws and rules of the State, or subject to the jurisdiction of the Commissioner of Insurance, that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services, including an insurance company, a health maintenance organization, a nonprofit health services corporation, or any other entity providing health coverage. “Health carrier” is further defined as any entity that is a pharmacy benefit manager, third party administrator of health benefits, provider of health benefits under an ERISA plan, or provider of health benefits under a self- administered plan as noted in RSA 167:b-4.

Under federal law Medicaid 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 as outlined in this section. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

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

When a third party denies a claim, for any reason, a copy of the notice of denial from the third party must be included with the claim submitted to the NH Medicaid Program. NH Medicaid will not cover a service denied by a third party if the third party claims processing was not correctly followed by the provider.

Providers are required to perform the following when third party insurance exists:

- Secure any prior authorization required by a third party
- Determine if there are coverage criteria as part of the member's other insurance that must be followed. For example, if the member's insurance covers a service only if the member obtains it from a provider in the network, and the provider is not within the network, it must be explained to the member that they needs to properly utilize the other insurance benefit first and obtain services from a network provider
- Properly file a claim with any third party, including Medicare, within the time frame specified by the third party, and obtain payment or a denial of payment prior to filing a claim with the NH Medicaid Program
- Indicate on the claim forms submitted to the NH Medicaid Program the identity of the other insurers and the amount of payment(s).

Providers should always ask the member about other insurance coverage, even when coverage is included in the NH Medicaid Program's member eligibility information made available to providers. The member is the best source of current and accurate coverage information. Providers must exercise due diligence in discovering, reporting and seeking payment from other third party coverage. This is particularly important if the services provided are related to an accident or injury where other parties might be liable (such as an automobile accident or work related injury or illness).

13.2.1 Identification & Billing of Third Party Resources

Third party coverage information for members is available to providers via:

- Automated Voice Response (AVR)
- NH MMIS Health Enterprise Portal
- 270/271 electronic transaction

Each of these methods will let the provider know what other coverage is available to a member, such as carrier(s) and policy number(s). The TPL information should be included on all claims submitted for payment to third parties (including Medicare). Space is provided on electronic and paper claims for this information.

Provider should always request all insurance cards from the member at the time of service. If a member presents an insurance card for a third party, and NH Medicaid does not have a record of the third party, the provider must bill the third party and follow all requirements before billing NH Medicaid. The provider can utilize the Carrier ID document to determine the correct carrier code to submit on the claim. The Carrier ID document can be found on the MMIS website under Documents and Forms.

13.2.2 Discrepancies in Reported TPL Resources

Providers should report any discrepancies in member insurance coverage to the Department (see contact information for the fiscal agent in Appendices Section). Discrepancies include:

- Member reports information to the provider that is different from what the provider obtains from the Automated Voice Response (AVR), NH MMIS Health Enterprise Portal, or 270/271 electronic transaction
- It is determined that third party coverage is no longer in effect
- There is additional third party coverage or other changes to coverage

Reporting of insurance coverage discrepancies should include:

- Member Medicaid and other insurance identification information
- Insurance carrier's letter or denial notice if available
- Any other relevant information that may help the Department in updating member insurance records

13.2.3 Medicare Supplemental Insurance

Providers should submit claims to the commercial health insurer for members who have Medicare Supplemental Insurance coverage. NH Medicaid will not pay a Medicare crossover claim if NH Medicaid has documented the existence of active Medicare Supplemental Insurance. If the supplemental health insurer denies benefits, the provider may submit a claim to the NH Medicaid Program. Documentation of the denial of benefits must be provided with the claim.

13.2.4 Exceptions to Billing Third Party Resources Prior to Billing NH Medicaid

There are limited exceptions to the requirement for billing third parties before billing NH Medicaid.

In accordance with federal regulation at 42 CFR 433.139 and departmental policy, a provider is not required to seek payment from third parties prior to billing the NH Medicaid Program for:

- Claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire).
- For services covered under the plan that are provided to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency, the State will make payment for such services without regard to third party liability that is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by the State Title IV-D agency, and seek reimbursement from such liable third party to the extent of legal liability, under the following conditions:
    a) The provider first bills the third party for the services.
    b) Up to 100 days have elapsed since the date the provider initially billed the third party.
    c) The provider has not received payment for the services.
    d) The provider must submit the claim to the Medicaid agency's MMIS (Medicaid Management Information System) with documentation of the billing to the primary insurance.

Additionally, providers are not required to seek payment from third parties prior to billing the NH Medicaid Program for services provided as part of the NH Medicaid to Schools Program or for Medicaid-only services such as non-emergency transportation.

For these exceptions, the NH Medicaid Program will pay the full amount allowed for the service and seek reimbursement from any liable third party up to the limit of liability. If a provider chooses to bill

the third party directly, all NH Medicaid Program policies regarding other insurance billing and processing as outlined in this section must be followed. If a provider chooses to bill a third party for EPSDT services, the provider cannot bill the NH Medicaid Program for services until they receive a payment or denial from the liable third party.

If a provider receives payment from both the liable third party and the NH Medicaid Program for the same service, the provider will be required to return the NH Medicaid Program's payment.

In a casualty (tort) situation, once the provider has billed the NH Medicaid Program for accident related medical services, the provider cannot reimburse the Department and then seek reimbursement from the liable third party in excess of the NH Medicaid Program reimbursement amount.

13.2.5 Third Party Payment as Payment in Full

If a third party payment exceeds the NH Medicaid allowance, no further payment is due from any source. This payment is considered payment in full.

13.2.6 Submitting Claims When Third Party Denies

The NH Medicaid Program will not reimburse claims when the denial reason given by the third party implies that the claim was not appropriately billed to the third party or that the third party payment was not appropriately pursued. Examples of third party denial reasons that the NH Medicaid Program will not accept include:

- No denial reason is given but zero is paid
- The claim is a duplicate claim
- There is insufficient information for processing the claim
- The claim is in process
- Authorization for the service is required before the delivery of the service
- Provider only receives a verbal denial of benefits or that services are not covered;
- The provider is out of network

Once a provider has appropriately pursued third party payment, if the third party payer denies the claim, providers may submit the claim to the NH Medicaid Program. An example of such would be if the member has met the allowed number of times for a service.

A copy of the third party Explanation of Benefits (EOB) must be provided with the claim in order to substantiate the denial. The denial must be indicated on the claim form.

13.2.7 Submitting Claims When No Response from Third Party

If a provider's attempts to bill a third party payer result in no response within six months from the date billed, a provider may submit a paper claim for payment to the NH Medicaid Program indicating that the third party insurance has not replied.

13.2.8 No Insurance Coverage

If a member denies having third party coverage, but there is active insurance information on the member file, the member should be directed to contact Bureau of Family Assistance Client Services at 1-844-

13.2.9 Accident & Trauma Claims

ASK-DHHS (1-844-275-3447) for verification and/or correction.

Under Federal law, the NH Medicaid Program is required to review claims that include diagnosis codes that may be accident or trauma related. To assist in identifying services that may be covered by a third party via a legal settlement, the NH Medicaid Program also uses specific claim Occurrence Codes, Accident Indicators, and the "Treatment Resulting From" information on the ADA Dental Claim.

