Choices for Independence (CFI) – Home & Community-Based Care
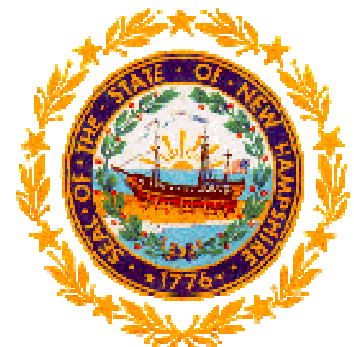
Provider Manual
Volume II

December 1, 2017

New Hampshire Medicaid

Table of Contents

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. This date is also included in the text box located on the left margin where the content change was updated.

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

Sub-Section/Page   Section number(s)/page number(s) to which the change(s) are made. If page change is not applicable "no pagination change" is stated.

Change Description   Description of the change(s).

Reason   A brief explanation for the change(s). If the reason is an administrative rule change, the rule number is added to the column.

Related Communication   References any correspondence that relates to the change (ex: Bulletin, Provider Notice, Control Memo, etc.).

Date Change to Manual	Effective Date	Sub-Section / Page	Change Description	Reason	Related Communication
12/2017	1/1/2018		Rebrand Document	Remove actual name of fiscal agent; change to "fiscal agent"	

1. NH Medicaid Provider Billing Manuals Overview

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

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

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

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

Intended Audience

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

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

Provider Accountability

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

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to providers by the 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.

Notifications & Updates

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

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

Description of Change Log

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

Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit. See the appendix for specific 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.
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2. Provider Participation & Ongoing Responsibilities

The Choices for Independence (CFI) program is a Medicaid Home and Community Based Care (HCBC) waiver program formerly known as the Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI) program. The CFI program serves individuals who are age 18 years or older, financially eligible for Medicaid coverage and clinically eligible for long term care services, and who choose to receive care in their home or another community setting instead of in an institutional setting.

All providers who provide CFI services shall enroll in NH Medicaid as CFI providers. Those CFI providers who will provide state plan services, in addition to CFI services, must enroll again as the appropriate state plan provider type.

Each provider shall report to the BEAS Statewide Registry any individual who is suspected of being abused, neglected, exploited or self-neglecting, in accordance with the Adult Protection Law.

Each service provider shall develop and implement a written care plan that is consistent with the scope, duration, and intent of the comprehensive care plan developed by the member's case manager and the Bureau of Elderly and Adult Services' (BEAS) authorization.

Each service provider shall obtain an automated authorization from BEAS prior to providing services.

Specific requirements for each CFI service provider are as follows.

<u>Adult Family Care</u>
  Adult Family Care providers must:

- Be at least 21 years of age;

- Possess and maintain a NH driver's license and current automobile liability insurance;

- Have personal injury liability insurance for the residence and maintain certificates of insurance on file at the premises;

- Have a written agreement with an oversight agency;

- Receive orientation and training by the oversight agency regarding the program, policies and procedures, as well as training on the member's specific care needs and other aspects related to providing support in the home;

- Provide care in accordance with the member's care plan, the fire safety plan, and the personal safety plan;

- During a planned absence or in the event of an emergency, collaborate with the oversight agency and the member's case manager to arrange for a substitute caregiver in accordance with the member's care plan;

- Allow other service providers into the home to provide medical care and support for the member's other needs if identified in the member's comprehensive care plan;

- Obtain a life safety inspection by the local fire department prior to the commencement of service provision and remain in compliance with the requirements of the life safety inspection as mandated by the local fire department;

- Comply with the oversight agency in obtaining a criminal record check, motor vehicle records check, and BEAS state registry check, per RSA 161-F:49, for all household members age 17 years or older; and

- Not have, and ensure that no one else in the household has had, a felony conviction or a misdemeanor conviction that involves physical or sexual assault, violence or exploitation, theft, or any other conduct that represents evidence of behavior that could endanger the well being of a member.

Adult In-Home Care Services
    Providers of Adult In-Home Care services must be either:
- A Home Health Care provider licensed in accordance with RSA 151:2, and He-P 809, or
- A Home Care Service provider licensed in accordance with RSA 151:2, and He-P 822.

Adult Medical Day Care Services
    Providers of Adult Medical Day services must be an Adult Day Care program licensed in accordance with RSA 151:2 and He-P 818, and comply with the provider requirements of New Hampshire Nursing Home rules, He-E 803.

Environmental Accessibility Adaptation Services
    Providers must:
- Be licensed if the work to be completed requires licensure, such as plumbing or electrical work;

- Be registered with the NH secretary of state to do business in the state of NH;

- Be insured with general liability insurance for person and property for a minimum amount of $50,000; and

- Have submitted documentation to the department's fiscal agent.

