

# Community Mental Health

Provider Manual  
Volume II

August 2025

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New Hampshire  
Medicaid



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# 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 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 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 range of supplemental materials such as Contact Information, Common Acronyms, and 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 & 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 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 & 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.

Community Mental Health (CMH) providers approved prior to August 22, 1997 shall be authorized to continue to provide NH Medicaid Program funded community mental health services pursuant to He-M 426. CMH providers shall only provide those services for which they have received approval pursuant to applicable New Hampshire Administrative Rule.

### 2.1 Community Mental Health Programs

To participate in NH Medicaid as a Community Mental Health Program (CMHP), all CMHP's must be approved pursuant to He-M 403 and enrolled in NH Medicaid. The CMHP, or its subcontractors, shall be authorized to provide the NH Medicaid funded CMH services.

CMHPs shall meet all applicable requirements in New Hampshire Administrative Rules Chapter He-M 400.

### 2.2 Staff Qualifications for Community Mental Health Programs and Providers

Coverage is limited to those services that the provider is legally qualified to practice under New Hampshire Law. Provider qualifications for CMHC services can be found in New Hampshire Administrative Rule He-M 426.

## 3. Covered Services & 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.

New Hampshire provides benefits for CMH rehabilitative services. Services recommended by a licensed or certified practitioner of the healing arts shall be provided in accordance with NH Administrative Rules and state and federal laws. It is the provider's responsibility to be familiar with all state and federal regulations. All information is subject to change as state or federal regulations impacting NH Medicaid are revised or implemented.

### 3.1 Covered Services

The services posted in the CMH fee schedule on the NH MMIS website are covered CMH services, available under the NH Medicaid program to all eligible NH Medicaid members when provided or recommended by a licensed practitioner of the healing arts pursuant to all requirements specified in NH Administrative Rules He-M 400. Eligibility determination requirements are specified in He-M 401. Documentation requirements are specified in He-M 408. Service requirements are specified in He-M 426. Specific attention should be given to billing of Individualized Resiliency and Recovery Oriented Services (IROS) as noted below.

The following IROS services shall be billed separately from one another, with one claim submitted per day for each category

- Illness management and recovery, group;
- Illness management and recovery, individual;
- Evidence-based supported employment;
- Crisis intervention;
- Group therapeutic behavioral services; and
- Individual therapeutic behavioral services, family support services, and medication support services.

The CMHP shall separately aggregate the minutes for each category listed in 1-6 above that are provided in a single day into a single claim before determining the number of billable 15 minute units for each category

- 1 unit: ≥ 8 minutes through 22 minutes
- 2 units: ≥ 23 minutes through 37 minutes
- 3 units: ≥ 38 minutes through 52 minutes

- 4 units: ≥ 53 minutes through 67 minutes
- 5 units: ≥ 68 minutes through 82 minutes
- 6 units: ≥ 83 minutes through 97 minutes
- 7 units: ≥ 98 minutes through 112 minutes
- 8 units: ≥ 113 minutes through 127 minutes

CMH programs may provide all services identified in the CMH fee schedule. CMH providers shall only provide those services for which they have received approval.

## 3.2 General Requirements

Individual Service Plans (ISPs) must be written and signed by a psychiatrist or APRN recognized under NH law prior to services being provided.

Progress notes for services billed must be documented in accordance with all state and federal regulations prior to services being billed.

CMH services shall be overseen by a psychiatrist or APRN responsible for the member's care as documented in the ISP.

Periodic (at least every 180 days) reviews shall be done to document the individual's progress or continued need for services in accordance with He-M 401.

Pursuant to He-M 401 services available to individuals who meet Bureau of Behavioral Health eligibility requirements shall only be billed for dates of service that fall within the eligibility period.

All services covered under other primary insurance must be billed to the primary insurance prior to billing NH Medicaid. "Covered" means that the service is included within the plan benefit. Non-payment for service, where insurance conditions are not met, does not meet the definition of non-covered.

