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.

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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 remainder of the 2007 calendar year are:

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 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.

FREQUENTLY ASKED BILLING QUESTIONS

Can I get a copy of a previous Remittance Advice?

The Remittance Advice (RA) is a tool intended to be used by providers for reconciling accounts receivable, and should **not** be discarded. RAs are considered legal documents, and must be maintained by providers for a minimum of six (6) years. EDS cannot routinely be providing copies of this document for you.

What is the time limit for filing my claims with NH Title XIX (Healthy Kids-Gold/Medicaid) Program?

Claims must be filed within **one year of earliest date of service** on claim, and resubmissions can be submitted up to 15-months from the service date.

- Claims previously submitted and denied, that exceed the 12-month filing limit but are within the 15-month filing limit, must be sent on paper using the 957X form (One Year Override Request Form) to the One Year Override Unit, with request for consideration. Attach proof of the original submission (corresponding page from your NH Medicaid remittance advice, Official EDS Correspondence, or 8-digit batch number, if billed electronically).
- Claims exceeding the 12-month filing limit, that are within 6 months of a correction made to the recipient's eligibility, must also be sent on paper with the 957X form (One Year Override Request Form) to the One Year Override Unit with request for consideration.

Can providers bill the recipient for services not paid by the NH Title XIX (Healthy Kids-Gold/Medicaid) Program?

You may NOT bill Medicaid recipients if the only reason for claim denial is a provider billing error, e.g., provider name/number mismatch. There are very limited circumstances when you may bill a NH Title XIX (Healthy Kids-Gold/Medicaid) Program recipient. You may bill the NH Title XIX (Healthy Kids-Gold/Medicaid) Program recipient for:

- Non-covered services
- Services exceeding the service limit cap if a prior authorization to exceed the cap has not been obtained

You may only bill the recipient if you inform the recipient in writing before the service is provided that she or he will be responsible for the bill and why.

** Please note, in accordance with federal guidelines, recipients **cannot** be billed for missed or broken appointments.

How do I submit a claim when both Medicare covered and non-covered services are on the same Medicare explanation of benefits (EOMB)?

An EOMB may have multiple lines for the same claim. In instances where there are both allowed and non-covered Medicare services on the same EOMB, they must be submitted to EDS as two **(2) separate claims**; one (1) claim for the Medicare *covered* services, and one (1) claim for the Medicare *non-covered* services.

Please follow the guidelines below for proper claims processing:

The Medicare **covered** items must be submitted as follows:

- Send a claim with only the Medicare covered service(s) listed, making sure the carrier code "0088" is indicated in the proper field (CMS1500 form field 9D, UB04 form field 50A).
- Attach the EOMB crossing out the Medicare non-covered services and updating the totals on the EOMB accordingly to match the claim totals. Another option is to use a Crossover Form to replace the EOMB. This form can be found on our website or use this link (Crossover Form)
- In box 29 for the CMS1500 Form and box 54 for the UB04, enter the amount that **Medicare paid**.
- Submit claim to EDS for processing as a Medicare crossover claim.

The Medicare **non-covered** items must be submitted as follows:

- Send a claim with only the Medicare non-covered service(s) listed, making sure the carrier code "0088" is indicated in the proper field. (CMS1500 form field 9D, UB04 form field 50A.)
- List required denial reason in remarks field (e.g. "non-covered service by Medicare" in field 19 for the CMS1500 form, field 80 for the UB04 form.)
- Do NOT attach EOMB.
- Submit claim to EDS for processing as NH Title XIX (Healthy Kids-Gold/Medicaid) primary paid claim.

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.

MEDICAID MEDICAL SERVICES UNIT HAS RELOCATED

The unit previously known as the NH Medicaid Prior Authorization Unit, now called Medicaid Medical Services, has moved from its Hazen Drive location. Please update your files with the new information:

Medicaid Medical Services
129 Pleasant Street
Annex-1
Concord, NH 03301-3857

The **new fax number is: (603) 271-8431**

The staff members and their corresponding phone numbers remain the same, as follows:

Patti Dean	271-5219
Chip Nadeau	271-4364
Jane Turgeon	271-4823

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 that went into effect 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, it was likely that DHHS' claims processing system run by EDS would 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 after May 23, 2007. This Provider Identifier is the eight-digit number that was assigned to providers by EDS.**

2. **All Providers must submit their National Provider Identifier(s) and corresponding taxonomy code(s) 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 can also be found in the March 2007 NH Medicaid Quarterly Bulletin. 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 identification number 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 from 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 identification number 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 identification number is included on all claims and other electronic transactions. At the end of this notice are the exact specifications of where to place the NH Title XIX provider identification number on electronic claims. Also provided is information regarding where to place the NPI and taxonomy code(s).

It is imperative that the NH Title XIX (Healthy Kids-Gold/Medicaid) provider identification number continues to be included on all claims following the May 23, 2007 effective date. 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 identification number is an 8-digit number.

When applying for a NPI, providers must designate the taxonomy code(s) that best represents their provider type, classification, and area of specialization. The taxonomy code 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 identification number(s). If, prior to requesting your NPI(s) and taxonomy code(s) from the enumerator, you have questions regarding your taxonomy code(s) 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 code(s) as soon as possible. Please forward both your NPI and taxonomy code(s), along with your NH Title XIX (Healthy Kids-Gold/Medicaid) provider identification number(s) that map to your NPI(s), on your office letterhead, or provide a copy of your response letter from the enumerator. Please 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 code(s) 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 ADL's) require NPI. Emergency response services and home modifications are atypical
061	RESPITE 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 ether depending on the service

PROVIDER PAYMENT RATE INCREASES

As a result of Chapter 263:109, Laws of 2007, the provider types listed below received rate increases. Contact the EDS Communications Unit at 1-(800)- 423-8303 (NH & VT only) or (603) 224-1747, for the correct modifier and rate information.

PROVIDER TYPE	EFFECTIVE DATE OF RATE INCREASE	RATE INFORMATION
Skilled Nursing Facilities and Intermediate Care Facilities	7/1/07	BEAS will apply a 2% rate increase through its semi-annual rate setting process that occurs in August and February.
Ambulance Services	7/1/07	Mileage rate was increased 13%, from $2.60 per mile to $2.94 per mile.
Home Health Services	8/1/07	Skilled nursing visits increased by 3.7%, from $20.73 to $21.50 per 15 minute unit. Home health aide visits <2 hours (7 or fewer units) increased by 3.8%.
HCBC-ECI Homemaker Services	7/1/07	Rate was increased from $4.38 to $4.47 per 15 minute unit.
Physician Services	7/1/07	Seven eye care code rates, including eye exams, refraction, and fitting of spectacles, were increased to be equal to 60% of the Medicare rates for these services. Rate increases ranged from 35% to 146%. The psychiatric diagnostic interview rate increased by 35% from $65 to $87.82, bringing it up to 60% of the Medicare rate. Ten physician services, including immunization, surgery, and treatment of injuries, received rate increases as a means of improving access to care. The rates for these codes were increased to 31.5% of the Medicare rate.
Dental Services	7/1/07	Seventeen dental procedure code rates were increased. The procedure codes target services for children 0-3 years of age for both periodontic and comprehensive oral evaluations, as well as preventative and restorative treatments.
Wheelchair Van Services	7/1/07	Each of the five procedure codes that apply to wheelchair van services, were increased by 2%.