Home-Delivered Meals Services
    Providers of home-delivered meals services must:

- Have a current contract with DHHS to provide home-delivered nutrition services to adults;

- Ensure that meals are prepared and delivered in compliance with the comprehensive care plan and with any applicable state or local requirements;

- Provide meals that accommodate diabetic or salt restricted diets, or both, if such are requested by the case manager;

- Provide visual verification that the member is home and that there are no unusual circumstances that may cause someone to suspect harm or potential harm to the member; and

- Report any observations of unusual circumstances to the designated agency supervisor or, in the case of an emergency, call emergency personnel.

Home Health Aide Services

Providers of Home Health Aide services must:

- Be licensed in accordance with RSA 151:2 and He-P 809; and

- Employ licensed nursing assistants (LNAs) licensed in accordance with RSA 326-B and Nur 700 to provide the Home Health Aide service.

Homemaker Agencies

Providers of Homemaker services must be either:

- A Home Health Care provider licensed in accordance with RSA 151:2 and He-P 809; or

- A Home Care Service provider licensed in accordance with RSA 151:2 and He-P 822

Non-Medical Transportation Services

Providers of Non-Medical Transportation must be:

- A Home Health Care provider licensed in accordance with RSA 151:2 and He-P 809;

- A Home Care Service provider licensed in accordance with RSA 151:2 and He-P 822;

- An Other Qualified Agency certified in accordance with RSA 161-I and He-P 601; or

- An agency under contract with BEAS to provide services, which include the provision of transportation, funded by the Older Americans' Act or the Social Services Block Grant; and

- Use vehicles for providing non-medical transportation services that have a current inspection sticker.

Drivers providing non-medical transportation services must:

- Have a current and valid driver's license;

- Provide documentation of having car insurance that:

    a. Includes uninsured motorist coverage; and

    b. Is for a minimum of $100,000 per passenger per occurrence and $300,000 per occurrence; and

- Be 18 years of age or older.

Personal Care Services

Providers of Personal Care Services must be:

- Licensed as a Home Health Care provider in accordance with RSA 151:2 and He-P 809;

- Licensed as a Home Care Service provider in accordance with RSA 151:2 and He-P 822; or

- Certified as an Other Qualified Agency in accordance with RSA 161-I and He-P 601.

Residential Care Facility Services

Providers of Residential Care services must be facilities licensed in accordance with RSA 151:2 and either He-P 804 (Assisted Living Residence - Residential Care Licensing) or He-P 805 (Assisted Living Residence – Supported Residential Health Care Licensing).

Respite Care

Respite Care services may be provided either in the member's home or in a licensed facility.

Providers of Respite Care services in a facility must be licensed as either:

- A Medicaid-enrolled nursing facility, in accordance with RSA 151:2 and He-P 803 (New Hampshire Nursing Home Rules);

- A Medicaid-enrolled residential care facility in accordance with RSA 151:2 and He-P 804 (Assisted Living Residence - Residential Care Licensing) or He-P 805 (Assisted Living Residence – Supported Residential Health Care Licensing).

Providers of Respite Care services in a member's home must be:

- A licensed Home Health Care provider in accordance with RSA 151:2 and He-P 809;

- A licensed Home Care Service provider in accordance with RSA 151:2 and He-P 822; or

- Certified as an Other Qualified Agency in accordance with RSA 161-I and He-P 601

Skilled Nursing Services

      Providers of Skilled Nursing services must be licensed to provide Home Health Care services in accordance with RSA 151:2 and He-P 809, and must employ registered nurses (RNs) or licensed practical nurses (LPNs) to provide services.

Supportive Housing Services

      Providers of Supportive Housing Services must be Home Health Care providers licensed in accordance with RSA 151:2 and He-P 809. This service is provided to members who live in federally subsidized individual apartments.

3. Covered Services & Requirements

Covered services must be provided as specified in the member's comprehensive care plan established by the member's case manager; provided in accordance with the service descriptions in He-E 801, and must be authorized by BEAS.

CFI services are as follows:

- Adult family care services;

- Adult in-home care services;

- Adult medical day services;

- Environmental accessibility adaptations;

- Home-delivered meals services;

- Home health aide services;

- Homemaker services;

- Non-medical transportation services;

- Personal care services;

- Personal emergency response system services;

- Residential care service;

- Respite services;

- Skilled nursing services;

- Specialized medical equipment services; and

- Supportive housing services.

Adult Family Care Services
    Covered services include the services required by He-P 813.

