HOME INFUSION

Provider Manual
Volume II

June 2023

New Hampshire
Medicaid

Table of Contents

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:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes which 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 Manuals – 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 the NH Medicaid Program 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 General Billing Manual – Volume I Appendices section encompasses a wide range of supplemental materials such as Contact Information, Common Acronyms, and 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*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

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

1.2 Provider Accountability

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

1.3 Document Disclaimer/Policy Interpretation

It is the Department's 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.

1.4 Notifications and 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, website 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 email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 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.

1.6 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 and Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

Each participating provider of home infusion services shall be:

- Registered or licensed in the state in which the provider practices;
- A practitioner authorized to dispense pharmaceuticals, pursuant to RSA 318 or applicable state law in which the home infusion provider is located; and
- An enrolled NH Medicaid provider.

3. Covered Services and Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit these requests can be found in this Provider Specific Billing Manual - Volume II.

With the exception of those items specified in He-W 570, the following FDA approved pharmaceuticals, if rated effective, and if produced by manufacturers who are participating in the United States Department of Health and Human Services' (USDHHS) drug rebate agreement, shall be covered when prescribed by a practitioner and subject to the service authorization (also known as prior authorization) requirements in He-W 570.

1. Legend medications, only when prescribed as part of the course of medical treatment for a specific illness, injury, or disease for use specified by the FDA, or for non-experimental purposes, as supported by accepted medical practice, and in accordance with He-W 570;

2. Non-legend medications, with the exception of those specified in He-W 570, and only when prescribed as part of the course of medical treatment for a specific illness, injury, or disease for use specified by the FDA, or for non-experimental purposes, as supported by accepted medical practice, and in accordance with He-W 570;

3. Select non-legend medications will be covered as listed on the Department's website (Medicaid Pharmacy Benefit Management | New Hampshire Department of Health and Human Services (nh.gov))

4. Compound pharmaceuticals when at least one ingredient can be identified by a rebatable NDC; and

5. Nutritional supplements when needed to sustain life.

3.1 Service Limits

The following dispensing limitations shall apply to prescriptions:

1. Pharmacists shall follow current standards of practice in accordance with Ph 501;
2. Non-controlled drug prescriptions shall be refilled pursuant to Ph 704;
3. Controlled drug substances shall follow dispensing requirements pursuant to RSA 318-B:9,IV.;
4. Controlled drug substances shall follow refill requirements pursuant to 21 CFR 1306.22;

5. Refill extensions authorized by the prescribing practitioner shall be treated as a new prescription; and
6. Maintenance medications shall be dispensed in a quantity sufficient to treat the member as follows:
    a) Solid oral medications shall be dispensed as:
        i. A minimum supply of 28 days and a maximum supply of 12 months for oral contraceptives; and
        ii. A minimum supply of 30 days and a maximum supply of 90 days for solid oral medications with the exception of oral contraceptives, as described in He-W 570;
    b) If the prescribing practitioner's professional judgment indicates possession of the minimum supply of solid oral medications, as described in He-W 570.08, would not be in the member's best medical interest, the prescribing practitioner shall clearly indicate, on the prescription, that an exception to the minimum supply is being made; and
    c) For non-solid medications, such as ointments, aerosols, injectables, and liquids, the medication shall be dispensed in the most commonly dispensed sized container to cover a minimum of 7 days of therapy.

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 will be responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

Non-covered items for home infusion include:

1. Experimental or investigational pharmaceuticals not approved by the FDA;
2. Medications listed by the FDA as being DESI drugs or IRS drugs;
3. Legend and non-legend medications that are not part of a medical treatment for a specific illness, injury or disease;
4. Non-legend medications when:
    a) A legend medication effecting the same health outcome is available, and:
        i. Is more clinically effective; or
        ii. Is therapeutically equivalent and more cost effective; or
    b) The non-legend medication is being used to primarily treat discomfort or to maintain comfort, including but not limited to:
        i. Anti-diarrheals;
        ii. Anti-flatulants;
        iii. Nasal decongestants;
        iv. Eye and ear preparations; and
        v. Topical anti-pruritics;
5. Non-legend medications and supplies, which are household and medicine chest items, including, but not limited to:
    a) Band-Aids;
    b) Corn plasters;
    c) Contact lens products;
    d) Cough drops and lozenges;
    e) Mouthwash;
    f) Nursery supplies;
    g) Nutritional supplements when not needed to sustain life;
    h) Odor barrier products;
    i) Personal hygiene items;
    j) Sunscreen;

k) Soaps and cleansers;
l) Acne products;
m) Products to mitigate seborrheic dermatitis; and
n) Fluoride preparations;

6. Legend and non-legend medications used for the symptomatic relief of cough and colds, pursuant to Section 1396r-8(d)(2)(D) of the Social Security Act;
7. Legend and non-legend medications used for cosmetic purposes or hair growth, pursuant to Section 1396r-8(d)(2)(C) of the Social Security Act;
8. Legend and non-legend medications which enhance or promote fertility or procreation, or for which the labeled use is ovulation stimulation, pursuant to Section 1396r-8(d)(2)(B) of the Social Security Act;
9. Legend and non-legend medications without a prescription from a licensed practitioner;
10. Legend and non-legend medications when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration, pursuant to Section 1396r-8(d)(2)(k); and
11. Items that are free to the general public.

5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization for a specific item or service.

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The contact information in the Appendices of the General Billing Manual or on the SA form itself should be consulted for the name and method of contact.

For drugs requiring service authorizations, please refer to the NH Medicaid Pharmacy Program website at Medicaid Pharmacy Benefit Management | New Hampshire Department of Health and Human Services (nh.gov)

6. Documentation

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 the resolution of any legal action(s) commenced in the six year period, whichever is longer. See the "Record Keeping" section of the General Billing Manual – Volume I for more detailed documentation requirements.