## 3.3 Waivers to CMH Administrative Rules

The Administrative Rules for covered CMH services can be found in He-M 400, Community Mental Health, and He-M 1002, Certification Standards For Behavioral Health Community Residences.

A CMHP or a member may make a written request to the Department for a waiver of specific procedures outlined in the administrative rule. A waiver request shall include a specific reference to the section of the rule for which a waiver is being sought, a full explanation of why a waiver is necessary, and a full explanation of alternative provisions or procedures proposed by the CMHP or member. No provision or procedure prescribed by statute shall be waived.

A request for a waiver shall be granted after the Department determines that the alternative proposed by the CMHP, or the member meets the objective or intent of the rule, and:

- Does not negatively impact the health or safety of the member(s); or

- Is administrative in nature, and does not affect the quality of member care.

Upon receipt of approval of a waiver request, the CMHP's or the member's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which waiver was sought.

Waivers shall be granted in writing for a specific duration not to exceed five years except as noted.

Those waivers which relate to the following shall be effective for the CMHP's current certification period only:

- Fire safety
- Other issues relative to member health, safety or welfare that require periodic reassessment

A CMHP or a member may request a renewal of a waiver from the Department within the timeframes outlined in Chapter He-M 400 of the NH administrative rules.

## 3.4 Service Limits

Under He-M 426, certain Functional Support Services (FSS) are indicated to have daily limits. Prior to 9/1/2024 Community Support, Individual and Group Therapeutic Behavioral Health, Family Support, and Medication Support (inclusive of procedure codes H2015, H2019, T1017, and T1027 respectively) required prior authorization from the Bureau of Mental Health Services to exceed the established 10-unit daily limits. As of 9/1/2024, the 10-unit daily limit is no longer applicable, and these procedure codes no longer need prior authorization or a UA modifier to process. No other He-M 426 requirement, applicable to these services, has changed.

CMH services provided in an inpatient hospital setting are only reimbursable through NH Medicaid if provided by a legally qualified psychiatrist.

CMH services provided in an Institute for Mental Disease are not reimbursable.

### 3.4.1 Medication Related Services

Pharmacologic management is considered part of and Evaluation and Management (E/M) service.

E/M services provided on the same day as psychotherapy shall be billed using the appropriate E/M code as well as the appropriate add-on psychotherapy code. The two services must be significant, and separately identifiable. There must be distinct and separate documentation for each service.

Nursing assessment and evaluation shall be limited to no more than one procedure billed per member per day.

Nurse assessment and evaluation, brief office visit, or evaluation and management shall be limited to one service per day, and shall not be billed on the same day.

Brief office visits, nursing assessment and evaluation, or evaluation and management for the purpose of pharmacologic management shall not be billed for members on days during which the member is in attendance at a partial hospitalization program.

Comprehensive medication service for clozapine/clozaril management may be provided up to a maximum of once per day when a documented drop in the member's white blood cell count (WBC) occurs. Third party billing rules also apply to this procedure.

Administration of medication by injection and medication check may be billed, using the respective billing codes, as part of the same visit.

### 3.4.2 Psychotherapeutic Services

Psychiatric Diagnostic Codes:

- Can be reported once per day;
- Cannot be reported on the same day as E/M by the same provider; and
- Cannot be reported with psychotherapy service on the same day.

The following shall apply to Individual Psychotherapy:

- Individual therapy with medication management shall be billed as two procedures including the E/M component as well as the add-on psychotherapy component;
- Psychotherapy time includes face-to-face time spent with the individual and/or family member;
- When time with patient and/or family crosses half of the time for the code, that code can be used;
- Psychotherapy of less than 16 minutes is not reported; and
- Recipient must be present for all or some of the service.

Crisis psychotherapy shall be a covered service when provided by individuals meeting psychotherapy requirements outlined in He-M 426. Crisis psychotherapy shall be billed in 30 and 60 minute increments; 60 minutes for the initial intervention and then each subsequent 30 minutes.