Adult In-Home Care Services
    Covered services are as follows:

- Laundering the member's personal clothing items, towels, and bedding;

- Light cleaning limited to the member's bedroom, bathroom, and mobility and medical devices;

- Preparing non-communal meals and snacks, unless for multiple CFI members, including cleaning the food preparation area after the food is served;

- Hands-on assistance with activities of daily living or cuing a member to perform a task; and

- Medication administration as allowed in He-P 809 and He-P 822.

Adult Medical Day Services

Covered adult medical day services shall be those services that are provided in accordance with He-E 803, except that the requirement contained in He-E 803, which requires attendance for a minimum of 4 hours in a day, shall not apply.

Environmental Accessibility Adaptations

Environmental accessibility adaptations (EAA) services are covered when:

- A NH Medicaid-enrolled licensed practitioner or physical or occupational therapist has determined the need for one or more of the environmental accessibility adaptations noted below;

- The member's case manager has requested a service authorization for the service in accordance with the "Service Authorization" section of this manual;

- BEAS has authorized the service in accordance with the "Service Authorization" section of this manual; and

- The service is completed by a provider or contractor enrolled in the CFI program.

The following environmental accessibility adaptations shall be covered when authorized:

- Installation of ramps;

- Installation of grab bars;

- Widening of doorways to accommodate the member's wheelchair or other mobility access equipment; and

- Other adaptations authorized by BEAS that are necessary for the health and safety of a member that are not otherwise covered under the Medicaid State Plan.

Home Delivered Meals

Covered home-delivered meals services include the following:

- The delivery of nutritionally balanced meals to the member's home; and

- The monitoring of the member and the reporting of emergencies, crises, or potentially harmful situations to emergency personnel or the member's case manager, as appropriate.

To be covered, home-delivered meals must be nutritionally balanced and contain at least one-third of the current Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

Home Health Aide Services

Covered home health aide services are as follows:

- Those services allowed within the LNA scope of practice, pursuant to Nur 700; and

- Personal care services, as described in He-E 801, when the member's care plan contains documentation that his or her medical condition necessitates the performance of such tasks by an LNA and not an unlicensed provider.

Homemaker Services

Covered homemaker services are limited to the following non-hands-on general household services:

- Laundering the member's personal clothing items, towels, and bedding;

- Light cleaning limited to the member's bedroom, bathroom, and mobility and medical devices;

- When the member lives alone, light cleaning of the kitchen and entryway areas, in order to maintain a safe environment;

- Errands for necessary tasks identified in the comprehensive care plan; and

- Preparation of non-communal meals and snacks, unless for multiple CFI members, including cleaning the food preparation area after the food is served.

Non-Medical Transportation

Non-Medical transportation is covered when it is authorized by BEAS to access a waiver service or other destination to implement the member's comprehensive care plan; and shall include transportation to and from the authorized destination.

Personal Care Services

Covered personal care services shall include the following services:

- Hands-on assistance with the activities of daily living or cuing a member to perform a task;

- Assisting the member with eating, as specified in the care plan;

- Under the direction of the member, assistance with self-administration of oral or topical medication as prescribed, to include;

  1. Reminding the member regarding the timing and dosage of the medication, and to take his or her medication as written on the medication container;

  2. Placing the medication container within reach of the member;

  3. Assisting the member with opening the medication container;

  4. Assisting the member by steadying shaking hands; and

  5. Observing the member take the medication and recording the same in the member's record;

- Accompanying the member when:

  1. The assistance of the personal care worker is required for the member to access necessary services that are documented in the comprehensive care plan; and

  2. The need for re-direction or direct assistance, or both is documented in the clinical assessment or, if the member needs oxygen or other equipment during the course of

the trip that he or she cannot manage independently, is documented in the comprehensive care plan;

- When non-medical transportation services are authorized, hands-on assistance at the authorized destination when the comprehensive care plan documents that this assistance is required at the destination; and

- General household tasks, limited to the following:

    1. Laundering the member's clothing items, towels, and bedding;

    2. Light cleaning limited to the member's bedroom, bathroom, and mobility and medical devices;

    3. When the member lives alone, light cleaning of the kitchen and entryway areas, in order to maintain a safe environment;

    4. Errands for necessary tasks identified in the comprehensive care plan; and

    5. Preparing non-communal meals and snacks, unless for multiple CFI members, including cleaning the food preparation area after the food is served.

Personal care services shall not be covered for the purpose of transportation.

Personal Emergency Response System Services

Personal emergency response systems are communication services that provide socially isolated members with 24-hour direct access to a medical control center through an electronic device that allows the member to alert the control center in the case of an emergency.

