



NEW HAMPSHIRE MEDICAID BULLETIN

This publication is an important link between your office and the New Hampshire Medicaid (Title XIX) Program, and should be read by all medical and administrative staff within your organization. We recommend that all issues of the newsletter be maintained with your Medicaid Billing Manual to be used as a handy reference of provider requirements related to NH Medicaid (Title XIX) policy and billing matters.

TITLE XIX BULLETIN	VOLUME IX	ISSUE IV	DECEMBER 2002
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***** ALL PROVIDERS *****

Is there an article you would like to see in this publication? If so, please send your suggestions, on your company letterhead, to: EDS, 7 Eagle Square, Concord, NH 03301, attn: Michelle Dodge. Our staff will research your suggestion for the article, and possibly publish your requested article. Thanks for helping us help you!

EDS HOLIDAYS

EDS holidays for the first half of 2003:

Martin Luther King Jr. Civil Rights Day	Monday	January 20, 2003
Presidents' Day	Monday	February 17, 2003
Memorial Day	Monday	May 26, 2003

CLAIMS PROCESSING TIPS

All **paper claims** are imaged as the first step in claim processing and payment. You can **prevent delays** to your anticipated payment date by following these tips:

- **DON'T FAX claims.** Faxed claims are too light and unclear to be imaged.
- **DON'T use highlighters** on any claim form(s) or adjustment(s). Highlighted areas show up as black lines, just as they do when highlighted forms are photocopied.
- **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.
- **DO** use only **blue or black ink** on **ALL** claims or adjustments that you submit to EDS. The EDS imaging system reads only **blue or black ink**.
- **DO** make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
- **DO** call the Communications Unit at 1-800-423-8303 (NH and VT only) or (603) 224-1747 if you have questions.

HINTS AND TIPS

Timely Filing - All claims must be submitted to EDS within one year of the date of service. Claims that are beyond the one-year filing limit, but have previously been submitted and denied, must be resubmitted on paper. This resubmission must be received within 15 months of the date of service. Please refer to the June, 2002 Edition of the NH Medicaid Bulletin for detailed information and process requirements.

EDS MAILING ADDRESSES

The address for paper claims submission is:

EDS Claims Processing
PO Box 2001
Concord, NH 03302-2001

The address for written correspondence/claims status inquiries is:

EDS Provider Services
PO Box 2040
Concord, NH 03302-2040

NOTE: Please allow 4-6 weeks processing time before checking on the status of a claim.

In order for EDS to process your claim request in a timely manner, please include your **Provider Name and Provider Number** on **ALL** correspondence. If checking on the status of a claim, please attach a copy of the claim so that we may resubmit the claim if it is not already on file.

OPTICAL CHARACTER RECOGNITION (OCR) PAPER CLAIMS SCANNING PROCESS

Information regarding the move to using OCR, which begins in July of 2003, was provided to you in the September 2002 edition of the NH Medicaid Bulletin. In order to take full advantage of the OCR process, some providers may need to modify the way they submit paper claims. Accuracy, completeness and clarity will be extremely important. Forms will not be processed if applicable information is not supplied or is illegible.

To ensure that forms are scanned and processed efficiently, please adhere to the following instructions:

Handwritten forms:

- ◆ Should be printed neatly and accurately using black ball point pen **only**
- ◆ Use capital letters whenever possible, for clarity and accuracy
- ◆ Handwritten data increases the likelihood that the OCR process will fail

Typed forms:

- ◆ Use capital letters whenever possible, for clarity and accuracy
- ◆ Use 10 point font or larger (not to exceed the size of the field)
- ◆ Do not use script or italic font
- ◆ Typed or computer generated data on the claim form is most accurately OCR'd

General:

- ◆ Forms must be original red background (dental claim forms are the only exception)
- ◆ No copies will be accepted - photocopy or fax

Because the OCR process pulls claims data directly from the claim form, it is essential that claims be filled out according to the OCR standards.

Throughout the coming months, EDS will keep you updated as to our progress and provide you with information as it pertains to changes in claims submission requirements.

If you have any questions or concerns about the implementation of OCR, please contact Michelle Dodge at (603) 225-4899, ext. 3041.

BROKEN OR MISSED APPOINTMENTS

Please note that broken or missed appointments may **not** be billed to NH Title XIX. NH Title XIX recipients **also** may **not** be billed for broken or missed appointments.