### 3.4.3 Emergency Services

As follow-up to the initial emergency response, a member shall be eligible to receive a maximum of five emergency service sessions. Billing shall consist of no more than six 15-minute face-to-face units per session, for the purpose of *stabilization of the emergency situation* prior to intake or referral to another service or agency.

Emergency services shall be billed in 15-minute units, and shall be limited to six units per member per day to a maximum of six sessions per period of acute psychiatric crisis.

#### **Rapid Response/Mobile Crisis**

Current Billing Guidance is for multi-disciplinary, community based, up to two (or more) person crisis responses for individuals in crisis for both the initial crisis and crisis stabilization for up to 30 days. Services include:

- Peer Billing & Interventions
- Bachelor's Level Billing & Interventions
- Master's Level Billing & Interventions
- Any combination thereof.

Current billing guidance also allows for the following services or combinations of services to exceed the \$1,800 threshold for Emergency Services and for medical need for both an initial crisis episode and or for any subsequent episodes within the same calendar year:

- H2011 – Crisis Intervention Mental Health Services for two-person team or Masters' level only. \$129.11 or \$101.28 respectively, per unit.
- S9485 – Crisis Intervention Mental Health Services per diem for a two-person team and Masters' level only. \$1215.38 or \$607.69 respectively.
- S9484 – Crisis Stabilization Services for less than Bachelors' level, Bachelors' level, Masters' level – only & for two person responses. \$27.83, \$27.83, \$50.64 and \$64.56 respectively per unit.
- 90839 & 90840 – Psychotherapy in Crisis first 60 minutes and additional 30 minutes – Master's level only \$89.19.

### 3.4.4 Evaluations and Testing

Psychiatric diagnostic interview exam shall be billed as one event for the initial intake service.

All E/M services shall be billed as one event when provided on the same day by the same provider.

Psychological testing shall be a covered CMHP service, and consist of psychometric, or projective tests, or both with a written report. This procedure shall be billed per hour and be limited to six hours per member per six month period. Only persons licensed by state statute to provide psychological services shall provide this service.

Neuropsychological tests shall be billed per hour, and be limited to six hours per member per six month period.

### 3.4.5 Partial Hospital Services

Programs shall operate a minimum of six hours per day on weekdays and 4 hours per day on holidays and weekends for each day for which services are billed.

Billing for partial hospitalization services shall be in half day or full day units, as follows:

- One half day of partial hospitalization shall be attendance at staff directed programs for at least two and less than three hours; and
- A full day of partial hospitalization shall be attendance at staff directed programs for three or more hours.

Reimbursement for partial hospitalization services shall be limited to services for outpatients.

On a day that a member receives partial hospitalization services, no reimbursement for other covered services shall be made except as follows:

- Case management services when provided under an approved case management option of the NH Medicaid program;
- Emergency visits if they occur outside of the normal operating hours of the partial hospitalization program;
- Services provided by a continuous treatment team;
- Individualized resiliency and recovery oriented services;
- Medication checks for clozaril/clozapine management; and
- Psychiatric evaluation for NH Medicaid eligibility.

#### **Intensive Partial Hospitalization**

Participation shall not exceed 20 treatment days per acute episode without a written order from a psychiatrist and a documented service plan review. There shall be no reimbursement from NH Medicaid for any treatment exceeding 30 days per episode, or 90 days per state fiscal year.

Programs shall operate a minimum of six hours per day on weekdays and four hours per day on holidays and weekends for each day for which services are billed.

#### **Restorative Partial Hospitalization**

Placement and participation in restorative partial hospitalization services shall be based on the needs of the member as documented in the ISP, and functional deficits identified in the eligibility determination process pursuant to He-M 401.

Only members certified to receive long-term care services pursuant to He-M 426.18 shall be eligible to receive IROS.

IROS shall not be eligible for reimbursement if provided in an office setting with the exception of Illness Management and Recovery (IMR), crisis intervention and medication support.