Personal Care Attendant Services and HCBC-ECI Personal Care Services	7/1/07	The rate for these services was increased by 2%, from $4.38 to $4.47.
Adult Medical Day Services	7/1/07	The rate for this service was increased by 2% from $49.24 per day to $50.22 per day.
Specialized Transportation to Adult Medical Day Services	7/1/07	The rate for this service was increased by 2%, from $10.94 to $11.16.

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 PERFORMING 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, which were 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, diagnostic radiology, and pharmaceutical services (with the exception of those pharmaceutical products supplied and administered in a physician's office) must be submitted to:

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

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

There have been some revisions made to the current prior authorization forms, along with the addition of some new forms. You will find a copy of all of the forms used for services that are requested through Schaller Anderson at the end of this bulletin in the appendix, and on the EDS provider website at: www.nhmedicaid.com, the Schaller Anderson website at:

www.mynewhampshirecare.com, and soon to be available on the DHHS website at www.dhhs.state.nh.us. There are no changes being made to the processing requirements. All clinical information must still 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.

ADULT DISPOSABLE INCONTINENCE SUPPLY COVERAGE

As a result of HB 826 of the 2007 legislative session, now RSA 167:3-h, IV, disposable diapers and related incontinence items will be covered with **prior authorization** for NH Medicaid recipients ages 21 and over, effective with dates of service beginning **September 21, 2007.**

Authorization for incontinence items will be approved in accordance with the clinical criteria below. Urinary stress incontinence is not a covered condition.

The recipient's type of incontinence must be:

- Secondary to a disease process which results in irreversible loss of control of the urinary bladder and/or rectal sphincter; **or**
- Secondary to an injury to the brain or spinal cord; **or**
- Attributed to a profound cognitive disability, such as severe mental retardation or dementia, that results in an inability to achieve continence through bladder training.

The codes, modifiers, daily/monthly limits, and unit prices for diapers and other disposable incontinence products **for adults** are as follows:

National Code	Billing Modifier	Item Description	Max. # of Units Allowed per Day/Month	Price per Unit
T4521 T4522 T4523 T4524	N/A	Adult size disposable incontinence product, brief/diaper (small, med., large, XL)	6/186	$0.90 each
T4533	U1	Youth sized disposable incontinence product, brief/diaper	6/186	$0.90 each
T4535	U1	Disposable liner, shield, guard, pad, undergarment for incontinence (Description does not indicate age, so can use for all ages)	3/93	$0.45 each
T4541	U1	Incontinence product, disposable underpad, e.g., Chux – Large (Description does not indicate age, so can use for all ages)	3/93	$0.30 each

The number of units billed for disposable diapers and other disposable incontinence products must equal the number of items dispensed (e.g. 186 units, not 2 cases). The items are not interchangeable for purposes of staying within the limits. You may dispense and bill for no more than one month's supply at a time, which is a maximum of 186 disposable diapers/briefs. As always, these supplies should be billed in accordance with the usual and customary requirements of RSA 126-A:3, III. The maximum amount that will be paid for each item is noted above.

To obtain a prior authorization for adult disposable diapers and related incontinence supplies, the prescribing provider must complete The Durable Medical Equipment/Medical Supply Prior Authorization Request Form (form 272D), and include a letter of medical necessity from the ordering physician or healthcare provider. The prior authorization form is located on the provider services website: www.nhmedicaid.com. The form and letter must be returned to:

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

The process for children under the age of 21 remains the same, and procedures can be found in the December 2005 Provider Notice at www.nhmedicaid.com. Please note that prior authorization is **not** required for children under the age of 21, but a letter of medical necessity must be on file. Please review the coverage criteria in the December 2005 Provider Notice. If you have any questions regarding this notice, or billing for these services, please contact the Communications Unit at EDS: 1-(800)-423-8303 (NH & VT only) or (603) 224-1747.

POTENTIAL COSMETIC SURGICAL PROCEDURES REQUIRING PRIOR AUTHORIZATION

Effective October 1, 2007, prior authorization will be required for certain surgical procedures that could potentially be considered cosmetic surgery. Some examples include, but are not limited to, laparoscopy, blepharoplasty, mammaplasty, and gastric restrictive procedures. For the specific surgical procedure codes, please contact the EDS Communications Unit at: 1-(800)-423-8303 (NH & VT only) or (603) 224-1747. All requests for surgical prior authorization must be submitted to Schaller Anderson at:

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

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.

TAMPER RESISTANT PRESCRIPTION PAD REQUIREMENT

Effective April 1, 2008, a new federal law goes into effect requiring all Medicaid covered outpatient drugs, including over-the-counter drugs, to be written on tamper resistant prescription pads. Effective for dates of service on and after April 1, 2008, a tamper resistant prescription pad **must** include **ONE** of the following:

1. Features designed to **prevent unauthorized copying** of a completed or blank prescription form. Examples include, but are not limited to:
   - A high security watermark on reverse side of blank
   - Thermochromic ink
   - Word(s) such as "VOID" appears when copied
   - Colored security background
   - Security watermark or holograms on the back or front to verify the document is an original
   - Microprinting in border or signature line that cannot be copied

2. Features designed to **prevent erasure or modification** of information written on the prescription by the prescriber. Examples include, but are not limited to:
   - Tamper-resistant background ink which would show erasures or any attempts to change written information

3. Features designed to **prevent the use of counterfeit** prescription forms. Examples include, but are not limited to:
   - Sequentially numbered blanks
   - Hidden fibers

Effective for dates of service on and after October 1, **2008**, a prescription pad **must** contain **ALL THREE** of the numbered characteristics listed above.

The tamper-resistant prescription pad requirements **do not apply** to:

- The refills of written prescriptions presented at a pharmacy before April 1, 2008
- Electronic prescriptions transmitted to the pharmacy
- Prescriptions faxed to the pharmacy from a known medical entity
- Prescriptions communicated to the pharmacy by telephone by a prescriber or their agent

Emergency fills for non-controlled prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72-hours from the time the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. Verbal orders for a prescription written on a non-compliant prescription pad must be documented in writing on the face of the otherwise non tamper-resistant prescription.

Drug Enforcement Administration and New Hampshire Board of Pharmacy laws and regulations pertaining to written and electronic prescriptions for controlled, drugs still apply. Additionally, the State of NH will not endorse specific vendors that supply tamper-resistant prescription pads.

The State of New Hampshire encourages prescribers to adopt the use of electronic prescribing as an effective and efficient method of communicating prescriptions to pharmacists for all of their patients. For additional information, please contact Lise Farrand, R.Ph. at 603-271-4419 or **lfarrand@dhhs.state.nh.us** or visit the NH Medicaid Pharmacy Program websites at: **http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/PBM.htm** and http://newhampshire.fhsc.com/

SPECIALIZED TRANSPORTATION TO TITLE XIX COVERED ADULT MEDICAL DAY CARE (AMDC) SERVICES

Specialized transport of Title XIX recipients to and from Title XIX covered AMDC services can be provided by the AMDC center or any other Title XIX enrolled provider approved by the Bureau of Elderly and Adult Services to provide specialized transport. Enrollment is not limited to wheelchair van providers. Drivers must meet the requirements in the Bureau of Elderly and Adult Services rules at He-E 803.02(b)(2). Please be reminded that the specialized level of transport requires you to provide assistance during transport as identified in the recipient's treatment plan. Services must be billed using the specialized transportation code, and payment will be at the specialized transportation rate. Please call (800) 423-8303 (NH/VT only) or (603) 224-1747 if you have questions regarding this service.

