Dental Provider Manual

Provider Manual
Volume I
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New Hampshire Medicaid Program

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1. NH Medicaid Provider Billing Manuals Overview

Thank you for being a leader in your community by caring for children and adults in partnership with New Hampshire (NH) Medicaid programs. Only with your help can NH Medicaid provide comprehensive dental treatment to eligible children and emergency dental treatment to adults eligible for NH Medicaid benefits.

Provider manuals are written to provide information that dentists, their staff, and billing agents may use to facilitate participation in NH Medicaid Program. This manual gives an overview of the NH Medicaid Dental Program to assist you in serving patients whose treatment is covered by NH Medicaid. The manual will answer many frequently asked questions and includes instructions for completing the forms and documents to submit for prior authorizations and payment for services. The information in this dental provider manual is subject to change. When changes occur, NH Medicaid will update this manual and provide notification to providers.

Thank you for your willingness to provide professional care for children and adults who receive dental coverage through New Hampshire Title XIX, the New Hampshire Medicaid Program. We depend on dentists to help improve oral health and offer a better quality of life to thousands of members of our community. Thank you for helping children and adults live free of the pain and disfigurement of oral disease.

We want to make your experience not only pleasant and gratifying by providing information about policies and process, but also we hope to make billing easy and payment timely. Your understanding of the information in this manual will increase your ability to more quickly and easily work with the New Hampshire Medicaid Program and its fiscal agent, Xerox.

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

It is important that the provider and the provider's staff be familiar and in compliance with all information contained in the General Billing Manual – Volume I as well as this Provider Specific Billing Manual – Volume II.

- **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider who bills the Medicaid program. 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, access to fee schedules, claims processing, and obtaining reimbursement for providing services. The General Billing Manual also includes general information about enrolling 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.

- **Provider Specific Billing Manual – Volume II:** Specific to a single provider type and designed to guide that provider through specific policies applicable to the provider type. This Dental Provider Billing Manual is a provider specific billing manual for dentists, referred to as "providers" in this manual.

Intended Audience

The General Billing Manual - Volume I and the Dental Provider Billing Manual – Volume II are designed for participating NH Medicaid health and dental care providers, their staffs, and provider-designated billing agents.

These manuals are ***not*** designed for use by members.

Provider Accountability

Participating providers, their staffs and authorized billing agents can use both the general and specific provider billing manuals to remain aware of NH Medicaid policies and procedures and changes to policies and procedures that relate to the provision and billing of services for NH Medicaid members.

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to NH Medicaid providers by the Xerox Communications staff, be accurate and timely. Nonetheless, in the event of inconsistencies between fiscal agent communications 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, memos, letters, web site updates, newsletters and updated pages to the General Billing Manual and/or the Provider Specific Billing Manual. It is important that providers share these documents with their service providers, billing agents and staffs.

Billing Manual updates are distributed jointly by the Department and its contracted fiscal agent, Xerox. Participating providers receive notification of manual updates through messages 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 State of NH Department of Health and Human Services. The change log is located at the front of this document.

Contacts for Billing Manual Inquiries

Any errors or omissions identified in the General Billing Manual - Volume I or the Dental Provider Billing Manual - Volume II may be directed to the Xerox Provider Relations Unit. (See General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to claim submission, claim payment or denial, and related procedures outlined in the manuals should be directed to Xerox, the fiscal agent

Questions relating to policy issues outlined in this manual for the NH Medicaid Program may be directed to Xerox, Provider Relations Unit, or to the Dental Director, at (603) 271-9250.

2. Provider Participation & Ongoing Responsibilities

To receive payment for dental services rendered, an individual or group must be enrolled with New Hampshire Title XIX (also known as "NH Medicaid") as a dental billing provider. Dental services must be performed by a dentist, or under the supervision of a dentist, who is enrolled as an individual provider and is currently licensed by the state in which services are performed. The dentist must, if required, request and obtain service authorization from Xerox, the Department's fiscal agent..

Providers agree to notify Xerox in writing of any changes in enrollment status occur, such as a new address, telephone number, additional practice or office locations, the closure of any individual practice or dissolution of a group practice, or voluntary terminations. Each notice must appear on practice letterhead, be signed by the enrolled Medicaid provider, and indicate the date on which the change is to take effect.

Providers agree to bill for procedure(s) using the CDT codes that most accurately describe the services rendered. Dentists may not separate into smaller coding units the components of a treatment, any part of a treatment that is by practice included as part of another procedure. For example, a dentist may not file a claim for a pulpotomy and a root canal treatment performed on the tooth on the same date of service.

Providers agree to bill using the usual and customary fee charged by their offices for each New Hampshire Medicaid covered treatment or service.

All Providers participating in the NH Medicaid program must provide services in accordance with the rules and regulations of the New Hampshire Medicaid program. These include the New Hampshire Administrative Rules, Chapter He-W 500: Medical Assistance. The rules specific to NH Medicaid's dental services are found in He-W 566: Dental Services. The Dental Services rule describes the dental services that are covered by NH Medicaid, the service authorization process required for some of these services, and the provider payment structure. Other regulations governing Medicaid and dental practices include: Title XIX of the Social Security Act; the New Hampshire Dental Practice Act (RSA 317-A); and He-W 546 (EPSDT) of the New Hampshire Code of Administrative Rules.

If you have questions about the content of this manual or about participating in the NH Medicaid dental program, please contact the NH Medicaid Dental Director's Office by telephone at 603 271-9250, by fax at 603 271-0557, or by emailing *NHSmiles@dhhs.state.nh.us*

Service Standards

Dentists participating in NH Medicaid shall provide services in accordance with the rules and regulations of the NH Medicaid program. Dental care provided in the NH Medicaid program must meet prevailing professional standards for the community-at-large. Any dental provider who undertakes dental treatment, including but not limited to orthodontia, as covered by NH Medicaid must be qualified by training and experience in accordance with the NH Board of Dental Examiners' rules and regulations.

All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association (ADA). All dental services, including without limitation,

examinations, radiographs, restorative, preventive and surgical treatment, as well as record keeping are to be provided in accordance with current ADA guidelines and the ADA Code of Ethics, and are to be coded according to the definitions and descriptions in the current ADA CDT Manual. All dental services must conform to the statutes, regulations and rules governing the practice of dentistry in the state in which treatment takes place.

Enrollment

NH Medicaid requires that all dentists who provide treatment or supervise non-dentists in dental treatment of CHIP and/or NH Medicaid eligible children or adults, called "members", must be appropriately enrolled for payment of claims for their services or services of those they supervise. To be enrolled as a NH Medicaid provider, a dentist must be duly licensed by the state in which the dental treatment takes place.

Dentists are enrolled as NH Medicaid providers in two ways: Group enrollment and Individual enrollment. Group enrollment is required for any group of one or more dentists practicing or supervising non-dentists within an entity that uses a Federal Employer Identification Number (FEIN) to report income to the IRS, or any other entity that employs or uses the services of dentists. The NH Medicaid number assigned to the Group enrollment refers to the entity filing claims or receiving payment for claims made on behalf of any of the dentists who own, are employed by, contracted by, supervise non-dentists employed by or associated with, or are otherwise associated with the group. The Group enrollment number represents the "billing provider."

Each dentist who provides patient care or supervises non-dentists in providing patient care must enroll as an "Individual Provider". The individual provider number is used on claims to denote the performing provider, which means the dentist who actually performed the treatment or under whose supervision the treatment was performed by a non-dentist.

Dental services performed by a dentist who is not enrolled as an individual provider and/or those provided by a non-dentist supervised by a dentist who is not enrolled as an individual provider, may not be billed to NH Medicaid under any other provider's group or individual enrollment number. The duly enrolled individual provider who actually performed the treatment or supervised a non-dentist performing treatment, must be identified on the claim by the performing dentist's own individual enrollment number.

A dentist enrolled as an individual provider must report the name of each group in which he/she treats NH Medicaid eligible patients or supervises non-dentists in the care of NH Medicaid eligible patients. Each group must timely report the names of dentists who treat NH Medicaid eligible patients or supervise non-dentists in the care or treatment of NH Medicaid eligible patients.

Additional information about enrolling as a NH Medicaid provider can be found in the general billing manual at *www.nhmmis.nh.gov* or by calling the Dental Director's office (603) 271-9250) or the Department's fiscal agent Xerox Provider Relations (866) 291-1674.

Termination of Enrollment

Providers may terminate enrollment in NH Medicaid by writing to Xerox, the Department's fiscal agent, at the following address:

Xerox Provider Relations
PO Box 2059
Concord, NH 03302-2059

The provider who is requesting termination of enrollment needs to sign a letter on office letterhead requesting termination. When extenuating circumstances prevent signing by the enrolled provider, agent may sign the letter to terminate enrollment. Verbally requesting termination of enrollment, submitting a letter signed by someone other than the enrolled provider, or simply announcing that the office is no longer accepting NH Medicaid patients does not terminate a provider's enrollment in NH Medicaid.

How to Check a Patient's NH Medicaid Eligibility

It is the provider's responsibility to ensure that the patient is NH Medicaid eligible on the date of service, even if a service authorization has been issued. A dentist providing services without verifying eligibility and coverage for each date of service does so at the risk of not being reimbursed for the services.

Providers have 3 ways to verify a patient's NH Medicaid status:

1) On line at www.nhmmis.nh.gov

2) Call (866) 291-1674 to speak with a representative from Xerox, the Department's fiscal agent

3) Use the Automated Voice Response (AVR) system, available 24 hours a day, 7 days a week by calling (866) 291-1674 (Within NH or VT) OR (603) 223-4774 (Outside the NH/VT)

To save time when using the AVR system, have the following information ready, and enter it when prompted:

- Dentist's NH Medicaid enrollment number
- Patient's NH Medicaid ID number
- Date of service (dd/mm/yyyy format)

Because coverage for certain procedures is limited to a specific interval or frequency, dentists may need to learn about a NH Medicaid patient's dental claim history by contacting a Xerox representative directly by calling 603-223-4774.

Please remember:

- NH Medicaid eligible persons who are over age 21 have only limited NH Medicaid coverage for dental services, usually limited to extractions to treat pain or infection
- Adults with QMB or SLMB eligibility have no dental coverage unless otherwise eligible for NH Medicaid
- Eligibility information is guaranteed accurate only on the date it is provided

If you have questions about the extent of NH Medicaid coverage for a specific service or NH Medicaid eligible patient, please speak with a Xerox representative by calling (603) 223-4774.

