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 IV	MARCH 2006

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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 2006 calendar year are:

Memorial Day	Monday	May 29, 2006
Independence Day	Tuesday	July 4, 2006
Labor Day	Monday	September 4, 2006
Veteran's Day	Friday	November 10, 2006
Thanksgiving Day**	Thursday	November 23, 2006
Day after Thanksgiving	Friday	November 24, 2006
Christmas Day	Monday	December 25, 2006

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.

BULLETIN CHANGE – IMPORTANT! PLEASE TAKE NOTE

As announced in the December, 2005 NH Medicaid Bulletin, this March, 2006 Bulletin is the first edition for which providers are being mailed a fold-over, single page document which contains the table of contents of this edition (instead of the entire NH Medicaid Bulletin), instructing them to download and print the bulletin. **Providers are expected to download and maintain a copy of the bulletin in order to comply with their signed provider enrollment agreement** which states, in part: ". . . agree to abide by all the rules, regulations, billing manuals, and bulletins promulgated by the Department pertaining to the provision of care or services under NH Title XIX and the claiming of payments for those services."

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 in any of the above-noted areas, 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." 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.

ONE-YEAR OVERRIDE REQUEST

The purpose of an override request is to allow a claim that has previously been submitted and denied to be resubmitted for consideration after the one year filing limit and within fifteen (15) months of the date of service, or to allow a claim to be submitted when the recipient's NH Title XIX eligibility has been made retroactive, if after the one-year filing limit. Form 957X, "Override Request," is to be used when making this request; a copy of this form may be found in the appendix at the end of this bulletin, or as a download from the EDS Provider web-site at:

www.nhmedicaid.com

To complete the override request, please enter the information as requested in items 1 through 4 on Form 957X.

Please complete **item 5** if the **claim had previously been submitted and denied** within 12 months from the date of service. Please remember, as stated in item 5, that a copy of the applicable Remittance Advice showing the denial within 12 months of the date of service must accompany each resubmitted claim and override request.

Please complete **item 6** if claim is being submitted during a **retroactive eligibility period, even if the claim had been previously submitted**. Please write in the retroactive eligibility start date. The claim must be received within six months of the retroactive eligibility determination.

Please submit this request along with a completed claim which meets OCR guidelines, and, when applicable, a copy of the Remittance Advice, to:

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

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

OPTICAL CHARACTER RECOGNITION (OCR) PAPER CLAIMS SCANNING PROCESS

We are reminding all providers that the current paper billing guidelines went into effect on July 1, 2003. In March 2003, providers received an important notice regarding these changes; workshops were held in April and May of 2003, and June and October of 2004, as well. If you did not receive this information please go to our provider web site www.nhmedicaid.com to obtain a copy of the information that was provided.

To avoid a delay in your payment because of claims returned as unable to be processed, please remember the following:

- Include the other insurance **4 digit** carrier code **(do not include carrier name)** in the appropriate area on the claim (if applicable)
  - CMS 1500 - box 9d
  - UB-92 - box 50
  - ADA 1999, version 2000 - box 36
- Please indicate the other insurance payment on the claim form (if applicable)
  - CMS 1500 - box 29
  - UB-92 - box 54
  - ADA 1999, Version 2000: total fee - payment by other plan = carrier pays (box 60)
- Other insurance denial reason(s) should be indicated on claim; please enter information in correct box (if applicable)
  - CMS 1500 - box 19
  - UB-92 - box 84
  - ADA 1999, version 2000 - box 60

Remember, effective July 1, 2003, paper crossovers were required to be attached to a claim form. The claim form must:

- Match the claim type of the EOMB; and
- Outpatient claims can not have a date span.
  - If crossovers span more than a day on outpatient, 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 services up to one claim, carefully adding the units and dollars.

What Will Cause My Claim to be Returned as Unprocessed Under the OCR Rules?

As of July 1, 2003, **paper claims** began to be imaged and then went 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 UB92 or CMS 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.

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.

HOW TO BILL COVERED AND NON-COVERED SERVICES WHEN MEDICARE IS PRIMARY- REVISED ARTICLE

The December 2005 article entitled "How to Bill Medicare Covered and Non-Covered Services to Medicaid When Medicare is Primary" has resulted in questions from the provider community. The article did not specifically state that Medicare covered services means Medicare **approved services, applied to deductible or coinsurance.** Therefore, this revision is to clarify that Medicare **covered services means Medicare approved services, applied to deductible or coinsurance** and that providers must send an Explanation of Medicare Benefits (EOMB) with each claim.