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCP) – BILLING INFORMATION

Since 2001, the NH Medicaid program has provided coverage to a specific group of women screened through the NH Breast and Cervical Cancer Program (BCCP). The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows for Medicaid eligibility, for the full range of NH Medicaid benefits, to be provided to women who have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program, and who need treatment for breast or cervical cancer, including pre-cancerous conditions of the breast or cervix. In order for these individuals to become eligible, they must not be otherwise covered by other creditable insurance, must not be eligible for Medicaid under any mandatory categorically eligibility group, must be both a NH resident and a US citizen, and must not have attained age 65.

The program was implemented through a manual eligibility and payment process, due to the small number of women expected to become part of the eligibility group at the time of program inception in 2001. However, the program has since grown significantly and is expected to increase before the transfer of the BCCP claims from the manual claims processing system to the automated claims processing system. To provide some clarification to the current manual claims billing process, some important reminders are listed below:

- The NH Medicaid Program funds the BCCP. All NH Medicaid administrative rules apply.
- A recipient enrolled in the BCCP is entitled to FULL Medicaid coverage, not just for the treatment of breast or cervical cancer. Such recipients must identify themselves as Medicaid BCCP patients at every provider visit by showing their BCCP identification card.
- Recipients may not be billed or balance billed, nor may their names be submitted to a collection agency.
- All claims must be submitted on official claim forms, i.e., medical claims on the CMS 1500 or UB 04, and pharmacy claims on the "Let No Woman Be Overlooked" pharmacy claim form or the universal claim form. All Medicaid billing procedures apply. Claims must be completely and properly filled out.
- The performing provider's 8 digit NH Medicaid provider identification number must be provided on every claim.
- This is a manual billing process. Paper claims must be mailed to:

Breast and Cervical Cancer Program
NH Division of Public Health Services
29 Hazen Drive
Concord, NH 03301

- Claims should NOT be sent to EDS, the Medicaid fiscal agent, for processing.
- Once claims are received, recipient eligibility is verified, and then the claim goes to Medicaid Finance for pricing and payment authorization, then to Accounts Payable for the check to be prepared.
- Claims are generally authorized for payment within 2 months from the date of service on the claim, and a check for payment is then cut approximately 2 weeks from the date of authorization.
- Routine billing of duplicate claims within this timeframe tends to slow the turnaround time of claims for payment. It is recommended that providers allow the state the given time to process the claims, and then check in house records, before sending in another request or calling the state for status.

AMBULANCE PROVIDERS

AMBULANCE MEDICAL NECESSITY FORMS - REVISED

Please note that the Ambulance Medical Necessity Forms, ALS (Advanced Life Support) and BLS (Basic Life Support), have been revised (dated 10/07). Copies are located at the end of this bulletin. The forms may also be printed from the EDS web site at: www.nhmedicaid.com. Revisions are editorial in nature, and documentation collected using the previous version (dated 10/04) will be acceptable. Please refer to the December, 2004 quarterly bulletin for complete details regarding the documentation and billing of ambulance transport.

DENTAL PROVIDERS

ORAL EXAMINATIONS REQUIRE APPROPRIATE RECORDING OF FINDINGS, DIAGNOSES, AND TREATMENT RECOMMENDATIONS

NH Medicaid requires that for claims for payment of codes related to dental or oral examinations of patients, that the exams be conducted and recorded in a manner consistent with code descriptions in the CDT 2007/2008 manual, and be fully documented in the patient's dental record, in a manner consistent with professional standards and state statutes, including the Dental Practice Act, and the professional Standards of Ethics as outlined by the American Dental Association.

A dental or oral examination must include recording in the patient's dental record, all of the activities and findings of the examination, including but not limited to, the extent of the examination, any objective or subjective means of evaluation that were employed, such as radiographs or medical history, and recording of diagnoses and recommended treatment.

A notation in the recipient's dental record stating only that an examination has taken place, without appropriate documentation of the methods, findings, diagnosis and treatment recommendations, is **insufficient** evidence of the completion of an examination, and if reviewed or audited, will not support a claim for payment by NH Medicaid.

Additional information regarding professional standards and NH state statutes that pertain to documentation of dental examinations may be found in the ADA CDT 2007/2008 manual, in the NH practice act at: www.state.nh.us/dental, and at: www.ada.org.

CLEANING OF TEETH LIMITED TO USE OF A TOOTHBRUSH NOT TO BE BILLED AS PROPHYLAXIS

Claims for dental prophylaxis must be performed and submitted in accordance with the ADA CDT 2007/2008 description, for D1110-Prophylaxis Adult or D1120-Prophylaxis Child. These codes are described as "Removal of plaque, calculus, and stains from the tooth structure…".

Because calculus and stains cannot be removed by toothbrush alone, claims for so-called "toothbrush prophylaxis" should not be submitted. Codes D1110 or D1120 are not intended for "toothbrush prophylaxis".

ADDED COVERAGE OF CAST/PORCELAIN CROWNS

Coverage for cast/porcelain crowns will be limited to permanent teeth only. Titanium cast crowns and partial crowns will **not** be a covered service. No prior authorization is required. For questions related to crowns, please call (800) 852-3345 (in state only) or (603) 271-0555 (out of state).

SEALANTS REQUIRE EXAMINATION OF THE PATIENT BY A DENTIST BEFORE PLACEMENT

Please be reminded that, in accordance with NH statutes regulating dental practice, dental sealants require the examination of the recipient by a licensed dentist within 3 months before sealant placement. The date of the dentist's examination, name of examining dentist, findings, and recommendation for the placement of dental sealant must be documented in the recipient's dental treatment record. The date of sealant placement and other appropriate treatment information must also be recorded in the treatment record.

EXTRACTIONS FOR SYMPTOMATIC TEETH ONLY - REMINDER

As a reminder, NH Medicaid covers extractions for **symptomatic teeth only.** Asymptomatic tooth extractions are only covered with prior authorization. The criteria and justification for the extraction(s) must be documented in the recipient's dental treatment record**.**

EVALUATIONS AND RADIOGRAPHS TO ASSESS COURSE OF ORTHODONTIC TREATMENT NOT SEPARATELY BILLABLE

Payment for all orthodontic evaluations, radiographs, and other means used by the provider to assess the course of orthodontic treatment, is **included** in the interceptive or comprehensive orthodontic treatment fee. Orthodontic evaluations, radiographs and other means used to evaluate the course of orthodontic treatment **cannot be billed separately**. If a request for interceptive or comprehensive orthodontic treatment has been denied, radiographs and other procedures that are ancillary to the denied treatment are not billable to NH Medicaid

NURSING FACILITY PROVIDERS

HEARING AND VISION SERVICES FOR RECIPIENTS IN A NURSING FACILITY

For a recipient residing in a nursing facility, a NH Medicaid enrolled audiologist can bill NH Medicaid directly **only** for the actual hearing aid device. The same holds true for eyeglasses. A NH Medicaid enrolled Optometrist or Optician can bill NH Medicaid directly **only** for the dispensing of glasses and/or lenses. Other services related to the hearing aid, glasses, or lenses are **included** in the reimbursement rate of the nursing facility.

