Developmental Services

Waiver & Non-Waiver Services

Provider Manual
Volume II

December 1, 2017

New Hampshire Medicaid

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Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Change Control Number	Number present in the text box located on the left margin where the content change was updated.
Date Change to the Manual	Date the change was physically made to the manual. This date is also included in the text box located on the left margin where the content change was updated.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Sub-Section / Page	Section number(s) / page number(s) to which the change(s) are made. If page change is not applicable "no pagination change" is stated.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s). If the reason is an administrative rule change, the rule number is added to the column.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, Control Memo, etc.).

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

1. NH Medicaid Provider Billing Manuals Overview

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

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

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

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

Intended Audience

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

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

Provider Accountability

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

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

Notifications & Updates

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

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

Description of Change Log

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

Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

All community residences shall be certified by the Department's Bureau of Developmental Services and the Centers for Medicare and Medicaid Services (CMS) pursuant to He-M 521, He-M 525, or He-M 1001. Community residences that serve four or more people shall also be licensed by the Department's Bureau of Health Facilities.

A residence funded under the Home and Community Based Care (HCBC) Waiver or the Acquired Brain Disorders (ABD) Waiver that is licensed as a supported residential care facility or a residential treatment and rehabilitation facility under RSA 151 shall not be required to be certified as a community residence pursuant to He-M 1001.

Personal care services described in He-M 521, or He-M 525, and provided in the family home of a member who is 18 years of age or older shall be certified.

Area Agencies shall be enrolled with NH Medicaid as providers in order to receive reimbursement for the provision of services.

An Area Agency or provider agency shall allow the Department to examine its service and financial records at any time for the purposes of audit or review.

When services are to be provided by a subcontractor of an Area Agency, the Area Agency shall establish a contract specifying the roles of the Area Agency and subcontractor agency in service planning, provision and oversight, or any requirements as set forth in He-M 503, He-M 507, He-M 510, He-M 513, He-M 517, He-M 521, He-M 522, He-M 524, He-M 1001, or He-M 1201 including:

1. Implementation of the service agreement;
2. Specific training and supervision required for the service providers;
3. Compensation amounts and procedures for paying providers;
4. Oversight of the service provision, as required by the service agreement;
5. Documentation of administrative activities and services provided;
6. Fiscal intermediary services provided by the Area Agency or subcontractor agency to facilitate the delivery of consumer-directed services;
7. Quality assessment and improvement activities as required by rules pertaining to the service provided;
8. Compliance with applicable laws and rules, including delegation of tasks by a nurse to unlicensed providers pursuant to RSA 326-B and He-M 1201;
9. Family support service coordination provided by the Area Agency;
10. Procedures for review and revision of the service agreement as deemed necessary by any of the parties; and
11. Provision for any of the parties to dissolve the contract with notice.

To be eligible for reimbursement by the Bureau of Developmental Services or by NH Medicaid for day services provided to members, day services shall be certified by the Department.

Eligibility for Services

Based on availability of funds, HCBC is available to any individual whom:

1. Is found to be eligible for services by an Area Agency pursuant to He-M 503, He-M 510, He-M 522, or He-M 524;
2. Is found to be eligible for Medicaid by the Department pursuant to He-W 602 through He-W 690, as applicable;
3. Has also been determined to be eligible under He-M 503, 510, or He-M 522;
4. Has been determined to meet a level of care as follows:
    a. A developmental disability that requires at least one of the following:
        - Services on a daily basis for performance of basic living skills, intellectual, physical, or psychological development and well-being, medication administration and instruction in, or supervision of, self-medication by a licensed medical professional, or medical monitoring or nursing care by a licensed professional person;
        - Services on a less than daily basis as part of a planned transition to more independence, or
        - Services on a less than daily basis but with continued availability of services to prevent circumstances that could necessitate more intrusive and costly services, or
    b. An ABD that requires skilled nursing or skilled rehabilitative services on a daily basis, where ABD is defined as a disruption in brain functioning that:
        - Is not congenital or caused by birth trauma;
        - Presents a severe and life-long disabling condition which significantly impairs a person's ability to function in society;
        - Occurs prior to age 60;
        - Is attributable to external trauma to the brain such as a motor vehicle incident or fall; anoxic or hypoxic injury to the brain such as cardiopulmonary arrest or carbon monoxide poisoning; infectious diseases such as encephalitis or meningitis; brain tumor; intra cranial surgery or cerebrovascular disruption such as a stroke; toxic exposure; and other neurological disorders such as Huntington's disease or multiple sclerosis that predominantly affect the central nervous system; and
        - Is manifested by significant decline in cognitive functioning and ability or deterioration in personality, impulse control, judgment; modulation of mood or awareness of deficits; and
5. Agrees to make the appropriate payment toward the cost of care as specified in He-W 654.