The provider must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement, including all medications dispensed including specific refill orders documented at the time of original fill. The provider shall also maintain all letters of medical need described in He-W 571 and prescription documentation.

Retention of such documents shall meet the requirements of RSA 318:47-c, except that such records shall be maintained 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. .

The home infusion provider shall make available to DHHS the following documents for utilization and review purposes:

1. All prescriptions for both members and non-members filled during the time period specified by DHHS, with all identifying information blocked out;
2. All price lists that were in effect for such time period; and
3. Invoices showing the actual acquisition cost of the pharmaceuticals and supplies.

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 Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations, CMS transmittals, provider manuals, fee schedules and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for care, services, or supplies provided to NH Medicaid members.

Utilization review activities may be conducted prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic fraud and Abuse Detection system that is in place.

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, the Medicaid program 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 exclusions as outlined in this section or in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume 1.

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

10. Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

Payment for pharmaceuticals shall be:

1. Made for products whose manufacturer has a signed rebate agreement with the federal DHHS, or for single or innovator multiple-source products exempt from such agreements, pursuant to Section 4401 of P.L. 101-508, OBRA '90;
2. Reimbursed at the lesser of the following:
   - The AAC using NADAC files when available, plus the dispensing fee; The WAC, when a NADAC is not available, plus the dispensing fee;
   - The usual and customary charge to the general public;
   - The NHMAC plus the dispensing fee; or
   - The FUL plus the dispensing fee; and
3. Subject to the following conditions and restrictions:
   a) The payment for multiple source drugs, listed as having a FUL by the USDHHS, shall be reimbursed at a rate which does not exceed the FUL plus the dispensing fee, except as determined by the Centers for Medicare and Medicaid Services (CMS) of the USDHHS;
   b) The payment for multiple source drugs, listed as having a NHMAC by the department, shall be reimbursed at a rate which does not exceed the maximum allowable cost plus the dispensing fee;
   c) The NHMAC and FUL shall not apply when a licensed practitioner certifies on the face of the prescription in his/her own handwriting, pursuant to He-W 570.09, that a specific brand of drug, which is a NHMAC or FUL drug, is medically necessary for a particular member;
   d) The payment for any refill prescriptions for the same member for solid oral maintenance medications within a time period that does not allow for usage of 75% of the supply of the prescription shall be only for the cost of the medication unless the reason for the exception is documented on the prescription or the practitioner's order; and
   e) The payment for compound prescriptions and sterile preparations for parenteral use shall be at the rate established by the department.

11. Claims

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis and Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue 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 home infusion provider shall submit pharmacy, medical supply and equipment claims with Healthcare Common Procedure Coding System (HCPCS) codes (and NDC codes where applicable).

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.

11.2 Service Authorizations (SAs)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, NH Medicaid does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

11.3 Claim Completion Requirements for Home Infusion

Home infusion providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P. Unless you are submitting a claim after Medicare has paid or allowed the charge, this claim would be a crossover and you would submit the same claim type you submitted to Medicare.

Paper claims are imaged and will 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 suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted area show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. 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.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

12. Terminology

Actual acquisition cost (AAC): Actual acquisition cost as defined at 42 CFR 447.502, namely, the agency's determination of the pharmacy providers' actual prices paid to acquire drug products marketed or sold by specific manufacturers.

Compound Prescription: A pharmaceutical product prepared by the pharmacist using more than one ingredient.

Dispensing Fee: A payment for the pharmacist's service of dispensing medication.

Drug efficacy study implementation (DESI) drugs: means pharmaceuticals found to lack substantial evidence of effectiveness as determined by the Food and Drug Administration (FDA) and also includes identical, related or similar (IRS) drugs.

Federal upper limit (FUL): The maximum cost allowed by the federal government for certain multiple source drugs.

General Public: Individuals purchasing pharmaceuticals at the usual and customary retail price.

Healthcare Common Procedure Coding System (HCPCS): A uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies.

Legend Medication: A medication which is dispensed only with a prescription from a licensed practitioner.

Maintenance Medication: A pharmaceutical prescribed for routine continuous daily therapy for at least 120 days.

Medicaid: The Title XIX and Title XXI programs administered by the department, which makes medical assistance available to eligible individuals.

Member: Any individual who is eligible for and receiving medical assistance under NH Medicaid.

National average drug acquisition cost (NADAC): National price benchmark that represents the national average invoice price derived from retail community pharmacies for drug products based on invoices from wholesalers and manufacturers, and which is updated and published weekly by the Centers for Medicare and Medicaid Services (CMS) and available at https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html.

Non-legend Medication: A medication prescribed by a licensed practitioner, which is normally purchased over the counter.

Parenteral: Drug administration other than by the mouth or rectum, such as by injection, infusion, or implantation.

Pharmacist: "Pharmacist" as defined in RSA 318:1, VII.

Pharmacy lock-in program: A program established to prevent members from obtaining excessive quantities of, or from inappropriately using, prescription drugs through multiple pharmacies.

Practitioner: "Practitioner" as defined in RSA 318:1, XV.

Prescription: "Prescription" as defined in RSA 318:1, XVI.

Prior Authorization: The process by which a prescriber seeks approval from DHHS to make payments for drugs which are considered to have a high potential for misuse or abuse, are high cost, or should be monitored for correct adherence to clinical protocols.

Usual and customary: "Usual and customary" as defined in RSA 126-A:3 III.(b).

Wholesale acquisition cost (WAC): The drug manufacturer's list price to wholesale distributors or direct purchasers, not including prompt pay or other discounts, rebates, or reductions in price, as reported in wholesale price guides or other publications of drug or biological pricing data.