Please be reminded that services such as physical therapy, occupational therapy, laboratory and radiology services are also included in the cost base, and therefore included in the reimbursement rate of the nursing facility. The exceptions are pharmacy services and prescribed drugs. These costs have been excluded from the per diem rate, and can be billed separately.

Please refer to the Nursing Home Provider Billing Manual for additional information.

PHYSICAL THERAPY PROVIDERS

PHYSICAL THERAPY SERVICES PROVIDED BY A PHYSICAL THERAPY ASSISTANT
New Hampshire Statutes, Chapter 328-A, Physical Therapy Practice Act, Section 328-A:2 and Section 328-A:11, allow a physical therapy assistant to work under a physical therapist's general supervision. General supervision means that the physical therapist is not required to be on site for direction and supervision, but must be available at least by telecommunication.

However, the NH Title XIX (Healthy-Kids Gold/Medicaid) Program requires a physical therapist to be present during the provision of the service when a physical therapy assistant is providing the service. Please refer to the Medical Assistance Rules, Chapter He-W 568.05.

In order to be reimbursed by NH Medicaid, providers must follow state licensing rules, and must also adhere to any Medicaid regulations that may be stricter.

PHYSICIAN ASSISTANTS

PHYSICIAN ASSISTANT REMINDER
Please be reminded that physician assistants can only enroll as "performing" providers, must be under the supervision and direction of a licensed physician in accordance with RSA 328-D, and must have their Title XIX enrollment affiliated with physicians and/or groups. Physician assistants **cannot** enroll independently. Additionally, physician assistants are **not allowed** to independently bill the NH Title XIX program or to directly receive payment from the NH Title XIX program. The federal regulations do not recognize physician assistants as independent Title XIX providers. Any payments made directly to physician assistants are subject to recoupment.

THIRD PARTY LIABILITY CARRIER CODE ADDITIONS/CHANGES

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

CODE	COMPANY NAME
0795	ALICARE, PO Box 1442, New York, NY 10116-1442
0796	COBRASERV NATIONAL SERVICE CENTER, PO Box 534099, St. Petersburg, FL 33742
0797	PROVIDENCE HEALTH PLANS, PO Box 3125, Portland, OR 97207
0798	DAVIS VISION, Vision Care Processing Unit, PO Box 1525, Latham NY 12110
0799	UMWA HEALTH & RETIREMENT FUNDS, Claims Processing Center, PO Box 619099, Dallas, TX 75261-9741
0800	WEB TPA, PO Box 99906, Grapevine, TX 76099
0801	UNITED HEALTHCARE-STUDENT INSURANCE, PO Box 908025, Dallas, TX 75380-9025
0802	PRIVATE HEALTHCARE, PO Box 5079, Westlake Village, CA 91359

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

CODE	COMPANY NAME
0181	CENTRAL STATES HEALTH & LIFE CO OF OMAHA, (formerly called Central States Health and Life)

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

CODE	COMPANY NAME
0641	NEIGHBORHOOD HEALTH PLAN (correction to phone #: 617-772-5500) AND Add phone number 800-462-5449
0779	ACEC/HEALTH PLAN SERVICES INC., PO Box 44109, Las Vegas, NV 89116-2109 (Address change only)

NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

DURABLE MEDICAL EQUIPMENT (DME)/MEDICAL SUPPLY PRIOR AUTHORIZATION REQUEST

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ____________________________ **RECIPIENT MEDICAID ID #:** ________________________

PROVIDER INFORMATION

DATE OF REQUEST: ____/_____/_______ **CONTACT PERSON:** _______________________________________

PROVIDER NAME: ______________________ **NH MEDICAID PROVIDER #:** ________________________________

ADDRESS: ______________________________ **CITY/STATE/ZIP:** ____

TELEPHONE #: _________________________ **FAX #:** ____

ICD-9 CODE(S): ________________________ **ORDERING PHYSICIAN:** ____________________________________

WRITTEN DIAGNOSIS: ____

EQUIPMENT/SUPPLY INFORMATION (indicate N/A if it doesn't apply to your request)

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

You must indicate your costs for each item/service listed. For equipment, 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 any written documents you deem necessary for the processing of this request for determining if medial criteria are met.

"I certify that the above items/services will be provided, and that documentation regarding our acquisition costs reflects best price (usual & customary pursuant to Section 126-A:3). The certificate(s) of medical necessity (including the physician's signed prescription, when appropriate), are attached for review by NH Medicaid Prior Authorization staff."

_______________________________________ _______________________________________
DME or Medical Supply Provider Signature **Date**

_______________________________________ _______________________________________
Print Name **Title**

CERTIFICATION OF MEDICAL NECESSITY

Pursuant to He-W 571.06, to document the medical necessity for the item/service requested above, the **written** diagnosis and supporting clinical information **must be attached and included** with your request, and **signed** by a PCP or treating physician/ARNP.

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

53 Regional Drive ■ Suite 201 ■ Concord, NH 03301 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335

NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

MEDICAL EQUIPMENT REQUEST EVALUATION FORM
NON-WHEELCHAIR

This evaluation must be completed by a New Hampshire **licensed** physician, occupational therapist, or physical therapist specializing in rehabilitation medicine. Evaluator must have an understanding of the recipient's condition for which the equipment is being requested and broad knowledge of the various rehabilitation equipment available in the market today that may benefit the recipient. **NOTE:** Requests for wheelchair equipment should not be made on this form. Wheelchair equipment requests should be made using, "Form 272M - Mobility Evaluation."

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ______________________________ **RECIPIENT MEDICAID ID #:** ______________________

RECIPIENT HEIGHT: ____________________________ **RECIPIENT WEIGHT:** ___________________________

PROVIDER INFORMATION (FOR LICENSED MD/OT/PT PERFORMING THE EVALUATION)

PROVIDER NAME: __________________________ **NH MEDICAID PROVIDER #:** _____________________________

ADDRESS: __________________________________ **CITY/STATE/ZIP:** ______________________________________

TELEPHONE #: _____________________________ **FAX #:** ____

DATE OF EVALUATION: _____/______/_____ **PLACE OF EVALUATION:** ______________________________

DIAGNOSIS (written, not ICD-9) **PRIMARY:** ____

SECONDARY: ____

EQUIPMENT REQUESTED:

☐ Stander ☐ Gait Trainer ☐ Positioning Chair ☐ Bath Equipment ☐ Other (non-wheelchair only) _______________

Please provide medical justification for providing the equipment requested above:

Is the requested equipment replacing a piece of equipment that the recipient currently has? ☐ Yes ☐ No

Does the requested equipment duplicate a piece of equipment that the recipient currently has? ☐ Yes ☐ No

If **YES** to either of the above, please answer the following:

Model and make of current equipment:____

____

Age and condition of current equipment: ______________________________

Reason for replacing or duplicating: ______________________________

Where is the primary location of use? ☐ Home ☐ School ☐ Other ______________________________

Given the recipient's age and expected rate of growth, what is the anticipated number of years the recommended equipment is expected to be functional? ______________________________

With respect to the growth potential of the recommended equipment, what is the maximum height and weight capacity?