The Bureau of Developmental Services shall deny services through the HCBC Waiver if it determines that the provision of services will result in the loss of federal financial participation for such services.

3. Covered Services & Requirements

Services shall be eligible for reimbursement in accordance with the HCBC Waiver if such services are identified within a member's service agreement or Individualized Family Support Plan.

All services shall be specifically tailored to, and provided in accordance with, the member's needs, interests, competencies, and lifestyle as described in the member's service agreement. Services provided shall be designed to maintain and enhance each member's natural supports.

Service Coordination Services

Service coordination services shall be provided pursuant to He-M 503, He-M 517, He-M 522, or He-M 524, and shall include the following:

1. Monthly contacts, at a minimum, with the member or other people who support or serve the member, unless more frequent contacts are indicated by the service agreement;
2. Quarterly visits with the member at the member's residence or site of service;
3. Quarterly determination of the member's satisfaction with services through contact with the member and his or her family, guardian, friends, or service providers, as applicable to the member's services;
4. Coordination and facilitation of all supports and services delineated in the service agreement or Individualized Family Support Plan;
5. Development and revision of the service agreement or Individualized Family Support Plan;
6. Monitoring, ongoing review, and follow-up of all service agreement or Individualized Family Support Plan services, and
7. Referral to the Bureau of Developmental Services for the assessment of the member's continued need for services.

Personal Care Services

Personal Care Services shall be provided pursuant to He-M 521, He-M 524, He-M 525, or He-M 1001, as applicable, and consist of assistance, excluding room and board, provided to members to improve or maintain their skills in basic daily living, community integration, and personal development, as delineated in the service agreement or Individualized Family Support Plan.

Day Services

Day Services shall be provided in accordance with He-M 507 or He-M 525, and shall include the following as required by the member's service agreement or Individualized Family Support Plan:

1. Instruction and assistance to learn, improve, or maintain basic living skills, personal decision-making, social skills in different community settings, safety skills at home and in the community, a healthy lifestyle, good nutrition, and rights and responsibilities as citizens;
2. Employment services, except as described in He-M 507;
3. Assistance in finding and maintaining a volunteer position;

4. Participation in a wide variety of experiences in settings that are available to the general public;
5. Opportunities to become aware of and use community services and resources;
6. Consultation services in response to members' needs and as specified in their service agreements, to improve or maintain communication, mobility, and physical and psychological health; and
7. Transportation.

Day services shall exclude employment services for individuals working 30 or more hours per week and earning 50% or more of the prevailing wage for one year.

Employment Services

Employment Services shall be provided in accordance with He-M 518, and shall be available to any member who identifies employment as a goal in his or her service agreement, and is not authorized and funded by the Bureau of Vocational Rehabilitation for the same supported employment service.

Employment Services shall consist of assistance provided to members to improve or maintain their skills in employment activities or enhance their social and personal development or wellbeing within the context of vocational goals. Employment services shall include consultation services as needed by each member in communication, mobility, physical, psychological or any combination of these items.

Respite Services

Respite Services shall be provided pursuant to He-M 513, and consist of the provision of short-term assistance, in or out of a member's home, for the temporary relief and support of the family with whom the member lives.

Environmental Accessibility Modifications

Environmental Accessibility Modifications shall be provided pursuant to He-M 517 and include modifications or adaptations to the member's home environment to ensure his or her health and safety along with those required by the member's service agreement and are needed to accommodate the medical equipment and supplies that are necessary for the welfare of the member. Environmental accessibility modifications shall include modifications or adaptations to the vehicle used by the member in order to enable him or her to travel in greater safety, access the community, carry out activities of daily living, and comply with applicable state and local building and vehicle codes.

Crisis Response Services

Crisis Response Services shall be provided pursuant to He-M 517 and consist of direct consultation, clinical evaluation or support to a member who is experiencing a behavioral, emotional, or medical crisis in order to reduce the likelihood of harm to the person or others and to assist the member to return to his or her pre-crisis status. Crisis response services shall also include training and staff development related to the needs of the member and on-call staff for the direct support of the member in crisis. The services shall be authorized for a period of up to six months.

Community Support Services

Community Support Services shall be provided pursuant to He-M 517 and be available for a member who has developed, or is trying to develop, skills to live independently within the community, and consist of assistance, excluding room and board, provided to a member to improve or maintain his or her skills in basic daily living and community integration, and enhance his or her personal development and well-being.