An EOMB may have multiple lines for the same claim. In cases where there are both allowed and denied service lines on the same claim, two separate claims must be submitted, one for the covered services (any line indicating a **deductible** or **coinsurance** amount), and one claim for the non-covered services. In these cases, please adhere to the following guidelines for proper claims processing:

<u>Covered services must be billed as follows</u>:

1. Send a claim with only the covered service(s) listed. Make sure the carrier code "0088" is indicated in the proper field (CMS 1500 form field 9D, UB92 form field 50A);
2. Attach the EOMB and cross out the non-covered service(s) and update the totals on the EOMB accordingly to match the claim totals, or use a crossover form which can be obtained from the provider website at www.nhmedicaid.com;
3. Enter the amount that Medicare paid, in box 29 on the CMS 1500 form, or box 54 for the UB92 form; and
4. Submit claim to EDS for processing:

a) The claim will process the Medicare allowed service(s) on the EOMB based on the NH Medicaid allowed amount.

Non-covered services must be billed as follows:

1. Send a claim with only the non-covered service(s) listed, making sure the carrier code "0088" is indicated in the proper field (CMS 1500 form field 9D, UB92 form field 50A);
2. List the required denial reason in the remarks field (e.g. "non-covered service by Medicare") in field 19 for the CMS 1500 form, or field 84 for the UB92 form;
3. Do **NOT** attach the EOMB; and
4. Submit the claim to EDS for processing:
   a) The claim will process the Medicare non-covered service(s) based on the NH Medicaid allowed amount.

"WEB PASSWORD HAS EXPIRED" – WHAT TO DO IF YOU GET THIS ERROR MESSAGE

If you receive the error message "Web Password Has Expired" when attempting to access the EDS website that requires a password to access, please follow these instructions:

1. Go to www.nhmedicaid.com ;
2. Click on "Transaction Services";
3. Click on "Production Login";
4. Enter your Trading Partner ID# for the "User ID" (Trading Partner ID's are nine digits long, beginning with an "8");
5. Enter your most current web password in the password field;
6. Click "Log In" (You will be prompted to enter a new password and confirm it);
7. Enter a new password, ensuring you use at least 6 characters (alphanumeric characters only, no symbols or punctuation);
8. Click "Continue" (You will then be taken to a page that allows you to upload or download);
9. In the upper right-hand portion of screen click "Log Off";
10. Now open the Provider Electronic Solutions software program;
11. (Please note: the password you just changed on the web did NOT change the password to open the software program);
12. From the Main Menu at the top of the screen, select "Tools";
13. Under the "Tools" menu, click on "Options" (DO NOT click on "Change Password" as that function does not pertain to the web password);
14. On the "Batch" tab you will see a "Password" field on the right-hand side of the screen, next to "Submitter ID." Change this password to match the one you just selected on the website; and
15. Click "OK." The screen will save and close. (DO NOT click "Close" or the screen will close without saving the changes.)

This will need to be done approximately every 30 days. For security purposes, Web passwords for all Trading Partners expire at random intervals.

IMPORTANT NOTE: If after following these instructions you have another failed submission, check your Communication Log for error messages. If you receive an error message stating "user authentication failure" that means that the web password listed on the "Batch" tab in the software does not match your Trading Partner web password. If this happens, please try all steps again.

If further assistance is needed, please contact the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

THIRD PARTY LIABILITY CARRIER CODE ADDITIONS/CHANGES

The following third party liability carrier codes have been re-activated (taken out of archives) since the December 2005 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0349	PACIFIC SOURCE HEALTH PLANS, 110 International Way, Springfield, OR 97477

The following third party liability carrier codes have been added since the December 2005 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0755	HBS Claims, SCA Claims Unit, PO Box 292580, Lewisville, TX 75029-2580
0756	CIGNA Prescription Management, PO Box 3598, Scranton, PA 18505-3598
0757	DELTA DENTAL- TN, 240 Venture Circle, Nashville, TN 37228-1699
0758	DELAWARE PHYSICIANS CARE INC, Claims Submission, PO Box 61145, Phoenix, AZ 85082-1145
0759	CAREFIRST, 300 Cornerstone Dr., Suite 305, Williston, VT 05405
0760	NATIONAL PHARMACEUTICAL SERVICES, PO BOX 407, Boystown, NE 68010