Height: ____________________ Weight: ____________________

How frequently is the equipment expected to be utilized each day or week, and for how long each day or week?

____

Has the recipient completed a trial period of at least two (2) weeks with the recommended equipment? ☐ Yes ☐ No

Is similar equipment currently available or being utilized by the recipient at school, home, or other site? ☐ Yes ☐ No

If **YES**, please explain:

____

____

Please identify any plans to obtain funding from any other sources (e.g., private insurance, Grants, "Medicaid to School"):

____

____

What other, less costly equipment alternatives have been considered (provide specific makes and models)? Why were they not chosen? ______________________________

____

Please explain why no other alternative equipment options were considered, if applicable: ______________________________

____

Please check **ALL** that apply regarding the recommended equipment:

☐ Recipient's home has sufficient space to utilize and store the equipment.

☐ Potential growth of recipient has been taken into consideration in selecting the size of equipment, which should provide at least 5 years of use.

☐ Recipient or recipient's caregiver has demonstrated proficiency in the safe operation of the equipment.

☐ Less costly models have been ruled out as inappropriate.

ADDITIONAL COMMENTS:

____

____

____

______________________________ ______________________________

SIGNATURE OF NH LICENSED OT/PT OR PHYSICIAN COMPLETING THE EVALUATION **DATE**

INDIVIDUALS PRESENT DURING EVALUATION:

1) ______________________________ Representing/Relationship to recipient: ______________

2) ______________________________ Representing/Relationship to recipient: ______________

3) ______________________________ Representing/Relationship to recipient: ______________

RECIPIENT, PARENT OR LEGAL GUARDIAN (please check the statement that applies)

☐ **I accept** the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment's options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.

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

____

____

____

______________________________ ______________________ ______________________

SIGNATURE OF RECIPIENT/PARENT/LEGAL GUARDIAN **RELATIONSHIP** **DATE**

MEDICAL EQUIPMENT SUPPLIER

Please check the statement that applies. If a statement does not apply, please provide your response in the comments section below:

☐ **I concur** with the recommendations made, and I am unaware of any other **less costly** equipment models or alternatives in the market at this time that would meet this recipient's needs.

☐ To the best of my knowledge, the recipient ☐ **does** ☐ **does not** expect to receive a similar piece of equipment from any other funding source.

COMMENTS: ____

____

____

____

______________________________ ______________________________

SIGNATURE OF AUTHORIZED MEDICAL EQUIPMENT SUPPLIER **DATE**

______________________________ ______________________________

PRINTED NAME OF AUTHORIZED REPRESENTATIVE **PRINTED NAME OF MEDICAL EQUIPMENT COMPANY**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

53 Regional Drive ■ Suite 201 ■ Concord, NH 03301 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335

NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

MOBILITY EVALUATION FORM

This evaluation must be completed by a New Hampshire licensed physician, occupational therapist, or physical therapist specializing in rehabilitation medicine. Evaluator 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 a physician or OT/PT; a rehabilitation specialist may complete the form.

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ______________________________ **RECIPIENT MEDICAID ID #:** ______________________

RECIPIENT HEIGHT: ____________________________ **RECIPIENT WEIGHT:** ___________________________

PROVIDER INFORMATION

PROVIDER NAME: _________________________ **NH MEDICAID PROVIDER #:** ___________________________

ADDRESS: ________________________________ **CITY/STATE/ZIP:** _________________________________

TELEPHONE #: ____________________________ **FAX #:** ____

DATE OF EVALUATION: _____/_____/_________ **PLACE OF EVALUATION:** ____________________________

DIAGNOSIS (written, not ICD-9) **PRIMARY:** ____

SECONDARY: ____

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

CURRENT AMBULATORY STATUS

Please address the following: Would the recipient be confined to a bed if a wheelchair were not provided? Is the recipient able to use a walker, cane, or walk with assistance? What is the distance the recipient 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

Make: ____________________ MODEL: ____________________ AGE/CONDITION: ____________________

IDENTIFY ANY PROBLEMS WITH CURRENT SEATING SYSTEM:

PLEASE COMMENT ON RECIPIENT'S:

VISION: ____________________

COGNITION: ____________________

ABILITY TO COMMUNICATE: ____________________

DAILY ACTIVITY LEVEL: ____________________

MOBILITY EVALUATION (STRENGTH/TONE/CONTRACTURES ETC.): ____________________

ANTICIPATED SURGICAL PROCEDURES/ORTHOTICS: ____________________

OTHER SPECIAL CONSIDERATIONS: ____________________

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 As necessary):

____

____

____

____

____

____

TO BE COMPLETED BY PERSON PERFORMING THE EVALUATION

THE FOLLOWING OPTIONS ARE MEDICALLY NECESSARY:

	OPTION	**JUSTIFICATION**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
16.		
17.		
18.		

RECOMMENDED CHAIR

MAKE: ______________________________ **MODEL:** ______________________________

CHECK ALL THAT APPLY. INDICATE N/A IF NOT APPLICABLE:

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

SUMMARY / COMMENTS

____

____

____

____

____

____

____ __________

Signature of licensed physician, therapist or rehab specialist (non-custom. only) completing the evaluation **Date**

____

Printed name of licensed physician, therapist or rehab specialist (for non custom. only) completing the evaluation

INDIVIDUALS PRESENT DURING EVALUATION:

1) ______________________________ Representing/Relationship to recipient: ____________________

2) ______________________________ Representing/Relationship to recipient: ____________________

3) ______________________________ Representing/Relationship to recipient: ____________________

4) ______________________________ Representing/Relationship to recipient: ____________________

RECIPIENT, PARENT OR LEGAL GUARDIAN (please check the statement that applies)

☐ I **accept** the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment's options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.

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

____

____

____

Signature of Recipient/Parent/Legal Guardian	**Relationship**	**Date**

WHEELCHAIR SUPPLIER (Please check all of the following statements that apply. If a statement does 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 or options in the market at this time that would meet this recipient's needs.

☐ The recipient ☐ **is** ☐ **is not** a nursing facility resident or awaiting placement to a nursing facility.

☐ The recipient is a nursing facility resident but is awaiting discharge.

☐ To the best of my knowledge, the recipient ☐ **has** ☐ **has not** received, nor is expected to receive, a wheelchair (seating system) from other sources.

☐ To the best of my knowledge, the recipient ☐ **does** ☐ **does not** have insurance or funding sources for this seating system.

☐ The chair being requested ☐ **is** ☐ **is not** a backup seating system to any current mobility system the recipient now has or is expected to obtain.

☐ Any and all components (i.e. cushions, trays, headrests) that can be utilized from the recipient's current wheelchair will be placed on the new wheelchair.

☐ I have visited the recipient'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:

____

____

____

____

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: 1. **Delivery** and assembly of the chair; 2. **Explanation** as to the proper care and preventive maintenance of the chair; 3. **Demonstration** as to the chair's proper operating procedure; and 4. Any necessary **follow-up for training** and/or **adjustments** required for the chair within 30 days following the delivery of the chair.