Claims that meet the criteria for an accident or possible accident may be suspended until the member returns a properly completed Medical Service Questionnaire (MSQ) which seeks additional information regarding the cause for the services that were provided, possible liability coverage and any legal representation. Claims for members 18 and under will not be suspended.

The provider's assistance in assuring that the liable parties are identified early and correctly will result in timely reimbursement.

13.2.10 Workers Compensation Claims

Services known to be work related should be billed to the Workers Compensation carrier. The NH Medicaid Program instructs providers to identify services that are related to employment by using the correct claim form indicator for services related to the work-related injury and attaching any other pertinent documentation to the claim.

14.0 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. Coverage and limitations as well as reimbursement guidelines are found in the Provider Specific Billing Manuals - Volume II for each provider type.

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.

14.1 Rate Determination

The Department utilizes a variety of reimbursement methodologies for the various NH Medicaid covered services. It is important for each provider type to understand how services are to be billed and reimbursed. Please see the appropriate Provider Specific Billing Manual - Volume II for further detail. Some of the key reimbursement methodologies that may be used include fee-for-service and cost based reimbursement (retrospective and prospective). Other methodologies may take into account acquisition cost, manufacturer's retail price, dispensing fees, or volume purchase reduced prices.

14.2 Payment Disbursements

There are two types of payment disbursements: Electronic Funds Transfer (EFT) or hard copy checks. The Department strongly recommends providers choose EFT as their payment disbursement method for enhanced security and expedited payment receipt.

14.3 Electronic Funds Transfer (EFT) Payments

Providers who elect to receive electronic funds transfer payments from the NH Medicaid Program must complete the NH Medicaid Electronic Funds Transfer Application and EFT EnrollmentAgreement during the enrollment process or at any time thereafter.

14.4 Checks

To simplify accounts receivable reconciliation, providers receive NH Medicaid payment in one check along with the Remittance Advice for any claims processed in the claims cycle that generates an actual payment amount. The check is issued in the name shown on the enrollment application for the individual or the group provider.

14.5 Refunds of Medicaid Payment

In the event of a payment error identified by the Department or the provider, according to regulation and state rules, payments in error must be corrected.

A check may be written in the amount of the overpayment, or the claim may be adjusted or voided if payment has not yet been made.

Any overpayment from the NH Medicaid Program for a paid service must be returned to NH Medicaid with information sufficient to identify the claim for which the payment was made.

- Transaction Control Number (TCN)
- Member Name
- Member Medicaid Number
- Date of Service
- Amount Paid by Medicaid
- Overpayment amount being returned.

14.6 Rate Changes

The Department may adjust the reimbursement rate of any provider whose rate is established specifically for that provider on the basis of cost reporting whenever the Department determines that such adjustment is appropriate.

The Department's Rate setting unit will perform quarterly reviews of all provider requests to NH Medicaid to amend rate methodologies or fee schedules.

15.0 Provider Enrollment Process Overview

The provider enrollment process is completed online through the NH MMIS Health Enterprise Portal. Eligible providers must complete an enrollment application for each type of service they provide. Providers with additional service locations must also complete required information for those service locations.

When submitting an application online, required forms can be uploaded into the application with the signature page. Required documents not uploaded with the application can be faxed, or mailed to the fiscal agent's Provider Relations Unit, with the application tracking number (ATN) on the cover sheet. All applications and forms must contain signatures. Receipt and approval of the required documents is a condition that must precede each provider's enrollment.

Some provider types are required to submit proof of licensure or certification and other related documentation. Requirements apply to in-state and out-of-state providers.

Each approved provider is assigned a unique provider ID number to be used in all correspondence with NH Medicaid. NH Medicaid payment is made only to providers who are actively enrolled in the NH Medicaid Program.

The effective date of enrollment is typically the date that any necessary screenings are completed. Specific criteria for enrollment effective dates for specific provider types under certain scenarios other than the above can be found at 42 CFR 431.108. The effective date may also be retroactive up to one year if all provider requirements are met as detailed at 42 CFR 431.108(d)(2). (See Section 15.3.1 below.)

Border hospitals should refer to the Provider Specific Hospital Billing Manual - Volume II, Section II regarding enrollment.

15.1 Types of Applications

The following applications may be completed electronically on the NH MMIS Health Enterprise Portal:

- BillingProvider Enrollment Application: Group or Individual
- Non-Billing Provider Enrollment Application: Individual Rendering providers, or Ordering/Referring/Prescribing
- Trading Partner Enrollment Application

Additional required forms must be uploaded at the end of electronic application or mailed/faxed to the fiscal agent's Provider Relations Unit:

- Enrollment/Revalidation Signature Page ***(signature required)***
- NH Medicaid Provider Participation Agreement ***(signature required)***

15.1.1 Individual vs. Group Provider Enrollment Applications

The Individual Enrollment Application must be completed by an ***individual, non-billing provider*** affiliated with a Medicaid group or a ***provider operating as a sole proprietorship*** who does not have a Federal Employer ID Number (FEIN*).

The Group Provider Enrollment Application must be completed for a ***corporation, a partnership, or another group-type business entity*** **or** ***sole proprietorship with a Federal Employer ID Number (FEIN).***

15.1.2 Multiple Provider Types

Providers with more than one provider type must complete a separate Enrollment Application for each provider type.

15.1.3 Trading Partners

Healthcare providers that utilize EDI to submit/receive claim information on their own behalf must complete the "Electronic Transaction Submission" section of the Provider Enrollment application and indicate which X-12 compliant transaction will be submitted. Healthcare applicants must also sign and submit the State-Issued Trading Partner Agreement.

Providers who have indicated they will upload transactions directly to the portal must also sign and submit the State-Issued Trading Partner Agreement.

Providers indicating they intend to use a Clearinghouse(s) or a Billing Agent to submit X-12 compliant transactions on their behalf must sign and send the appropriate billing agent agreement form. One form for each Clearinghouse or Billing Agent must be completed.

Organizations enrolling with the intent to submit X-12 transactions on behalf of Medicaid enrolled providers must complete a Trading Partner Application to become an enrolled trading partner.

Once an applicant has been approved for enrollment in the NH Medicaid Program, they may be contacted to arrange for testing of EDI transaction files.

15.2 Application Submittal

Applications, forms and instructions are located online through the NH MMIS Health Enterprise Portal. From the Homepage, listed under Quick Links, Enrollment is an option. In the "Become a Provider" section of the Provider Enrollment page, links include:

- FAQs
- Instructions
- Group Provider Enrollment
- Individual Billing Provider Enrollment

15.2.1 Mandatory Attachments

The following is a list of mandatory attachments that must be received by the fiscal agent prior to processing enrollment applications/forms.

- Register for Web Access Form
- Provider Participation Agreement (with signature)
- Enrollment Application Signature Page (with signature)
- IRS W-9 Form - The taxpayer identification information, Federal Employer Identification (FEIN) and/or Social Security Number (SSN) must be identical to the information that the provider submits to the Internal Revenue Service (IRS).
- Letter from IRS giving provider's FEIN.
- Copy of NPI Verification Page

15.2.2 Conditionally Required Attachments

The following attachments are conditionally required:

- EFT Form
- Proof of licensure, certification, accreditation, or registration according to NH laws and regulations.