The following third party liability carrier codes have had changes since the December 2005 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0001	AETNA US Healthcare, PO Box 981109, El Paso, TX 79998-1109
0009	CIGNA/CONN GENERAL, PO Box 5200, Scranton, PA 18505-5200
0043	CIGNA HEALTHCARE OF NH, PO Box 2041, Concord, NH 03302-2041
0053	AP-CIGNA, PO Box 5200, Scranton, PA 18505-5200
0104	CIGNA RX PRIME, PO BOX 3598, Scranton, PA 18505- address change only
0114	Retail/Caremark Pharmacy Program (formerly Retail Pharmacy Program)- name change only
0639	IBEW Local 490 Health and Welfare Fund, 48 Airport Road, Concord, NH 03301- address change only

STATE AND FEDERAL EXCLUSIONS

Has your practice or agency hired an excluded individual?
Exclusions are sanctions imposed by state or federal agencies prohibiting individuals, health care practices, corporations, and/or other entities from participating in any Medicaid and Medicare Programs. State and federal rules and regulations prohibit health care providers and entities from employing or entering into contracts with excluded individuals or entities to provide items or services to state and federal program recipients. Providers that receive state and/or federal funds may employ or contract with excluded individuals only in those situations where state and federal

funds are not used to compensate the individual and the services are provided solely to non-state/federal program recipients.

Please be aware that under certain circumstances, healthcare providers may be held financially liable for employing or contracting with excluded individuals or entities. In addition to full restitution, providers may be subject to Civil Monetary Penalties (CMP) of up to $10,000 for each item or service furnished by the excluded individual or entity.

All providers are urged to take precautionary measures to ensure that they are not employing or contracting with excluded individuals/entities. As a first step, providers should check the federal Department of Health and Human Services, Office of Inspector General's (OIG) web site that provides a searchable national database of all excluded individuals and entities at:

http://oig.hhs.gov/fraud/exclusions.html

It is recommended that health care providers periodically check this web site, for determining exclusion of current employees and contractors. This site is updated monthly.

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

Provider tips:

- Check all potential employers or contractors on the OIG web site;
- Include a question on all applications for employment asking whether the applicant **has ever** been excluded from participating in Medicaid and/or Medicare;
- Include a question on all applications for employment asking whether the applicant **is currently** excluded from participating in Medicaid and/or Medicare;
- Ask the applicant to produce a letter from the federal Department of Health and Human Services and/or the state Department of Human Services indicating their reinstatement into Medicaid and/or Medicare, if an applicant indicates that their exclusion has expired; and
- Begin an ongoing process to periodically verify that all current employees and contractors are not listed on the OIG exclusion database.

The intent of this article is to inform providers of the increased interest at the federal level in monitoring compliance of the exclusion provisions. As failure to comply may carry severe financial penalties, we hope this information will be of some assistance to our provider community in preventing such penalties.

RECORD KEEPING REQUIREMENTS

We are reminding all providers of the requirement specified on the provider enrollment agreement, signed by providers upon enrollment into the Title XIX program, that clinical records to support claims submitted for reimbursement must be maintained for a period of at least 6 years from the date of service or until the resolution of any legal action(s) commenced in the 6 year period, whichever is longer.

RATE CHANGES
The following rate changes are in place effective January 1, 2006 for the following **home care services:**

National code	National Code Description	Modifiers	Current Rate	New Rate
G0154	Nursing-HHCP- Svs of RN, Ea 15 min.		$18.95	$19.82
G0154	Nursing-HHCP- Svs of RN, Ea 15 min	U5 (Level of Care 5)	$18.95	$19.82
G0154	Nursing-HHCP- Svs of RN, Ea 15 min	U9 (Level of Care 9)	$18.95	$19.82
G0156	Home Health Aid/Lower Rate		$5.25	$5.49
S9123	Nursing Care In-Home RN		$38.00	$39.75
T1019	Personal Care Services		$4.00	$4.18
97110	Physical Therapy- Exercise 15 minutes		$23.25	$24.32
97140	PT Therapy Techniques (mobilization manual lymphatic 15 minutes)		$23.25	$24.32
97530	OT Therapeutic Activities, Direct 1 on 1 Patient Contact 15 minutes		$21.45	$22.44
92507	Speech, Language, Hearing Therapy- Individual 15 minutes		$16.80	$17.57
S5102	Adult Day Care Services		$45.00	$47.07

*** AMBULANCE SERVICES PROVIDERS ***

NEW AMBULANCE CODE
Effective for dates of service (DOS) on and after January 1, 2006, New Hampshire Title XIX will adopt the Current Procedural Terminology and Healthcare Common Procedure Coding (HCPCS) code A0998 (ambulance response and treatment, no transport) that replaces HCPCS procedure code T2006. The allowable amount will be $35.00. This code is to be used exclusively after an ambulance responds to the scene, and the recipient receives an evaluation and treatment only, with no subsequent transport.