### 3.4.6 Community Residence

Reimbursement for services provided on a per diem basis in an acute psychiatric residential treatment program designated pursuant to He-M 1005.04 shall preclude the possibility of billing for any other service described in He-M 426 except case management services, emergency services, and psychological testing.

### 3.4.7 CMH Services - Inpatient Setting

Services provided in an inpatient hospital setting shall only be reimbursable through NH Medicaid if provided by a legally qualified psychiatrist.

### 3.4.8 Other Services

***Copying a portion of a member's record*** to be used for NH Medicaid eligibility determination shall be limited to one unit per six-month period

***Psychiatric evaluation*** for NH Medicaid eligibility shall be limited to one session per member per six-month period.

Case management shall be billed only by the agency that is the primary service provider for individuals who receive services from both the behavioral health and developmental services systems. Comprehensive case management must be provided in accordance with state and federal laws including a comprehensive assessment, individual care plan, referral, linkage and monitoring of the identified needs.

NH Medicaid billing for evidence based supported employment shall be limited to community based, direct, active, face-to-face clinical interventions necessary for the individual to achieve the goals and objectives identified on the ISP.

## 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 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. 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.

Services provided in an Institution for Mental Disease shall not be reimbursable. Services provided in an inpatient setting shall not be covered when provided by non-physician practitioners.

The Evidence Based Supported Employment components shall not be a NH Medicaid billable service when they, either:

- Do not include the member, or
- Do not address symptoms related to an individual’s mental illness

The Vocational Assessment components of Evidence Based Supported Employment, including competency testing, screening for exclusionary criterion, work readiness evaluations, vocational testing, interest inventories, situational assessments, and transitional employment shall not be billed to NH Medicaid.

**Office Based IROS** – IROS shall not be eligible for reimbursement if provided in an office setting, with the exception of IMR, crisis intervention and medication support. Office setting includes any meeting room where the CMH staff and members are scheduled to meet to the exclusion of non-CMH members coming and going. The intent is for IROS services to be provided in the individual’s home or community.

## 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 – Volume I or on the SA form itself should be consulted for the name and method of contact.

## 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 CMHP or CMH provider shall maintain clinical information, and documentation of services, as required by federal regulation, and He-M 400 (including 401, 408 and 426). This clinical record shall include:

- The signature of the service provider;
- The service provider’s credentials;
- The legible name of the service provider, including a typed name, name stamp, or printed name within proximity of the credentials and signature of the service provider;
- The date of service; and
- The date of documentation.

All documentation in the clinical record of a CMHP service shall comply with the following requirements:

- The specific services rendered;
- The date and actual time the services were rendered;
- Who rendered the services;
- The setting in which the services were rendered;
- The amount of time it took to deliver the services;
- The relationship of the services to the treatment regimen described in the Plan of Care (PoC) PoC; and
- Updates describing the patient’s progress

## 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 fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services or supplies provided to NH Medicaid members.

Utilization review activities may be done 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 I.

### 7.1 Quality Service Reviews

Additionally, CMH service(s) providers shall have multidisciplinary staff conferences pursuant to He-M 401 to review the progress of current cases. Each CMHP shall have a quality assurance program including utilization and peer review to evaluate the effectiveness of covered services

## 8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, or Department rules, policies or procedures. See the "Adverse Action" section of the General 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 in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume I.

Community Mental Health Providers only need to obtain one denial annually for a member that the service is not covered by Medicare or other primary insurance where the service is given on a regular basis, such as monthly therapy. The one denial (EOB) can be used for all claims during the year. Annually, the provider is required to obtain a new denial (EOB) showing the service continues to not be covered by Medicare or other primary insurance.

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.

The NH Medicaid Program shall reimburse CMHPs and CMH providers only when supervision of providers occurs, and is documented.

The Department will recover any NH Medicaid payments in excess of the NH Medicaid payment limit per state fiscal year for a member including, but not limited to, each of the following circumstances:

- The member's record lacks a properly completed eligibility statement which covers long-term care services billed for the period under review;
- The eligibility period has expired and the redetermination of eligibility has not been completed;
- Documentation in the clinical record fails to substantiate that the member meets the criteria for certification for long-term care; and
- The member's diagnosis does not meet the criteria in He-M 401.