15.3 Application Review Process

The fiscal agent's Provider Enrollment Unit is responsible for the administration of all NH Medicaid provider screening and enrollment processes. The Department maintains full responsibility for making all provider enrollment determination decisions. Applications may be subject to review by the Department's Program Integrity Unit. The Department reserves the right to deny a provider application for just cause.

Providers are notified of enrollment approval and denial decisions via US mail.

15.3.1 Retroactive Enrollment

The Department may consider granting retroactive enrollment as detailed at 42 CFR 431.108(d)(2), to eligible providers who submit a written justification. The department will consider requests for limited situations such as emergency care provided or for providers that have recently been screened by Medicare. The request must be submitted within 30 days of the date of the NH Medicaid approval letter.

15.4 Enrollment Status

Once a provider has ***submitted*** an application and is assigned an Application Tracking Number (ATN) via the NH MMIS Health Enterprise Portal, the provider may view the status (approved, denied or in process) of the application using the ATN.

The Department reserves the right to request additional information for clarification or completion of an enrollment application. Requested documentation must be received at the Department within 15 business days of the request unless other arrangements have been made with the Department.

A provider is notified through the U.S. mail of the Department's decision to accept or deny the completed application for enrollment.

15.4.1 Approved Application

If the application is approved, the provider will receive a NH Medicaid approval letter. The letter will include a provider number and the effective date of enrollment. The Department will not reimburse for services rendered prior to the effective date of enrollment.

15.4.2 Denied Application

If the application is denied, the applicant will receive notification from the Department explaining the reason(s) for the denial and the applicant's right to appeal.

15.4.3 Incomplete Application

An application is considered incomplete if required fields are not accurately completed or if required attachments are not received.

The provider will be notified by letter from the fiscal agent stating the reason why the application is incomplete.

Applications that remain incomplete for more than 30 days from the date of submission are canceled. The applicant is required to resubmit the application and all supporting documents for reconsideration if desired at a later date.

15.5 Disenrollment

An enrolled provider may voluntarily terminate participation in the NH Medicaid program by giving 60 days written notice to the fiscal agent's Provider Enrollment Unit. Voluntary termination subsequent to the Department's issuance of notice of proposed adverse action may result in the Department's retention of reimbursement until the resolution of the matter that caused the Department to issue a Notice of Adverse Action.

16.0 NH Medicaid Claims & Claims Payment

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.

The following policies and procedures regarding submission of NH Medicaid claims are generally applicable to all providers. However, providers must also refer to the Provider Specific Billing Manual - Volume II to identify any unique requirements or exceptions for claims submission that may apply to them. Failure to comply with defined claims requirements will result in claims being denied or returned to the provider unprocessed.

16.1 Claims Completion

All claims submitted for processing must meet the following minimum requirements of a valid claim. If any of the following requirements are not met, the claim will be returned to the provider unprocessed or will result in denial of the claim. Medicaid claims, except for pharmacy Point of Sale (POS) claims, must be submitted on one of the three nationally-accepted provider claims forms for professional (CMS-1500), institutional (UB-04), and dental (ADA-2006) services. Claims submitted on forms other than those approved by NH Medicaid will be returned to the provider unprocessed.

16.1.1 CMS-1500 Claim Form

The CMS-1500 Claim Form must be used when billing professional services. The following are examples of provider types that must bill services on the CMS-1500 Claim Form:

- Ambulance service providers
- Durable medical equipment (DME) suppliers
- Independent Laboratories
- Physicians, podiatrists and psychologists
- Language interpreters
- Outpatient hospitals and clinics
- Home health and home care agencies
- Community mental health centers
- School-based medical service providers
- Home infusion services provided by pharmacies
- Waiver service providers

16.1.2 UB-04 Claim Form

The UB-04 Claim Form must be used for billing services provided in an institutional setting. The following are examples of provider types that must bill services on the UB-04 Claim Form:

- Hospitals (inpatient/outpatient services, distinct part units)
- Nursing facilities

- Hospital-based rural health centers
- Hospice providers

16.1.3 ADA-2006 Claim Form

The ADA 2006 Claim Form must be used for billing dental services in an office or school- based setting. The following are examples of provider types that must bill services on the ADA Claim Form:

- Dentists
- Dental group practices
- School-based dental service providers

16.1.4 Provider ID

Any claim submitted without an active provider ID number will be returned unprocessed to the submitter.

Healthcare providers must include a valid NH Medicaid ID or National Provider Identification (NPI) number on each claim submitted for processing. Atypical providers, those that render non-medical services such as personal care attendants, must use the Medicaid number in lieu of a NPI number.

16.1.5 Provider Status

Providers must be enrolled in the NH Medicaid program with an active NH Medicaid provider ID number as of the date(s) of service on the submitted claim. If the billing Provider ID is not active or the rendering provider ID is not active or absent from the claim as of the date(s) of service, claims will deny.

16.1.6 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, the NH Medicaid Program 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 clients whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above.

16.1.7 Required Data Fields

All fields labeled “Required” on the claim form must be completed or the claim will deny. Some fields that are not labeled “Required” are mandatory for specific provider types. All claim forms should be completed with the service location address prior to submission. Providers should refer to the Provider

Specific Billing Manual - Volume II for more detailed instructions on applicable data requirements for claim completion.

16.1.8 Diagnosis & Procedure Codes

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

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

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

Some exceptions to the required use of industry standard diagnosis and procedure codes apply to atypical providers. On occasion, procedure codes assigned to atypical services may require unique codes assigned by the NH Medicaid Program. Detailed instructions are provided in the Provider Specific Billing Manual - Volume II.

16.1.9 Service Authorizations (SAs)

Some services require pre-approval by the NH Medicaid Program in order to be considered for payment. Providers must obtain pre-approval and a corresponding service authorization number in accordance with the policies outlined in this manual and in the Provider Specific Billing Manuals - Volume II. Service authorizations approved for each provider are maintained and stored within the NH MMIS. Please see section above for more information on Service Authorizations.

The standard claim forms used by the NH Medicaid Program allow 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, or the claim will be denied.

16.1.10 Required Claim Attachments

Some claims require supplemental attachments such as sterilization consent forms, an Explanation of Benefits, or medical records. The Provider Specific Billing Manual - Volume II outlines the circumstances that warrant claim attachments and identifies the required corresponding attachments.

All supplemental attachments must be submitted in hardcopy format. Providers who submit claims on paper should have the claim attachment placed 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 mailed 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.

16.2 Claims Submission

The NH Medicaid Program accepts three methods of submitting claims. Providers may submit claims electronically via Electronic Data Interchange (EDI), via direct data entry on the NH MMIS Health Enterprise Portal, or via hardcopy paper. Each method has its own process requirements.

Providers are generally encouraged to submit claims electronically via EDI or via the web portal to improve resource efficiency, speed payment, increase data security and reduce the possibility of human error. Ultimately, however, providers have the option of using whichever method is most beneficial to them.