REMINDERS
Title XIX will cover emergency ambulance services when the services are documented as medically necessary, meet the destination limits of nearest acute care hospital, and are provided by an ambulance service that is licensed by the state.

Also, please note that a maximum of one unit is allowed for each base rate trip.

Medical Necessity

- Ambulance services must be documented as medically necessary by using the advanced life support (ALS) or basic life support (BLS) Ambulance Medical Necessity form, completed by someone with medical knowledge of the case, and signed by a physician (MD), physician assistant (PA), advanced registered nurse practitioner (ARNP), registered nurse (RN),

clinical nurse specialist (CNS), or discharge planner who is directly responsible for the patient's care;
- The Ambulance Medical Necessity Form must be submitted with each paper claim submission or kept on file if the claim is submitted electronically; and
- Providers must use the appropriate form for either advanced life support services or basic life support services specific to the NH Title XIX Program, entitled "Ambulance Medical Necessity Form", which can be obtained at www.nhmedicaid.com.

Definitions:

Advanced life support (ALS) services means services provided by an ambulance certified to provide specialized life-sustaining services and equipment such as intravenous medication, anti-shock trousers, establishing and maintaining a patient's airway, defibrillating the heart, relieving pneumothorax conditions, and EKG monitoring within the scope of practice rendered by advanced emergency medical care providers.

Note: An ALS assessment does not necessarily result in a determination that the recipient requires an ALS level of service. Payment is based on level of service provided, not on the vehicle used. Even if a local government requires an ALS response for all calls, Title XIX pays only for the level of service provided and when medically necessary.

Basic life support (BLS) services means services provided by an ambulance that provides transportation plus the equipment and staff needed for such services as control of bleeding, splinting fractures, treatment for shock, delivery of babies and cardio-pulmonary resuscitation within the scope of non-invasive practice rendered by emergency medical care providers.

Billable ambulance services procedure codes:

A0425	Ground mileage ALS and BLS	Refer to fee schedule
A0427	Ambulance Service, Advanced Life Support, multiple levels	Refer to fee schedule
A0428	Ambulance service, non-emergency transport (BLS)	Refer to fee schedule
A0429	Ambulance service, basic life support emergency (BLS)	Refer to fee schedule
A0433	Advanced Life Support	Refer to fee schedule
A0434	Specialty Care	Refer to fee schedule
A0998	Ambulance response and treatment, no transport	Refer to fee schedule

DURABLE MEDICAL EQUIPMENT AND PHARMACY PROVIDERS

CRANIAL HELMET- CORRECT BILLING CODE AND PRIOR AUTHORIZATION

Effective immediately, **procedure code S1040** is to be used for **ALL** cranial remolding orthoses. Additionally, the NH Title XIX program requires that all services for this procedure code be prior

authorized for medical necessity. Documentation to support medical necessity of the cranial remolding helmet must be included with each request for prior authorization to include skull base asymmetry measurements. The helmet must not be fabricated until a request for prior authorization has been approved.

To ensure that prior authorization requests are processed accurately and timely, please provide the following information with the prior authorization request:

- The NH Title XIX billing provider number of the cranial helmet provider;
- The HCPC code S1040 with any applicable billing modifiers;
- Any medical information that will assist with the review of the request for prior authorization, such as the patient's diagnosis, the reason the service is being requested, and any additional tests or services that were performed prior to the request;
- Skull base asymmetry measurements; and

Please fax the request for prior authorization to the Prior Authorization Unit at (603) 271-4376.

When billing for the above prior authorized service, please be sure that the following information is included on the claim so that your claim does not deny:

- The NH Title XIX billing provider number;
- The HCPC code S1040 with applicable billing modifiers (must match the prior authorization);
- The number of units requested (must match those listed on the prior authorization, and must not exceed what has been authorized as indicated on the prior authorization);
- The date of service on the claim must fall within the date range listed on the prior authorization;
- The prior authorization number assigned via the prior authorization letter is included in the appropriate form locator on the claim:
    1. Form locator 23 on the CMS/HCFA 1500 claim form; and
    2. Form locator 63 on the UB92.