Personal emergency response systems shall be a covered service for members who:
- Live alone, live only with someone in poor or failing health, or who are alone at home for greater than 4 hours each day;
- Are one of the following:
    1. Are ambulatory and have been identified as being at risk of falls after an assessment of fall risk by a registered nurse or occupational or physical therapist; or
    2. Have been identified as being at risk of having a medical emergency in the clinical eligibility determination or by a primary care practitioner, registered nurse, or occupational therapist; and
- Would require ongoing supervision if the personal emergency response system were not provided.

Residential Care Services

The following services are included in the payment for residential care services:
- Those services described in He-P 804 or He-P 805;
- Twenty-four hour per day supervision; and
- Transportation to medical services except when a course of prescribed treatment requires any of the following:
    1. Emergency Transportation;
    2. Transportation more than once per week; or

3. Transportation to a treatment location that is a greater distance from the facility than the member's primary care physician.

Respite Care Services

Respite care services are services provided by an allowed provider for the short-term relief of the member's family or other unpaid caregiver.

Skilled Nursing Services

Skilled nursing services shall be covered for the provision of chronic long-term care and not short-term or intermittent care.

Specialized Medical Equipment Services

Covered specialized medical equipment services are limited to the following items:

- Raised toilet seats;

- Shower/tub seats and benches;

- Tub lifts;

- Transfer benches;

- Bedside commodes;

- Dressing aids and grabbers;

- Non-slip grippers to pick up and reach items;

- Adaptive utensils;

- Transport wheelchairs;

- Wheelchair cushions;

- Walkers;

- Hoyer lifts;

- Slings;

- Semi-electric beds;

- Bed rails;

- Mattress overlay pads; and

- Seat lifts, including the chair, or seat lift mechanisms when the following criteria are met:

> 1. Member has a severe condition that causes the member to require assistance to come to a standing position; and

> 2. Member is completely incapable of standing up from a regular armchair or any chair in their home; and

> 3. The member's attending physician, or a consulting physician treating the member for the disease or condition resulting in the need for a seat lift, documents that the seat lift mechanism is a part of the physician's course of

treatment to provide support for a condition that is not likely to improve and that may worsen.

- Medication dispensing devices, including training on their use, when the following conditions are met:

    1. The member or caregiver is able to use the device;

    2. The member does not live in a licensed facility, except that BEAS may authorize sealed medication packets for a member in a licensed facility based on a request made by the member's case manager;

    3. When the use of this service is documented to either replace another service of equal or greater cost or avoid the addition of another service; and

    4. The type of medication dispensing device is determined by the BEAS nurse to be the least costly device that is appropriate for the member.

Supportive Housing Services

The following supportive housing services are included in the per diem payment:

- Personal care services, as described in He-E 801.22;

- Assistance with the following activities;

    1. Making telephone calls; and

    2. Obtaining and keeping appointments;

- Home health aide services;

- Homemaker services, as described in He-E 801;

- Personal emergency services, and

- Medication reminders and other supportive activities as specified in the comprehensive care plan or which promote and support health and wellness, dignity and autonomy within a community setting.

Service Limits

The following limits apply to CFI services:

- Authorizations: Covered CFI services are limited to those that are authorized by BEAS.

- Lifetime maximum coverage: Coverage of Environmental Accessibility Adaptations and Specialized Medical Equipment services is limited to separate lifetime maximums of $15,000 per member per lifetime. The limit is applied to each service independently of the other.

Respite care services are limited as follows:

- Respite is provided to the member on a short-term basis because of the temporary absence or need for relief of those persons normally providing that member's care.

- Respite services are limited to a maximum number of units not to exceed twenty 24-hour days per state fiscal year (July 1 through June 30).

4. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

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

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.

No service or item shall be covered though the CFI program if the service or item:

- Is covered through any other program or third party payer such as NH Medicaid, managed care programs, other waiver programs, Medicare or any other insurance, and the member is eligible for such programs or insurances.

- Is provided as a component of any other covered service;

- Duplicates another service being provided to the member;

- Addresses needs being met by another paid or unpaid service;

- Is provided by a legally responsible relative;

- Is primarily for the purpose of recreation; or

- Is not authorized by BEAS.

Room and Board: With the exception of respite care provided in an intermediate care facility or residential care facility, payment for CFI services shall exclude room and board.

Adult In-Home Care Services are not covered when:

- For the purposes of food preparation for meals and snacks provided to both the member and non-members; or

- When provided to a member receiving residential care services.