16.2.1 Electronic Data Interchange (EDI)

EDI is the computer-to-computer exchange of structured information with a minimum of human intervention.

EDI provides tools that enable the submission of NH Medicaid claims and other transactions twenty-four hours a day, seven days a week and the auto-generation of confirmation receipts of each file transferred.

The NH Medicaid Program utilizes the services of the fiscal agent's EDI Gateway, Inc. to enable providers and their clearinghouses and billing agents to submit and receive electronic claims transactions. The fiscal agent's EDI Gateway, Inc. provides connectivity, processing, and validation of the electronic data interchange transactions.

The increased speed of claims adjudication and the reduced potential of human error associated with paper claims are additional benefits of EDI billing. Claims submitted electronically via EDI are generally available for status inquiry the week after submission.

The following transactions can be processed twenty-four hours a day, seven days a week.

- 270 Eligibility Inquiry
- 271 Eligibility Response
- 272 Claim Status Response
- 276 Claim Status Inquiry
- 278 Service Authorization Inquiry and Response
- 835 Remittance Advice Inquiry and Response
- 837D Dental Health Care Claim
- 837I Institutional Health Care Claim
- 837P Professional Health Care Claim
- 997 Transaction Rejection

Generally, providers with a high volume of NH Medicaid claims tend to benefit the most from EDI transaction processing. Use of EDI for NH Medicaid claims submission is highly encouraged for all providers who already use this method for billing other government and private health insurance claims. Providers who currently utilize a software vendor or other type of billing agency may gain increased efficiency from that relationship by expanding services to include EDI processing of NH Medicaid claims.

All entities that send electronic transactions to the fiscal agent's EDI Gateway, Inc. for processing and retrieval of reports and responses are required to enroll as EDI Trading Partners. The Trading Partner enrollment application is available on the NH MMIS Health Enterprise Portal.

16.2.2 Web Portal Entry

The NH MMIS Health Enterprise Portal includes a user-friendly, secure interface that enables direct data entry of provider claims and provides an array of functionality to assist providers with MMIS billing and claims management.

Web portal entry features and benefits include:

- Password protection for enhanced security
- Two options for claims data entry format: EDI version or standard data entry
- Ability to save partially completed work and recall the claim at a later time
- Data entry audits and error messages
- Immediate printable confirmation of claim submission
- Real-time adjudication remarks and explanations
- Online claim inquiry
- Claims history availability
- Claim templates for similar repeat submissions
- Field-by-field instructions and Online Help
- 24 hours per day, 7 days per week availability

When claims are submitted via the web portal, providers will receive immediate and specific feedback regarding the data validity of the claim via pop-up messages and explanations. This feature will allow providers to make immediate corrections to data initially submitted. Claims submitted via the NH MMIS Health Enterprise Portal are immediately available for status inquiries.

Direct data entry of claims via the portal is a good option for providers whose claim volume does not support EDI but who prefer the advantages of automated features of web portal entry.

16.2.3 Paper Claims

Providers who do not choose to utilize EDI or the NH Health Enterprise Portal can mail hardcopy paper claim forms to the fiscal agent for processing. Detailed instructions for completing paper claims are included in the Provider Specific Billing Manual - Volume II.

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

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

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

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

Paper claims and other documents can be mailed to:

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

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

If the fiscal agent receives paper claims that do not meet these quality requirements, they will be returned to the provider with a letter describing the reason the claims cannot be processed. The provider can complete a new claim form correcting the issue and send it to the fiscal agent for processing.

Under normal circumstances, paper claims will be adjudicated within 30 calendar days of receipt of the claim by the fiscal agent. The status of paper claims will be reported on the Remittance Advice after the claim has been processed. To obtain a claim status prior to the RA report, providers may call the fiscal agent Provider Relations Unit.

16.3 Claim Processing and Adjudication

The NH MMIS claims processing function reviews data as submitted by the provider on the claim form, applies corresponding edits and audits reflecting the policies and procedures established by the Department, and adjudicates claims to final disposition.

Claims submitted via the portal are adjudicated in real-time, i.e. immediately upon submission. Claims submitted via EDI or on paper require overnight batch processing prior to adjudication.

16.3.1 Policy Edits & Audits

The NH MMIS systematically reviews all submitted claims to ensure compliance with NH Medicaid policies, administrative rules, and billing guidelines.

A complete range of system edits are applied to each claim to verify the validity of data on the claim including member eligibility, diagnosis and procedure coding, service authorizations, and Third Party Liability (TPL). All claims are audited against a complete claims history to review quantity limitations, sequence of procedures performed, duplicate billing, etc. The NH MMIS also subjects claims to review by industry-accepted third party software to ensure that services paid by the NH MMIS comply with generally accepted standards of medical practice.

16.3.2 Transaction Control Number (TCN)

The MMIS assigns a Transaction Control Number (TCN) to each claim for identification and tracking purposes. TCNs are assigned once the claim is submitted to the MMIS and are reported on the provider's Remittance Advice. When inquiring about a claim, providers should reference the TCN from the Remittance Advice to help identify the correct claim.

16.3.3 Line Item Processing vs. Header Processing

Claim edits review header-level data and line-item data of each claim.

A claim header consists of data representing the entire claim. Header-level errors result in denial of the entire claim. For example, use of an invalid claim form would result in a header- level (entire claim) denial.

Line item editing identifies errors on a specific claim line but does not deny other lines billed on the claim. For example, use of an invalid procedure code would result in a line item denial while the rest of the claim remains eligible for processing and payment.

16.3.4 Claim Status

The NH MMIS processes claims to a final disposition of paid or denied. Prior to final disposition, editing may cause some claims to "suspend" for manual review. Suspended claims remain in this status until a pay or deny decision is made by a reviewer. All claims that have been paid, denied, or suspended during the past weekly payment cycle appear on the provider's Remittance Advice.

The status of claims submitted via EDI is normally available on the Remittance Advice the following week. Claims submitted via the web portal return an immediate claim status. Claims submitted on paper and mailed to the fiscal agent are normally available for status inquiries two to three weeks after submission.

In addition to web portal and electronic claim status verification, individual claim status checks can be made via a telephone call to the fiscal agent's Provider Relations Unit.

16.3.5 Remark Codes & Explanation of Benefits (EOBs)

Claims edits produce specific HIPAA-compliant remark codes which provide an explanation of the claim payment adjustment and/or disposition status. These remark codes can be seen in the claim history on the web portal and on the provider's Remittance Advice.

Expanded EOBs are also listed on the Remittance Advice describing reasons for claim denials and the required action, if any.

16.4 Claim Adjustments & Voids

Under certain circumstances, it may be necessary to make a change to a claim that has already been paid. Changes may be made by the Department, the fiscal agent, or by a provider to correct an error on the data submitted on the original claim or an error in the adjudication process. The Department may also make a retroactive change in payment rates and/or policies that must be applied to a claim after it has been paid. Changes and corrections may require an adjustment to the amount originally paid on the claim or could result in voiding the entire claim.

16.4.1 Adjustments

A change to a paid claim that modifies the data submitted on the original claim is called an adjustment. Claim adjustments may or may not result in a change to the amount originally paid.