Note: When submitting a paper claim, you must adhere to OCR billing guidelines.

If the prior authorization letter does not contain the correct information, please forward a corrected prior authorization request to the Prior Authorization Unit indicating you are making a "correction request".

A prior authorization does not guarantee payment. Please confirm the following information with the Communications Unit or via the AVR by calling 1-800-423-8303 (NH & VT only) or (603) 224-1747 prior to providing the service:

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

HOSPITAL AND PHYSICIAN PROVIDERS

REMINDER- STERILIZATION CLAIM POLICY

Federal regulation, 42 CFR Part 50, requires that documentation of informed consent be obtained when medical procedures, funded by a federally assisted public health program, are performed that result in the sterilization of a recipient. Documentation of informed consent must include the signatures of the recipient, the person obtaining the consent, the interpreter if used, and the attending physician.

All procedures that result in the sterilization of a recipient require documentation of informed consent. Informed consent is obtained from the recipient by using Form 112. This completed consent form must be attached to the claim form when submitting charges. A signed Form 112 must be obtained from all recipients undergoing a sterilization procedure.

The sterilization cannot be performed sooner than 30 days after the Form 112 is signed or later than 180 days after the date of signature on the Form 112. The only exceptions to this time frame are for Premature Delivery or Emergency Abdominal Surgery.

A copy of the Form 112 appears in the Appendix of this bulletin and may also be obtained in both English and Spanish, from the provider website at: www.nhmedicaid.com. Any claims for sterilization procedure charges received by EDS that do not have a valid Form 112 attached will be denied.

Detailed billing guidelines for submitting claims related to sterilization procedures may be found in Section 2 of your provider-specific NH Title XIX Billing Manual.

If you have questions regarding the content of this article, please contact the Communications Unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1717.

PHYSICIANS

ANESTHESIA SERVICES- (SUPERVISION AND BILLING)

Please note that the NH Title XIX program currently does not allow for separate billing for the nurse anesthetist and the supervising anesthesiologist. These services must be billed as one service. The department is currently researching the feasibility of allowing for the services to be billed separately.

PHYSICIAN, ARNP AND DIAGNOSTIC IMAGING PERFORMING FACILITIES

NEW DIAGNOSTIC IMAGING PRIOR AUTHORIZATION REQUIREMENTS

The Department of Health and Human Services, will soon launch a prior authorization program for certain non-emergent, high cost diagnostic imaging services. This program is part of an effort to seek balance between excellent clinical care and sound business practice. The following diagnostic radiological services will require prior authorization:

- Computerized tomography (CT);
- Magnetic resonance imaging (MRI);
- Magnetic resonance angiography (MRA);
- Positive emission tomography (PET); and
- Nuclear cardiology.

The above diagnostic imaging services will be exempt from prior authorization requirements when services are provided:

- As part of a hospital emergency department visit;
- As part of a recipient's inpatient hospitalization; or
- Concurrent with, or on the same day as, an urgent care facility visit.

Please watch for upcoming provider notices, as well as individual mailings, that will outline the specific details and timeframes concerning this new program.

State of New Hampshire
Department of Health & Human Services
Office of Medicaid Business and Policy

957X
02/02

OVERRIDE REQUEST

Provider Name: ________________________________ Date: ______________________
(Please type or print)

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 Dated __________ ☐ Official EDS Correspondence Dated __________ ☐ 8-digit batch # (if billed electronically) 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

FORM 112

Form Approved OMB
No. 0937-0166 Exp. date 12-95

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from ______________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ______________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ______________ (Month Day Year)

I, ______________________, hereby consent of my own free will to be sterilized by ______________ (doctor) by a method called ______________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

______________________ Signature   Date: ______________ Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

______________________ Interpreter   Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before ______________________ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation ______________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

______________________ Signature of person obtaining consent   Date

______________________ Facility

______________________ Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon ______________________ (Name: individual to be sterilized) on ______________ (Date: sterilization operation) I explained to him/her the nature of the sterilization operation ______________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's expected date of delivery: ______________

☐ Emergency abdominal surgery:
(describe circumstances):

______________________ Physician

Date ______________

1. Patient

(CUT ALONG THIS LINE)

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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:

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