Dental Benefits for Children (Birth to Age 21 Years)

Federal Medicaid regulations require states to provide coverage for medically necessary comprehensive dental services for Medicaid eligible children from birth to the 21st birthday under a set of requirements referred to as "Early and Periodic Screening, Diagnosis and Treatment" (EPSDT)The federal EPSDT requirement is for states to provide Medicaid coverage for early and periodic screening of members, including early and periodic dental screenings and examination. States are also required to provide Medicaid coverage of services determined to be medically necessary in order to treat conditions discovered by screening, examination and diagnosis. All NH Medicaid eligible children between birth and 21 years of age are entitled to coverage for medically necessary EPSDT services, including comprehensive dental services.

The NH Medicaid program provides coverage for most preventive, restorative, routine and emergency dental care for Medicaid eligible children from birth up to age 21 years.

NH Medicaid promotes regular periodic examinations by a dentist beginning before age one and continuing at six months intervals or as recommended by the dentist. NH Medicaid promotes the use of preventive fluoride and application of sealants to permanent molars for all Medicaid eligible children in accord with the recommendations of the American Dental Association (ADA) and American Academy of Pediatric Dentists (AAPD) for prevention of tooth decay in this high risk population.

NH Medicaid eligibility criteria become more restrictive at age 19; therefore, many children may no longer be eligible for NH Medicaid after turning19 years old. Nonetheless, any person between the ages of 19 and 21 who remains eligible for NH Medicaid will remain entitled to coverage for comprehensive EPSDT dental services up to age 21 years.

NH Medicaid does not cover treatment that is not medically necessary, that is cosmetic in nature, is experimental or provided for the convenience of the patient. Providers are obliged to provide the most effective and least costly treatment for the condition which is medically necessary to treat.

Prevention, Oral Health and Periodicity of Dental Treatment For Children From Birth to Age 21 Years

NH Medicaid promotes oral health by providing coverage for routine, periodic oral examinations and preventive treatment**,** fluoride treatment, and sealant application for children. Dental visits should also include anticipatory guidance to help families understand the child's oral development and practices that promote oral health

NH Medicaid's coverage of preventive and routine services is guided by the recommendation of the AAPD and ADA. Periodic dental examinations and routine preventive treatment should begin with eruption of the first tooth and before the first birthday, and should continue every six months or as recommended by the dentist. (See sections describing coverage of medically necessary treatment, below.)

NH Medicaid strongly encourages dentists to apply sealants to prevent decay in all unrestored permanent molars without cavitated lesions. NH Medicaid sealant policy, which is provided in further detail in the Covered Services section below, is guided by the ADA's recommendations for sealant use. The ADA recommends sealant placement on all non-carious permanent molars as well as on permanent molars with non-cavitated lesions for all children enrolled in NH Medicaid without the need to perform any other risk assessment.

Accordingly, NH Medicaid promotes sealant placement on all non-cavitated permanent molars as soon after eruption as possible for all Medicaid eligible children.

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NH Medicaid also administers the Children's Health Insurance Program (CHIP), a health insurance program that provides health insurance to eligible uninsured New Hampshire children under the age of 19 years. The CHIP dental benefit is identical to that available to children eligible for Medicaid except that eligibility in CHIP ends at age 19. Any Medicaid enrolled dental provider may provide dental treatment to CHIP-eligible children following the guidelines in this manual and the General Provider Billing Manual. Covered services, policies and billing procedures are identical for children with either CHIP or Medicaid eligibility.

For enrollment information, dentists who wish to provide care to NH Medicaid or CHIP eligible children are invited to visit *www.nhmmis.nmh.gov* or call the NH Medicaid Dental Director's office at (603) 271-9250 for information.

Dental Benefits for Adults (21 Years and Older)

NH Medicaid dental benefits for adults, members 21 years and older, are generally limited to treatment to relieve acute pain and eliminate acute infection. In most cases, the NH Medicaid benefit is limited to extraction of the tooth or teeth causing the acute pain or acute infection.

Dental Benefits for QMB and SLMB Members

The Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB), programs of NH Medicaid pay some portion of **Medicare** costs, such as premiums, deductibles and co-payments, for Medicare beneficiaries of modest means. QMB and SLMB do not pay dental providers for dental treatment.

There is no dental benefit associated with QMB or SLMB programs.

Qualifying for QMB or SLMB alone does not entitle a member to NH Medicaid benefits such as dental treatment.

There are no NH Medicaid covered dental services for those whose eligibility category is limited to QMB or SLMB. The only QMB or SLMB beneficiaries who may have Medicaid dental benefits are those who are coincidentally and separately qualified for Medicaid dental benefits by virtue of being eligible for a NH Medicaid category that does provide dental benefits.

The QMB and SLMB programs do not provide payment for dental or medical treatment.

NH Medicaid Enrolled Residents of Nursing Facilities

NH Medicaid members who are residents of a nursing facility shall receive routine and emergency dental services to the same extent provided by NH Medicaid as part of the care provided by the nursing facility. This means that dental services are to be provided by the nursing facility, or at its expense, for comprehensive dental services for NH Medicaid eligible children from birth to age 21, and for dental treatment for acute pain and infection for adults over age 21 years. Payment to the provider will be made by the nursing facility for NH Medicaid covered services.

NH Medicaid covered dental services are the financial responsibility of the nursing facility and not the resident.

Special Eligibility for Comprehensive Orthodontics

Although patients must be eligible for NH Medicaid on the date of services for a service to be reimbursed, there is an exception for members who are undergoing comprehensive orthodontic treatment. These individuals are given "special eligibility". Details of this exception can be found in *Section VII, E., Coverage of Orthodontic Treatment Under Special Eligibility Provisions*

Quarterly Surveys of NH Medicaid Dental Providers

To obtain up-to-date information the NH Medicaid Dental Director's Office sends short surveys to all NH Medicaid enrolled dental providers each quarter. The surveys arrive on stamped, return addressed mailers so that dental office staff can easily respond to the few questions, refold the mailer, and send it by return mail to the Dental Director's office.

This quarterly survey ensures that information about providers' dental practices and publication preferences is current and correct. Response to the surveys is optional and greatly appreciated. The information is used to support the role of Medicaid Client Services in matching Medicaid families' needs with available dentists. Effective matching helps to direct calls to dentists who offer the services needed by a specific patient and ensures that dentists' information is published only to the extent expressed in the survey responses. The surveys also include a few lines for dental offices to send their comments or questions to the Dental Director if they wish.

Federal regulations under the Children's Health Insurance Program Reauthorization Act (CHIPRA) require states to provide a list of NH Medicaid enrolled dentists who are available to accept new NH Medicaid patients. CHIPRA requires this information to be updated at least quarterly. To comply with these federal regulations, NH Medicaid reports the names of dentists who have given permission to have their names published on the federal list of dentists available to accept new NH Medicaid patients.

Questions or updates to an enrolled provider's information can be e-mailed to the NH Medicaid Dental Director's Office at: NHSmiles@dhhs.state.nh.us.

3. Covered Services and Requirements

NH Medicaid encourages regular dental examinations by a dentist beginning before a child's first birthday and recommends that parents comply with the dentist's recommendations about diet and daily oral hygiene, and continue routine preventive dental visits every six months or as recommended by the dentist or physician. NH Medicaid promotes application of sealants to all non-cavitated, permanent molars for all CHIP and NH Medicaid eligible children without additional risk assessment, in accord with the recommendations of the ADA and AAPD.

For children from birth to 21 years, NH Medicaid covers comprehensive, routine, and emergency dental services, as well as orthodontic treatment for patients meeting established criteria. Covered services for members 21 years of age and over are more restrictive and limited to the treatment of acute pain and acute infection, typically by extraction of the involved teeth.

NH Medicaid applies certain limits to procedures based on frequency, age, and eligibility category of the recipient. For example, prophylaxis is covered for NH Medicaid eligible patients only under the age of 21 years and limited to once every 150 days. Serviceauthorization (SA) may be required for certain services.[1]

A table listing covered services by CDT code, the NH Medicaid maximum reimbursement rate for each code, and additional notes regarding service limits and requirements may be found at www.nhmmis.nh.gov. Additional information regarding coverage limitations may be found in the Appendix of this manual.

Please note that services that are not listed as covered by NH Medicaid may be requested and approved in accordance with EPSDT (medical necessity) guidelines.[2]

Covered Services for NH Medicaid Patients Under the Age of 21

For convenience, the following overview of NH Medicaid coverage under the Dental Services rule (He-W 566) is provided. Please review the rules for a more specific and complete description of covered services, including limitations, restrictions and requirements for service authorizations, etc. The complete rule may be found at: http://gencourt.state.nh.us/rules/state_agencies/he-w500.html.

Subject to certain limitations and restrictions outlined in the dental services rule at He-W 566, NH Medicaid covers the following dental services for NH Medicaid members who are under 21 years of age:

- Prophylaxis, no more frequently than every 150 days
- Restorative treatment

[1] For more information about this process, please refer to the Prior Authorization section below.
[2] For more information about this process, please refer to the EPSDT section below.

- Periodic examination, no more frequently than every 150 days, unless they are medically necessary to diagnose an illness or condition

- Vital pulpotomy

- Extraction of symptomatic teeth if associated with diagnosed pathology, such as tumor, cyst or infection

- Extraction of asymptomatic teeth, subject to service authorization and as follows:
    - When associated with diagnosed pathology, such as tumor, cyst or infection
      Or
    - When extraction is part of an orthodontic treatment plan that has been approved through service authorization

- Third molar extraction, subject to service authorization

- General anesthesia when medically necessary

- Nitrous oxide analgesia

- Comprehensive orthodontic treatment for severe handicapping malocclusion, subject to service authorization

- Interceptive orthodontic treatment, subject to service authorization
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- Space maintainers when medically necessary to replace prematurely lost deciduous or permanent molar(s) or bicuspid(s)

- Limited orthodontic treatment

- Radiographs as follows
    - Complete series or panographic survey, once every 5 years
    -
    - Bitewings every 12 months if medically necessary
    -
    - All types of dental radiographs regardless of limits noted above, if required to rule out a differential diagnosis

- Palliative treatment, if such service meets the definition of a palliative service per He- W 566 and documentation describes the treatment and demonstrates that treatment was completed

- Removable prosthetic replacement of permanent teeth, subject to service authorization

- Topical fluoride treatment applied twice per year until age 15

- Endodontia, including root canal therapy, only if radiograph is submitted with the claim and the department deems that it demonstrates that the therapy was successful, effective, and complete (See E, below)

- Crowns
- Periodontal treatment limited to prophylaxis, scaling, and root planing
- Surgical periodontal treatment subject to service authorization
- Sealants for permanent and deciduous molars every 5 years, until age 17
- Diagnostic and preventive dental services, with the exception of orthodontic treatment, available for EPSDT-eligible children
- Other services determined by the Office of Medicaid Business and Policy (OMBP) to be medically necessary in accordance with He-W 546.06

Crowns

Crowns are covered when medically necessary. No service authorization is required. Patient records should document the medical necessity for crowns.