Assistive Technology Support Services

Assistive Technology Support Services shall be provided pursuant to He-M 517 and consist of evaluation, consultation, or education in the use, selection, lease, or acquisition of assistive technology devices, as well as designing, fitting, and customizing of devices, and not cover the actual cost of assistive technology devices.

Specialty Services

Specialty Services shall be provided pursuant to He-M 517 and be available to members whose medical, behavioral, therapeutic, health or personal needs require services that are particularly designed to address the unique conditions and aspects of their developmental disabilities or ABDs. Specialty services shall consist of one or more of the following: assessment, consultation, design, development and provision of services, training and supervision of staff and providers, and evaluation of service outcomes. Specialty services shall include documentation indicating the nature of the service, date, and number of units.

Early Intervention Services

Early Intervention Services shall be provided pursuant to He-M 510 and be available to children birth through age two who have a diagnosed, established condition that has a high probability of resulting in delay, are experiencing developmental delays, or are at risk for substantial developmental delays if supports and services are not provided.

Targeted Case Management

Targeted Case Management services shall be provided pursuant to He-M 503 to coordinate and facilitate all supports and services delineated in the service agreement or Individualized Family Support Plan.

Participant Directed and Managed Services

Participant Directed and Managed Services shall be provided pursuant to He-M 525 and be available for members and their families in order to improve or maintain each member's health and his or her experiences and opportunities in work and community life. Consolidated services shall consist of assistance and resources within a flexible process that allows the family and member to control, to the extent desired, the service provision, including, for each service the type, the amount, the location, the duration, and the service provider.

Participant Directed and Managed Services shall be based on a written proposal that includes a description of the services to be provided that also specifies the expenditures to be made, a line-item budget, and a process for measuring the member's degree of satisfaction with the services provided.

Participant Directed and Managed Services shall be provided by persons qualified pursuant to He-M 506 in cases where services are provided by relatives other than parents or by friends

Providers should verify member eligibility on the date of service. If the member's name or address has changed, the member should call and inform the Department's District Office (see Appendices).

The member shall be responsible for payment of the entire cost of a service if the individual is not eligible for the NH Medicaid program on the date of service, the service is not covered by Medicaid, and the member has been made aware that he/she will be treated as a private patient for the non-covered services.

Transfer Across Regions

If a member plans to relocate residency to another region and wishes to transfer his or her Area Agency affiliation to that region, the member or guardian shall notify in writing the Area Agency in the current region and the Area Agency in the proposed region that he or she is moving and wishes to transfer services.

The current Area Agency shall send to the proposed Area Agency all information regarding the member, including information concerning funding for the member's services.

The current Area Agency shall transfer to the proposed Area Agency all funds being spent for the member's services, including funds allocated for administrative costs, with the exception of regional family support state funds.

Service coordinators shall coordinate individual transfers so that benefits obtained from third party resources such as NH Medicaid and the Division of Vocational Rehabilitation shall not be lost or delayed during the transition from one region to another.

4. Non-Covered Services

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

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

If a non-covered service is provided to a member, the provider must inform the member, **prior to** delivery of the service, that it is non-covered by NH Medicaid and that should the member still choose to receive the service, then the member is responsible for payment for the service. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that s/he understands that the service is non-covered and that s/he agrees to pay for it.

Non-covered services include educational services or education programs for members who are under 21 years of age that are the responsibility of the local education authority, post-secondary education, sheltered workshop services transportation to and from a centralized service site at the beginning and end of each day, and custodial care programs provided only to maintain an individual's basic welfare.

Participant Directed and Managed Services shall not be provided by the spouse of a member or the parent of a member where the member is a minor child.

5. Service Authorizations

A Service Authorization (SA), also known as a Prior Authorization (PA), is an advance request for authorization of payment for a specific item or service.

A service authorization does not guarantee payment. To ensure payment, providers must verify the following before providing a service.

1. The member is eligible on the date(s) of service;
2. The performing and billing NH Medicaid providers are actively enrolled providers on the date(s) of service; and
3. The procedure code(s) and billing modifier(s) are active codes and valid combinations for billing under NH Medicaid.

For annual review for continued authorization of services, the Area Agency shall submit a utilization review form at least 30-days prior to, but not more than 45 days prior to, the expiration of the current authorization. The utilization review form shall contain the following current information:

1. The name, address, and the NH Medicaid provider identification number of the agency providing care;
2. The member's name, date of birth, age, sex, diagnosis, Medicare and NH Medicaid identification numbers;
3. The member's current functional, mental, and physical status, including assessment of the member's:
    a. Daily living skills;
    b. Mobility;
    c. Sensory impairments;
    d. Physical disabilities;
    e. Need for assistive devices;
    f. Level of social participation; and
    g. Need for therapeutic services;
    h. The reason(s) for the member's continued need for services;
    i. The date of the utilization review; and
    j. Additional information as is necessary to reach a determination of need for services.