NH Medicaid payments shall be made for CMHP services rendered to members with both psychiatric and mental retardation diagnoses for services related to the psychiatric diagnosis. Medical and billing records shall support this classification. The claim shall indicate the primary diagnosis related to the service rendered.

CMH services shall be paid at rates set by the Department based on the audited costs of covered services as determined by units of services provided by all CMH providers divided by the sum of costs for member transportation, staff, and staff related costs to provide such services incurred by all CMH providers.

**MIPPA** - Section 102 of Medicare Improvement for Patients and Providers Act (MIPAA) requires that the current 62.5% outpatient mental health treatment limitation (under which Medicare pays 50% of the approved amount, and the patient pays 50%) is reduced as follows: **2010-2011**=68.75% - Medicare pays 55% and the patient pays 45%; **2012**=75% Medicare pays 60% and the patient pays 40%; **2013**= 81.25%

- Medicare pays 65% and the patient pays 35%; and **2014 and onward**=100%-Medicare pays 80% and the patient pays 20%.

## 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 & Procedure Codes

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

For medical services, NH Medicaid 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.

#### CMH MODIFIERS

HE		NON CMH ELIGIBLE (or presumed eligible if mobile crisis)
HW	U1	CMH Eligible (HW) Based on SEVERE/PERSISTENT MENTAL ILLNESS (SPMI) (U1)
HW	U2	CMH Eligible (HW) Based on SEVERE MENTAL ILLNESS (SMI) (U2)
HW	U5	CMH Eligible (HW) Based on SPMI at LOW UTILIZER (U5)
HW	U6	CMH Eligible (HW) Based on SERIOUS EMOTIONALLY DISTURBED CHILD (SED) (U6) – <b><i>none of these codes can have service limits</i></b>
HW	U7	CMH Eligible (HW) Based on SERIOUS EMOTIONALLY DIST CHILD INTERAGENCY INVOLVEMENT (SED-I) (U7) <b><i>none of these codes can have service limits</i></b>
HW	U8	CMH Eligible (HW) and in Specialty Residential Service (U8)
HW	U9	CMH Eligible (HW) and delivered by Mobile Crisis Response Team (U9) Note: if H2020 – it is a bed used for crisis purposes

- Modifiers in alphabetical order (if not entered that way, system still processes them that way)
  - HE shall always be in the first modifier position
  - HW shall always be in the first modifier position

- U codes typically in second to fourth positions (never first)
- All other modifiers will follow HE or HW
- Mobile Crisis Special Modifiers (effective 7/1/2021)
  - The following modifiers affect pricing, and are specifically tied to Rapid Response MCRT staff performing a service in that specific role
    - HM – a one-person response and it is a peer
    - HN – a one-person response, and it is a bachelor level person
    - HO – a one-person response and it is a master level staff
    - HT – a two-person response

**Other Modifiers:**

V2	Reentry
Q2	CCBHC
HF	SUD
HQ	Group Setting
HK	ACT Team services (reason: special cost centers and for Medicaid directed payment purposes)
GY	Item or service statutorily excluded from having to go through Medicare first (non-covered)
UA	Used when the service limit override for 10 units of adult functional support services is waived. This modifier does not accompany U6 or U7 as they do not have limits. (Discontinued in September 2024 – 10 unit limit of adult FSS was suspended.)

## 11.2 Claim Completion Requirements for Community Mental Health Centers

Community Mental Health Centers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P.

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

For additional guidance on how to complete a CMS1500 claim form please refer to the [National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual](#).

## 12. Terminology

**Acute episode** means a sudden, generally unexpected, debilitating, and precipitous event in a psychiatric disorder.

**Care plan** means the care plan that specifies the goals and actions to address the medical, social, educational and other services needed by an individual.

**Certified recovery support worker (CRSW)** means “certified recovery support worker” as defined in RSA 330-C:2, namely, “an individual certified by the board to provide recovery support to persons with substance use disorders.”