Signature of wheelchair vendor	**Date**

Print Name of wheelchair vendor	**Name of wheelchair vendor's company**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

53 Regional Drive ■ Suite 201 ■ Concord, NH 03301 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335

NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

REQUEST FOR PRIOR AUTHORIZATION IN EXCESS OF SERVICE LIMITS

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ________________________ **RECIPIENT DOB:** ____/____/____
RECIPIENT MEDICAID ID #: ________________________

PROVIDER INFORMATION

DATE OF REQUEST: ____/____/____ **CONTACT PERSON:** ________________________
PROVIDER NAME: ________________________ **NH MEDICAID PROVIDER #:** ________________________
ADDRESS: ________________________ **CITY/STATE/ZIP:** ________________________
TELEPHONE #: ________________________ **FAX #:** ________________________

DIAGNOSIS (written, not ICD-9) **PRIMARY:** ________________________
SECONDARY: ________________________

TYPE OF TREATMENT	PROCEDURE CODE	FREQUENCY OF TREATMENT	TOTAL # OF UNITS	DATES OF SERVICE	
				START	END

ANTICIPATED RESULT(S) OF PROVIDING THESE EXTRA SERVICES: (use additional paper as necessary)

CLINICAL INFORMATION:
Please attach physician's order and clinical notes supporting the medical necessity for the requested services, and providing goals and objectives, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes.

CERTIFICATION OF MEDICAL NECESSITY
(to be signed by the PCP or treating physician/ARNP)

I certify that the requested treatments and/or therapies are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

________________________ ________________________
Signature **Date**

________________________ ________________________
Print Name/Title **Specialty (if applicable)**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

53 Regional Drive ■ Suite 201 ■ Concord, NH 03301 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335

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NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

GASTRIC BYPASS SURGERY PRIOR AUTHORIZATION REQUEST

PLEASE PRINT OR TYPE ALL INFORMATION

RECIPIENT NAME: ______________________________ **RECIPIENT MEDICAID ID #:** ______________________

DATE OF BIRTH: _____/_____/_____ **RECIPIENT HEIGHT:** ___________ **RECIPIENT WEIGHT:** ___________

DIAGNOSIS: ____________________ **ICD-9:** _________________________ **CPT:** _________________________

PROVIDER INFORMATION

DATE OF REQUEST: ________/________/__________ **CONTACT PERSON:** ______________________________

PROVIDER NAME: ______________________________ **NH MEDICAID PROVIDER #:** ______________________

ADDRESS: ______________________________________ **CITY/STATE/ZIP:** ______________________________

TELEPHONE #: __________________________________ **FAX #:** ______________________________________

MEDICAL NECESSITY CRITERIA FOR GASTRIC BYPASS SURGERY

☐ **ROUX – EN – Y GASTRIC BYPASS** ☐ **LAPAROSCOPIC GASTRIC BANDING**

Roux-en-Y Gastric Bypass surgery **may** be covered for **non-cosmetic** indications for Medicaid recipients 18 years of age or older, but less than 65, when **all of the following criteria are met**:

☐ The recipient has lost and maintained the loss of at least 15% of body weight prior to scheduling surgery.

Percentage of body weight lost: ______%

AND

☐ Body Mass Index (BMI) must be between 35 and 40 with life threatening co-morbidities of cardio-pulmonary problems, cardiovascular disease, uncontrolled severe Diabetes Mellitus, or medically refractory hypertension. Inadequate treatment of a co-morbid condition should not be used as an indication for Roux-en-Y Gastric Bypass surgery.

BMI: ___________ **Co-morbidities:** ____

____

OR

☐ BMI > for greater than 5 years

BMI: ___________ **No. of Years:** ___________

AND

All of the following criteria must be met:

- ☐ The recipient has participated in a physician-supervised/directed program including nutritional counseling, a low calorie diet, increased physical activity, and behavioral modification. This needs to be documented in the recipient's medical record. The nutrition and exercise program must be supervised and monitored by a physician. It must also be for a minimum cumulative total of 6 months or longer in duration and occur within 2 years of surgery, with participation in one program of at least 3 consecutive months. Diet plans of Jenny Craig, Weight Watchers etc., are not considered physician directed/monitored nutritional weight loss programs. Physician visits consisting of only pharmacological management are also not considered toward this goal;

AND

- ☐ The recipient has the ability to adhere to lifestyle changes/modifications;

AND

- ☐ The recipient does not have a specific correctable cause for the obesity, such as an endocrine metabolic disorder;

AND

- ☐ A comprehensive psychological evaluation has been done to rule out an undiagnosed underlying psychological disorder, to determine the recipient is able to understand, tolerate, and comply with all phases of care and is committed to long-term follow-up requirements;

AND

- ☐ The recipient has had previous conservative weight reduction attempts without long-term weight reduction;

AND

- ☐ The recipient has attended **AT LEAST** three gastric bypass seminars at his/her own expense, and passed the tests given.

CERTIFICATION OF MEDICAL NECESSITY

I certify that the above information is true and accurate to the best of my knowledge.

______________________________	______________________________
Signature	**Date**
Print Name/Title	**Specialty**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

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NEW HAMPSHIRE MEDICAID

PREGNANCY NOTIFICATION FORM

To assist you in supporting your patients, please provide us with the information below. Please notify us if the patient miscarries or develops complications after you have submitted this form. ***In lieu of this form you may submit your standard form****. Thank You.*

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ________________________________ **RECIPIENT MEDICAID ID #:** ____________________

STREET ADDRESS: _______________________________ **CITY/TOWN/ZIP:** ________________________________

TELEPHONE #: ___________________________________ **RECIPIENT DATE OF BIRTH:** ______/_______/______

DATE OF 1ST PRENATAL VISIT: ______/______/_______ **GRAVIDA/PARA:** _____________/______________

DUE DATE: _______/________/_________

PROVIDER INFORMATION

NAME: _____________________________________ **NH MEDICAID PROVIDER #:**_____________________________

STREET ADDRESS: _________________________ **CITY/TOWN/ZIP:** ______________________________________

TELEPHONE #:______________________________ **DELIVERY HOSPITAL:**__________________________________

PLANNED: VAGINAL ☐ **C-SECTION:** ☐ **VBAC** ☐

RISK FACTORS – CHECK ALL THAT APPLY (PAST OR CURRENT)

Past	Current		Past	Current	
☐	☐	Advanced Maternal Age	☐	☐	Placenta Previa-Abruptio Placenta
☐	☐	Chronic Illnesses	☐	☐	Preeclampsia
☐	☐	Deep Vein Thrombosis	☐	☐	Pregnancy Induced Hypertension
☐	☐	Diabetes Mellitus	☐	☐	Premature Rupture of Membranes
☐	☐	Domestic Violence	☐	☐	Preterm Labor
☐	☐	Gestational Diabetes	☐	☐	Smoking
☐	☐	Hyperemesis with TPN/HIT	☐	☐	Substance Abuse
☐	☐	Hypertension	☐	☐	Teen pregnancy
☐	☐	Incompetent Cervix/Cerclage Placement	☐	☐	Toxemia
☐	☐	Infertility History/IVF	☐	☐	Uterine Abnormalities
☐	☐	Malignancy	☐	☐	Other
☐	☐	Multi Fetal Pregnancy	☐	☐	None

FOR OFFICE USE ONLY:
Recipient Eligibility Date: ____________________________________

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NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