Endodontic Treatment (D3310, D3320, D3330)

Effective endodontic treatment is covered without requiring service authorization. Effective endodontic treatment can be performed only if teeth are restorable. Endodontic treatment of a non-restorable tooth is not covered by NH Medicaid. An endodontic treatment will be considered complete when all radiographically demonstrable canals are obturated at the foraminae. Digital images may be sent to Xerox along with electronic claims for endodontic treatment. Radiographic films must be submitted to the Dental Director's Office, at the address below. Radiographic films should not be sent to Xerox.

The following procedures may not be billed when performed on the same tooth and on the same date as endodontic treatment: palliative treatment, sedative fillings, pulpotomy, pulpectomy, or temporary restorations, and any other procedures typically performed as part of endodontic treatment of a tooth.

To submit a claim for endodontic treatment, submit a completed ADA 2006 claim form along with pretreatment and post-treatment radiographs to demonstrate medical necessity and complete obturation of all canals at the foraminae. Mail claims for endodontic treatment along with radiographs to:

NH Department of Health and Human Services
Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301
Attn: Dr. David Gruette

Limited Orthodontic Treatment (D8010, D8020, D8030)

NH Medicaid covers limited orthodontic treatment in any combination of D8010, D8020 and D 8030 up to and not exceeding two units of limited orthodontic treatment per patient. Limited orthodontic treatment immediately preceding or concomitant with interceptive or comprehensive orthodontic treatment is not covered.

NH Medicaid gives dentists the freedom to use the materials and techniques they feel are most appropriate for a given patient. The NH Medicaid fee includes all charges for any materials. A dental provider may not charge the recipient to upgrade a covered service, such as charging a fee for ceramic versus metal brackets.

When a general dentist refers a NH Medicaid eligible patient to an orthodontist for evaluation, the Department requests that the general dentist provide to the orthodontist the following information, which the orthodontist should include with his/her service authorization request:

- Length of time the recipient has been under the dentist's care
- Whether oral hygiene instructions to the patient have been successful in controlling dental caries and in establishing periodontal health
- The number of appointments the patient has failed to keep since the commencement of their treatment with the general dentist
- The general dentist's chief concerns that initiated the referral to an orthodontist
- The patient's or guardian's chief concern regarding the need for orthodontic treatment

Dental providers undertaking orthodontic treatment for children with severe handicapping malocclusions must be qualified by training and experience in accordance with the NH Dental Board rules and the ADA Code of Ethics

Coverage of Comprehensive Orthodontic Treatment (D8070, D8080, D8090) Under He-W 566

Forms and instructions for submitting prior authorization requests for comprehensive orthodontic treatment are provided in *Appendix E* at the end of this manual.

Demonstration of medical necessity by meeting the dental criteria listed in He-W 566. is necessary for approval of Medicaid coverage of comprehensive orthodontic treatment of severe handicapping malocclusions for NH Medicaid members under age 21 He-W 566 describes severe handicapping malocclusions as those that limit function, and, if untreated, would result in damage to the dental structures or surrounding tissue as a result of any of the following conditions:

- Crowding of teeth greater than 12 mm in a single arch
- Deep impinging overbite with destruction of tissue
- Cross bite of anterior teeth with destruction of tissue
- Over jet greater than 9 mm

- Reverse over jet greater than 3.5 mm

- Severe traumatic deviations demonstrated by gross pathology

If an orthodontic provider determines that at least one of the above criteria can be demonstrated, the provider may submit a request for prior authorization to the Department's Medicaid Dental Director's Office in accordance with the requirements described in the *Section VIII C., "Service Authorizations for Comprehensive and Interceptive Orthodontic Treatments."*

The request for service authorization for comprehensive orthodontic treatment requires the provider to certify the following:

- Sealants must be present on all erupted permanent molars not previously restored

- The patient must be free of untreated decay, periodontal or other dental disease, and

- The provider must sign and submit a statement attesting that the patient demonstrates a willingness to comply with treatment, including keeping appointments, as well as the ability to maintain oral hygiene consistent with maintaining periodontal health during the course of orthodontic treatment

The covered comprehensive orthodontic benefit is limited to one comprehensive orthodontic treatment per NH Medicaid recipient per lifetime.

Coverage for comprehensive orthodontic treatment includes treatment of both arches. The recipient may not be billed for treatment of a single arch not exhibiting serious malocclusion in cases where coverage of the opposite arch has been approved for comprehensive orthodontic coverage by NH Medicaid.

Payment for comprehensive orthodontic treatments is made in three equal payments, each equal to 1/3 of the total fee for comprehensive orthodontics. Each payment is made upon the Department's receipt of an orthodontic claim as follows:

- Following the application of the appliances

- Following the completion of the 12th month of treatment and submission of a 12-month progress report

- Following case completion and the submission of the final treatment report along with photographs depicting the completed case

Payment for comprehensive orthodontic treatment is inclusive of, but not limited to, the following:

- All examinations associated with the orthodontic treatment including periodic and emergency examinations

- All periodic adjustments associated with the orthodontic treatment

- All radiographs, diagnostic models, images and other records associated with the orthodontic treatment

- Space maintenance, when performed by the orthodontic provider within 2 years of the banding
- Appliances as applied
- Application and removal of appliances
- Replacement and repair of brackets, bands and arch wires
- Retainers and follow-up examinations
-
- Treatment ancillary to the orthodontia, including, but not limited to, separators and radiographs
- Palliative treatment related to the orthodontic treatment or appliancesand
- Closing records

Coverage of Interceptive Orthodontic Treatment (D8050, D8060) Under He 566

Forms and instructions for submitting prior authorization requests for interceptive orthodontic treatment are provided in the *Appendix* at the end of this manual.

He-W 566 limits coverage of interceptive orthodontic treatment to members under age 21, presenting with at least one of the following conditions:

- Constricted palate
- Deep impinging overbite with demonstration of destruction of tissue
- Anterior cross bite
- Dentition exhibiting results of harmful habits

If an orthodontic provider determines that at least one of the criteria necessary for coverage of interceptive orthodontic treatment can be demonstrated, the provider may submit a request for service authorization to the Department's Medicaid Dental Director's Office in accordance with the requirements described in *Section VIII C, "Service Authorizations for Comprehensive and Interceptive Orthodontic Treatment."* Coverage of interceptive orthodontic treatment is limited to one treatment per arch per lifetime, for a total or two billable interceptive orthodontic services per member.

Interceptive orthodontia is covered as a treatment of a single arch, and prior authorization is based on demonstration of medical necessity of treatment in each arch being submitted for review relative to the criteria set forth in He-W566.

Payment for interceptive orthodontic treatment is inclusive of, but not limited to:

- All examinations associated with the orthodontic treatment including periodic and emergency examinations
- All periodic adjustments associated with the orthodontic treatment
- All radiographs, diagnostic models, images and other records associated with the orthodontic treatment
- Space maintenance, if applicable
- Appliances as applied
- Application and removal of appliances
- Replacement and repair of brackets, bands and arch wires
- Retainers and follow-up examinations, if applicable
- Treatment ancillary to the orthodontia, including but not limited to separators and radiographs
- Palliative treatment related to orthodontic treatment or appliances
- Closing records

Coverage of Limited Orthodontic Treatment under the age of 21

Limited orthodontic treatment is covered for members under the age of 21 and is limited to no more than once per arch per member per lifetime. Service authorization is not required.

Coverage of Orthodontic Treatment through EPSDT, Under He-W 546

Orthodontic treatment for malocclusions that do not meet the criteria described above may be considered for coverage in accordance with He-W 546, the EPSDT prior authorization provisions for medically necessary treatment. Request for consideration based on medical necessity of orthodontic treatment in cases not meeting the criteria for severe handicapping malocclusion must be submitted to the Department in accordance with the requirements described in the EPSDT section of this manual, and in accordance with He-W 566.04 (b), (c) and (d).

Because submission of an orthodontic case for consideration under He-W 546 is extraordinary and requires specific, additional documentation that is different from that required for consideration under He-W 566.05, it is recommended that providers contact the Medicaid Dental Director for guidance in submitting cases under He-W 546 or He-W 566.04.

Coverage of Orthodontic Treatment Under Special Eligibility Provisions

In order for NH Medicaid to cover comprehensive orthodontic treatment, the patient must be eligible for NH Medicaid on the date the orthodontic appliances are applied to the teeth. If a patient subsequently loses NH Medicaid eligibility, NH Medicaid will continue to cover the

authorized orthodontic treatment plan until the patient reaches age 21. .. This is called "special eligibility", and applies only to an approved orthodontic treatment plan and not to any other Medicaid covered service.

If the Medicaid eligible child's orthodontic treatment extends beyond the recipient's 21st birthday, it is the patient's responsibility to pay for continued treatment. Acknowledgement of the recipient's understanding of this responsibility is one of the signed statements that must be submitted as part of the service authorization request for orthodontic treatment.

Coverage of Orthodontic Evaluations and Radiographs

Payment for comprehensive and interceptive orthodontic treatment is all inclusive and includes payment for all orthodontic records, including models, radiographs and other means used to document the need for, or assess the course of, orthodontic treatment.
Pre-treatment records are not to be billed to Medicaid separately. It is expected that a provider who is qualified to treat serious malocclusions will have the expertise to determine through a comprehensive examination (D0150) whether the case demonstrates or exceeds the criteria that describe severe handicapping malocclusion under He-W566 and will be able to collect sufficient information to describe the nature and extent of the malocclusion. The comprehensive examination (D0150) may be billed to Medicaid, and during the examination the provider determines whether the malocclusion meets the dental criteria described in He-W 566.05, or whether there is any other medical necessity for treatment as described in He-W 566.04. and He-W546 (EPSDT). . The provider may then submit appropriate models, photographs, and other materials for review and approval for a service authorization for comprehensive or interceptive orthodontic treatment.