Adult Medical Day Services are not a covered service when provided:

- For non-medical reasons;

- To a member receiving residential care services.

Environmental Accessibility Adaptations: The following environmental accessibility adaptations shall not be covered:

- Improvements that are of general utility and do not have direct or medical remedial benefit to the member;

- Adaptations which add to the square footage of the home;

- Purchase of or modifications to a motor vehicle;

- Electrical or plumbing work that is beyond what is required to support the authorized adaptation;

- Electrical or plumbing work for which the proposed provider or contractor is unable to state, in writing, that the proposed adaptation can be done within the current electrical or plumbing capacity of the home; and

- Adaptations to a residential care facility or other licensed facility, except for adaptations in an adult family care home when approved for a specific member.

Home Delivered Meals services are not covered when the meal is provided at an adult medical day program, at a residential care facility, or at a congregate meal site.

Home Health Aide Services are not covered separately when provided at an adult medical day program or at a residential care facility.

Homemaker Services are not covered:
- For the purposes of food preparation for meals and snacks that include both the member and non-members; or

- Separately when provided at a residential care facility.

Non-Medical Transportation Services are not covered for the following purposes:
- Assistance with tasks at the destination;

- Transportation to or from medical appointments or services; and

- Transportation provided to a member receiving residential care or adult family care services.

Personal Care Services are not covered:
- For the purpose of transportation;

- For the purposes of food preparation for meals and snacks provided to both the member and non-members;

- When provided in any of the following settings:
  1. A residential care facility;
  2. A hospital;
  3. A nursing facility;
  4. A rehabilitation facility;
  5. An adult family care home; and

6. An adult medical day program; and

- When provided by any of the following individuals:

    1. The member's personal care services representative;

    2. The member's designated power of attorney, regardless of whether the power of attorney has been activated; or

    3. The member's legal guardian.

Personal Emergency Response Systems are not covered separately when provided to a member receiving residential care services or adult family care services.

Skilled Nursing Services shall not be covered when provided:

- On the same day that the member attends an adult medical day program if the identified need is within the scope of what would normally be provided by the program;

- For the purpose of nursing oversight of authorized LNA services; or

- At a residential care facility.

5. Service Authorizations (SA)

Service Authorizations (SA), also referred to as Prior Authorizations (PA), is an advanced request for authorization of payment for a specific item or service.

CFI services are covered only as authorized by BEAS, based on the needs identified in the clinical assessment completed by an RN, and the comprehensive care planning process completed with the member by the case manager. Providers receive automated notifications of service authorization through either the Options Information System or the Medicaid Management Information System (MMIS).

A service authorization (SA) does not guarantee payment. Providers must verify the following before providing a service.

- The member is eligible on the date(s) of service;

- The performing and billing NH Medicaid providers are actively enrolled providers on the date(s) of service; and

- The HCFA Common Procedure Coding System (HCPC) or Current Procedural Terminology (CPT) procedure code(s) and billing modifier(s) are active codes and valid combinations for billing under the NH Medicaid.

Authorizations for Environmental Accessibility Adaptations (EAA)

The member's case manager shall complete and submit the following when requesting service authorization for an EAA:

- A completed Form 3715, "Choices for Independence Prior Authorization Request Form" which is obtained from BEAS;

- A copy of the evaluation that describes:

    1. The medical or functional need for the adaptation;

    2. The description and measurements required for the adaptation; and

    3. The proposed training plan for the member and caregiver to ensure safe use of the adaptation;

- Proposals from at least two registered providers or contractors, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the project:

    1. A list of supplies and materials;

    2. Blueprints or scaled drawings;

    3. The name(s) of an subcontractors that will be involved;

    4. Written confirmation of whether or not a building permit is required;

5. If electrical or plumbing work is required to support the adaptation, then:

   a) A statement signed by the provider or contractor stating that the requested adaptation can be done within the current electrical or plumbing capacity of the residence; and

   b) A copy of the electrician or plumber's license;

6. A statement signed by the member or contractor affirming knowledge of all applicable building codes and permitting requirements and affirming that any subcontractors involved in the work are appropriately licensed; and

7. An agreement signed by the member or contractor stating that reimbursement for the authorized service through CFI will be payment in full;

- If a member prefers one bid over the other(s), then an explanation of the preference shall be submitted; and

- A notarized written statement from the property owner granting permission to complete the project if the member is not the owner of the residence.