To request service authorization of a change in covered services within a current authorization period, the Area Agency shall submit a written request for authorization of the change, and an updated utilization review form, if the Area Agency determines that the patient care referral form or utilization review form most recently submitted no longer accurately documents the individual's status.

The Bureau of Developmental Services shall approve or deny requests for service authorization of services following determination of the need for services pursuant to member eligibility. Approval of service authorizations will also take into account if the requested services are medically necessary and if coverage is supported by the clinical documentation provided.

For initial service determinations and annual reviews of eligibility, the Department will notify the Area Agency, the Department's district office, and the fiscal agent of the approval.

In every case of denial of a request for service authorization of services, the Area Agency shall notify the individual affected, in writing, of the decision and the reasons for the denial.

The notification shall include:

1. The specific rules that support, or the Federal or State law that requires, the action;
2. An explanation of the individual's right to request an appeal and the procedure and timelines;
3. Notice that the individual has the right to have representation with an appeal by: legal counsel, a relative, a friend, or another spokesperson;
4. Notice that neither the Area Agency nor the Department is responsible for the cost of representation; and
5. Notice of organizations that might offer assistance or representation to the individual, including pro bono or reduced fee assistance.

6. Documentation

Providers of Developmental Services must maintain supporting documentations for each service for which a claim has been submitted to NH Medicaid for reimbursement. Please see the "Record Keeping" section of the General Billing Manual – Volume I, for documentation requirements.

Documentation shall be maintained in accordance with the regulations outlined in the following rules: He-M 503, He-M 506, He-M 507, He-M 510, He-M 517, He-M 521, He-M 522, He-M 524, He-M 525, He-M 528, He-M 1001, and He-M 1201.

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

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

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

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

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

- Recovery of erroneous and improper provider payments;
- Provider education regarding appropriate documentation to support the submission and payment of claims;
- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid program;
- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG);
- Potential termination from NH Medicaid; or
- Other administrative actions.

If a provider is found to have abused the NH Medicaid requirements, the provider may be restricted, through suspension or otherwise, from participating in NH Medicaid for a reasonable period of time. In addition, the provider may also have their claims placed on a prepayment pend or hold status for additional review by the Program Integrity Unit.

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

8. Adverse Actions

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

9. Medicare/Third Party Coverage

Under federal law, Medicaid is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume 1. Providers who receive payment in full from a third party are not required to file zero-payment claims with NH Medicaid.

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

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

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

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

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

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

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

10. Payment Policies

Reimbursement for community based services is made according to rates established by the Department and approved by CMS for services. Authorization by the Department must be received by the Area Agency prior to providing the member with community based waiver services.

Community based care providers shall submit claims for covered community based care services on form CMS 1500, Health Insurance Claim Form to:

NH Medicaid Claims Unit
Suite 200
2 Pillsbury Street
Concord, NH 03301-3523

For those members whose net income exceeds the appropriate standard of need, providers shall subtract the cost of care from NH Medicaid billings for the members.

Assistive Technology Support Services

Assistive Technology Support Services shall be reimbursed at quarter hour rates.

Community Support Services

Community Support Services shall be reimbursed at a quarter hour rates.

Participant Directed and Managed Services

Participant Directed and Managed Services shall be reimbursed monthly by independent pricing for services provided.

Crisis Response Services

Crisis Response Services shall be reimbursed at a quarter hour rate.

Day Services

Day Services shall be reimbursed at a quarter hour rates or by independent pricing, except that quarter hours of service shall not include time spent traveling to and from a centralized service site at the beginning and end of each day.

Employment Services

Employment Services shall include transportation to and from work site, and be reimbursed at a quarter-hour rates or by independent pricing.

Personal Care Services

Personal Care Services shall be reimbursed at daily rates or by independent pricing.

Respite Services

Respite Services shall be reimbursed at a quarter hour rates.

Service Coordination Services

Service Coordination Services shall be reimbursed at monthly rates.

Specialty Services

Specialty Services shall be reimbursed at a quarter hour rates or by independent pricing.

Early Intervention Services

Early Intervention Services shall be reimbursed at weekly or semiannual rates.

Targeted Case Management

Targeted Case Management shall be reimbursed at monthly rate.

11. Claims

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis and procedure codes. One procedure code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

Timely Filing

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

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

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

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