**Community mental health program (CMHP)** means a program defined in RSA 135-C:2. IV, approved by the department pursuant to He-M 403 and operated by the state, city, town, or county, or a community-based New Hampshire nonprofit corporation for the purpose of planning, establishing, and administering an array of community-based, mental health services.

**Community mental health provider** means a provider of community mental health services enrolled as a New Hampshire Medicaid provider that has been previously approved by the commissioner to provide specific mental health services pursuant to He-M 426 and who is not a Community Mental Health Program.

**Covered services** means rehabilitative, transitional, treatment, and other community mental health services that are funded by the department and are available through CMHPs, community mental health providers, or agencies affiliated with such programs or providers.

**Current Procedural Terminology (CPT)** means a listing of descriptive terms and identifying codes for reporting and billing medical services and procedures, developed by the American Medical Association (AMA), as set forth in CPT 2023 Professional Edition or the most current edition, available as listed in Appendix A.

**Department** means the New Hampshire department of health and human services.

**Facility** means New Hampshire hospital, a receiving facility designated pursuant to RSA 135-C:26 and He-M 405, Glencliff Home, or an acute psychiatric residential treatment program pursuant to He-P 830.

**Family member** means the parent, foster parent, legal guardian, child, stepchild, brother, sister, spouse, significant other, grandparent, grandchild, stepparent, aunt, uncle, first cousin of the individual, or surrogate family member who have a non-professional, relationship with the individual.

**Illness management and recovery (IMR)** means a specific set of services aimed at promoting recovery that are based on the Illness Management and Recovery Evidence Based Practice Kit (2010) or the most current edition, available as listed in Appendix A.

**Individual** means a person who has applied for or is receiving a services defined in He-M 426 from a community mental health program or a community mental health provider.

**Intensive partial hospitalization services** means clinically oriented programs designed to promote stabilization and rapid amelioration of the symptoms of any combination of acute or severe psychiatric disturbances.

**Licensed practitioner of the healing arts** means a person who meets the qualifications necessary to provide psychotherapy without supervision pursuant to He-M 426.08(i).

**Long-term care** means services covered by Medicaid for Medicaid recipients who have been determined eligible pursuant to the criteria outlined in He-M 401.

**Nursing facility** means an institution as defined pursuant to He-E 802.01(s).

**Peer support specialist** means CMHP or community mental health provider staff who self-identify as having experience with a mental health condition and have successfully completed department-approved training to become a certified peer support specialist.

**Psychotherapy** means direct, personal, clinical intervention or assessment, psychoeducation, and monitoring necessary to determine the course and progress of therapy that:

- (1) Is based on psychological treatment principles;
- (2) Has as its purpose the improvement of interpersonal and self-care skills, psychological understanding, or a change in behavior(s), or any combination of these;
- (3) Is provided by a professional qualified pursuant to He-M 426.08(i)-(m);
- (4) Is monitored through the clinical record; and
- (5) Is based on an ISP.

**Recipient** means an individual who is eligible for reimbursement of CMHP and community mental health provider services under the state Medicaid program.

**Restorative partial hospitalization services** means evidenced informed services that address integrated health care goals and objectives and are intended to impact the person's whole health status, improve physical and overall health status indicators, as these factors have an important impact the individual's mental health, maximize an individual's strengths, increase his or her ability to function in his or her living environments, and lead to integration of the individual into the community.

**State fiscal year** means the period of time extending from July 1 of one year through August 30 of the following year.

**Subcontractor** means any person or organization that enters into an agreement with a CMHP to receive payments from the CMHP for the delivery of Medicaid-funded mental health services described in an ISP.

**Transitional employment** means time-limited employment for the purpose of vocational assessment or training.

**Unit** means a period of time during which services are rendered. Where units refer to a specific length of time, units are reimbursed in whole units and time of service is rounded to the nearest whole unit.

**Visit** means all services provided to an individual per appointment or encounter with a provider.