If the provider determines that the service authorization is likely to be denied because the dental relationships or other conditions do not meet the NH Medicaid criteria for medical necessity, but the member insists on evaluation by the department, the provider may indicate to the member that the orthodontic dental records, including casts, radiographs and other related diagnostic services, are non-covered; as such, it is permitted to require that the Medicaid member pay for these services. The provider must inform the member in writing, before the service is provided, that the Medicaid member will be responsible for payment for the records in order to submit a request for service authorization to NH Medicaid for a case that the provider has found does not meet NH Medicaid criteria for coverage. It is suggested that the provider obtain member acknowledgement of this agreement and keep this documentation in the patient record. If such an orthodontic prior authorization request is subsequently approved by the Department, the provider must return payment to the member, because the orthodontic payment is inclusive of the orthodontic records.

Time Limits Relative to Comprehensive Orthodontic Appliance Application

The patient must have appliances applied within 60-days of the provider having received the service authorization approval. The prior authorization will expire after 60-days, but a new prior authorization request may be submitted.

Please contact the Dental Director if you have an orthodontic service authorization that has expired prior to application of appliances and briefly explain the need for extending the service authorization.

Comprehensive Orthodontic Treatment Progress Reports

Providers submit claims to the Department along with information as described in He-W 566 in order to receive the second and third payments for comprehensive orthodontic treatment.

The claim for the second payment includes a completed ADA 2006 claim form, anda completed treatment progress report, which can be found in Appendix E in this manual. The claim for the second payment may be submitted to the Department no sooner than twelve months after the date of application of appliances. The 12- month treatment report includes a description of the patient's compliance with the treatment plan, including appointment keeping, and a report of objectives achieved to date.

The claim for the third payment includes a completed ADA 2006 claim form and a final treatment report, which can be found in the Appendix to this manual. The final treatment report must include diagnostic models or post treatment photographs of the dentition in centric relation from center, right and left sides that demonstrate that the specific treatment objectives, as listed in the original service authorization request, have been attained.

Forms to accompany claims for the second and third payments for comprehensive orthodontics may be found in *Appendix E* of this manual.

Handling Non-Compliance with Orthodontic Treatment

Non-compliance with orthodontic treatment can negatively affect the member by exacerbating oral disease. NH Medicaid requests that providers notify the Department as soon as a pattern of non-compliance is noted. Non-compliance includes, for example, the member's failure to adhere to recommended oral hygiene regimens, missed appointments, and failure to properly wear or maintain the appliances. The Department may assist families in resolving problems that may otherwise result in termination of treatment. If non-compliance continues, NH Medicaid permits the orthodontic provider to terminate the patient's treatment. If the patient's orthodontic treatment is terminated and orthodontic appliances are removed prior to completion of treatment, the patient may no longer qualify for NH Medicaid coverage of continued or new orthodontic treatment.

For your convenience, a form is provided in *Appendix E-10* that you may complete and submit to report non-compliance.

Early Termination or Change to a New Provider for Orthodontic Care

Providers may terminate treatment early due to non-compliance, as above,or if the patient transfers to another provider. Terminating treatment due to non-compliance should be done only after the Department has been given an opportunity to intervene or if continued treatment is likely to result in a damage to the child's oral or overall health.

Dentists are obliged to demonstrate due diligence in performing professional duty in providing notice of termination, consistent with the *ADA Code of Ethics* and rules of the New Hampshire Dental Board. Assessing documentation of due diligence having been performed in contacting the patient to arrange for removal of appliances and fabrication and application of a retainer will be part of the Department's review of terminated cases.

Removal of appliances and fabrication and application of a retainer is included in the NH Medicaid payment for which a claim is made at the time of application of appliances. In the event that early termination of treatment is necessary, payment for treatment may be pro-rated

accordingly (see *Section X.(G), "Payment for Comprehensive Orthodontic Treatment for Terminated Cases or Patients Changing Providers During Orthodontic Treatment*").

Service authorizations (SA) are not transferable because each SA represents a contract between NH Medicaid and a specific provider for specific services to be rendered. When a NH Medicaid member changes providers during orthodontic treatment, the status of the case must be reviewed to determine coverage of subsequent orthodontic treatment. The new provider will need to submit a new SA request for subsequent orthodontic treatment.

Replacement of Lost or Broken Retainers (D8692)

Prior authorization is required for replacement of a lost or broken retainer. NH Medicaid will cover the cost of replacement for one maxillary and one mandibular appliance only if all of the following pertain:

- The patient is a currently enrolled NH Medicaid member
-
- The replacement is not required as a result of the patient's neglect, wrongful disposal, intentional misuse or abuseThe request is within 3-years of the treatment having been completed.

NH Medicaid will cover the cost to replace each retainer only one time. All other replacement costs are the responsibility of the member.

Space Maintainers (D1510, D1515, D1525)

NH Medicaid coverage of space maintainers is limited to those that are medically necessary to maintain space due to premature loss of deciduous or permanent molars or bicuspids.

When submitting a claim for a space maintainer, indicate the tooth or teeth that the space maintainer is being used to retain in the box labeled "*Missing Teeth Information",* Box #34 on the 2006 ADA claim form.

Prophylaxis (D1110, D1120)

To be covered by NH Medicaid, dental prophylaxis must be performed and submitted in accordance with the ADA CDT description for D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis). These codes are described as "removal of plaque, calculus, and stains from the tooth structure".

Claims for "toothbrush prophylaxis" should not be coded as D1110 or D1120, and should not be submitted for payment. NH Medicaid does not pay claims for "toothbrush prophylaxis" as indicated by claims or patient records.

Limitations Based on Frequency

Specific services have limitations based on frequency. For example, for children under the age of 21 years, a prophylaxis is covered once every 150 days, panoramic radiographs are covered once every 5 years, and reimbursement for periapical radiographs is limited to three units per date of service. Service limitations are indicated in the "description" column and/or in the "Max Units" column of the fee schedule (refer to Appendix B).

Limitations may be exceeded when medical necessity is demonstrated and service authorization has been provided. Please refer to EPSDT, Section IX below for additional information about submitting documentation for consideration of medical necessity.

Covered Services for Adult Members: 21 Years of Age and Older

Dental services for members 21 years of age and older is limited to the treatment of acute pain and acute infection. This generally means NH Medicaid covers extraction and services related to extraction to relieve pain or acute infection. For example, covered services for an adult with a complaint of acute pain may include a problem-focused examination and radiographs to the extent needed to diagnose and document the need for the extraction, as well as needed to perform the extraction itself. NH Medicaid covers the following for eligible adults:

- Palliative treatment if such service meets the definition of a palliative service per He- W 566 and documentation submitted describes the treatment and demonstrates that palliative treatment was completed
- Extraction of the causative tooth or teeth
- Treatment of severe trauma, when a determination is made by the attending clinician using standard medical parameters for emergency conditions, which shall include but not be limited to:
    - Hemorrhage
    - Laceration requiring suturing
    - Abrasion requiring debridement
    - Bone fracture requiring reduction
    - Examination and radiographs as necessary to diagnose the conditions listed above.

Extractions (D7111, D7140, D7210, D7250)

Requests for service authorization (SA) for an extraction should include a completed form "DOCUMENTATION OF MEDICAL NECESSITY FOR EXTRACTIONS", found at Appendix D at the end of this manual.

For children up to age 21, NH Medicaid covers extractions of teeth that are involved with acute infection, acute pain, cyst, tumor or other neoplasm, radiographically demonstrable pathology that may fail to elicit symptoms, and extractions that are required to complete an approved orthodontic treatment plan and as described in the approved orthodontic treatment plan.

NH Medicaid covers extractions of symptomatic teeth when associated with diagnosed pathology, such as apical abscess, tumor, cyst or infection causing the symptoms. Dental records are important in documenting the dental origin of symptoms, findings on examination and diagnosis of specific teeth that are to be extracted in order to file claims related to extraction of symptomatic teeth.

Extractions of asymptomatic teeth and all third molars require service authorization and are covered only when associated with diagnosed pathology or if the extractions are part of an

approved orthodontic treatment plan as documented by the orthodontist and as included in the orthodontic treatment plan approved by the Department.

Payment for an extraction includes local anesthesia, sutures, and routine postoperative care. Extractions of primary teeth are not authorized for payment when normal exfoliation is imminent or predictable, consistent with the patient's age or development.

The medical necessity for each extraction must be documented in the patient's dental treatment record. The record must include the findings on examination and diagnosis that justify medical necessity of the extraction. The medical necessity must also be supported by the patient's medical and dental history. Diagnosed pathology must be demonstrable at the time of examination; authorization will not be based on presumption of future possibility of pathology.

Coding for surgical extractions shall be allowed or modified based on the degree of difficulty or impaction as evidenced by the diagnostic radiographs. When radiographs do not accurately depict the degree of difficulty or anatomic relationships, written documentation and/or photographs may be submitted in addition to radiographs for consideration.

In the event of an emergency in which a delay may result in harm to the patient, the SA request, along with the claim for payment, may be submitted post-operatively. NH Medicaid will cover this procedure when documentation justifies the need for the extraction, as described above.

Palliative Treatment (D9110)

NH Medicaid covers palliative treatment under the CDT code D9110 billed on a per visit basis. This code should not be used to file claims for orthodontic adjustments, writing or calling in a prescription to the pharmacy, or to address situations that arise during multi-visit treatments covered by a single fee, such as endodontic, surgical or orthodontic treatment.

In the event of an audit, the treatment record must include a description of the palliative service rendered, consistent with palliative treatment as defined by *New Hampshire's Dental Services Rule (He-W 566).*

Limited Oral Evaluation (D0140)

Limited oral evaluation is covered when provided as defined in the current "*ADA Practical Guide to Dental Procedure Codes (CDT Manual)*". D0140 refers to a limited; problem focused oral evaluation related to a specific oral health complaint. This may require interpretation of information acquired through additional diagnostic procedures, which should be reported separately. Definitive procedures may be required on the same date as the evaluation. Patients receiving this type of evaluation typically present with specific problems and/or dental emergencies, trauma, or acute infection. This code should not be used to address situations that arise during multi-visit treatments covered by a single fee, such as endodontic therapy, routine surgical follow up visits, or orthodontic adjustments. This code should not be used to bill for post-operative visits in surgical cases, for nonclinical encounters with patients such as telephone conversations or for ordering prescription medication for a patient.