Authorizations for Specialized Medical Equipment:

The member's case manager shall submit the following when requesting Service Authorization for specialized medical equipment:

- A completed Form 3715, "Choices for Independence Prior Authorization Request Form";

- A copy of the evaluation that describes:

  1. The medical or functional need for the equipment;

  2. The description and any measurements required for the equipment; and

  3. The proposed training plan for the member and caregiver to ensure safe use of the equipment;

- Proposals from at least two enrolled providers, except that one proposal may be submitted with a written explanation of why only one proposal is available or appropriate, including the following, as applicable to the equipment:

  1. A list of supplies and materials; and

  2. A description, including measurements, of the equipment; and

- If a member prefers one bid over the other(s), then an explanation of the preference.

6. Documentation

Care Plan

With the exceptions of EAA; home-delivered meals services; non-medical transportation services; personal emergency response system services and specialized medical equipment services, each participating provider, shall develop, maintain, and implement a written care plan as follows:

- The care plan shall be developed in consultation with the member and the member's legal representative, if any;

- The provider shall communicate with the member's case manager in order to ensure the care plan is consistent with, and addresses the applicable service needs identified in, the comprehensive care plan;

- The care plan shall contain, at a minimum:

  1. A description of the member's needs and the scope of services to be provided;

  2. The dates upon which services will begin and end;

  3. The frequency of the services;

  4. The total number of service units authorized and the number that will be provided on each date of service;

  5. Information on the member's health condition, medications, allergies, and special dietary needs as it relates to the provision of the service; and

  6. The anticipated goals and outcomes of service provision;

- The care plan shall be updated at least annually and as necessary; and

- The provider shall communicate the elements of the care plan to the member's case manager, upon the completion or revision of the plan, and document the date it was communicated.

Providers of the following services shall not be required to develop a care plan:

- Environmental accessibility adaptations;

- Home-delivered meals services;

- Non-medical transportation services;

- Personal emergency response system services; and

- Specialized medical equipment services.

Documentation

Each participating provider shall:

- Maintain documentation in accordance with applicable licensure, certification or other requirements;

- Maintain any other supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement in accordance with He-W 520. Also, please see the "Record Keeping" section of the General Billing Manual – Volume I, for documentation requirements;

- Maintain documentation in their records to fully support each claim billed for services including the specific service provided, the number of service units provided, the name of the employee who provided the service, and the date and time of service provision, as applicable; and

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

All Services:

Service documentation must include the following, at a minimum:

- The member's name;

- The date(s) of service delivery;

- The type(s) of service(s) delivered;

- The total amount of time in which service was delivered;

- An evaluation, which shall include information on the member's progress and the outcome of service provision; and

- The name of the member's caregiver.

Personal Care Services

In addition to requirements above, documentation of personal care services shall include verification of the personal care services worker's time, including, when paper time sheets are used, the signature of the member or PCS representative indicating that the service was provided in accordance with the care plan and to the member's satisfaction.

Home-Delivered Meals Services

Home-delivered Meals Services shall document service provision by recording the member's name and the dates that services are provided.

Nursing Services

Nursing Services shall be documented by the service provider in written progress notes that include, but are not limited to:

- The member's name;

- The date(s) of service delivery;

- The type(s) of service (s) delivered;

- The total amount of time in which service was delivered;

- An evaluation, which shall include information on the member's progress and the outcome of service provision; and

- The name of the member's caregiver.

Respite Care

Respite Care providers shall document the services provided in written progress notes that include, but are not limited to, the member's name, the date(s) of service delivery, the type(s) of service (s) delivered, the total amount of time in which service was delivered, an evaluation, including information on the member's progress and the outcome of service provision, and the name of the member's caregiver.

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

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Program Integrity Unit is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse. These utilization review activities are required and carried out in accordance with Federal regulations at 42 CFR 455 and 42 CFR 456, and they are done to ensure that accurate and proper reimbursement has been made for care, services and/or supplies that have been provided to a member, and for which a provider has received payment. The department shall also monitor utilization of CFI services in accordance with He-W 520 and He-E 801

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

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

- Recovery of erroneous and improper provider payments;

- Provider education regarding appropriate documentation to support the submission and payment of claims;

- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid Program;

- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG);

- Potential termination from the NH Medicaid Program; 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.

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

8. Adverse Actions

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

9. Medicare/Third Party Coverage

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

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

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

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

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

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

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

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

10. Payment Policies

All third party obligations shall be exhausted before NH Medicaid may be billed.

If third party liability exists, and the provider is not enrolled with the third party in a manner that allows the provider to submit a claim for service, the provider shall not bill Medicaid or the member for the service provided.

Reimbursement to providers of CFI services shall be made in accordance with rates established by BEAS. Reimbursement for CFI services shall be made only for those services which have been authorized by BEAS, and which are included in the comprehensive care plan developed with the member and the CFI case manager.