REQUEST FOR PRIOR AUTHORIZATION IN EXCESS OF SERVICE LIMITS PSYCHOTHERAPY SERVICES

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ______________________ **RECIPIENT MEDICAID ID #:** ______________________

PROVIDER INFORMATION

PROVIDER NAME: ______________________ **NH MEDICAID PROVIDER #:** ______________________

ADDRESS: ______________________ **CITY/STATE/ZIP:** ______________________

TELEPHONE #: ______________________ **FAX #:** ______________________

CLINICAL INFORMATION

DIAGNOSIS (written) **PRIMARY:** ______________________

SECONDARY: ______________________

AXIS I: ______________ **AXIS II:** ______________ **AXIS III:** ______________

AXIS IV: ______________________ **AXIS V:** ______________________

CURRENT MEDICATION	DOSE	FREQUENCY

Has a prior authorization been requested on behalf of this recipient during this fiscal year? (7/1-6/30)

☐ YES ☐ NO

If **YES**, Authorization #: ______________________

Is the recipient also covered under Medicare? ☐ YES ☐ NO

RECIPIENT HISTORY:

LEVEL OF FUNCTIONAL IMPAIRMENT:

WHY ARE THE SERVICES MEDICALLY NECESSARY?

TREATMENT PLAN (include time frames and progress information):

ARE THERE EXTENUATING CIRCUMSTANCES? IF YES, PLEASE ADVISE:

In the case of a child, is he/she coded? ☐ Yes ☐ No
Does he/she have an IEP? ☐ Yes ☐ No (A copy of the IEP must be included)
Do you consult with the school regarding this child? ☐ Yes ☐ No
Is the case open to DCYF or Division of Juvenile Justice? ☐ Yes ☐ No

If **YES,** document the name of contact or referral individuals: ____________________

____

SPECIFIC REQUEST ABOVE THE SERVICE LIMIT

Identify each service to be billed, provider name, and provider number. Each service must be identified with the number of sessions requested. (The start date is the **13th** visit for psychotherapy services provided by ARNP's, pastoral counselors, social workers, and psychologists. The start date is the **19th** visit for physicians/psychiatrists, i.e., psychiatrist and physician services are combined and count toward the physician service limit of 18 visits.)

PROVIDER	PROVIDER #	BILLING CODE	START DATE OF EXTENDED SERVICE	# OF SESSIONS REQUESTED	FREQUENCY PER MONTH

OTHER PROVIDERS

NAME	TITLE/LICENSE	AFFILIATION/SERVICE PROVIDED

CERTIFICATION OF MEDICAL NECESSITY
(to be signed by a physician, ARNP with a psychiatric/mental health specialty, or a psychotherapy provider licensed by the board of mental health practice)

I certify that the requested treatments and/or therapies are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

____________________ ____________________
Signature **Date**

____________________ ____________________
Print Name/Title **Specialty**

NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

PANNICULECTOMY PRIOR AUTHORIZATION REQUEST

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ______________________________ **RECIPIENT MEDICAID ID #:** ______________________

RECIPIENT HEIGHT: ____________________________ **RECIPIENT WEIGHT:** ____________________________

DIAGNOSIS: ___________________ **ICD-9:** _________________________ **CPT:** __________________________

PROVIDER INFORMATION

DATE OF REQUEST: ______/_______/_______ **CONTACT PERSON:** ___________________________________

PROVIDER NAME: _________________________ **NH MEDICAID PROVIDER #:** ____________________________

ADDRESS: _________________________________ **CITY/STATE/ZIP:** _____________________________________

TELEPHONE #: ____________________________ **FAX #:** ____

MEDICAL NECESSITY CRITERIA FOR PANNICULECTOMY

A Panniculectomy **may** be covered for non-cosmetic indications for Medicaid recipients 18 years of age or older, when **all of the following criteria are met.** Please check all that apply.

☐ The pannus hangs at or below the level of the symphysis;

AND

☐ Is unresponsive to treatment including adequate hygiene and topical anti-infective medications;

AND

☐ Causes recurrent and significant bacterial or fungal skin infection that has failed at least 2 treatments with an oral antibiotic;

AND

☐ Has been present for over a 6-month period resulting in fibrosis and thickening of the pannus with discoloration and/or lymphedema or peau d'orange effect (pitting or prominence of pore due to fibrosis and swelling) of the overlying skin;

AND (if applicable)

☐ If there has been a significant weight loss (> 100 lbs.) the recipient must meet the criteria above;

AND

☐ a. If the weight loss was accomplished without bariatric surgery, the recipient must have maintained a stable weight for a minimum of 6 months;

OR

☐ b. If the weight loss is a result of bariatric surgery, a panniculectomy will not be considered for prior authorization until at least 18 months after surgery and only after weight has been stable for at least 6 months.

*****LIMITATION TO SERVICE: This service has a limit of once per lifetime*****

CLINICAL INFORMATION:

The following may be requested for verification of above information:

- Preoperative photograph(s) are required, frontal and lateral views.
- History and physical including all previous surgeries including the recipient's weight loss history.
- Medical documentation of medical conditions and complications of infections outlining all treatments including duration and responses.
- Documentation of limitations on mobility and daily activities due to the pannus or resulting complications.

CERTIFICATION OF MEDICAL NECESSITY

I certify that the above information is true and accurate to the best of my knowledge.

______________________________ ______________________________

Signature **Date**

______________________________ ______________________________

Print Name/Title **Specialty**

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NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

REDUCTION MAMMAPLASTY PRIOR AUTHORIZATION REQUEST

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ______________________________ **RECIPIENT MEDICAID ID #:** ______________________

RECIPIENT HEIGHT: ____________________________ **RECIPIENT WEIGHT:** ___________________________

PROVIDER INFORMATION

DATE OF REQUEST: _____/______/________ **CONTACT PERSON:** __________________________________

PROVIDER NAME: ________________________ **NH MEDICAID PROVIDER #:** ___________________________

ADDRESS: ________________________________ **CITY/STATE/ZIP:** ______________________________________

TELEPHONE #: ___________________________ **FAX #:** ____

MEDICAL NECESSITY CRITERIA FOR BREAST REDUCTION SURGERY

Breast Reduction surgery for non-cosmetic indications for women age 18 or older **or** for whom growth is complete, will be covered when **either** criteria **A or B** are met **and** criteria **C and D** are both met.

PLEASE CHECK ALL OF THE CRITERIA BELOW THAT APPLY

A. Macromastia: All of the following criteria must apply:

☐ Patient has persistent symptoms affecting daily activities for at least one year. Pain in upper back, neck, and shoulders, resulting in a physical disability or loss of function or restriction of physical activity;

OR

☐ Pain or severe discomfort or ulceration from bra straps cutting into shoulders;

AND

☐ Provider documents that chronic pain symptoms are caused by macromastia;

AND

☐ Recipient has undergone an evaluation by a provider who has determined that **all of the following** have been met:

- ☐ The pain cannot be solely explained by a musculoskeletal condition (e.g. arthritis, spondylitis,); **and**
- ☐ Reduction mammaplasty is likely to result in improvement of the chronic pain; **and**

☐ Pain symptoms persist as documented by provider, despite two trials of a 3-month duration of adequate conservative treatment with support garments, NSAIDs, physical therapy, and an exercise program or posturing maneuvers.