Some providers have been interpreting the inclusion of broken appointments on the non-covered services list to mean that recipients may be billed, as is the case with actual non-covered services. Broken or missed appointments were included on the non-covered services list for the purpose of making it clear to providers that the broken or missed appointments are **not** NH Title XIX reimbursable. However, providers may not impose those charges on NH Title XIX recipients. Broken or missed appointments are not, per federal regulations, a distinct, reimbursable medical service, but are a part of the cost of doing business.

This clarification is in line with Regional Bulletin 99-06 issued by the Centers for Medicare and Medicaid Services (CMS).

Broken or missed appointments are being removed from non-covered services lists as the affected sections of the NH Administrative Rules, NH Title XIX Billing Manuals, and NH Title XIX forms are revised.

If you have additional questions regarding broken or missed appointments, please contact the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION

This is to remind you that Durable Medical Equipment (DME) requires authorization in advance of the services being provided when there is intent to bill NH Title XIX. Effective immediately, the NH Medicaid DME Prior Authorization Unit will begin strict enforcement of the rule requirement at He-W 520.04(c) that authorization be requested prior to service delivery. In cases where service needs to be provided over a weekend or on a legal holiday, the request must be submitted on the next business day.

Requests for prior authorization of all DME must include the following:

- Durable Medical Equipment (DME) Prior Authorization Request Form (Form 272 D): This form should be used for all DME prior authorization requests. Please include the appropriate HCPC procedure codes obtained from the most current HCPCS Level II code assignment book for the equipment and any accessories or requested options. The form should also state the provider acquisition cost for each item.

Requests for custom wheelchairs, strollers, and other mobility equipment should also include the following in order for NH Title XIX to more efficiently review and process your PA request:

- Mobility Evaluation Form (Form 272M): All sections must be completed, including a description of less costly chairs that were considered and why those chairs were ruled out. The client, vendor, and evaluating therapist must sign the form in the spaces provided.
- Medicare's Certificate of Medical Necessity: This should be completed and signed by the recipient's attending physician.
- Manufacturer's Itemized Order Form: This form should list options requested and the Manufacturer's Suggested Retail Price (MSRP) of those options.

Please note the following:

- No allowances for labor will be included in any authorizations for the purchase of new DME.
- Options/accessories may be considered as reimbursable if they provide proper seating alignment and support.
 - Options such as lights, baskets, “necessity” bags, backpacks, seat elevators, environmental controls, wheelchairs designed for sports or off-road use, options to assist in climbing grades or stairs, titanium frames, canopies, crutch holders, and other non-medical items are not covered, and will not be included in any reimbursement provided.
 - Trays for wheelchairs will only be provided if it is clearly documented that the recipient requires the tray as a means to provide support not otherwise obtained by vests or other devices, or if necessary to access a NH Title XIX approved, or approvable, Augmentative, Assistive Communication device. If a tray is provided to create a work surface, the tray is not considered a medical necessity.

Copies of Form 272D, “Durable Medical Equipment (DME) Prior Authorization Request Form,” and Form 272M, “Mobility Evaluation Form,” are included at the end of this notice. You are welcome to make copies of these forms as needed.

If you have any questions about mobility equipment or the mobility evaluation form, please contact Chip Nadeau, NH Medicaid DME Prior Authorization Unit, at 1-800-852-3345, ext. 4364 (in-state only) or (603) 271-4364. Questions about the DME process or forms for all DME may be directed to the NH Medicaid DME Prior Authorization Unit at 1-800-852-3345, ext. 4795 (in-state only) or (603) 271-4795.

GLOVES: STERILE AND NON-STERILE - BILLING

The NH Title XIX claims processing system has been updated to reflect the following changes:

- Procedure Code A4927, TOS 9 now reads: “gloves, non-sterile per 100,” using the 2002 HCPCS code book description. The prior description read: “gloves, sterile or non-sterile, per pair.”
- Effective with January 1, 2002 dates of service, one (1) box of 100 non-sterile gloves must be billed as one (1) unit.
- The maximum allowable amount per box for non-sterile gloves has been changed to \$20.00 to reflect the description and unit change.

Documentation which validates medical necessity and includes quantity ordered and dispensed must be kept on file when billing NH Title XIX for non-sterile gloves.

Providers are reminded to use Procedure Code A4649, TOS 9, when billing NH Title XIX for sterile gloves. The acquisition cost, as well as a description of why sterile gloves are medically necessary, **must** be included.

As stated in the provider enrollment contract, and as required by NH statute, providers should be billing NH Title XIX with their usual and customary charge when using either of the above-noted billing codes.

If you have additional questions regarding billing for sterile or non-sterile gloves, please contact the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

ADULT ABUSE REPORTING PROCESS

The following is a re-print of an article first published in the December 2000 edition of the NH Medicaid Bulletin:

New Hampshire law (RSA 161-F:42-57) contains a provision (RSA 161-F:46) requiring persons who have reason to believe that an incapacitated adult is being abused, neglected, exploited or is self-neglecting to report their concerns to the Division of Elderly and Adult Services (DEAS). DEAS is mandated by this law to be the agency which receives and investigates these reports. Persons making such reports in good faith are immune from civil or criminal liability.

An incapacitated adult is defined as a person age 18 or older whose physical, mental or emotional ability is such that he/she is unable to manage personal, home, or financial affairs in his/her own best interest, or delegate responsibility to a responsible caretaker or caregiver.

Abuse may be physical (hitting or other methods of physical force), emotional (verbal harassment, intimidation or unreasonable confinement) or sexual (any form of sexual contact that takes place without the involved incapacitated adult's informed consent), and includes several forms of mistreatment. Mistreatment may mean neglecting an adult's needs for adequate food, clothing, shelter or medical care, or exploiting him/her by unlawfully obtaining or using income, resources or other property.

Some adults may also become self-neglecting through lack of attention to personal hygiene, poor nutrition, inability to handle finances or other activities of daily living, and/or living in a home that is animal-infested or contains other hazards.

Victims of abuse and neglect may be living in their own homes, with relatives or friends, in nursing homes or other residential care facilities, in specialized group homes, or in shelters for the homeless. Some victims have no fixed address. Perpetrators of abuse and neglect may be spouses, adult children or other relatives, or paid caregivers.

Once DEAS receives a report, an investigation is initiated and, if necessary, protective services are offered. This can include services to help a person maintain his/her health and independence, such as homemaker or home-delivered meals, or helping an adult find a different living arrangement. The person's right to make decisions is always respected when services are offered.

Although DEAS is responsible for protecting vulnerable adults, RSA 161-F:46 makes reporting abusive or neglectful situations the responsibility of all New Hampshire citizens. Participation by our providers is critical to this effort, since DEAS cannot address a situation until a report of abuse or neglect is received.

Reports regarding suspected adult abuse concerning individuals who live in their own homes or apartments, with relatives or friends, in a boarding home or other independent residence facility, or who have no permanent address may be made by telephone, in writing, and/or in person to DEAS at any of the statewide District Offices, or by calling the **DEAS Central Office at 1-800-852-3345, Ext. 4384.**

Reports regarding suspected adult abuse concerning individuals who live in nursing homes or other residential care facilities should be made to the **Office of the Long-Term Care Ombudsman at 1-800-442-5640.**

Reports regarding suspected adult abuse concerning individuals who live in specialized group homes, such as homes for the mentally ill or developmentally disabled, should be made to the **DEAS Central Office at 1-800-949-0470.**

If you have reason to believe that one of your adult patients, or anyone else you know, could be a victim of abuse, we would encourage you to contact DEAS and make a report.

The following is a list of the Department of Health and Human Services District Office addresses and telephone numbers:

BERLIN
231 Main Street
Berlin NH 03570
603-752-7800 or
800-972-6111

CONWAY
73 Hobbs Street
Conway, NH 03818
603-447-3841 or
800-552-4628

LACONIA
65 Beacon Street
Laconia, NH 03246
603-524-4485 or
800-322-2121

PORTSMOUTH
30 Maplewood Ave.
Portsmouth, 03801
603-433-8300 or
800-821-0326

CLAREMONT
17 Water Street
Suite 301
Claremont, NH 03743
603-542-9544 or
800-982-1001

KEENE
809 Court Street
Keene, NH 03431
603-357-3510 or
800-624-9700

MANCHESTER
361 Lincoln Street
Manchester, NH 03103
603-668-2330 or
800-852-7493

ROCHESTER
150 Wakefield Street
Suite 22
Rochester, NH 03867
603-332-9120 or
800-862-5300

CONCORD
40 Terrill Park Drive
Concord, NH 03301
603-271-6200 or
800-322-9191

LITTLETON
80 North Littleton Road
Littleton NH 03561
603-444-6786 or
800-552-8959

NASHUA
19 Chestnut Street
Nashua, NH 03060
603-883-7726 or
800-852-0632

SALEM
154 Main Street
Salem, NH 03079
603-893-9763 or
800-852-7492

HIPAA QUESTIONNAIRE FOR ENROLLED NH MEDICAID (TITLE XIX) PROVIDERS

The Department of Health and Human Services (DHHS) and its fiscal agent, Electronic Data Systems (EDS), have prepared a short questionnaire for all NH Title XIX Providers regarding the HIPAA rule for Transactions and Code Sets. The information supplied by our Title XIX Providers on this questionnaire will assist EDS in testing and implementing HIPAA enhancements.

We are asking that all NH Title XIX Providers, including those who do not use electronic claim submission, assist our HIPAA enhancement efforts by detaching and completing the questionnaire located at the end of this bulletin. Please return all completed questionnaires by February 17, 2003 to:

EDS
Attn: EDI Coordinator
PO Box 2040
Concord, NH 03302-2040

Thank you for taking the time to fill out and return this questionnaire. If you have any questions, or need assistance in completing the questionnaire, please contact the EDI Coordinator, Kat McCalsky, at (603) 225-4899 ext. 3014.

For general questions about HIPAA requirements, please contact Provider Services, at 1-800-423-8303 (NH & VT) or (603) 224-1747.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

New Challenges for Healthcare

The State and EDS are actively involved with the HIPAA regulations. This article is the ninth in a series of technical information articles we have been sharing with our providers. Past articles may be found in the NH Medicaid Bulletins for March, September, and December 2000; March 2001; June 2001; September 2001; March 2002; June 2002 and September 2002 at:

<http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/LIBRARY/default.htm>

on the NH Department of Health and Human Services (DHHS) website. Click on “Medicaid Bulletin” to locate these editions.

EDS and DHHS will continue to keep you updated on our progress with becoming HIPAA compliant, and will provide you with updated, useful information to enable you to meet the HIPAA regulations as well.

Business Associate

HIPAA defines a business associate as “a person or entity who performs a function or activity involving the use or disclosure of protected health information (PHI) on behalf of a covered entity.” The Department of Health and Human Services (DHHS) is the covered entity under HIPAA; EDS is their business associate.

NH DHHS Readiness

On September 10, 2002, NH DHHS filed for an extension to the HIPAA compliance date of October 2002. NH DHHS’s deadline is now October 16, 2003, allowing time in which to deal with several claims processing systems across DHHS that require remediation to achieve HIPAA compliance. The EDS claims processing system (NHAIM) is just one of them. NH DHHS is working to ensure that contingency and disaster recovery plans are in place for each of its claims processing systems.

DHHS has appointed a privacy officer as required by HIPAA. An outside vendor has completed a privacy assessment and DHHS is currently working toward compliance with the HIPAA privacy rule.

EDS Readiness:

EDS completed an assessment for DHHS of the NHAIM system in December of 2000. DHHS extended the contract with EDS to make the NHAIM system HIPAA compliant. HIPAA remediation work began in May of 2002. This is a tri-state effort with Vermont and Rhode Island to leverage resources across all three (3) states.

Ready, Set, Go!

EDS has completed both the requirement definition and design phases of the HIPAA remediation project, construction is currently in process, and DHHS/EDS estimate that provider testing will begin in April of 2003. EDS will begin receiving compliant transactions in August of 2003. At that time we will accept both compliant and non-compliant transactions until the October 16, 2003, HIPAA compliance deadline.

For nursing facility providers the TAD claim form, either in electronic or paper format, will no longer be accepted after the August 2003 date. At that time you will switch to the HIPAA compliant transaction type, institutional claim format and for paper, a UB92 claim form.

HIPAA Compliance Advantages

What are the advantages to being HIPAA compliant? Providers will be able to use a standard format to submit their electronic claims to all payers. EDS will be supplying a HIPAA compliant version of our electronic claims submission software package, "Provider Electronic Solutions," to all providers who are currently utilizing it. The software package will also be available to any provider who wishes to begin using it, and is free to any NH Title XIX provider for submitting electronic claims to NH Title XIX only. In addition there will be web based provider access for electronic claims status inquiries, electronic adjustments and electronic remittance advices.

Outreach

EDS has been conducting outreach activities since January 2000, when the first in a series of HIPAA articles began appearing in the NH Medicaid Bulletin. The provider relations manager at EDS also co-chairs the Education & Awareness Workgroup of NHVSHIP.

Future outreach activities by EDS will include mailing of revised billing guidelines to providers in March of 2003, and workshops regarding those revised billing requirements between May and June 2003. EDS will provide both a dedicated testing environment and support staff for provider testing of HIPAA transactions beginning in April of 2003.

Questions about the information in this article, or about DHHS or EDS HIPAA readiness, should be directed to:

DHHS HIPAA Readiness Questions:

Patti Lambert (603) 271-7240
 Diane Delisle (603) 271-7238

EDS HIPAA Readiness Questions:

Michelle Dodge (603) 225-4899, ext. 3041

THIRD PARTY LIABILITY CARRIER CODE ADDITIONS/CHANGES

The following third party liability carrier codes have been changed since the complete list of carrier codes was published in the June 2002 edition of the NH Medicaid Bulletin.

CODE	COMPANY NAME
0005	UNICARE, PO BOX 51130, SPRINGFIELD, MA 01151-5130
0018	AARP, PO BOX 740819, ATLANTA, GA 30374-0819
0233	FIRST HEALTH CA, PO BOX 11420, TUCSON, AZ 85734

The following third party liability carrier codes have been added since the complete list of carrier codes was published in the June 2002 edition of the NH Medicaid Bulletin.

CODE	COMPANY NAME
0654	UFCW NATIONAL FUND, PO BOX 751, ENGLEWOOD, NJ 07631
0655	CHOICE PLUS OF NEW ENGLAND, PO BOX 581, SYRACUSE, NY 13217
0656	PREFORMAX, PO BOX 61505, KING OF PRUSSIA, PA 19406
0657	AAO/TPA, 401 NORTH LINDBERGH BLVD, ST LOUIS, MO 63141
0658	AMERICORPS, PO BOX 33757, INDIANAPOLIS, IN 46203
0659	NPNN/FED EX, 419 EAST MAIN STREET, MIDDLETOWN, NY 10940

Providers are welcome to call the Communications Unit at 1-800-423-8303 (NH and VT only) or (603) 224-1747 with any questions.

***** DENTAL PROVIDERS *****

ORTHODONTIC SERVICES - PRIOR APPROVAL

When billing for NH Title XIX covered orthodontic services, prior approval **must** be obtained from the NH Medicaid/Healthy Kids-Gold dental consultant **before** services are rendered and the claim is submitted to EDS for payment. If a claim for NH Title XIX covered orthodontic services is submitted to EDS before receiving prior approval from the NH Medicaid/Healthy Kids-Gold dental consultant, the claim will be denied.

Please submit all requests for prior approval for orthodontic services, as provided under He-W 566.05, to:

Dental Consultant
Orthodontic Services
6 Hazen Drive
Concord NH 03301

If you have additional questions regarding billing NH Title XIX covered orthodontic services, please contact the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

***** PHARMACISTS AND PRESCRIBING PROVIDERS *****

DRUG LABELER CODES

The following drug labelers have signed rebate agreements and will be **joining/rejoining** the NH Medicaid Drug Rebate Program effective **10/1/02**:

NAME	LABELER CODE
Vindex Pharmaceuticals, Inc.	67204
Thanes Pharmaceuticals	49188

The following drug labelers **were terminated** from the NH Medicaid Drug Rebate Program effective **10/1/02**:

NAME	LABELER CODE
Sanofi-Synthelabo, Inc.	08024

The following drug labelers have signed rebate agreements and will be **joining/rejoining** the NH Medicaid Drug Rebate Program effective **1/1/03**:

NAME	LABELER CODE
Weeks & Leo Co., Inc.	11383
International Ethical Labs	11584
Western research Laboratories	64727
Aero Pharmaceuticals, Inc.	66440
aaiPharma	66591
ProPharma LLC	66594
TEAMM Pharmaceuticals, Inc.	67336
Sytho Pharmaceuticals, Inc.	66576

The following drug labelers **withdrew or will be terminated** from the NH Medicaid Drug Rebate Program effective **1/1/03**:

NAME	LABELER CODE
Pharmacia Corporation	00016
	00601
	42987
GlaxcoSmithKline	00081
RxHoldings, LLC	08367
D&K Healthcare Resources, Inc.	05304
	07985
Highland Packaging Company	55782
The Medicines Company	65293
Drug Abuse Sciences	65694
SeatrAce Pharmaceuticals	00551
Warner-Lambert Company	11370
Concord Laboratories	20254
Med-Derm Pharmaceuticals	45565
Heran Pharmaceuticals	45565
Zenith Goldline Pharmaceuticals	50732
Ohm Laboratories, Inc.	51660
3M Pharmaceuticals	55326
Lini, Inc.	58215
Welgen, A Division of BW Co.	61054
Inkine Pharmaceuticals	61607
A&Z Pharmaceuticals	61607
Medical Merchandising, Inc.	66572
LiquiSource, Inc.	66572

The following drug labelers have signed rebate agreements and will be **joining/rejoining** the NH Medicaid Drug Rebate Program effective **4/1/03**:

NAME	LABELER CODE
Dr. Reddy's Laboratories, Inc.	55111

Note: Guy & O'Neill Inc., Labeler 50862 is being replaced by BD Medical Systems, Labeler 08290. As First DataBank updates their system to reflect these changes, the correct NDC numbers will automatically appear in the system whether the obsolete or current numbers are entered.



NH TITLE XIX PROVIDER SURVEY

1. Please list your NH Title XIX provider number and practice name. If you have multiple provider numbers please list them all.

Number	Name	Type (EDS use)

2. Do you currently submit electronic claims?

- Yes (Continue with question 3) No (Skip to question 6)

3. Check off all methods that your practice currently uses for submitting electronic claims for NH Title XIX covered services to EDS

- Provider Electronic Solutions Software
- A program that you received from another vendor, or as part of your practice management software, which creates claim files that you send to EDS
- A Clearinghouse that takes all of your claims and distributes them to payers for you
- A Third Party Billing Agent submits claims for you

4. Check off all formats that your practice uses for electronic claim submission to EDS:

- Modem dial-up to the Bulletin Board System
- Mail-in 3.5 inch floppy diskette
- Mail-in, other media. Please specify: _____
- Modem dial-up to Clearinghouse or other Billing Agent
- Internet file transfer to Clearinghouse or other Billing Agent
- E-mail file transfer to Clearinghouse or other Billing Agent

5. What percentage of your total NH Title XIX Program claims do you submit in electronic format?

- 100%
- 75% - 99%
- 50 - 74%
- 25 - 49%
- less than 25%

6. Please check all methods used to verify Recipient Eligibility for the NH Title XIX Program:

- AVR (Automated Voice Response)
- POS (Point of Sale) device (Swipe card)
- Provider Electronic Solutions software
- Call the Communications Unit

7. Does your practice receive an electronic Remittance Advice (RA)?

- Yes No

If you answered "Yes" please indicate who receives and processes the electronic RA:

- Your own Practice Management system
- Your Third Party Billing Agent
- Your Corporate Office
- Your Claims Clearinghouse
- Other (please specify): _____

8. Are you planning to utilize the electronic RA when it is in the standard 835 format?

- Yes No

9. If you answered yes to #8, who will receive and process the 835 Remittance Advice?

- Your own Practice Management system
Product Name: _____
- Your Third Party Billing Agent
Company Name: _____
- Your Corporate Office
- Your Claims Clearinghouse:
Company Name: _____
- Other (please specify): _____

10. What type(s) of telecommunication lines do you have? (Please check all that apply)

- Analog telephone line (Plain Old Telephone Service or POTS)
- Integrated Services Digital Network (ISDN)
- Digital Subscriber Line (DSL)
- Cable/Broadband
- Satellite Internet

11. Do you, or will you, have Internet access by October 2003?

- Yes No

12. Do you currently use the Internet to access other Payers?

- Yes No

13. Would you use the Internet to download NH Title XIX Program forms and publications?

- Yes No

14. Have you filed with CMS for an extension to the October 2002 deadline for compliance with the "Transactions and Code Sets" requirements?

- Yes No

15. How will your practice produce electronic claims that meet HIPAA standards?

- Use the new version of Provider Electronic Solutions
- Upgrade existing Practice Management System
Product Name _____
- Purchase new Practice Management System
Product Name _____
- Contract with a Clearinghouse to convert claims to 837 format
Company Name _____
- Contract with a Third Party Billing Agent to produce claims in the 837 format
Company Name _____
- Not Applicable - Submitting only paper claims.

16. Please check all electronic forms that your practice will utilize:

- | | |
|--|--|
| <input type="checkbox"/> 837 Claim (circle one): | <input type="checkbox"/> 835 - Remittance |
| Institutional | <input type="checkbox"/> 270/271 - Eligibility inquiry and response status |
| Professional | <input type="checkbox"/> 277 - Unsolicited claim |
| Dental | <input type="checkbox"/> 267/277 - Claim status inquiry and response |
| | <input type="checkbox"/> 278 - Prior Authorization |

DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION REQUEST FORM

** PLEASE PRINT OR TYPE ALL INFORMATION WHEN COMPLETING THIS FORM **

DATE OF REQUEST: _____

PROVIDER
 NAME: _____

PROVIDER
 ADDRESS: _____

BUSINESS PHONE: () _____ PROVIDER NUMBER #: _____

RECIPIENT
 NAME: _____

RECIPIENT
 MEDICAID ID# (11 digits): _____

ITEM/SERVICE REQUESTED	PROCEDURE CODE	NUMBER OF UNITS	ACQUISITION COST (PER UNIT)	MANUFACTURER'S SUGGESTED RETAIL	MONTHLY RENTAL CHARGE	DATES FROM -TO	NEW OR USED

Pursuant to He-W 571.06, the written diagnosis and clinical information must be included with your request, to document the medical necessity for the service/equipment as listed above.

You must indicate your costs for each item listed. You must also indicate if the item requested for **purchase** is new or used.

If the equipment you are offering to **sell** is "used," you must indicate the make/model and year of manufacture, as well as any warranty for parts or labor, on this form. You must also indicate the expected life of the equipment given its present condition. Be sure to attach Medicare's certificate of medical necessity and any other documents you deem necessary for the processing of this request.

"I certify that the above services will be provided and that documentation regarding our acquisition costs as well as the certificate (s) of medical necessity (including the physician's signed prescription, when appropriate) are on file and available upon request for NH Medicaid reviews."

 Authorized Provider Representative Signature

Date

MOBILITY EVALUATION

Please Print or Type

This evaluation must be completed by a licensed Occupational Therapist (OT) or licensed Physical Therapist (PT), or a Physician specializing in rehabilitation medicine. Therapists must have a broad knowledge of the various seating systems and wheelchairs available in today's market.

Note: Requests for **standard/non-customized manual wheelchairs** do not require the completion of this form by an OT, PT or a Physician. For standard/non-customized manual wheelchairs, a rehabilitation specialist may complete this form.

Please submit the completed and signed form to: Chip Nadeau
Office of Health Planning and Medicaid
6 Hazen Drive
Concord, NH 03301-6527
Fax #: (603) 271-4376

Recipient Name: _____ **NH Medicaid ID# (11 digits)** _____

Address: _____ **Date of Birth:** _____

_____ **Recipient's Height:** _____

_____ **Recipient's Weight:** _____

Provider Completing Evaluation: _____ **Medicaid Provider #:** _____

Provider Business Address: _____ **Bus. Phone ()** _____

_____ **Extension:** _____

Date of Evaluation: _____ **Place of Evaluation:** _____

Primary Diagnosis: 1) _____
2) _____
3) _____

If this client has had multiple seating systems in the past three (3) years, or surgical procedures are anticipated, or growth or physical deterioration may limit client's ability to utilize the proposed seating system for less than five (5) years, then the client must be evaluated for an "adjustable growth" seating system that would accommodate any foreseeable changes.

Current Ambulatory Status - Please address the following: Would the client be confined to a bed if a wheelchair were not provided? Is the client able to use a walker, cane or walk with assistance? What is the distance client is able to ambulate without assistance?

Medical History - Please provide dates and names of recent surgical procedures and/or hospitalizations as well as other relevant information.

Current Seating System:

<hr/>	
	Make
<hr/>	<hr/>
Model	Age /Condition

Problems with Current Seating System: _____

Please Comment on Recipient's:

Vision: _____

Cognition: _____

Communication: _____

Daily Activity Level: _____

Mobility Evaluation (strength / tone / contractures etc.): _____

Anticipated Surgical Procedures / Orthotics: _____

Other Special Consideration: _____

Please indicate which less costly wheelchairs/seating systems have been considered and why they would not be appropriate to meet this recipient's needs (attach additional comments, if necessary):

1. _____

2. _____

3. _____

RECOMMENDED CHAIR: _____

MAKE

MODEL

TO BE COMPLETED BY PERSON PERFORMING THE EVALUATION -

The following options are medically necessary:

<u>OPTION</u>	<u>JUSTIFICATION</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____
16. _____	_____
17. _____	_____
18. _____	_____

RECOMMENDED CHAIR:

(Check all that apply. Indicate N/A at end of sentence if not applicable):

- will allow access to client's home.
- will allow access to school/place of employment.
- will meet van/bus/other transportation methods client currently needs.
- will meet client's mobility needs.
- Potential growth of client has been taken into consideration in selecting the size of chair so that it may provide at least **five (5) years** of use.
- Client's caregivers are familiar with care /maintenance/operation of this chair.
- Client has demonstrated proficiency in the safe operation of this chair.
- Less costly chairs have been ruled out as inappropriate.
- This chair will accommodate client's respiratory equipment and other special needs.

Summary /Comments:

Signature of physician, **licensed** therapist or rehabilitation specialist completing the evaluation

Date

Persons Present During Evaluation:

- 1. _____ Relationship to client: _____
- 2. _____ Relationship to client: _____
- 3. _____ Relationship to client: _____
- 4. _____ Relationship to client: _____

RECIPIENT:

(please check one)

_____ **I accept** the recommendations for the make, model and options of the wheelchair being requested on my behalf, and acknowledge that the wheelchair options and features have been fully explained to me. I have had an opportunity to try the chair (or similar chair) and I have no questions or concerns regarding the recommendations made.

_____ **I do not** agree with all of the recommendations and request changes based on the following:

Recipient Signature

Date: _____

Parent or Legal Guardian Signature (if applicable)

Date: _____

Parent or Legal Guardian Printed Name

Parent or Legal Guardian Address

Wheelchair Supplier: Please place a check mark by all of the following statements that apply. For those statements that do not apply, please state why they do not apply in the comments section below.

- I concur with the recommendations made and I am unaware of any other less costly wheelchairs, seating systems or options on the market at this time that would meet the client's needs.
- The client is ____ is not ____ a nursing facility resident or awaiting placement to a nursing facility.
- The client is a nursing facility resident, but is awaiting discharge.
- To the best of my knowledge, the client has ____ has not ____ received, nor is expected to receive, a wheelchair (seating system) from other sources.
- To the best of my knowledge, the client does ____ does not ____ have other insurance or funding sources for this seating system.
- The chair being requested is ____ is not ____ a back up seating system to any current mobility system the client now has or is expected to obtain.
- Any and all components (i.e., cushions, trays, headrests) that can be utilized from the client's current wheelchair will be placed on the new wheelchair.
- I have visited the client's home and have verified that the home may be accessed using this wheelchair (including bedroom, bath and other living spaces as needed).
- I recommend consideration of the equipment changes as listed below:

Comments (regarding make/model and options recommended or responses to comments as listed above):

By signing below, the selected wheelchair vendor acknowledges that the NH Medicaid payment for the wheelchair to the vendor is inclusive of the following services:

- Delivery and assembly of the chair.
- Explanation as to the proper care & preventive maintenance of the chair.
- Demonstration as to the chair's proper operating procedures.
- Any necessary follow-up for training, troubleshooting and/or adjustments required for the chair within 30 days following the delivery of the chair.

Printed Name of Wheelchair Vendor

Wheelchair Vendor's Signature

Date

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The goal of this publication is to provide current, accurate information relevant to providers of NH Medicaid. This publication is intended to complement the policy and billing information contained in the Provider Billing Manuals, Banner Pages, and Important Notices. We encourage input and feedback from you to assist us with this goal.

Please address inquiries and comments to the attention of your Provider Relations Representative at the address listed below:

EDS Provider Relations
PO Box 2040
Concord, NH 03301