11. Claims

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

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

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

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

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

- Claims submission via EDI, web portal, paper;

- Claims processing – edits & audits, transaction control numbers, line item vs. header processing, claim status, remark/EOB codes;

- Claim resubmission;

- Claim adjustments and voids;

- Medicare cross-overs;

- Claims payment; and

- Remittance advice.

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

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

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

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

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

Timely Filing

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

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

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

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

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 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.

Service Authorizations (SAs)

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

Required Claim Attachments

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

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

Claim Attachments		
		Add Attachment
Type Attachment ▼	Delivery Method ▲▼	Attachment Control # ▲▼
No Data		

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

- **Please mail claim attachments to:**
  NH Medicaid Claims Unit
  PO Box 2003
  Concord, NH 03302

- **Please fax claim attachments to:**
  (888) 495-8169

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

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

Claim Completions Requirements for CFI

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

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

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

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

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

Paper claims and other documents can be mailed to:

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

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

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

The format is: YYDDD M BBBB NNNNNN T, where

- • YYDDD is the Julian date when the batch was created.

- M is the media source, such as 1-web, 2-Elec Xover, 3-EMC, 4-System Generated, 5-Encounter, 7-OCR and 8-Paper.
- BBBB is the batch number.
- NNNNNN is the document number.
- T is the transaction type.

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

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

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

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

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

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

CMS-1500 Claim Form Instructions for CFI Providers

Item #	Description	Instructions
1		**Required**-Indicate NH Medicaid coverage by placing an X in the appropriate box. Only one box can be marked.
1A	Insured's ID Number	**Required** - Enter the NH Medicaid ID number (11 characters) shown on the ID card.
2	Patient's Name	**Required -** Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
3	Patient's Birth Date, Sex	**Required-**Enter the patient's 8-digit birth date (MM | DD | YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave blank.
4	Insured's Name	**Optional-** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Item #	Description	Instructions
5	Patient's Address (Multiple Fields)	**Optional-** Enter the patient's permanent residence address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. A temporary address or school address should not be used.
6	Patient Relationship to Insured	**N/A**
7	Insured's Address (multiple fields)	**Situational -**Enter the insured's address. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.
8	Reserved for NUCC Use	**N/A-** This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.
9	Other Insured's Name	**Situational -**If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
9A	Other Insured's Policy or Group Number	**Situational** – The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9. This field allows for the entry of 28 characters, alpha or numeric
9B	Reserved for NUCC Use	**N/A** -This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.
9C.	Reserved for NUCC Use	**N/A** -This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.
9D	Insurance Plan Name or Program Name	**Required -** If other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code Codes can be located on the NH MMIS Health Enterprise Portal under documents section This field allows for the entry of 28 characters.

Item #	Description	Instructions
10A-C	Is Patient's Condition Related To?	**Required-**When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.
10D	Claim Codes (Designated by NUCC)	**N/A** -When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes.
11	Insured's Policy, Group or FECA Number	**Situational** - Enter the insured's policy or group number as it appears on the insured's NH Medicaid identification card. If Item Number 4 is completed, then this field should be completed.
11A	Insured's Date of Birth, Sex	**Optional -**Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.
11B	Other Claim ID (Designated by NUCC)	**N/A**
11C	Insurance Plan or Program Name	**N/A**
11D.	Is There Another Health Benefit Plan?	**Situational-** Enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.
12	Patient's or Authorized Person's Signature	**N/A**
13	Insured's or Authorized Person's Signature	**N/A**

Item #	Description	Instructions
14	Date of Current Illness, Injury, Pregnancy	**Situational –** Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line**.**
15	Other Date	**Situational-**Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM│DD│YY) or 8-digit (MM│DD│YYYY) format. Enter the applicable qualifier to identify which date is being reported. 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines.
16	Dates Patient Unable to Work in Current Occupation	**Optional-**If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Item #	Description	Instructions
17	Name of Referring Provider or Other Source	**Situational –** Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Enter the applicable qualifier to identify which provider is being reported. DN Referring Provider DK Ordering Provider DQ Supervising Provider Enter the qualifier to the left of the vertical, dotted line**.**
17A.	Other ID #	**Situational –** The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.).
17B	NPI Number	**Situational –** Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b**.**
18	Hospitalization Dates Related to Current Services	**Optional -**Enter the inpatient 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization**.**
19	Additional Claim Information (Designated by NUCC)	**Situational-**Please refer to the most current instructions from the public or private payer regarding the use of this field. NH Medicaid-Used for providers to communicate information particular to this claim, not a duplicate or not covered by other insurance and why.