OR

B. Chronic dermatitis:

☐ Dermatitis lasting greater than 6 months that has not responded to conservative measures such as antibiotics or hygiene.

AND

C. Cosmetic surgery:

☐ Surgery is **NOT** being performed due to Breast Asymmetry*

**Medicaid does not cover breast reduction surgery for the purpose of correcting symmetry in a member who does not otherwise meet the above stated criteria; such treatment is considered cosmetic.*

AND

D. Amount of breast tissue to be removed:

☐ Surgeon estimates that at a minimum, 250 to 500 grams of breast tissue will be removed from each breast. Additional clinical guidance about the amount of tissue to be removed can be based on the Schnur Sliding Scale with the amount of tissue to be removed from each breast expected to be at least above the 22nd percentile. This minimum amount may be reviewed retrospectively through chart review and retrospectively withdrawn if not met.

PROPOSED AMOUNT OF TISSUE TO BE REMOVED FROM EACH BREAST:

LEFT: ____________________________ **RIGHT:** ______________________________

BSA: _______________________

CLINICAL INFORMATION:

Please attach physician's order and clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes.

I certify that the above information is true and accurate to the best of my knowledge.

______________________________ ______________________________

Signature **Date**

______________________________ ______________________________

Print Name/Title **Specialty**

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NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) & BILEVEL POSITIVE AIRWAY PRESSURE (BiPAP) MACHINE PRIOR AUTHORIZATION REQUEST FORM

RECIPIENT NAME: ____________________ **RECIPIENT MEDICAID ID** #: ____________________

ICD-9(written): ____________________ **CPT**: ____________________

MEDICAL NECESSITY CRITERIA FOR CPAP MACHINES

A CPAP machine may be approved when **all of the following** criteria are met:

☐ The recipient has a diagnosis of obstructive sleep apnea (OSA);

AND.

☐ The OSA is diagnosed and documented by a polysomnographic study performed at a medicare certified sleep study facility;

AND

☐ **ONE** of the following **TWO** clinical criteria are met:

☐ 1. The apnea-hypopnea index (AHI), which is the average number of episodes of apnea and hypopnea per hour of sleep based on a minimum of 2 hours of sleep, is greater than or equal to 15 events per hour;

OR

☐ 2. The AHI is from 5 to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, and insomnia;

AND

☐ a. Hypertension, Ischemic heart disease, or a history of stroke;

OR

☐ b. More than 20 episodes of oxygen desaturation less than

MEDICAL NECESSITY CRITERIA FOR BIPAP MACHINES

PA is required for BiPAP machines, and may be approved only if the department determines that the CPAP machine was not effective in treating the recipient's OSA.

I certify that the above documentation is true and accurate to the best of my knowledge.

____________________ ____________________
Provider Signature **Date**

____________________ ____________________
Print Name **Title**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

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AMBULANCE MEDICAL NECESSITY FORM

ADVANCED LIFE SUPPORT

NH Medicaid and Healthy Kids-Gold (NH Title XIX) benefits are payable for ambulance services provided to eligible NH Title XIX recipients only when the use of any other method of transportation is medically contraindicated by that patient's condition and only when the medical necessity for the ambulance services is documented, as required by the Centers for Medicare & Medicaid Services (CMS).

The Advanced Life Support Ambulance Medical Necessity Form must be completed by someone with medical knowledge of the case and be signed by one of the following: physician, advanced registered nurse practitioner, physician assistant, clinical nurse specialist, registered nurse, or discharge planner. Documentation of medical necessity must be kept on file to support each claim submitted to NH Title XIX. A copy of this form must be attached to the CMS 1500 claim form if billing by paper.

Patient Name: ______________________ DOB: ______________________

Patient's NH Medicaid ID# (11 digits): ______________________

Ambulance
Dispatched to: ______________________ Date Dispatched: ______________________

Patient taken to: ______________________

1. Suspected Diagnosis or Presenting Symptoms:
   - ☐ Cardiac arrest ☐ Chest pain ☐ Respiratory Arrest
   - ☐ Unconscious ☐ Shock ☐ Burns
   - ☐ Seizures ☐ Respiratory Distress ☐ OD/Poison
   - ☐ Dizziness or Syncope ☐ Other: ______________________
   - ☐ Trauma: ______________________
   - ☐ Acute Medical: ______________________
   - ☐ Chronic Medical: ______________________
2. Emergency Care:
   - ☐ CPR ☐ EOA/EGTA Placement ☐ Extrication
   - ☐ Endotracheal Tube Placement ☐ Bleeding Control ☐ EKG (circle one): Monitor Telemetry
   - ☐ O_2 Ventilation and Route ☐ I.V. Therapy ☐ Back/Neck Immobilization
   - ☐ MAST Trousers ☐ Splint/Traction Applied ☐ Defibrillation
3. Other Pertinent Information: ______________________

____

____

____

Name of person completing this form: ______________________
(Please type or print)

Ambulance Provider Number: ______________________

Signature of (circle one) MD ARNP PA CNS RN Discharge Planner If not a MD, signer is indicating that s/he has personal knowledge of the recipient's condition at the time the ambulance transport is ordered, or the service is furnished, and the signer is employed by the recipient's attending physician or by the hospital or facility where the recipient is being treated and from which the recipient is transported.

______________________ ______________________
Signature Date

AMBULANCE MEDICAL NECESSITY FORM

BASIC LIFE SUPPORT

NH Medicaid and Healthy Kids-Gold (NH Title XIX) benefits are payable for ambulance services provided to eligible NH Title XIX recipients only when the use of any other method of transportation is medically contraindicated by that patient's condition and only when the medical necessity for the ambulance services is documented, as required by the Centers for Medicare & Medicaid Services (CMS).

The Basic Life Support Ambulance Medical Necessity Form must be completed by someone with medical knowledge of the case and be signed by one of the following: physician, advanced registered nurse practitioner, physician assistant, clinical nurse specialist, registered nurse, or discharge planner. Documentation of medical necessity must be kept on file to support each claim submitted to NH Title XIX. A copy of this form must be attached to the CMS 1500 claim form if billing by paper.

Patient Name: ____ DOB: ______________________________

Patient's NH Medicaid ID# (11 digits): ____

Ambulance
Dispatched to: ______________________________ Date Dispatched: ______________________________

Patient taken to: ____

1. Please describe the patient's condition: ____

   ____

   ____

   ____

2. Was the patient ambulatory? ☐ Yes ☐ No

3. Could other means of transportation (automobile, chair car, van, public transportation) have been used without endangering the patient's condition? ☐ Yes ☐ No

4. If the patient was transported to the outpatient department of a hospital, indicate the services performed:

   ☐ Scheduled Clinic Visit

   ☐ Emergency Services

   ☐ X-ray (specify type) ____

   ☐ Other (specify type) ____

5. If the patient was transferred from one institution to another, please give reason: _______________________

____

____

Name of person completing this form: ____
(please type or print)

Ambulance Provider Number: ____

Signature of (circle one) MD ARNP PA CNS RN Discharge Planner If not a MD, signer is indicating that s/he has personal knowledge of the recipient's condition at the time the ambulance transport is ordered, or the service is furnished, and the signer is employed by the recipient's attending physician or by the hospital or facility where the recipient is being treated and from which the recipient is transported.

____ ________________

Signature Date