Providers are responsible for submitting adjustments to paid claims whenever an error is self- identified or whenever the provider is notified by the Department or fiscal agent of an error requiring a claim adjustment.

The following are examples of reasons for submitting a claim adjustment:

- To correct a procedure code or date of service
- To correct a fee schedule amount
- To implement a retroactive change by the Department in the fee schedule of a particular service

- To apply the receipt of a third-party payment that should be added to the claim

To submit a claim adjustment, a provider must complete an Adjustment Form. The Adjustment Form is found on the NH MMIS website at www.nhmmis.nh.gov under "documents and forms." The provider must attach to the Adjustment Form a copy of the original completed claim with corrections made. A copy of the Remittance Advice with the previously paid Transaction Control Number circled must also be attached.

A claim adjustment results in a transaction that recoups the entire claim payment and repays the claim. Adjustments will appear on the provider's Remittance Advice as two transactions: a negative transaction reversing the original payment and a positive transaction re-paying the claim.

Adjustments are not done to denied claims.

16.4.2 Voids

An error that invalidates the entire claim requires a transaction called a void. The following are examples of reasons a paid claim would be voided:

- The member ID number on the claim was incorrect
- The service billed was not rendered as indicated on the claim
- The service billed is a component of another service previously billed on a separate claim

A void results in a transaction that reverses the entire payment without re-paying the claim. A void appears on the Remittance Advice as a single negative transaction.

16.4.3 Mass Adjustments

An adjustment that must be applied to a large volume of claims is called a mass adjustment. Mass adjustments may occur when the Department institutes a retroactive change in payment policies, such as a service rate. The nature of the policy being implemented will dictate how the mass adjustment is applied. For example, mass adjustments may be applied to all providers in a certain category, all claims for a specific service, or all claims for a range of specified dates.

The mass adjustment transaction reprocesses the affected claims and pays the difference between the original payment amount and the adjusted amount, if any. Mass adjustments will appear on the Remittance Advice in the same manner as regular adjustments: a negative transaction reversing the original payment and a positive transaction re-paying each claim with the change(s) made.

When processing a mass adjustment, the Department typically notifies impacted providers by sending a letter in advance.

16.5 Claim Resubmissions

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.

16.5.1 Resubmission Criteria

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information that has been 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.

16.5.2 Resubmission Process

Denied claims that have been corrected must be resubmitted as a new claims transaction on paper, via the web portal, or electronically via EDI.

Photocopies of claim forms cannot be used and are returned without further processing.

16.6 Medicare Cross-Over Claims

Medicare cross-over claims are claims for dually eligible Medicare/NH Medicaid members that were originally filed in a timely manner with Medicare, allowed by Medicare, and then "crossed over" to NH Medicaid for potential payment of coinsurance and deductibles. This process is referred to as "Medicare claim crossover."

Medicare cross-over claims must be received by the NH Medicaid program within 12 months of the date of service in order to meet the NH Medicaid timely filing standards.

16.6.1 Automatic Crossover of Claims

Medicare carriers and fiscal intermediaries have the capability to automatically transfer claims for dually eligible individuals to NH Medicaid fiscal agents for further processing once the claim has been fully adjudicated by the Medicare system. When automatic crossover of claims occurs, providers do not have to submit a NH Medicaid claim.

To enable claims to "cross over" from Medicare to NH Medicaid, Medicare identifies claims selected for automatic crossover from member eligibility files that NH Medicaid forwards to them on a periodic basis. The provider's Medicare number/NPI must be on file with NH Medicaid in order for automatic transfer of claims to occur.

When Medicare claim crossover automatically occurs, providers receive notice on the Explanation of Medicare Benefits or Medicare Remittance that the claim was forwarded to NH Medicaid.

Claims will not cross over automatically if one or more of the following conditions exist:

- The provider's Medicare number/NPI is not on file with the fiscal agent or is not associated with an active Medicaid provider number.
- The member was not listed on the NH Medicaid eligibility file sent to Medicare for the month the claims were processed.

Providers should submit claims directly to NH Medicaid if the provider is aware that any of these conditions exist.

If the Explanation of Medicare Benefits or Medicare Remittance indicates that the claim has been forwarded for processing but is not paid or denied by NH Medicaid within 45 days from receipt of Medicare payment, a NH Medicaid cross-over claim may be submitted directly to the fiscal agent.

16.6.2 Medicare Denied Claims/Medicare Denied Charges

If Medicare denies a claim for a dually eligible member because Medicare benefits are exhausted or services are not payable, the claim is not crossed over to NH Medicaid since there is no corresponding coinsurance or deductible for NH Medicaid to consider.

If Medicare denies a claim, as a whole or in part, a provider may submit a claim directly to NH Medicaid. In instances where there are both allowed and non-covered Medicare services on the same Explanation of Medicare Benefits, the NH Medicaid claim must be submitted as two separate claims: one claim for the Medicare covered services, and one claim for the Medicare non-covered services.

16.6.3 Medicare Crossover Claim Submission

NH Medicaid claims for Medicare-covered services must include the following:

- A claim form for services that are all covered by Medicare should contain the Medicare carrier code in the proper field (CMS-1500 form field 9D, UB-04 form locator 50A).
- The Medicare EOMB copy must be submitted with the claim, with Medicare non- covered services crossed out and totals updated on the EOMB to match the claim totals.

NH Medicaid claims for Medicare non-covered items must include the following:

- A claim showing NH Medicaid as the primary payer with the Medicare non-covered service(s) listed with the Medicare carrier code in the proper field (CMS-1500 form field 9D, UB-04 form field 50A)
- "Non-covered Medicare service" entered in the proper field (CMS-1500 form field 9D, UB-04 form field 50A)

The EOMB attachment is not needed when submitting a claim for Medicare non-covered services.

16.7 Claim Payments

The NH MMIS uses a variety of pricing methodologies corresponding to various services and providers, as described in the Payment Policies section of this manual and in the Provider Specific Billing Manual - Volume II. To arrive at the net payment amount of each claim, the NH MMIS calculates an allowed amount and subtracts applicable third party payments and member liability. The Remittance Advice outlines net payments made by NH Medicaid.

Payment can be issued as an electronic bank deposit or a paper check. One payment is issued for all claims paid on a given remittance advice; separate payments are not issued for each claim.

Payments are made to the legal name, as recorded from the provider enrollment application, that correspond to the billing provider ID listed on the claim.

16.7.1 Payment Frequency/Schedule

The NH Medicaid program issues payment on a weekly basis for claims adjudicated in the previous week. All claims adjudicated during the week appear on the Remittance Advice and one payment for the net amount is issued to each provider.

16.7.2 Electronic Funds Transfer (EFT) Payment

EFT enables direct deposit of claims payments into a provider's account at a specified financial institution. EFT direct deposit improves payment security and provides immediate access to funds.

Providers are encouraged to utilize the EFT option for NH Medicaid claims payments. Providers can register for EFT during the provider enrollment process. Alternatively, providers can register for EFT after enrollment by completing the NH Medicaid Electronic Funds Transfer Application and Agreement Forms and submitting it to the fiscal agent. The EFT Application and Agreement Forms can be accessed on the NH MMIS Health Enterprise Portal web site.

16.7.3 Paper Checks

Providers are generally encouraged to utilize the EFT option for Medicaid claims payments. However, if providers have unusual or extenuating circumstances that prohibit registration for EFT, paper checks will be issued.

17.0 Remittance Advice (RA)

The Remittance Advice provides payment or denial information on each claim processed by NH Medicaid. It is intended to assist the provider in maintaining accurate records of claims submitted and serves as notification of the action taken on each NH Medicaid claim processed.

The RA includes a listing of claims paid, claims denied, and newly suspended claims. The RA also reflects voids and adjustments, if applicable.

For providers billing more than one of the following types of service, there are separate listings for each claim type billed for each rendering provider:

- Inpatient
- Outpatient
- Medical
- Dental
- Medicare A cross-over
- Medicare B cross-over

The RA includes the following data for the claim(s) processed:

- Member name and ID number
- From/Thru dates of service
- Medical Record Number
- Charges – total and line item
- Units of service
- Procedure/revenue code
- TPL payments

The RA includes the following data regarding claim adjudication:

- Allowed amount
- Transaction Control Number
- Adjustment reasons
- Remark codes
- EOBs
- Claim/line status
- Claim dollar totals

17.1 Frequency

The Remittance Advice is issued weekly if the provider has adjudicated claims in this time period.

17.2 Delivery Method

The Remittance Advice media options consist of:

- The 835 Health Care Claim Payment Advice
- A web delivery to the provider's Message Center
- Hardcopy (only when there is documentation of extenuating circumstances requiring this delivery method)

Providers select the media option at the time of provider enrollment; changes can be made at a later date

by contacting the fiscal agent's Provider Relations Unit.

17.2.1 Paid Claims

The Remittance Advice lists each claim paid and the total amount paid for each claim. Some paid claims may have an individual line that is denied. The reason for the denial is listed for each line that was disallowed. Some claims in paid status may have paid zero dollars as a result of the claims payment determination.

17.2.2 Suspended Claims

The Remittance Advice lists those claims that require further research, evaluation, or other action before they can be paid or denied. These claims are referred to as suspended claims.

If a claim is suspended, it is not appropriate for a provider to submit a duplicate claim. The Suspended Claims section reflects only those claims that have been entered into the MMIS. EDI paper claims that have been entered but are still being prepared for system entry by the fiscal agent are not shown.

17.2.3 Denied Claims

The Remittance Advice lists the adjustment reason code(s) and remark code(s) that specify why a particular claim or service could not be paid.

The denial of a claim constitutes the termination of the transaction between the Department and the provider for the services billed.

Possible reasons for denial include but are not limited to:

- The service for which reimbursement is claimed is not a covered service.
- The patient was not an eligible NH Medicaid member when the service was rendered.
- The provider failed to obtain a required service authorization.
- The limit for the type of service billed was exceeded.
- The claim was not completed according to NH Medicaid requirements.

17.2.4 Adjustment/Void Claims

The Remittance Advice lists positive adjustments to previous payments made to the provider and negative adjustments and voids resulting from rate changes, retrospective review, or other actions by the provider or the Department.

18.0 Provider Support

The fiscal agent's Provider Relations Unit, web-based services, Automated Voice Response (AVR) telephone services, training and site visits are available to support providers who are enrolling, inquiring on claims or confirming member eligibility. The content in this section includes detailed information pertaining to these support services. Contact information for the fiscal agent's Provider Relations Unit and the AVR are located in the Appendices Section.

18.1 Fiscal Agent Provider Relations Unit

The Provider Relations Unit is comprised of associates who specialize in enrollment, claims inquiry, MMIS training and publications.

The associates are trained to answer provider questions relating to but not limited to:

- Billing Procedures
- Claim Resubmission Procedures
- Claim Status
- Electronic Claim Submission Criteria
- Member Eligibility
- Program Benefits
- Provider Enrollment Status
- Provider Revalidation
- Remittance Advice
- Service Authorizations
- TPL Billing

Associates are available by telephone Monday through Friday from 8:00 a.m. to 5 p.m. Eastern Time. The Provider Relations Unit may also conduct training and site visits upon request.

18.2 Web Based Provider Services & Inquiry

Access to self-service features, through the NH MMIS Health Enterprise Portal, are available 24 hours per day, 7 days per week, with the exception of scheduled maintenance periods. Web based information is secure and restricted to enrolled providers.

Enrolled providers must have a valid user ID and password to utilize the web-based service features. Providers with a user account may log into the NH MMIS Health Enterprise Portal through the Sign In Pod located on the Homepage.

The provider must enter a ***required*** User ID and Password in the Login section of the portal.

Once the user account is validated, the Provider's secure homepage is displayed. This page displays the Provider quick links and the Provider Message Center Inbox where providers receive their remittance advices (RAs), messages to the Provider community or specific Provider types and answers to Provider inquiry questions.

Providers may inquire, through the Provider Inquiry page, about Member eligibility, service authorizations

and claim entries. Authorized users may also upload and download X12 files via the portal. To upload a file, the user must be a registered Trading Partner.

The quick links menu allows the provider access to training registration forms, a provider inquiry screen, and a provider resources page. On-line help is also available.

18.3 Telephone Services

Provider Relations associates are available to answer questions by telephone for providers and their designees Monday through Friday 8:00 a.m. – 5:00 p.m. Associates are not available on NH state holidays except for Veterans Day and the day after Thanksgiving. The associates will not be able to answer member inquiries or other non-provider entity questions. For identification and security purposes, providers will be asked to HIPAA verify theor account by providing the following three items:

- Provider ID/NPI
- Provoder Name (of the account being referenced)
- SSN or Tax ID

18.4 Automated Voice Response (AVR)

Automated Voice Response (AVR) is a telephone support service available 24 hours per day, seven days per week, except for scheduled maintenance periods. Providers inquire through voice automated telephone menus for information such as:

- Member Eligibility
- Claim Status
- Provider Remittance Advice totals/dates

The following information is needed to access the AVR:

- NH Medicaid Provider ID Number and PIN (NPI is not used for this service)
- NH Medicaid Member ID Number
- Date of Service

18.4.1 AVR Menu Options

Member Eligibility Option allows providers to inquire about a specific member's eligibility. Inquiries include:

- Eligibility Verification
- Medicare Coverage
- Third Party Liability Coverage
- Scope of Medicaid benefits

Claim Status Option may be accessed using the Transaction Control Number (TCN), or the Member ID and Date(s) of Service of the claim. Information returned to the provider includes:

- Claim Date of Service
- Member ID
- TCN
- Claim Status (Paid, Denied, Suspended)
- Claim Paid Date and Amount Paid

Remittance Advice Option may be selected through the AVR Main Menu. The AVR returns the most recent payment history which includes:

- Date of Remittance
- Remittance Amount

See Appendices Section for an AVR Quick Reference Guide.

18.5 Hardcopy Correspondence

Provider inquiries may be submitted in writing. If providers choose to inquire in writing, all relevant information should be provided. If the inquiry is requesting a review or a resubmission of a claim, a claim form copy must be attached to the inquiry. Other documentation such as a remittance copy or required claim attachments may need to be included to allow claim resubmission or adjustment processing.

18.6 Training & Site Visits

Fiscal agent field representatives are available for training purposes, resolution of complex or time-consuming issues, or to speak at provider association meetings on topics that relate to the billing of NH Medicaid claims. Training and site visits may be requested through the fiscal agent's Provider Relations Unit.

19.0 Appendices

The Appendices Section contains supplemental materials applicable to the NH Medicaid Program.

19.1 Appendix A ~ Fee Schedules, Manual Pricing, Forms, and Instructions

Providers may access the fee schedules on the NH MMIS website at www.nhmmis.nh.gov under the documentation tab, "documents and forms," see fee schedules. Please note that if the fee schedule shows a price of zero, it does not necessarily mean that the code is not covered. It may be "manually priced," meaning that the pricing depends upon individualized factors. Please refer to the appropriate provider specific billing manuals, Volume II, to find instructions on submitting manually priced claims. Codes that are manually priced can be identified by a "G-3" in one of the columns on the fee schedule, or by accessing the fee schedule with "manually priced" in the heading. A code noted as G-6 means the code is non-covered.

Forms and instructions, as applicable, may be accessed on the NH MMIS website, same tab, noted above.

19.2 Appendix B ~ Contact Information

Name	Address	Telephone/Fax Number	*Purpose*
Fiscal Agent Claims Submission	NH Medicaid Claims Unit PO Box 2003 Concord NH, 03302-2003	Telephone: 866-291-1674	*Paper claims submissions*
Fiscal Agent Provider Relations Unit	P.O. Box 2059 Concord, NH 03302-2059 Email: nhproviderrelations@conduent.com NH MMIS Health Enterprise Portal web site: www.nhmmis.nh.gov	Telephone: 866-291-1674	*Enrollment & Inquiries*
Automated Voice Response (AVR)		Telephone: 866-291-1674	*Member Eligibility, claims status, RAs*
Medicaid Medical Services Unit	129 Pleasant St Concord, NH 03301 Email: ServiceAuthorizationFFS@DHHS.NH.gov	Telephone: 603-271-9384 Fax: 603-314-8101	*NH Medicaid Service Authorization Unit*
Bureau of Elderly & Adult Services (BEAS) – State Registry		Telephone: 800-852-3345 Ext. 8154	*HCBS –CFI and other Elderly Services*
Adult Protection Central Intake Unit	Email: APSCentralIntake@dhhs.nh.gov	Telephone: 603-271-7014	*Adult Protection Reporting Line*
DHHS Customer Service Center		Telephone: 844-275-3447	*General Customer Service*
Disability Determination Unit (DDU)	129 Pleasant St. Concord, NH 03301 Attn: Disability Determination Unit	Telephone: 800-852-3345 Ext. 4445 Fax: 603-271-4376 Medical Records Fax: 855-347-1326	*Consultative Exams for NH DHHS*
Program Integrity Unit	Thayer Building 97 Pleasant Street Concord, NH 03301 Email: ProgramIntegrity@dhhs.nh.gov	Telephone: 603-271-8029 Fax: 603-271-8113	*Fraud reporting or questions*

Name	Address	Telephone/Fax Number	*Purpose*
ServiceLink	Website: https://www.servicelink.nh.gov/	Telephone: 866-634-9412	*Aging and Disability Resource Centers*
Third Party Liability Unit	Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Telephone:800-852-3345 Ext. 5218	*Coordination of benefits questions*
Administrative Appeals Unit	Main Building 105 Pleasant Street Concord, NH 03301 Email: dhhs.aau@dhhs.nh.gov	Telehone: 800-852-3345 Ext. 4292 Fax: 603-271-8422	*Appeals process questions*
Department District Offices	Refer to this link to find your district office: https://www.dhhs.nh.gov/about-dhhs/locations-facilities		*In-Person Member Services*
Department Rules Website	http://www.gencourt.state.nh.us/rules/about_rules/listagencies.aspx		*NH State Rules Listing*
National Plan and Provider Enumeration System	https://nppes.cms.hhs.gov/	1-800-465-3203	*NPI Registry*

19.3 Appendix C ~ NH AVR Quick Reference Guide

NH MEDICAID PROVIDER RELATIONS AVR QUICK REFERENCE GUIDE

1-866-291-1674 - 24 hours per day/7 days per week
(except scheduled system maintenance hours)

LOG-IN:

1. Enter 1 for NH Medicaid Healthcare Provider
2. Enter 7 digit NH Medicaid provider ID #
3. Enter your 6 digit PIN mailed upon enrollment

Transaction	Required Caller Input
Member Eligibility (Menu option 1)	Medicaid Member ID numbers (11 characters) (If number contains an alpha character, precede alpha character by a star or press 8# for help) Eligibility inquiry dates (to and from)
Claim Status (Menu option 2)	To Inquire by TCN: Enter 17 digit TCN number To inquire without TCN: • Medicaid Member ID number • To/From Service Dates
Remittance Advice (Menu option 3)	None; Remittance Advice search is automatic

Hot Key	Function
9	Return to the Main menu.
0	Transfer to a fiscal agent call center.
#	• When prompted for a "from date of service", the pound key inserts the current date. • When prompted for a "to date of service", the pound key inserts the "from date of service" previously entered by the caller. • The pound key is also used after entering a member ID, to show AVR that the member ID is complete.
8#	For help entering alpha characters in a member ID.

19.4 Appendix D ~ Acronyms

Acronyms included in this section apply to the NH Medicaid Program. The acronyms are global to the Provider Specific Billing Manuals and are included in this manual only.

Acronym	Definition
AAC	Actual Acquisition Cost
AAC	Alternative Augmentative Communication
AAU	Administrative Appeals Unit
ABD	Acquired Brain Disorder
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
ALS	Advanced Life Support
ANB	Aid to the Needy Blind
AMA	American Medical Association
AMDC	Adult Medical Day Care
APC	Ambulatory Patient Classification
APRN	Advanced Practice Registered Nurse
APTD	Aid to the Permanently and Totally Disabled
ARS	Acuity Rate Setting
ASC	Ambulatory Surgical Center
ATN	Application Tracking Number
AVR	Automated Voice Response
AVRS	Automated Voice Response System
BDS	Bureau of Developmental Services
BEAS	Bureau of Elderly and Adult Services
BLS	Basic Life Support
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvements Amendment
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
COS	Category of Service
CPAP	Continuous Positive Airway Pressure
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Practitioner
CSD	Children with Severe Disabilities
CT	Computed Tomography
DBA	Doing Business As
DBH	Division for Behavioral Health
DCSS	Division of Child Support Services
DCYF	Division for Children, Youth and Families
DD	Developmentally Disabled
DDU	Disability Determination Unit
DEA	Drug Enforcement Agency
DESI	Drug Efficacy Study and Implementation
BFA	Bureau of Family Assistance

Acronym	Definition
DHHS	Department of Health and Human Services
DJJS	Division for Juvenile Justice Services
DME	Durable Medical Equipment
DMS	Division of Medicaid Services
DO	Doctor of Osteopathy
DO	District Office
DOB	Date of Birth
DOD	Date of Death
DOS	Date of Service
DPHS	Division of Public Health Service
DRA	Deficit Reduction Act
DRF	Designated Receiving Facility
DPU	Distinct Part Unit
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospital
DSM	Disease State Management
DURS	Drug Utilization Review System
DX	Diagnosis
EAC	Estimated Acquisition Cost
ECC	Enhanced Care Coordination
CFI	Choices for Independence (formerly called ECI)
ECM	Electronic Claims Management
ECS	Electronic Claims Submission
EDI	Electronic Data Interchange
EFADS	Electronic Fraud Abuse Detection System
EFT	Electronic File Transfer
EFT	Electronic Funds Transfer
EKG	Electrocardiogram
E/M	Evaluation and Management
EMAR	Enterprise Management and Administrative Reporting
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERISA	Employee Retirement Income Security Act
ESRD	End State Renal Disease
FA	Fiscal Agent
FAQ(s)	Frequently Asked Question(s)
FDOS	First Date of Service
FDOS	From Date of Service
FEIN	Federal Employer Identification Number
FFP	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year
FIFO	First In First Out
FMAC	Federal Maximum Allowable Cost
FMAP	Federal Medical Assistance Payment or Percentage
FP	Family Planning
FQHC	Federally Qualified Health Center
FS	Fee Schedule
FFS	Fee For Service
FSS	Family Service Specialist
FY	Fiscal Year

Acronym	Definition
FYE	Fiscal Year End
G&C	Governor and Council
GAAP	Generally Accepted Accounting Principles
HBRHC	Hospital Based Rural Health Clinic
HCBS-ABD	Home and Community Based Services for Individuals with Acquired Brain Disorders
HCBS-CSD	Home and Community Based Services for Children with Severe Disabilities
HCBS-DD	Home and Community Based Services for the Developmentally Disabled
HCBS-CFI	Home and Community Based Services - Choices for Independence
HCBS	Home and Community Based Service
HC-CSD	Home Care for Children with Severe Disabilities
HCPCS/CPT	Health Care Common Procedure Coding System / Current Procedural Terminology
HICN	Health Insurance Control Number (Medicare ID number)
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment
HIPPS	Health Insurance Premium Payment System
HMO	Health Maintenance Organization
ICD9-CM	International Classification of Diseases, Volume 9 Clinical Modification
ICD 10	International Classification of Diseases, Volume 10
ICF	Intermediate Care Facility
ICF-IID	Intermediate Care Facility - Individuals with Intellectual Disabilities
ID	Identification Number
IEP	Individual Education Plan
IFSP	Individual Family Support Plan
IMD	Institution for Mental Disease
IME	Indirect Medical Education
IMR	Illness Management and Recovery
IOP	Intensive Outpatient (treatment)
IROS	Individualized Resiliency and Recovery Oriented Services
IRS	Identical Related Similar (Drug)
IRS	Internal Revenue Service
ISO	Individual Service Options
ISP	Individual Service Plan
LDOS	Last Date of Service
LEA	Local Education Agency
LMN	Letter of Medical Necessity
LOC	Level of Care
LOS	Length of Stay
LPN	Licensed Practical Nurse
LTC	Long Term Care
LUPA	Low Utilization Payment Adjustment Rate
M1	Modifier 1
M2	Modifier 2
M3	Modifier 3
M4	Modifier 4
MA	Medical Assistance
MAC	Maximum Allowable Cost
MCCA	Medicare Catastrophic Coverage Act
MCO	Managed Care Organization
MDS	Minimum Data Set
MEAD	Medicaid for Employed Adults with Disabilities
MID	Medicaid Identification Number
MOAD	Medicaid for Employed Older Adults with Disabilities
MMA	Medicare Modernization Act
MMIS	Medicaid Management Information System

Acronym	Definition
MN	Medically Needy
MOU	Memorandum of Understanding
MQIP	Medicaid Quality Incentive Program
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRT	Medical Review Team
MSQ	Medical Service Questionnaire
MSRP	Manufacturer's Suggested Retail Price
MTD	Month to Date
NA	Non Applicable
NABP	National Association Boards of Pharmacy
NADAC	National Average Drug Acquisition Cost
NCCI	National Correct Coding Initiative
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
New HEIGHTS	New Hampshire Empowering Individuals to Get Help Transitioning to Self- Sufficiency
NF	Nursing Facility
NFQA	Nursing Facility Quality Assessment
NH MMIS	New Hampshire Medicaid Management Information System
NMEH	National Medicaid Electronic Data Interchange (EDI) HIPAA workgroup
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NSF	National Standard Format
NUBC	National Uniform Billing Committee
OBRA	Omnibus Budget Reconciliation Act
OCR	Optical Character Recognition
OI	Other Insurance
OIG	Office of Inspector General
OIT	Office of Information Technology
OOS	Out of State
OPPS/APC	Outpatient Prospective Payment System/APC Ambulatory Payment Class
OT	Occupational Therapy
PA	Prior Authorization
PA	Physician Assistant
PBM	Pharmacy Benefits Management
PCCM	Primary Care Case Management
PCP(s)	Primary Care Physician(s)
PD	Paid
PET	Positron Emission Tomography
PHI	Protected Health Information
PIN	Personal Identification Number
PNA	Personal Needs Allowance
PNMI	Private Non-Medical Institution
POA	Present on Admission
POS	Place of Service
POS	Point of Sale
PPS	Prospective Payment System
PRO	Peer Review Organization
PT	Physical Therapist
QA	Quality Assurance
QAP	Quality Assurance Plan
QC	Quality Control
QIO	Quality Improvement Organization

Acronym	Definition
QMB	Qualified Medicare Beneficiary
QMB-Plus	Qualified Medicare Beneficiary that also has NH Medicaid Assistance
RA	Remittance Advice
RBRVS	Resource Based Relative Value Scale
REOMB	Recipient Explanation of Medicaid Benefits
RHC	Rural Health Clinic
RID	Recipient Identification Number
RN	Registered Nurse
RRB	Railroad Retirement Board
RTP	Returned To Provider
RUG	Resource Utilization Group
RVG	Relative Value Guide
RVS	Relative Value System
SA	Service Authorization
SAU	School Administrative Unit
SDX	State Data Exchange (CMS)
SE	Supported Employment
SFY	State Fiscal Year
SFYTD	State Fiscal Year To Date
SLMB	Specified Low Income Medicare Beneficiary
SMAC	State Maximum Allowable Cost
SMM	State Medicaid Manual
SMS	Special Medical Services
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
ST	Speech Therapist
SURS	Surveillance and Utilization Review Sub System
TANF	Temporary Assistance to Needy Families
TCN	Transaction Control Number
TDD/TTY	Telecommunication Device for Deaf/TeleTypewriter
TDOS	Through Date of Service
TDOS	To Date of Service
TOB	Type of Bill
TOS	Type of Service
TPA	Third Party Administrator
TPL	Third Party Liability
TPL A & T	Third Party Liability Accident and Trauma
TPMS	Trading Partner Management System
U&C	Usual and Customary
UR	Utilization Review
WAC	Wholesale Acquisition Cost
WIC	Women, Infants and Children