Item #	Description	Instructions
20	Outside Lab? $ Charges	**Optional -**Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim**.**
21	Diagnoses or Nature of Illness or Injury	**Required -** Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the l
22	Resubmission and/or Original Reference Number	**Optional-**List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field (e.g., code). When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. 7 Replacement of prior claim 8 Void/cancel of prior claim This Item Number is not intended for use for original claim submissions**.**
23	Prior Authorization Number (Service Authorization)	****Not being used at this time**** **Situational-** Enter any of the following: prior authorization number, as assigned by the payer for the current service. The "Prior Authorization Number" is the payer assigned number authorizing service(s)

Item #	Description	Instructions
24A	Date(s) of Service (lines 1–6)	**Required -** Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. The number of days must correspond to the number of units in 24G. Date(s) of Service" indicates the actual month, day, and year the service(s) was provided.
24A	Shaded Area Supplemental Information	**Situational-**Enter the National Drug Codes (NDC), for J, Q and S drug procedure codes. The NDC Qualifier N4 should be entered in the first two positions, then the 11 digit NDC code without dashes or spaces. The NDC units of measure qualifier and NDC drug quantity should follow. The following qualifiers are to be used when reporting NDC unit/basis of measurement: F2 International Unit ME Milligram UN Unit GR Gram ML Milliliter
24B	Place of Service lines(1–6)	**Required -** In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The "Place of Service" Code identifies the location where the service was rendered. The Place of Service Codes are available at: www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf.
24C	EMG (lines 1–6)	**N/A**
24D	Procedures, Services or Supplies (Lines 1-6)	**Required-**Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description.

Item #	Description	Instructions
24E	Diagnosis Pointer (Lines 1-6)	**Required** - In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. This field allows for the entry of 4 characters in the unshaded area
24F	$ Charges (Lines 1-6)	**Required -** Enter the charge for each listed service. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. "Charges" is the total billed amount for each service line**.**
24G	Days or Units (Lines 1-6)	**Required -** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers left justified in the field. No leading zeroes are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management"). "Days or Units" is the number of days corresponding to the dates entered in 24A

Item #	Description	Instructions
24H.	EPSDT/Family Plan (Lines 1-6)	**Situational-**For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only. If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is right justified in the shaded area of the field. The following codes for EPSDT are used in 5010A1: AV- Available – Not Used (Patient refused referral.) S2- Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) ST- New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) NU- Not Used (Used when no EPSDT patient referral was given.) If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field.

Item #	Description	Instructions
24I	ID Qualifier (Lines 1-6)	**Required-**Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.) The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24J.	Rendering Provider ID Number (Lines 1-6)	**Required-**The individual rendering the service should be reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care.
25	Federal Tax ID Number	**Optional-**Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. Do not enter hyphens with numbers. Enter numbers left justified in the field.

Item #	Description	Instructions
26	Patient's Account Number	**Optional-**Enter patient account number. Do not enter hyphens with numbers. Enter numbers left justified in the field.
27	Accept Assignment?	**Required-** Enter an X in the correct box. Only one box can be marked. Report "Accept Assignment?" for all payers. The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	**Required –** Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. The "Total Charge" is the total billed amount for all services entered in 24F (lines 1–6).
29	Amount Paid	**Required-** Enter total amount the patient and/or other payers paid on the covered services only. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. The "Amount Paid" is the payment received from the patient or other payers**.**
30	Reserved for NUCC Use	**N/A -**This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated**.**
31	Signature of Physician or Supplier Including Degrees or Credentials	**Required –** "Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1. Enter the legal signature of the practitioner or supplier, or signature stamp Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY) the form was signed. This date must be on or after the last date of service on the claim. The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title.

Item #	Description	Instructions
32	Service Facility Location Information	**Situational-**The name and address of facility where services were rendered identifies the site where service(s) were provided. Enter the name, address, city, state, and ZIP code of the location where the services were rendered. NH Medicaid utilizes this information to assist with the NPI crosswalk**.**
32A	NPI #	**Situational -**Enter the NPI number of the service facility location in 32a. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.
32B	Other ID#	**Optional-** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number LU Location Number The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

Item #	Description	Instructions
33	Billing Provider Info & Ph #	**Required –** Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP Code Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code, including the hyphen. Do not use a hyphen or space as a separator within the telephone number. 5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here. The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.
33A.	NPI#	**Required** - Enter the NPI number of the billing provider in 33A. Not required for Atypical providers.

Item #	Description	Instructions
33B	Other ID#	**Required –** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.) The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field. The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional.