



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. **Please be sure to download the entire contents of this bulletin** by going to the NH Department of Health and Human Services website at: <http://www.dhhs.nh.gov/DHHS/MEDICAIDPROGRAM/LIBRARY/Newsletter/medicaid-bulletin.htm> or the EDS provider website at: www.nhmedicaid.com. 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 XII	ISSUE VII	JUNE 2007
---------------------------	-------------------	------------------	------------------

* * * TABLE OF CONTENTS * * *

SUBJECT	PAGE
Assistant Surgeon Billing Modifier.....	13
Billing for Periapical Radiographs.....	12
Dentists- Release and Authorization of Recipient Information.....	12
EDS Holidays	2
EDS Web Site	4
Employee Education about False Claims Recovery.....	5
Enteral Formulas- Reminder.....	13
Implementation of the NPI (National Provider Identifier).....	7
Medicaid Fraud Unit.....	3
New Paper Billing Requirements for CMS 1500 Form (08/05).....	11
New Paper Billing Requirements for UB04 Form.....	12
Prior Authorization-Reminder.....	4
Psychotherapy Services in Excess of Service Limits.....	14
Returned Unprocessed Claims.....	3
Schaller Anderson-Prior Authorization Contractor.....	4
Telephone Inquiries- Improving Processing Time.....	6
Third Party Liability Carrier Code Additions/Changes	5
Timely Filing of Claims.....	3

APPENDIX

- Form 957X - Override Request
- Attachment to the NPI Notice
- CMS 1500 Form (08/05) Instructions
- SMDL#06-025 (attached as a link within the article)
- False Claims Act Information
- False Claims section of the Social Security Act

***** 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 remainder of the 2007 calendar year are:

Independence Day	Wednesday	July 4, 2007
Labor Day	Monday	September 3, 2007
Veteran's Day	Monday	November 12, 2007
Thanksgiving Day**	Thursday	November 22, 2007
Day after Thanksgiving	Friday	November 23, 2007
Christmas Day	Tuesday	December 25, 2007

Please note:

** Electronic claim submissions must be received at EDS by 5:00 p.m. on the Tuesday prior to the holiday in order to guarantee they make that weekend's financial cycle.

MEDICAID FRAUD UNIT

The Medicaid Fraud Unit of the New Hampshire (NH) Attorney General's Office has statewide responsibility to investigate cases involving the suspected improper billing of NH Medicaid covered services. This unit, staffed by attorneys, investigators, and analysts, also investigates concerns of waste, fraud and abuse in the state administration of the NH Medicaid Program.

For more information, or to report concerns regarding Medicaid waste, fraud, abuse, or improper billing, please contact the Medicaid Fraud Unit by phone at (603) 271-1246, by e-mail at mfcuinfo@doj.state.nh.us, or by writing to: Medicaid Fraud Unit, 33 Capitol Street, Concord, NH 03301. Communications are treated as confidential.

TIMELY FILING OF CLAIMS

All claims must be submitted to EDS within one year of the date of service. 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" and a copy of the remittance advice showing the denial within one year from the date of service. A copy of Form 957x may be found at the end of this bulletin, or may be downloaded from the provider web site, at: www.nhmedicaid.com. 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.

What Will Cause My Claim to be Returned as Unprocessed Under the Optical Character Recognition (OCR) Rules?

All **paper claims** are imaged and 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 tips:

- **DO NOT submit laser printed red** claim forms;
- **DO NOT 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 or faxed;
- **DO submit only Red UB04 or CMS 1500 claim forms.** Faxed claims or claim copies will not be accepted;
- **DO** use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing;
- **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 **black ink** on **ALL** claims or adjustments that you submit to EDS. The **EDS imaging/OCR system reads only black ink**;
- **DO** make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s); and
- **DO** call the Communications Unit at 1-800-423-8303 (NH and VT only) or (603) 224-1747 if you have questions.

Remember, a paper crossover is required to have an EOMB attached to the claim form. The claim form must:

- Match the claim type of the EOMB; and
- Not have a date span if billing for an outpatient service.

Please note:

- If crossovers span more than one day for outpatient service, please enter the “from” and “to” date as the same in form locator 6; and
- If the services span across more than one claim form, roll the services up to one claim, carefully adding the units and dollars.

EDS WEB SITE

Have you visited our provider web site, www.nhmedicaid.com? This is a great tool for obtaining the latest provider billing information, researching covered procedure codes for your provider type, or for just sending us an e-mail with your question. You should receive a response to your e-mail within 1-2 business days.

PRIOR AUTHORIZATION REMINDER

A prior authorization does not guarantee payment. Please contact the EDS Communications Unit to confirm the following information, prior to providing a service:

- The recipient is eligible on the date(s) of service;
- The performing and billing NH Title XIX (Medicaid/Healthy Kids-Gold) providers are actively enrolled providers on the date(s) of service; and
- The HCPC or CPT procedure code(s) and billing modifier(s) are active codes and valid combinations for billing under the NH Title XIX program.

The EDS Communications Unit may be reached by calling 1-800-423-8303 (NH and VT only) or (603) 224-1747.

SCHALLER ANDERSON TO PERFORM PRIOR AUTHORIZATION ACTIVITIES

The New Hampshire Medicaid Program has contracted with Schaller Anderson Medical Administrators, Inc., to perform its medical services and durable medical equipment prior authorization activities previously completed by state staff in the Prior Authorization Unit and state Behavioral Health staff in the Psychotherapy Service Limits Override Unit. Beginning July 9, 2007, all requests for prior authorizations, with the exception of augmentative communication device requests, must be submitted to:

Schaller Anderson Medical Administrators, Inc.
NH Medicaid Prior Authorization Unit
53 Regional Drive Suite 201
Concord, NH 03301

Telephone: (866) 499-9335
Fax: (866) 499-9334

There is no change in the forms that should be submitted or processing requirements. All clinical information must be submitted with the original request.

If you have any questions about prior authorizations, please contact the NH Medicaid Prior Authorization Unit administered by Schaller Anderson at the telephone number listed above.

If you have any questions about the contents of this notice, please contact Jane M. Hybsch, RN, MHA, at 1-800-852-3345, ext. 2245 (in-state only), or (603) 271-2245.

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY

This is to inform you that the department is implementing Section 6032 of the Deficit Reduction Act of 2005 (DRA) which established Section 1902(a)(68) of the Social Security Act.

Please note that if you, as an "entity," receive or make payments for Medicaid covered services which total at least \$5,000,000 annually, then it is your responsibility, as a condition of receiving such payments, to establish and disseminate written policies to all employees, and any contractor or agent of the entity, which include detailed information about the False Claims Act, and other provisions in Section 1902(a)(68)(A) of the Social Security Act.

For calculation and compliance purposes, the annual time period is based upon a federal fiscal year. An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in federal fiscal year 2006 (which ends September 30, 2006). If this is applicable to you, please put these requirements in place as soon as possible. We are currently running reports which will identify those entities that have met the \$5,000,000 annual threshold, and we will notify the applicable entities. However, this will not release entities from the responsibility to self identify if they have met the threshold amount. Future determinations regarding an entity's responsibilities under the DRA based on the \$5,000,000 threshold amount will be made by January 1 of each subsequent year based upon the amount of Medicaid payments an entity received or made during the preceding federal fiscal year.

Attached, please find a [Dear State Medicaid Director letter, SMDL #06-025](#), which provides a detailed explanation of the requirements and which also defines "entities." Information regarding the False Claims Act is also attached, as is the pertinent section of the Social Security Act.

If you have any questions as to the education requirements or your obligation to follow these requirements, please contact Nita Tomaszewski at 1-800-852-3345, extension 3772 (in-state only), or (603) 271-3772.

THIRD PARTY LIABILITY CARRIER CODE ADDITIONS/CHANGES

The following third party liability carrier codes have been added since the March 2007 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0783	ADVANTRA FREEDOM, PO Box 7154, London, KY 40742
0784	MERITANE HEALTH, PO Box 853921, Richardson, TX 75083
0788	COVENTRY HEALTHCARE, PO Box 8400, London, KY 40742

CODE	COMPANY NAME
0789	AVMA GROUP HEALTH & LIFE INSURANCE TRUST, PO Box 8789, Scottsdale, AZ 95252-8789
0790	WORLD INSURANCE COMPANY, PO Box 5348, Bellingham, WA 98222-5348
0791	GENWORTH FINANCIAL, Group Dental, PO Box 40011, Lynchburg, VA 24506
0792	GENWORTH LIFE, Claims Processing Center, PO Box 10821, Clearwater, FL 33757-10821
0793	FIRST SENIORITY FREEDOM, PO BOX 656653, San Antonio, TX 78265
0794	UNIVERA HEALTHCARE, PO BOX 39550, Rochester, NY 14604

The following third party liability carrier codes have been re-activated (taken out of archives) since the March 2007 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0406	UNITED TEACHERS' ASSOCIATION, PO Box 30010, Austin, TX 78755-3010

The following third party liability carrier codes have been archived since the March 2007 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0639	IBEW LOCAL 490 HEALTH AND WELFARE, 48 Airport Rd., Concord, NH 03301

The following third party liability carrier codes have had changes since the March 2007 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0021	NORTHERN NE BENEFIT TRUST (Name change from Northern NE Benefit Dental)
0133	ATLANTIC ADMINISTRATORS, PO Box 60608, King of Prussia, PA 10406-0608 (address change only)
0396	TRUSTMARK, PO Box 2909, Phoenix, AZ 85069-2909 (address change only)
0541	PREMIER HEALTH (formerly Olympic Health Mgt.), Medicare Supplement Operations, PO BOX 5348, Bellingham, WA 98227-5348 (name change only)
0626	WELL POINT PHARMACY MGT, PO Box 145433, Cincinnati, OH 45250-5433 (address change only)
0641	NEIGHBORHOOD HEALTH PLAN PO Box 10, Nutting Lake, MA 01865-0010
0722	WELLS FARGO THIRD PARTY ADMINISTRATORS (Name change from Accordia National, Inc.)

TELEPHONE INQUIRIES- IMPROVING PROCESSING TIME

In an effort to respond to provider inquiries faster, and reduce call times, we are reminding our providers that the following required information should be immediately accessible when providers call the Communications Unit:

- Your eight (8) digit NH Title XIX provider number. If you do not have this number, you may obtain it from your billing department. **Please note:** The provider number is **not** the same as the federal tax ID number.

- The NH Title XIX recipient's eleven (11) digit **NH Medicaid ID (MID)** number. If you do not have a recipient MID, you will need to provide the recipient's **last name, first name, and either a date of birth or social security number**. **Please note:** Name searches may only be done if the recipient, or guardian, has given a reasonable indication that the recipient is a NH Title XIX recipient.
- When checking on claim status, you will need the **"from and through"** dates that were billed on the claim form, as well as the **total billed amount** that was indicated on the claim form.

Please be advised that a call made to the Communications Unit that is placed on hold by the caller will be discontinued, because the telephone lines must be kept clear for other callers. Please make the call only when you have the required information on hand and the time to complete the call.

Other contact numbers for obtaining information regarding the provision of NH Title XIX covered medical services are as follows:

- Prescription/NDC inquiries by **providers** should be directed to:
FIRST HEALTH
Provider Services: 1-866-664-4511
Prior Authorizations: 1-866-675-7755

NH Title XIX **recipients** who have questions about their NH Title XIX covered services, should be directed to:

- NH Title XIX Client Services:
In state: 1-800-852-3345, extension 4344
Out of state: 1-603- 271-4344

If you have questions concerning the contents of this article, please call the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

IMPLEMENTATION OF THE NPI (NATIONAL PROVIDER IDENTIFIER)

The NH Department of Health and Human Services (DHHS) and Electronic Data Systems (EDS) are working diligently to address the need for compliance with the implementation of the National Provider Identifier on May 23, 2007.

DHHS and EDS acknowledge that not all providers may have been ready by the May 23, 2007 compliance date and, despite all efforts undertaken, the DHHS' claims processing system run by EDS may not be ready to completely cut-over to processing with the National Provider Identifier (NPI) by the compliance date. Given the significance of this transition, we must execute an interim **Contingency Plan** to ensure that providers can continue, without interruption, to submit claims and other electronic transactions, and that the EDS run claims processing system is able to process those transactions and issue the appropriate response to providers.

The Contingency Plan **requires all providers and/or their agents** submitting transactions to EDS to do the following in order to prevent an interruption in services:

- 1. All Providers must continue to submit their NH Title XIX (Healthy Kids-Gold/Medicaid) Provider Identification number on electronically submitted claims in order for claims to be paid through NH Title XIX past May 23, 2007. This Identifier is the eight-digit number assigned to providers by EDS.**
- 2. All Providers submitting paper claim forms must continue to use the current CMS 1500 and UB92 claim forms and defer switching to NPI-compliant CMS 1500(08/05) and UB04 claim forms until receiving further instructions from EDS.**
- 3. All Providers must submit their National Provider Identifier(s) and corresponding taxonomy to EDS as soon as possible. The NPI is a 10-digit number, acquired by providers from the national enumerator.**

More specific information is provided below and in the Attachment at the end of this notice. DHHS and EDS request that all providers and/or their agents take the appropriate action to address each of the Contingency Plan requirements, and immediately review the details that follow with your billing agent, IT department, clearinghouse and/or software vendor to ensure the continued inclusion of the NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID on all submitted claims and electronic transactions.

The primary objectives of this contingency period are to ensure that claims and other electronic transactions submitted by providers are processed without interruption, and to ensure that providers receive the appropriate claims reimbursement and responses to their electronic inquiries. DHHS and EDS appreciate providers' efforts in working with us to maintain uninterrupted service delivery and claims processing during this challenging time.

Submitting Claims to EDS May 23, 2007 Forward

During the Contingency Plan period, it is extremely important that providers continue to include their NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID beyond the NPI effective date of May 23, 2007. DHHS and EDS will not be able to identify providers, nor process and pay claims received on/or after May 23, 2007, unless the eight-digit NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID is included on all claims and other electronic transactions. Attached to this notice are the exact specifications of where to place the NH provider ID on electronic claims. Also provided is information regarding where to place the NPI and taxonomy.

It is imperative that the NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID continues to be included on all claims past May 23, 2007. Without it, EDS will not be able to identify the provider submitting the claim and the claim will be rejected.

NPI and Taxonomy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all providers who submit electronic claims for medical services must apply for a National Provider Identifier (NPI) through the national enumerator. The intent of the NPI is to diminish the need for providers to maintain multiple different numbers to do business with different health plans. The NPI

is a ten-digit number, whereas the current NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID number is an 8-digit number.

When applying for a NPI, providers must designate the taxonomy(ies) that best represents their provider type, classification, and area of specialization. Taxonomy is a 10-character alphanumeric code.

Future EDS claims processing and payment depends on being able to crosswalk a provider's new NPI(s) and taxonomy code(s) to the current NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID number(s). If, prior to requesting your NPI(s) and taxonomy(ies) from the enumerator, you have questions regarding your taxonomy(ies) selection and how it might affect your claims payment with EDS, we encourage you to contact EDS for a review of your particular situation.

Sharing your NPI and Taxonomy

All NH Title XIX (Healthy Kids-Gold/Medicaid) providers who have applied for, or are in the process of applying for one or more NPI(s), are asked to provide EDS with their NPI(s) and corresponding taxonomy(ies) as soon as possible. Please forward both your NPI and taxonomy code, along with your NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID(s) that map to your NPI(s), on your office letterhead or provide a copy of your response letter from the enumerator. Please also include a contact name and phone number.

EDS' provider enrollment unit will be validating the information you provide, such as the address on the enumerator's response letter, your NPI(s), taxonomy(ies) selected and/or NH Title XIX provider number(s).

Please watch for future communication updates from EDS and DHHS on the NPI implementation status and what providers need to do to ensure uninterrupted processing of claims. Thank you for your patience and ongoing support of the program.

If you have any questions regarding this notice, please contact the EDS Provider Communications Unit at:

1-(800)- 423-8303 (NH & VT only) or (603) 224-1747.

Resources

For the latest information regarding NPI issues for health care providers, visit this web site:

<http://www.cms.hhs.gov/NationalProvIdentStand>

To obtain your NPI, visit this web site:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

For a complete list of taxonomy codes, visit this web site:

<http://www.wpc-edi.com/codes/taxonomy>

Non-healthcare or Atypical providers

The National Provider Identifier (NPI) final rule applies to healthcare providers only. All other providers are considered atypical/non-healthcare providers, and are not subject to the final rule. NH

Title XIX providers who supply non-healthcare services such as non-emergency transportation, meals on wheels, etc., will continue to submit claims and other transactions to EDS using their current NH Medicaid provider ID (Legacy ID).

The following provider types and/or non-healthcare services are considered atypical for NH Title XIX; therefore will not be sending an NPI.

Provider Type	Definition	Type	Comments
050	SCHOOL HEALTH SERVICES	B	Transportation would be atypical, code A0425 TM. T1027 TM
052	DIVISION OF PUBLIC HEALTH CLINIC	B	T1015 U2 would be atypical
053	CHAP CLINIC	B	T1027 TH, S0302 atypical
054	PLANNED PARENTHOOD CLINIC	B	T1027 TH, S0302, T1006 HF atypical
055	CHILD HEALTH CLINIC	A	T1027 TH atypical
058	ADULT MEDICAL DAY CARE	B	T2003, transportation, is atypical
059-COS 65 (DD)	HOME AND COMMUNITY BASED CARE	A	
059-COS 66(ECI)	HOME AND COMMUNITY BASED CARE-ECI	B	Res. Care assisted living, meals on wheels, homemaker services are atypical, but nursing services provided, respite care that is skilled care and home health aides (if not doing ADLs) require NPI. Emergency response services and home modifications are atypical
061	RESPIRE CARE	A	Per CMS non-healthcare
082	AMBULANCE SERVICE/WHEELCHAIR VAN	B	w/c van is atypical
084	SIGN LANGUAGE INTERPRETER	A	
093	MENTAL HEALTH CLINIC	B	Medical record copies not healthcare
094	PERSONAL CARE ATTENDANT	A	Per CMS non-healthcare services
22222222	SCPPR	B	Medical record copies are not healthcare

A= atypical provider

B= could be atypical provider depending on the service

NEW PAPER BILLING REQUIREMENTS FOR CMS 1500 FORM (08/05)

This notice contains important information regarding changes to the NH Title XIX (Healthy Kids-Gold/Medicaid) paper claims submission requirements for the revised CMS 1500 (08/05) form.

Beginning June 11, 2007 **all** CMS 1500 forms submitted to EDS for processing must utilize the reformatted CMS 1500 form (08/05). **Please Note:** claims **received** after June 8, 2007 using the old format will be returned to you without being processed.

It is extremely important that you continue to send us your NH Title XIX (Healthy Kids-Gold/Medicaid) provider ID, even after the effective date of NPI, May 23, 2007. DHHS and EDS will not be able to process and pay claims received on/or after May 23, 2007, **unless** you continue to send us your NH Title XIX (Healthy Kids-Gold/Medicaid) eight-digit provider ID (otherwise known as your legacy ID).

Please contact your software vendor, clearinghouse, and/or your internal IT department **immediately** to ensure that you can continue to send us your NH legacy provider ID on your claims. At the end of this notice are the exact specifications of where to **continue** to place your NH legacy provider ID. In addition, we have provided information regarding where to place your NPI.

These are the fields on the reformatted CMS 1500 form (08/05) that require you to make changes:

Box 17A

- In the first small box of this field
 - Use a two digit qualifier;
 - 1D= Medicaid Provider Number
- In the next box Use the Referring Physician's eight (8) digit NH Title XIX (Medicaid/Health Kids-Gold) provider number
 - Use 9999999 if provider number unknown
- field required when billing for a consultation, radiology or lab service

Box 17B

- Use the NPI of the referring provider (if available)

Box 24I

Individual Qualifier

- Use two digit qualifier
 - 1D - Medicaid Provider Number

Box 24J

Rendering Provider ID

- Use the eight (8) digit NH Title XIX (Medicaid/Health Kids-Gold) provider number in the shaded area
- Use the performing providers ten (10) digit NPI (National Provider Identification) number in the non-shaded area (if applicable)

Box 33A

- Enter the 10 digit billing provider NPI(if applicable)

Box 33B

- Use the eight (8) digit NH Title XIX (Medicaid/Health Kids-Gold) provider number

The revised billing instructions are included with this bulletin, and will also be available on the Provider Services website at: www.nhmedicaid.com.

If you have any questions regarding this notice, or need additional assistance, please contact the Communications Unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1747.

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

RELEASE AND AUTHORIZATION OF RECIPIENT INFORMATION

In order to facilitate the processing of dental requests from NH Title XIX dental providers, we thought it would be helpful for you to know that there are regulations that allow you to submit the requested recipient information to us, without an additional signed authorization from the recipient. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 164.512(d), the information sought by the Office of Medicaid, Business and Policy/Dental Unit is permitted disclosure of personal health information.

When recipients apply for medical assistance through the NH Title XIX program, they sign statements authorizing the Department of Health and Human Services to collect medical and dental records from their medical and dental providers.

If you have any questions regarding this notice, or need additional information, please contact Dr. David Gruette, at: 1-800-852-3345, ext. 4361 (in-state only), or (603) 271-4361.

BILLING FOR PERIAPICAL RADIOGRAPHS

Please note, that the reimbursement for procedure code D0230 (additional periapical radiograph) is limited to three units per date of service. If you have any questions regarding this, or need additional information, please contact Dr. David Gruette, at: 1-800-852-3345, ext. 4361 (in-state only), or (603) 271-4361.

*****HOSPITAL AND NURSING FACILITY PROVIDERS*****

NEW PAPER BILLING REQUIREMENTS FOR THE UB04 CLAIM FORM

This article contains important information regarding changes to the NH Title XIX (Medicaid/Healthy Kids-Gold) paper claims submission requirements for the revised UB04 claim form.

Beginning June 25, 2007 **all** UB claim forms submitted to EDS for processing must utilize the reformatted UB04 claim form. **Please note:** Claims **received** after June 22, 2007 using the old format will be returned to you without being processed.

It is extremely important that you continue to send us your NH Title XIX (Medicaid/Healthy Kids-Gold) provider ID, even after the effective date of NPI, May 23, 2007. DHHS and EDS will not be

able to process and pay claims received on or after May 23, 2007, unless you continue to send us your NH Title XIX eight-digit provider ID (otherwise known as your legacy ID).

Please contact your software vendor, clearinghouse, and/or your internal IT department **immediately** to ensure that you can continue to send us your NH legacy provider ID on your claims.

Of note, is the National Uniform Billing Committee's (NUBC) removal of a place for the signature. Therefore, NH Title XIX will no longer require a signature on paper UB04 claim forms. The additional changes in the reformatted UB04 Claim Form are too numerous to highlight within the body of this notice. Please review the **UB04 Paper Completion Instructions** for the specifications of where to place your NH Title XIX provider ID number (legacy ID), and information regarding where to place your NPI on your claims. This information can be found on the EDS provider website at www.nhmedicaid.com.

If you have any questions regarding this article, or need additional assistance, please contact the Communications Unit at 1-800-423-8303 (NH & VT only), or (603) 224-1747.

*****PHYSICIAN AND HOSPITAL PROVIDERS*****

ASSISTANT SURGEON BILLING MODIFIER

Please note, that when billing for services provided by an assistant surgeon, the modifier 80 must be used as the primary modifier or you will not be reimbursed correctly. If you use the modifier AS (Assist at Surgery), you will not receive the correct reimbursement rate, as this modifier is informational only.

If you have any questions concerning this notice, or need additional assistance, please contact the Communications Unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1747.

*****PHARMACY AND DME PROVIDERS*****

ENTERAL FORMULAS – REQUIRED STATEMENT OF MEDICAL NECESSITY

Please be reminded, as per provider notices of December 1992 and March 3, 1995, that when billing for enteral formulas, a statement of medical necessity must be kept on file with the dispenser. Prior authorization is not required, but the letter of medical necessity that is kept on file with the dispenser must state that the enteral formula is the sole source of nutrition and is needed to sustain life. A prescription alone will not be accepted as documentation.

Formulas for the “well child” are not covered.

Enteral formulas for children under 21 years of age, who do not meet the above criteria, will be covered only when the prescribing practitioner states that the formula is needed to sustain life, is medically necessary, and that it is the least restrictive, most cost effective service available to meet the child's needs. A current letter of medical necessity must be on file with the dispenser.

HCPC B codes are used for billing enteral formulas, and are now priced **per unit**, with a **unit being equal to 100 calories**. Therefore, the letter of medical necessity should state daily caloric diet requirements.

NOTE: Specialty Phenylketonuria (PKU) food products should be billed using code S9434 with the invoice attached to allow for manual pricing.

The above procedures do not apply to enteral formulas utilized in a nursing facility or ICF/MR, as this supply is included in the facility per diem rate.

If you have questions about enteral formula billing procedures, please contact the Communications Unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1747.

*****PSYCHOTHERAPY PROVIDERS*****

PSYCHOTHERAPY SERVICES IN EXCESS OF THE SERVICE LIMITS

Psychotherapy visits provided by ARNPs, pastoral counselors, social workers, and psychologists are limited to 12 visits per state fiscal year. Psychotherapy services provided by a psychiatrist are counted as physician visits and are included in the 18 physician visit limit per recipient per state fiscal year.

Claims exceeding the 12 visit psychotherapy limit will continue to require a prior authorization. If the prior authorization is not obtained, you will not receive reimbursement for those services. To obtain a prior authorization, you may download the “Application for Prior Authorization of Psychotherapy Services In Excess of the Service Limits” form from the EDS provider services website at www.nhmedicaid.com. Effective, July 9, 2007, requests for prior authorization of psychotherapy services in excess of the service limits must be submitted to:

Schaller Anderson Medical Administrators, Inc.
NH Medicaid Prior Authorization Unit
53 Regional Drive, Suite 201
Concord, NH 03301
Telephone: (866) 499-9335
Fax: (866) 499-9334

OVERRIDE REQUEST

Provider Name: _____
(Please type or print)

Date: _____

Provider Number: _____

Recipient Name:	Identification Number	Amount of Claim:
-----------------	-----------------------	------------------

INSTRUCTIONS:

1. Complete this form for each claim for which an override is being requested.
2. Enter the NH Medicaid Provider name, number and date of request in the spaces at the top of this form.
3. Enter the NH Medicaid Recipient's name, identification number, and the amount of the claim in the boxes provided at the top of this form.
4. Attach ONE CLEAN claim to this completed form for each request (please check type of claim being submitted): HCFA 1500 UB 92 Medicare Crossover TAD Dental

In order to be accepted the claim:

- must be legible,
- must have the exact FDOS as initial claim billed,
- must have like or corrected charges as initial claim billed.

5. If the claim was submitted previously, attach a copy of the Remittance Advice (please check all items that you have attached):

NH Medicaid RA Official EDS Correspondence 8-digit batch # (if billed electronically)
Dated _____ Dated _____ In this format: ___C_____
Dated _____

AN OVERRIDE REQUEST CAN NOT BE CONSIDERED FOR A PREVIOUSLY SUBMITTED CLAIM WITHOUT A COPY OF THE REMITTANCE ADVICE ATTACHED

- The RA must show the initial billing was less than 12 months from FDOS
 - The attached claim corrects the previous reason(s) for denial
 - All pertinent information must be circled on all RAs to pinpoint the facts and support the request: i.e., FDOS, RA dates, MID #s, Provider #s, Denial Codes
6. If the claim was not previously denied, but is over 12 months old, approval will be considered ONLY if (a) there was a delay in determining the NH Medicaid recipient's eligibility; (b) the claim is for a covered service provided during the retroactive eligibility period; and (c) the claim is submitted within six (6) months of the retroactive eligibility determination.

Please indicate type of NH Medicaid Recipient eligibility:

Regular NH Medicaid Eligibility Special Eligibility Nursing Facility

Send Completed Override Requests Plus Attachments to:

**EDS
PO Box 2040
Concord, NH 03301-2040
Attn: One Year Override**

ATTACHMENT TO THE NPI NOTICE

The following tables indicate the 837 transaction loops and segments where NH Medicaid Provider Identifiers and numbers, NPI and Taxonomy information, or your Medicare provider ID for crossover claims, are to be submitted for successful processing with NH Medicaid during our contingency period. The tables are broken out by claim types.

837I (Institutional)

X12N Loop Name	X12N Loop	Level
Billing/Pay-to Provider Hierarchical Level	2000A	Billing/Pay-to Provider Hierarchical Level
Billing Provider Name	2010AA	Billing/Pay-to Provider Hierarchical Level
Pay-to Provider Name	2010AB	Billing/Pay-to Provider Hierarchical Level
Attending Physician Name	2310A	Claim Level
Operating Physician Name	2310B	Claim Level
Other Provider Name	2310C	Claim Level
Attending Physician Name	2420A	Service Line Level (if different than claim level)
Operating Physician Name	2420B	Service Line Level (if different than claim level)
Other Provider Name	2420C	Service Line Level (if different than claim level)

In each of the loops indicated in the table above, the same “pattern” is used for reporting provider taxonomy, NPI, and other IDs. Specifically, the provider’s taxonomy is always reported in a “PRV” segment, the provider’s NPI is always reported in an “NM1” segment, and the provider’s NH Medicaid or Medicare ID is always reported in a “REF” segment. In each case, the “qualifier” element indicates what kind of identifier is being reported in the “identifier” element. The following table indicates the usage of these segments as expected by the NH Medicaid.

X12N Loop	X12N Segment	X12N Element	NH Medicaid Usage
All provider information loops (see table above)	PRV	PRV02	‘ZZ’ to indicate PRV03 is a Taxonomy Code.
	PRV	PRV03	10-character Provider Taxonomy
	NM1	NM108	‘XX’ indicates that NM109 is an NPI.
	NM1	NM109	10-digit NPI
	REF	REF01	‘1D’ to indicate REF02 is a Medicaid ID, ‘1C’ for Medicare ID.
	REF	REF02	8-digit NH Medicaid provider number or your Medicare ID

837P (Professional)

X12N Loop Name	X12N Loop	Level
Billing/Pay-to Provider Hierarchical Level	2000A	Billing/Pay-to Provider Hierarchical Level
Billing Provider Name	2010AA	Billing/Pay-to Provider Hierarchical Level
Pay-to Provider Name	2010AB	Billing/Pay-to Provider Hierarchical Level
Referring Provider Name	2310A	Claim Level
Rendering Provider Name	2310B	Claim Level
Purchased Service Provider Name	2310C	Claim Level (Doesn’t use PRV Segment)
Service Facility Location	2310D	Claim Level (Doesn’t use PRV Segment)
Supervising Provider Name	2310E	Claim Level (Doesn’t use PRV Segment)
Other Payer Referring Provider	2330D	Claim Level (Doesn’t use PRV Segment, NM1 not used for NPI)

X12N Loop Name	X12N Loop	Level
Other Payer Rendering Provider	2330E	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Purchased Service Provider	2330F	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Purchased Facility Location	2330G	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Supervising Provider	2330H	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Rendering Provider Name	2420A	Service Line Level (if different than claim level)
Purchased Service Provider Name	2420B	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Service Facility Location	2420C	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Supervising Provider Name	2420D	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Ordering Provider Name	2420E	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Referring Provider Name	2420F	Service Line Level (if different than claim level)

In each of the loops indicated in the table above, the same “pattern” is used for reporting provider taxonomy, NPI and other ID’s. Specifically, the provider’s taxonomy is always reported in a “PRV” segment, the provider’s NPI is always reported in an “NM1” segment, and the provider’s NH Medicaid or Medicare ID is always reported in a “REF” segment. In each case, the “qualifier” element indicates what kind of identifier is being reported in the “identifier” element. The following table indicates the usage of these segments as expected by NH Medicaid.

X12N Loop	X12N Segment	X12N Element	NH Medicaid Usage
2000A, 2010AA, 2010AB, 2310A, 2310B, 2420A, 2420F	PRV	PRV02	‘ZZ’ to indicate PRV03 is a Taxonomy Code.
	PRV	PRV03	10-character Provider Taxonomy
2000A, 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2310E, 2420A, 2420B, 2420C, 2420D, 2420E, 2420F	NM1	NM108	‘XX’ indicates that NM109 is an NPI.
	NM1	NM109	10-digit NPI
All provider information loops.	REF	REF01	‘1D’ to indicate REF02 is a Medicaid ID, ‘1C’ for Medicare ID.
	REF	REF02	8-digit NH Medicaid provider number or your Medicare ID

837D (Dental)

X12N Loop Name	X12N Loop	Level
Billing/Pay-to Provider Hierarchical Level	2000A	Billing/Pay-to Provider Hierarchical Level
Billing Provider Name	2010AA	Billing/Pay-to Provider Hierarchical Level
Pay-to Provider Name	2010AB	Billing/Pay-to Provider Hierarchical Level
Referring Provider Name	2310A	Claim Level
Rendering Provider Name	2310B	Claim Level
Service Facility Location	2310C	Claim Level (Doesn't use PRV Segment)
Assistant Surgeon Name	2310D	Claim Level
Other Payer Referring Provider	2330D	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Rendering Provider	2330E	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Rendering Provider Name	2420A	Service Line Level (if different than claim level)
Assistant Surgeon Name	2420C	Service Line Level (if different than claim level)

In each of the loops indicated in the table above, the same “pattern” is used for reporting provider taxonomy, NPI and other ID’s. Specifically, the provider’s taxonomy is always reported in a “PRV” segment, the provider’s NPI is always reported in an “NM1” segment, and the provider’s NH Medicaid or Medicare ID is always reported in a “REF” segment. In each case, the “qualifier” element indicates what kind of identifier is being reported in the “identifier” element. The following table indicates the usage of these segments as expected by the NH Medicaid.

X12N Loop	X12N Segment	X12N Element	NH Medicaid Usage
2000A, 2010AA, 2010AB, 2310A, 2310B, 2310D, 2420A, 2420C	PRV	PRV02	‘ZZ’ to indicate PRV03 is a Taxonomy Code.
	PRV	PRV03	10-character Provider Taxonomy
2000A, 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2420A, 2420C	NM1	NM108	‘XX’ indicates that NM109 is an NPI.
	NM1	NM109	10-digit NPI
All provider information loops.	REF	REF01	‘1D’ to indicate REF02 is a Medicaid ID, ‘1C’ for Medicare ID.
	REF	REF02	8-digit NH Medicaid provider number or your Medicare ID

NH Title XIX (Healthy Kids-Gold/Medicaid)
CMS 1500 Form (08/05) Completion Instructions

Box 1

Carrier identification

- Check the Medicaid box

Box 1a

Insured's ID number

- Enter the patient's Title XIX (Medicaid/Healthy Kids-Gold) ID#
- Must be eleven characters

Box 2

Patient's name

- Enter recipient's last name and first name as shown on their NH Title XIX (Medicaid/Healthy Kids-Gold) card

Box 3

Patient's Date of Birth

- Optional field

Box 9d

Insurance Plan Name or Program Name

- Indicate the other insurance plan(s) carrier code(s)
- Up to three (3) carrier codes in this field (one per carrier)
- The four digit carrier code can be obtained by:
 - Refer to provider website and quarterly bulletins for updates
 - The Carrier Code list can be located on the Provider Services website at <http://www.nhmedicaid.com/Downloads/Fees&Codes/OTHER%20INSURANCE%20LIST.xls> or;
 - Contact the Communications unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1747

Box 10

Is Patient's Condition Related To:

- Check boxes Yes or No for A, B and C

Box 11d

Is There Another Health Benefit Plan?

- Check Yes or No
 - If Yes, please ensure you have listed the appropriate carrier code(s) in Box 9d

Box 14

Date of Current:

- Use only if indicated Yes in Box 10
- Valid format of mmddccyy, e.g., 12012005

Box 17

Name of Referring Physician

- Use full name if number not known
 - Required when billing for a consultation, radiology or lab service

Box 17A

- Use two digit qualifier
 - 1D Medicaid Provider Number
- In the next box Use the Referring Physician's eight (8) digit NH Title XIX (Medicaid/Health Kids-Gold) provider number
 - Use 9999999 if provider number unknown
 - Required when billing for consultation, radiology or lab service

Box 17B

- Use the NPI of the referring provider (if available)

Box 19

Reserved for Local Use

- Enter remarks for unusual services, if applicable
 - Be clear and concise
 - Example: "This is not a duplicate" or "not covered by other insurance" and state why

Box 21

Diagnoses (Relate Items 1, 2, 3 or 4 to Item 24E by line)

- Up to four ICD9-CM codes
 - Follow the numbering of 1,2,3 or 4 in Box 21

Box 23

Prior Authorization Number

- Enter the NH Title XIX (Medicaid/Healthy Kids-Gold) prior authorization number that applies to this claim, if applicable

Box 24A

Date(s) of Service

- Enter the “From” and “To” date(s) of service
- Valid format of mmddccyy, e.g., 12012005

Box 24B

Place of Service (POS)

- Enter the appropriate two (2) digit POS code
- Use the provider billing manual as a reference guide.
- The billing manual can be located on the Provider Service website at <http://www.nhmedicaid.com/Downloads/manuals.html>

Box 24D

Procedure Code(s) (CPT/HCPCS and Modifiers)

- Enter the appropriate five (5) digit procedure code as per the current year CPT and HCPC II guidelines
- Use any applicable current year CPT and HCPC II guidelines modifiers
 - Medicaid allowed CPT and HCPC modifier combinations can be located on the Provider Service website at: http://www.nhmedicaid.com/Downloads/Fees&Codes/mod_06.xls

Box 24E

Diagnosis Code

- Enter applicable diagnosis pointer reference number(s) from Box 21 per line
 - Separate by comma if more than one diagnosis pointer per detail

Box 24F

Detail Charges

- Enter charge for services rendered by line
- Multiply your single unit charge by the number of units you billed in Box 24g and enter the calculated charge
- Must be in a valid currency format dd.cc, e.g., 24.00

Box 24G

Days or Units

- Enter number of days or units of service per line
 - Utilize the current year CPT/HCPC guidelines for the definition of a unit per procedure code
- Five (5) characters or less
- No decimal points

- Must be whole units or days only

Box 24H

EPSDT Family Plan

- N/A

Box 24I

Individual Qualifier

- Use two digit qualifier
 - 1D - Medicaid Provider Number

Box 24J

Rendering Provider ID

- Use the eight (8) digit NH Title XIX (Medicaid/Health Kids-Gold) provider number in the shaded area
- Use the performing providers ten (10) digit NPI (National Provider Identification) number in the non-shaded area (if applicable)

Box 25

Federal Tax I.D. number

- Optional field
- Enter your Federal Tax I.D. number or Social Security Number and check box indicating FEIN or SS#

Box 26

Patient's Account Number

- Optional field
- If you enter patient account number, we will report back to you on your remittance advice (RA)
- Up to twelve (12) characters

Box 28

Total Charge

- Enter your total charge
- Must equal the total of all entries on field 24f
- Up to nine (9) characters
- Must be in a valid currency format dd.cc, e.g., 24.00

Box 29

Amount Paid

- Indicate any payment for other insurance, if applicable
 - If none, leave blank
- If more than one payment add total payment together and enter one amount
- Up to nine (9) characters
- Must be in a valid currency format dd.cc, e.g., 24.00
- Must fill in if “other insurance” carrier code is indicated in Box 9d and there is nothing indicated in box 19

Box 30

Balance Due

- Subtract other insurance payment from your total charge in Box 28
 - This will be the balance to NH Title XIX (Medicaid/Healthy Kids-Gold) Program
- Up to nine (9) characters
- Must be in a valid currency format dd.cc, e.g., 24.00

Box 31

Signature of Physician or Supplier

- Must be an actual signature or signature stamp of the provider or individual authorized to sign on behalf of the provider
- Enter the date when the bill was signed
- Must be in mmddccyy format, e.g., 12012005
- Must be **on** or **after** the “To” date of service

Box 33

Billing provider Info & PH #

Box 33A

- Enter the 10 digit billing provider NPI (if applicable)

Box 33B

- Use the eight (8) digit NH Title XIX (Medicaid/Health Kids-Gold) provider number

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

STATE PLANS FOR MEDICAL ASSISTANCE^[3]



SEC. 1902. *[42 U.S.C. 1396a]*(a) A State plan for medical assistance must—

(68)^[35] provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code^[36], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section [1128B\(f\)](#));

**June 2007 - Volume XII, Issue VII
NH MEDICAID BULLETIN**

**Editors: Medicaid Policy Unit
Provider Relations, EDS**

Published quarterly by: NH MEDICAID/EDS

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