Hospital/Outpatient Costs

Dental treatment in a hospital or outpatient facility is covered only when services of such a facility are medically necessary. To be covered by NH Medicaid, the patient must receive a covered dental procedure as well as documentation of the medical necessity for use of the facility. NH Medicaid will cover the cost of an operating room (OR) when medically necessary to perform the services within such a facility, and if the services cannot be performed in the dental office setting. An example of a procedure demonstrating medical necessity for hospital/outpatient treatment is an extensive oral rehabilitation of a young child requiring multiple restorations, extractions, etc. In such instances, the cost of the facility and anesthesia are covered. NH Medicaid will not cover these costs when the OR is used for the convenience of the patient or provider in the absence of medical necessity for the use of the facility or OR..

Sedation and General Anesthesia (D9220, D9221)

NH Medicaid covers sedation and general anesthesia only when medical necessity has been established. A request by the patient is not sufficient justification for a finding of medical necessity. NH Medicaid is not permitted to cover sedation or general anesthesia for the convenience of the patient or provider. Dental records must document the medical necessity of either sedation or general anesthesia.

Interpreter Services

In general, payment for speech and language interpretation is included in the dental fee for service and not separately covered by NH Medicaid. Nonetheless, if an independently enrolled interpreter provides and bills for interpretation services, NH Medicaid will directly reimburse the NH Medicaid enrolled interpreter for interpretation services.

Duplicative or Unnecessary Services Not Covered

Services that are duplicative in nature or otherwise do not add value to the overall treatment may not be billed to NH Medicaid. Examples of unnecessary or duplicative services include attempted endodontia or restoration of an unrestorable tooth, extraction following incomplete root canal therapy; extraction of retained roots following an incomplete extraction, etc.

Coding and Bundled Services

Providers may not unbundle, or separate into smaller components of treatment, any part of a treatment that is by practice included in a single procedure code. For example, a dentist may not file a claim for a pulpotomy and for a root canal treatment performed on the same tooth and same date of service.

Early And Periodic Screening, Diagnosis And Treatment (EPSDT)

"Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" refers to a set of federally mandated services to be provided by state Medicaid programs for Medicaid eligible children from birth to age 21 years. The purpose of the federal mandate is to ensure that health problems are screened for, diagnosed and treated early, before they become more complex or more costly to treat. EPSDT also requires that state Medicaid programs provide for dental services to children, such as oral examination by a dentist, services for the relief of pain, treatment of infection, preventive treatment and restoration of teeth and maintenance of dental health.

Federal regulations require Medicaid programs to provide for all "medically necessary" treatment services, even if the service is not otherwise covered by the state's Medicaid program. In accordance with federal regulations, individual states determine services that are deemed "medically necessary."

In New Hampshire, "medically necessary" treatment pertaining to individuals under the age of 21 years is defined as treatment that is "…reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, [where] no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service."

Requesting Coverage For Non Covered Dental Services, Non-Orthodontic, Based on EPSDT Medical Necessity Under He-W 546

To obtain authorization to provide a medically necessary treatment that is not otherwise covered by NH Medicaid for member up to age 21 years, the provider must submit a request for service authorization. The request must include sufficient information for the Department to establish medical necessity.

In accordance with He-W 546 (commonly referred to as "EPSDT rules"), requests for prior authorization for medically necessary treatments must include the following information, in addition to the information required above:

- The recipient's name, address, and NH Medicaid identification number (MID)
- The recipient's diagnosis and prognosis, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition
- An estimation of the effect on the member if the requested service is not provided
- The medical justification for the services or equipment being requested
- The recommended timetable of the prescribed treatment
- A discussion of why the service is medically necessary
- The expected outcome of providing the requested service
- The recommended timeframe to achieve the expected outcome
- A summary of any previous treatment plans, including outcomes, which were used to treat the diagnosed condition for which the requested service is being recommended
- Listings of individuals or agencies to whom the member is being referred
- Assurance that the requested service is the least restrictive, most cost-effective service available to meet the recipient's needs

- A statement signed by either the treating physician or primary care provider; the treating advanced practice registered nurse; or the primary treating psychotherapist indicating that they concur with the request

Requesting Coverage for Orthodontic Treatment Based On EPSDT Medical Necessity Under He-W 546

Rarely, cases that do not meet the dental criteria listed in He-W 566.05 may be appropriate for consideration for orthodontic treatment under EPSDT Medical Necessity, He-W 546.

Because the documentation required to support a request for review under He-W 546 is more extensive than that required for review under He-W 566, any case that demonstrates the dental criteria under He-W 566.05 should be submitted under the dental criteria listed in He-W 566.05.

Orthodontic treatment criteria in He-W 566.05(a) and (b) of the Dental Services rules addressconditions that are medically necessary to treat based on dental and functional relationships, described therein, that result in severe handicapping malocclusion. Nonetheless, less severe orthodontic conditions may exist that are not described by the dental and functional criteria in He-W 566.05 that are medically necessary to treat by virtue of being a material part of treatment of some other condition that is demonstrably medically necessary to treat as described in He-W 546. For example, a child may present with a malocclusion that is not, in itself, a severe handicapping malocclusion, as described in He-W 566.05 (a) and (b); however, treatment of the malocclusion may be required as a substantive part of treatment of another condition that is determined to be medically necessary to treat. Such a request may be submitted in accordance with the EPSDT medical necessity provisions set forth in He-W 546, and by submitting information as described in He-W 566.04 (b), (c), and (d).

Submitting a request for orthodontic treatment based on medical necessity under He-W546 for cases not demonstrating the dental criteria listed in He-W 566.05(a) and (b) requires the provider to submit the following information to the Department, in addition to the information required in IX.(A) "Requesting Coverage For Non Covered Dental Services, Non-Orthodontic, Based on EPSDT Medical Necessity" above:

- Principal diagnosis
- Prognosis with and without treatment
- Date of onset of the illness or condition and etiology, if known
- Clinical significance or functional impairment or pathology caused by the illness or condition resulting from the malocclusion
- Demonstration of evidence of the degree to which the malocclusion contributes to the illness or condition
- Specific types of services to be rendered by each discipline associated with the total treatment plan
- Therapeutic goals to be achieved by each discipline and anticipated time for achievement

- Explanation of any existing conditions that are likely to limit efficacy of treatment, if applicable

- Extent to which health care services have been previously provided to address the illness or condition and summary of results demonstrated by prior care

- Orthodontic records

- Any additional documentation available that might assist the Department in making a determination of medical necessity of the proposed orthodontic treatment.

Health professionals sufficiently trained and duly licensed to diagnose and treat the non-dental aspects of the illness or condition creating the medical necessity for orthodontic treatment must also contribute to the documentation noted above and explain how the orthodontic treatment is necessary to effectively treat the condition that is medically necessary to treat. The NH Medicaid enrolled dental provider who will be completing the orthodontic treatment must compile and submit the documentation and make the request for prior authorization to the Department.

All EPSDT medical necessity dental prior authorization requests should be sent to:

New Hampshire Department of Health and Human Services
Office of Medicaid Business and Policy
Dental Director's Office
Attn: Dental Consultant
129 Pleasant Street (Brown Building)
Concord, NH 03301

Notification of EPSDT Medical Necessity Approvals and Denials

Requests for service authorization of dental or orthodontic treatment based on medical necessity will be approved by the Department if it is determined that the information provided (as described above) demonstrates medical necessity for the proposed treatment. Written notification of approved requests will be sent to the performing provider. If the request is denied, the Department will send written notification of denial to the member and to the requesting provider.

4. Non Covered Services

For convenience, the following overview of non-covered dental services is provided. Please review the Dental Services rule, He-W 566, for more specific and complete descriptions of non-covered services. Claims submitted for services that are performed more often than frequency limitations permit, or are listed as "non-covered" will be denied payment. Nonetheless, in cases of medical necessity for NH Medicaid members under age 21, authorization for coverage by NH Medicaid may be requested in accordance with the EPSDT (medical necessity) guidelines as described in He- W 546.06. The text of He-W 566 and He-W 546 can be found at:

http://gencourt.state.nh.us/rules/state_agencies/he-w500.html

For services that are non-covered or that are not approved for NH Medicaid payment under the EPSDT medical necessity guidelines, NH Medicaid members, if they so choose, may make arrangements with dentists to receive the services and to pay for the non-covered services themselves as private pay patients. It is advisable for the dentist to make a clear and written agreement at initial contact with the patient about financial responsibility for non-covered services.

NH Medicaid members should be notified that a procedure is a non-covered service prior to services being rendered. Both the dentist and patient should have a clear understanding of non-coverage and of payment expectations reflected in writing.

According to the Dental Services Rules (He-W 566.06), non-covered services include, but are not limited to, the following:

- A dental procedure which is attempted but cannot be completed
- Behavior management or the administration of psychotropic medication to modify the recipient's behavior in the dental office
- Experimental, investigational or cosmetic dental procedures
- Dental and orthodontic treatment or surgery for the purpose of preserving or improving appearance, except when required for the prompt repair of accidental injury
- Dental procedures that are for cosmetic purposes
- Services that have not been proven to be safe or effective, as documented in peer-reviewed scientific literature
- Fixed prostheses of more than one unit
- Implants

- Dental services rendered in locations other than the dental office, such as in outpatient hospital settings or ambulatory surgical centers, when such services could be performed in a dentist's office and there is no medical need for the use of an acute care, outpatient hospital or ambulatory facility

- Orthodontic treatment for members who have failed to comply with a prescribed treatment plan that has been approved through prior authorization by the department, including non-compliance with appointments, hygiene or care of appliances, with such failure documented by the provider

- Periodic examinations for members age 21 and over

- Services that are not dental in nature

- Services that are more costly than other services and which are expected to provide the member with the same functional outcome

- Replacement or repair of dental appliances required as a result of member neglect, wrongful disposition, intentional misuse or abuse

- Extractions of asymptomatic teeth, including third molars, unless the service is prior authorized by the department

- Periodontal treatment consisting of sub gingival placement of biological materials or chemotherapeutic agents

- Periodontal surgery, unless service is prior authorized by the department

- The portion of the orthodontic treatment plan carried out after the member turns age 21

- Any treatment, such as extractions, radiographs, examinations, and other services, that are ancillary to an orthodontic treatment plan that has not been approved for NH Medicaid coverage

- Dental records, including casts and radiographs, when such records do not meet the orthodontic criteria as set forth in rules

- Endodontia that has not been deemed complete

5. BROKEN OR MISSED APPOINTMENTS

In accordance with guidelines issued by the Centers for Medicare and Medicaid Services (CMS), providers may not bill NH Medicaid or recipients for broken or missed appointments, even if it is standard practice for dental offices to charge other patients for broken or missed appointments. Dentists may not bill or charge a fee for scheduling appointments for NH Medicaid patients.

Broken appointments and missed appointments are frustrating to the dentist and keep patients from receiving the treatment they need. Patient management techniques that have been found effective in reducing broken and missed dental appointments include the following:

- Create a written policy that clearly communicates your expectations. For example, if you expect a patient to honor each and every appointment, clearly state that expectation and do not otherwise convey that you allow a few missed appointments before consequences ensue;

- Begin the relationship with a clear statement of your philosophy and policy about appointment keeping. For example, state clearly that the appointment is time reserved only for that patient, and if a serious emergency arises the patient must call immediately to explain, or else may not be offered another appointment. Before the initial appointment is made state clearly that your office is not able to continue to provide appointments to patients who cannot keep their appointments;

- Consider that the parent may need supportive services such as transportation or language assistance; direct the parent to the back of his/her NH Medicaid card for the number for Medicaid Client Services to call to arrange supportive services so that they can attend appointments; Medicaid Client Services can arrange transportation, language support and other services that may be needed to permit children to attend dental appointments;

- Reiterate the appointment policy when making each subsequent appointment;

- Provide reminders to the patient or parent;

- If leaving a message, ask the patient or parent to call back to confirm if you suspect the person may not receive the reminder;

- If a patient is late, have staff call the parent to inquire about whereabouts. Calling the parent immediately conveys a sense that the absence has been noticed and attendance is expected. Immediate contact also provides an opportunity for the dentist to evaluate the dependability of the parent and make an informed decision about whether the patient should be re-scheduled or would understand better the importance of appointment keeping through some other accommodation, such as being put on a same-day only basis or, in extreme cases by being excused from the practice;

- Determine if transportation, language or other barriers to appointment keeping exist and have staff or the parent call Medicaid Client Services for help at (800) 852-3345.

No one wants to deprive a child of needed dental treatment because of the inability of the parent to attend appointments. Here are some measures that have been found to be effective in helping parents with a personal history of poor appointment keeping behavior:

- Explain calmly and in plain language the importance of appointment keeping; consider the possibility that the parent has not understood that appointment keeping is an important part of your being able to prevent oral disease and pain in the child;
- Discuss with the parent his or her goals for the dentist/child relationship; document and consider that your goals for providing preventive and routine care may not be well aligned with the parents' desire for episodic or emergency care; if you cannot increase the parent's value of routine and preventive care through education, consider making future appointments with the understanding that the probability of not showing increases with the length of waiting time for the appointment, so consider scheduling such patients on short notice;
- There are people whose children depend on them, but who are not able to make and keep appointments; be flexible in considering alternatives such as having a morning or day each month when you will see patients who arrive without appointments; call all the parents who have a poor appointment keeping history a few days before the open scheduling day and let them know that patients will be seen on a first come, first served basis on that day;
- The Medicaid Dental Director's Office is able to assist you in helping parents participate in their children's oral health care; please write or call the Dental Director's Office for assistance (603) 271-9250;

Remember that dentists are required by statute to report suspected abuse and neglect of children. Parents who refuse to obtain treatment for painful or pathological conditions that threaten the health and well being of their children will receive appropriate investigation and supportive services through the Division of Children and Youth Services (DCYF). You may report suspected abuse and neglect by calling the DCYF Central Intake Unit at 1-800-894-5533 between the hours of 8:00AM and 4:30PM, Monday through Friday. Local law enforcement will respond to emergency situations during non-business hours.

Be sure to document appointment keeping and discuss with the parent the impact it has on the child's oral health. Reduce the financial impact of poor appointment keeping by being aware of the individuals who fail to keep appointments; do not provide these families with long or multiple back-to-back appointments until the behavior can be addressed and improves.

If you find you must excuse a patient from your practice due to maladaptive appointment keeping behavior despite your best efforts, please review and follow the protocols and recommendations of the NH Dental Board for appropriate termination procedures.

6. Service Authorizations (SAs)

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

Adherence to the rules pertaining to service authorization requests allows for efficient payment for provided services. This section of the manual provides comprehensive instructions for submitting a service authorization request when required. The following dental services and procedures require service authorization (SA) from the Department:

- Comprehensive and interceptive orthodontic treatment
- Dental orthotic devices
- Replacement retainers
- Surgical periodontal treatment
- Extraction of all third molars and asymptomatic teeth
- Removable prostheses

Please refer to the EPSDT section below for information regarding service authorization requests for treatment based on EPSDT medical necessity criteria.

All service authorization requests should include a completed ADA 2006 claim form along with other information as described below. Forms and instructions for submitting service authorization requests may be found in the appendices at the end of this manual.

Procedure for Submitting a Non-Orthodontic Service Authorization (PA)

Except in the event of an emergency in which a delay would result in harm to the patient, all service authorizations must be obtained before providing the item or treatment. When the situation does not allow for advance request and service authorization, such as extractions that warrant immediate action, both the authorization request and the claim for payment are to be submitted together to the Department at the address below.

The form for submitting supporting information for a service authorization request for extractions is found in Appendix D of this manual.

All requests for dental service authorization requests may be sent to:

New Hampshire Department of Health and Human Services
Office of Medicaid Business and Policy
Dental Director's Office
Attn: Dental Consultant

129 Pleasant Street (Brown Building)
Concord, NH 03301

A request for service authorization must include sufficient, current medical and dental information to enable the Department to evaluate the medical necessity of the treatment in order to determine NH Medicaid coverage. This information shall include:

- An explanation describing the illness, special care, or specific condition, to enable the department to understand the physical and/or emotional problem of the member and the specific goal for which the item or treatment is being requested
- Assurance that the required treatment is the least restrictive, most cost-effective alternative
- Cost of the treatment, if known
- Diagnosis
- Expected outcome and recommended timetable of the prescribed item or treatment
- Name and address of the intended provider
- Name and address of person or agency making the request
- Radiographs
- Periodontal charting when surgical periodontal treatment is requested
- Member name, address, date of birth and NH Medicaid identification number (MID)

Response Time for Non-Orthodontic Service Authorization Requests

The usual response time for a non-orthodontic service authorization request is 2 to 4 weeks from the date the Department receives the request.

Service Authorization Requests for Comprehensive and Interceptive Orthodontic Treatments

Forms for submitting service **authorization requests for interceptive and comprehensive orthodontic treatment may be found in *Appendix E* of this manual.**

In addition to the information noted above, service authorization requests for comprehensive and interceptive orthodontic treatment must also include the following:

- A treatment plan, including the following:
    - Diagnosis and explanation describing the nature of the severe handicapping malocclusion or functional limitation associated with the malocclusion with

sufficient detail and documentation to support and demonstrate the existence of conditions described in He-W 566.05(a)-(b) or He-W 546.05

- Name of the (general) dentist referring the patient
- Chief complaint expressed by the referring dentist and/or the patient
- The plan for comprehensive oral care during orthodontic treatment
- An indication of the need for any extractions as part of the orthodontic treatment
- Specific treatment objectives to list the results to be achieved by the treatment as planned, , relative to each aspect of the severe,. Handicapping malocclusion under consideration for treatment
- Signed statement from the provider attesting that: (1) the member has received an oral examination and was found to be free of untreated oral disease; (2) the member demonstrates oral hygiene habits consistent with being able to prevent inflammation and dental decay during orthodontic treatment; and (3) sealants are in place on all of the recipient's erupted and unrestored molars
- Signed statement from the member or legal representative acknowledging: (1) the recipient's willingness to adhere to the treatment plan, comply with an oral hygiene regimen, attend any scheduled appointments, and to properly wear and maintain the appliances; (2) the provider's right to discontinue treatment if the member becomes non-compliant as described in immediately above; (3) that NH Medicaid will not pay for the cost of orthodontic treatment beyond the recipient's 21st birthday; and (4) that NH Medicaid does not cover orthodontic treatment more than once per recipient per lifetime if treatment is terminated due to non-compliance with the treatment plan

- Diagnostic models taken within 30 days of submitting the service authorization request

Radiographs that are current and are of adequate quality to allow for an accurate diagnosis of the malocclusion. Radiographs are not required when submitting a request for interceptive orthodontics unless requested by the Department

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When submitted in lieu of or in addition to radiographs, photographs of the teeth in full occlusion from the center, right and left perspectives

- Justification for early treatment if the request is for comprehensive treatment while deciduous teeth are presentor if all of the permanent teeth have not erupted

Requests for service authorizations will be returned to the provider if they do not contain sufficient information for the Department to make a decision, or when the information submitted is otherwise incomplete.

The service authorization must be obtained from NH Medicaid before services are rendered and before claims are submitted. Claims submitted for orthodontic treatment provided before a service authorization has been approved will be denied.

Submitting Radiographs with a Service Authorization Request

Radiographs submitted with a PA request must be of diagnostic quality. Radiographs should be labeled with the dentist's name, the patient's name, the date the radiographs were exposed, and the patient's left and right sides indicated.

A NH Medicaid dental consultant will examine each radiograph to determine whether the request may be authorized. If the radiograph is not clear or is not of diagnostic quality, the radiograph will need to be retaken and resubmitted, at no additional charge to NH Medicaid or to the NH Medicaid member. The Department asks that dentists send only those radiographs that are required for the specific purpose, consistent with good diagnostic procedure and ADA recommendations.

Providers may submit radiographs to the Department electronically. Please do not send radiographs to Xerox, the fiscal agent.

Submitting Casts With a Service Authorization Request for Orthodontia:

To avoid delay in processing requests for service authorization, please be sure casts are properly trimmed so that the casts resting on the back of the models will articulate in a manner that is representative of the patient's occlusion. Remove any plaster interferences so that the casts can be fully articulated. Send only casts that are clearly labeled with patient's name and date of impression-taking written on each cast, and bundled together in matched sets of a maxillary and mandibular cast for each patient.

It is helpful if the patient's name can be read without un-wrapping the casts.

Please wrap the casts in materials that will protect them from breakage during the mailing process. In particular, the occlusal surfaces should be well padded, and both casts should be secured together with a removable band. Please do not use tape.

Response Time for Orthodontic Service Authorization Requests

The usual response time for an orthodontic service authorization request is 8 to 12 weeks from the time the Department receives the complete materials required for review of the request. Cases that are determined to require additional information in order to be reviewed will be returned with a note to the provider indicating the additional information that is required. Returning cases for additional information adds to the time required for a determination of coverage to be completed.

Requests are processed in the order in which they are received. Requests for service authorization of replacement retainers may be expedited by provider request.

Notification of PA Approvals and Denials

A request will be approved if the Department determines that the treatment requested is appropriate, cost effective, and supported by the documentation submitted for review in accordance with the administrative rules. A written notification of approval will be sent to the provider and to the member.

If the service authorization request is denied, the Department will send a notice of denial to the member and to the provider, outlining the reason for the denial. The notice will include information about how the NH Medicaid client may appeal the decision.

Resubmitting Service Authorization (PA) Requests

All requests for service authorization that do not contain sufficient information for the Department to evaluate the request will be returned to the provider. The provider may resubmit the request with the information necessary to allow the evaluation to proceed.

A provider may also resubmit a denied service authorization (SA) request for review in the event that conditions change or new information becomes available. All SA requests, initial or resubmitted, must be complete and include all materials needed to consider the request. This includes current radiographs and models as well as the PA request forms and other documentation described above.

Forms and checklists for submitting orthodontic service authorization requests are provided in *Appendix E,* at the end of this manual.

Non-Transfer of Service Authorization

All approved service authorization requests, including those for orthodontic treatment, are provider specific and are not transferable between providers. If the provider who received authorization is unable to complete the treatment as authorized, or the member finds it necessary to go to another provider, the provider taking over treatment must submit a new and complete service authorization request and receive approval from NH Medicaid before the service is performed.

Denial of Coverage and Administrative Appeals

NH Medicaid eligible clients are notified of any denial of coverage for which a service authorization has been submitted. Denial notices contain information about the right to appeal the decision as well as providing information about how to request an appeal, which must be requested within 30 days of the denial letter. Any individual or organization dissatisfied with a decision made by any office within the Department may request an Administrative Appeal from the Administrative Appeals Unit (AAU).

The AAU is independent of the Department's Offices and Divisions. The AAU's mission is to conduct impartial hearings and render decisions in accordance with the requirements of NH Statutes and Administrative Rules. The hearings are formal legal proceedings, but are conducted in an informal manner. The hearings allow those challenging the Department's decision to relate the circumstances to an impartial hearing officer. Hearing officers review documentary evidence, hear testimony under oath from individuals, and issue written final legal decisions that may confirm, modify or reverse the original determinations made by the Department's program offices.

A request for an Administrative Appeal can be submitted verbally or in writing to the appropriate DHHS program or service. The appropriate time frames to appeal an action or decision vary. For dental related appeals, requests must be submitted within 30 calendar days from the date on the notice of non-coverage, the denial letter. The requesting party may represent himself or be represented by others, including legal counsel, at the member's own expense.

All of the materials used in the original determination of coverage and, in some cases, additional patient records may be needed by the Dental Consultant for the appeal proceeding. If requested, please send casts, radiographs and other diagnostic materials that are needed for a hearing to the Dental Director's office.

7. Documentation

Information to Include in a Dental Record

It is important for dentists to keep appropriate dental records of examinations, findings, diagnoses, and treatment of NH Medicaid eligible patients. NH Medicaid relies on providers' records not only to establish medical necessity of treatment but also to document the actual treatment that has been provided and by whom. Dentists are encouraged to generate and maintain accurate and complete records as described in accredited dental school curricula and many risk management courses for dentists. Information about standards for dental records can be obtained through the American Dental Association, in manuals such as "Dental Records," published by the ADA Council on Dental Practice, Division of Legal Affairs and available on line, or by taking courses offered by legal specialists at many of the larger dental meetings.

New Hampshire Medicaid requires that dental visits, including exams and treatments, be conducted and recorded consistent with code descriptions in the current ADA CDT manual. Dental visits should be fully documented in the patient's dental record consistent with professional standards and state regulations, including the ADA Code of Ethics and the New Hampshire Dental Practice Act (RSA 317-A:27-a). Dental providers should develop and maintain written documentation to support each billed service. Documentation is required for every visit and every treatment rendered to a patient.

For example, a patient record for a dental or oral examination should include recordings in the patient's dental record of all activities and findings of the examination, including but not limited to: the extent of the examination; any objective or subjective means of evaluation that were employed, such as radiographs or medical history; and recording of diagnoses and recommended treatment. A notation in the recipient's dental record stating only that an examination took place, without appropriate documentation of the methods, findings, diagnosis and treatment recommendations, is insufficient evidence of the completion of an examination, and if reviewed or audited, will not **support a claim for payment by NH Medicaid**.

NH Medicaid may request records in order to ascertain such information as dates of service, findings on examination, diagnosis and demonstration of medical necessity for treatment, the recommended treatment plan, details of actual treatment provided, and record of the specific person providing treatment. When records are requested, NH Medicaid asks providers to include copies of all documents generated by or in the possession of the provider that relate to the patient's care, including but not limited to the following:

- Patient information, including name, address, contact information, parental consent for treatment, etc.
- Medical history report by patient and results of review by provider
- History of any dental or other complaints provided by patient

- History and findings of any examination or assessment performed by provider or staff, including those related to radiographs, models, photographs, laboratory tests, charting of existing conditions, etc.
- Specific diagnosis of any conditions
- Treatment records and notes
- Any and all radiographs exposed or sent by any other practitioner
- Models, photographs or other representations of the patient's presentation
- Records received from any other practitioner
- Notes of telephone, in-person or other conversations, communications or consultations with the patient, parent, or other practitioner about this patient's diagnoses or treatment
- Copies of correspondence with any other practitioner about this patient's care, either from another provider or from you in consultation with another provider
- Treatment plan and treatment objectives
- Alternatives for recommended treatment
- Any other information that explains the rationale or otherwise supports the request for NH Medicaid coverage of the treatment plan or actual treatment rendered

At the time of establishing eligibility for NH Medicaid benefits all NH Medicaid members sign agreements to permit providers to release their records to NH Medicaid without additional permission being required. Therefore, dentists may promptly respond to requests from NH Medicaid for patient records without needing to seek further permission from **NH Medicaid members for release of records to NH Medicaid.**

Maintenance of Records

For purposes of NH Medicaid review records should be promptly completed, filed and retained for a period of 6 years (in accordance with He-W 520) from the date of service, or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is later.

All documentation must be made available upon request to any authorized representative of the NH Department of Health and Human Services or its authorized agent or official. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CRF 164.512(d), the information sought by NH Medicaid is permitted disclosure of personal health information.

Patient Requests for Records

Pursuant to Den 501.01(e) of the Dental Board Rules, the information contained in dental records is the property of the patient and must be provided to the patient within 20 days of a request. Providers may charge the patient a nominal fee not to exceed $15 for up to 30 pages and $0.50 per page thereafter. Radiographs and models should be provided without charge or for a nominal

fee. This obligation exists regardless of whether the patient's account is paid in full and whether the patient has paid for the records. Please refer to Section 1 of the ADA Principles of Ethics and Code of Professional Conduct for additional guidance on patient records and autonomy.

Audit of Records

At the time of an audit by the NH Department of Health and Human Services, all documentation must be available at the provider's place of business during normal business hours. Requested documentation that is stored off-site must be made available to Department personnel within three business days.

Existing regulations allow providers to submit the requested member information to NH Medicaid without any additional signed authorizations from the member. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CRF 164.512(d), the information sought by NH Medicaid is permitted disclosure of personal health information. In addition, when member apply for medical assistance through the NH Medicaid program, the member signs a statement authorizing the Department of Health and Human Services to collect medical and dental record from their medical and dental providers.
Submit claims on a 2006 ADA Dental Claim Form or electronically. Services may not be billed service to the date the services are actually performed. The patient must be eligible for NH Medicaid on the date of service even if a service authorization request for the treatment had been previously approved.[3] Providers are responsible for determining that the member is NH Medicaid eligible on the date of service.

[3] It is unlawful to falsify essential information, such as the date of service, in an effort to receive payment from Medicaid.

8. Surveillance and Utilization Review – (SURS)

The purpose of a Program Integrity Review program, which in NH, is administered by the Provider Program Integrity Unit, is to identify and correct occurrences of fraud, waste and abuse, by Title XIX providers. This is to ensure that accurate and proper reimbursement has been made for the care, services, or supplies provided to a NH Title XIX member.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, generated from member complaints, other providers, anonymous calls, or from the SURS reporting system.

For additional information regarding utilization review, refer to the SURS section of the General Billing Manual – Volume I.

9. 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 Section 10 of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

10. Medicare/Third Party Liability

Under federal law, the NH Medicaid Program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to Xerox in accordance with 42 CFR 433.139, except as outlined in this section or in the General Billing Manual – Volume I. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

A provider must first submit a claim to the third party within the third party's time limitations. If a third party or primary insurance plan does not pay at or in excess of the applicable NH Medicaid Program reimbursement level, a provider may submit a claim to the NH Medicaid Program 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 the NH Medicaid Program.

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

Certain services that are not covered by Medicare may be covered by the NH Medicaid Program for dually eligible members. Services identified in this manual as non-covered by Medicare may be billed directly to 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.

All third party obligations must be exhausted before Medicaid may be billed, in accordance with 42 CFR 433.139. Refer to the General Billing Manual – Volume I.

Third-Party Payments

If the member is under the age of 21 and therefore covered under EPSDT, NH Medicaid pays the provider for services rendered and pursues reimbursement from any other insurance. This process is commonly referred to as "pay and chase."

In general, for adults who have other dental insurance in addition to NH Medicaid, NH Medicaid serves as the payer of last resort. As such, when a patient has insurance coverage in addition to NH Medicaid benefits, coverage under the other insurance must be exhausted before NH Medicaid may be billed.

Payment from all sources will be no greater than the NH Medicaid fee for services provided. For example, if a dentist charges $50 for a service that the NH Medicaid rate is $40, and the patient's insurance pays $30, then NH Medicaid will pay $10 to bring the total payment from all sources to the $40 NH Medicaid rate.

All third party obligations shall be exhausted before claims shall be submitted to the Department's fiscal agent.

Payment for the RHC and FQHC services shall be made on the basis of an all-inclusive rate per visit.

RHC and FQHC providers shall bill for the services utilizing the encounter service assigned by the Department of Health and Human Services.

RHC and FQHC providers shall bill for services other than the outpatient RHC/FQHC services utilizing the appropriate procedure code listed in the current edition of Current Procedural Terminology.

Member encounters with more than one health professional, or multiple encounters with the same health professional, which take place on the same day for the same diagnosis or treatment, shall be counted as one visit.

RHCs and FQHCs shall bill for only one visit per member per day, except for cases in which the patient, subsequent to the first visit, suffers an illness or injury requiring additional diagnosis and treatment.

Payment shall be made in accord with encounter service rates established by DHHS.

Independent RHCs and FQHCs shall submit claims for payment to the fiscal agent of DHHS on Form CMS 1500.

Hospital-based RHCs shall submit claims for payment to the fiscal agent of DHHS on Form UB04.

The Form CMS 1500 and the Form UB04 shall include:

11. Payment Policies

Remittance Advice (RA)

Remittance Advice (RA) is a report available to providers online at www.nhmmis.nh.gov on the "transaction services" page. The report is computer-generated by the Department's Fiscal Agent on a weekly basis. Providers who are without internet access may receive a printed copy of the RA by sending a request, written on office letterhead, to the Department's Fiscal Agent at:

Xerox Provider Relations
PO Box 2059
Concord, NH 03302-2059

The RA indicates the status of all claims that have been submitted for processing. The RA is divided into the following sections:

BANNER PAGE: Messages are printed on the first page of the RA to keep providers informed of important changes in policy or billing procedures.

PAID CLAIMS: All claims paid in the current cycle, including Medicare crossover claims, with a zero payment.[4] The EOB numbers detail the reason(s) for the payment amount. There may be as many as 10 EOBs per header and per detail.

DENIED CLAIMS: All claims denied in the current cycle. The EOB numbers indicate the reason(s) for the denial. There may be as many as 10 EOBs per header and per detail.

IN PROCESS CLAIMS: Claims requiring manual review by either the fiscal agent or NH Medicaid will be identified in this section service to disposition. The purpose of this section is to inform the provider that the fiscal agent has received the claim, and payment or denial will be forthcoming.

ADJUSTED CLAIMS: Claims for which adjustments have been processed to correct overpayment, underpayment, or payment to the wrong provider. This section includes detailed information on both the original and the adjusted claim. The original claim data is displayed first, followed by the adjusted claim data and an explanation of the effect the adjustment had on the original claim.

FINANCIAL ITEMS: Financial transactions such as recoupments, manual payouts and TPL recoveries. This section is printed only when a financial activity other than claims adjudication takes place.

FISCAL PEND: This section includes information regarding fiscal pending claims. Each claim is shown separately by TCN with the amount from the claim that is in fiscal pend.

[4] Zero payment results when a claim is approved for payment but Medicare payment has exceeded the Medicaid allowance.

TPL INFORMATION: This section displays the member for whom claims are denied because of other insurance. It is generated only when such transactions occur. The report lists only the insurance carrier that caused the claim to fail.

EARNINGS DATA This section displays the financial data for the current RA and year-to-date. The error messages are any errors found on any claims (EOB codes) at the header or the detail level.

MESSAGE CODES: Defines the Explanation of Benefit (EOB) codes listed on the Remittance Advice. The EOB codes indicate the reasons for payment or denial of the claim. Please refer to Appendix 9 for a list of terms, acronyms and definitions to help clarify the information provided on the RA form.

How to Assure Timely Payment

AVOID MIS-DIRECTING MAIL

Send all claims for payment for completed services to the Department's Fiscal Agent (Please refer to Appendix 1 for the mailing address of the Department's Fiscal Agent). Claims sent by mistake the Medicaid Dental Director will be forwarded to the Fiscal Agent, but this delays processing and payment.

Send service authorization requests directly to the Medicaid Dental Director's Office for review at the following address:

Attn: Dental Consultant
New Hampshire Department of Health and Human Services
Office of Medicaid Business and Policy
Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301

AVOID BILLING ERRORS

Billing errors can create significant delays in payment. The table below lists some of the more common billing errors, which generally result when numbers are missing or incorrectly entered on the claim form.

DESCRIPTION OF THE ERROR AND HOW TO CORRECT IT
The member **name entered on the claim does not match the name linked to the member's MID number as provided on the claim form.** Be sure the patient's MID number has been written correctly on the claim form and that the name of the "policyholder" (Box 12 on the 2006 ADA claim form) is the name of the patient and not the name of the patient's spouse or parent.
The provider's NH Medicaid number on the claim does not match the number on the Service Authorization. This error often occurs when the provider's *individual* provider ID number is used on the SA request, but the claim indicates the provider's NH Medicaid *group* number, or vice versa. The provider ID numbers must be the same on the PA and the claim form.
Date of service not within SA dates. This occurs when the date-of-service is before the approval date of the SA, or after the SA has expired. Please contact the

Dental Director's Office for assistance with correcting this error.

NH Medicaid encourages providers to submit claims electronically. Submitting claims electronically helps to reduce errors and increases the speed of reimbursement.

For assistance with correcting billing errors, please contact the Dental Director's Office at (603) 271-9250.

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BillingMembers for Services Rendered

The NH Medicaid provider enrollment contract, as well as federal regulations, stipulates that enrolled providers accept NH Medicaid payment as payment in full. The balance may not be billed to the patient. NH Medicaid member may make arrangements with dental providers to receive and pay for non-covered services. It is advisable that the dental provider makes a clear written agreement at the point of initial contact with the patient about financial responsibility for non-covered services, and obtains written consent for payment for any specific non-covered service for which the dentist expects payment from the patient.

Usual and Customary Fees

When submitting claims for payment, dentists are advised to indicate their usual and customary fees on the claim form rather than indicating the NH Medicaid rate for the service. While billing NH Medicaid at the published NH Medicaid reimbursement rate may reduce the need for reconciling balances after receiving payment, there are several disadvantages to this practice.

First, NH Medicaid at times raises rates with short notice to providers, and sometimes retroactively. The provider who has filed a claim for an outdated amount will receive the lower amount as indicated on the claim. The dentist can correct such claims, but usually only by resubmitting all the claims that were submitted in error. Secondly, NH Medicaid uses claims data to review its dental reimbursement rates. By billing at the actual usual and customary rate, dental providers supply critical data used by NH Medicaid to support fee increases. When dental providers bill at the NH Medicaid rates they give NH Medicaid an inaccurate picture of how its rates compare to usual and customary fees. Please remember that RSA 126-A: 3 requires that providers bill no more than their usual and customary charge. Overstating charges not only skews NH Medicaid's data but is unlawful as well.

For the purpose of determining the lowest charge, fee or rate, the Department considers the following:

- If the provider offers discounts or rebates, then the amount after applying discounts or rebates shall be utilized

- If the provider offers a sale or limited period of time on any good or service, then the sale price shall be utilized during the sale period

- If the provider regularly accepts less than full charge from any customer, the amount regularly accepted shall be utilized

- If any good or service is covered under any warranty or guarantee offered by the provider, then the amount charged to the Department shall not exceed the amount which would otherwise be payable solely by the customer

- If a provider structures or packages its goods or services in a manner which is exclusively or primarily used for Medicaid, Medicare, or other third-party payors, then the charge for the most similar goods or services offered to any other consumer shall be utilized

Payment Structure for Comprehensive Orthodontics

Payments for dental services are made consistent with the rates established by the Department in accordance with RSA 161:4, VI (a).

Payment for comprehensive orthodontic treatments is made in three equal payments, each equal to 1/3 of the total fee for comprehensive orthodontics. The first payment includes, without limitation, all records required to submit the case for service authorization review, radiographs, preparatory treatment such as separators, banding and the appliances used, as well as debanding, follow up and retainers. The comprehensive examination needed to make a diagnosis and determine whether the case meets criteria under He-W 566 or under He-W 546 may be charged and a claim sent to NH Medicaid for payment.

Each of the three payments for comprehensive orthodontic treatment is made upon the Department's receipt of an orthodontic claim as follows:

1. Following the application of the appliances
2. No sooner than completing 12th months of treatment from the date of appliance application along with the 12- month progress report
3. Following case completion and the submission of the final treatment report and photographs depicting the completed case

Payment of Comprehensive Orthodontic Treatment in Terminated Cases or Cases of Patients Who Change Providers During Treatment

In the event of termination, provider payment for comprehensive treatment shall be pro-rated as follows:

- If the appliances have been applied and the member is terminated or changes providers before completing 12 months of treatment, the provider shall receive payment consistent with the payment schedule described in above, plus a payment equal to the reimbursement rate for each periodic adjustment the member received

- If the member has completed 12 months of treatment and is terminated service to case completion, the provider shall receive payment consistent the with payment schedule described above, plus a payment equal to the reimbursement rate for each periodic adjustment the member received following the 12th month of treatment, up to 10 periodic adjustments.

12. Claims

All providers participating in NH Medicaid must submit claims to the fiscal agent in accordance with NH Medicaid guidelines. Providers may note that NH Medicaid claim completion requirements may be different from those for other payers, previous fiscal agents, or fiscal agents in other states.

Providers participating in the New Hampshire Medicaid Program are responsible for timely and accurate billing. If the NH Medicaid Program does not pay because of billing practices of the provider, the provider cannot bill the member.

Claim completion guidelines in this manual should be followed for instructions on specific fields. The Companion Guide should be used for electronic claim filing instructions. While field-by-field requirements are shown for paper claims; the same required data is captured through web portal claim entry and through electronic submissions to EDI. Web portal submissions feature step-by-step claim completion instructions as well as tools such as Online Help to assist providers in correct claim completion.

Regardless of the method by 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.

The following claim-related topics are found in the General Billing Manual – Volume I:

- Claims Submission via EDI, web portal, paper
- Claims processing – edits & audits, transaction control numbers, line item vs. header processing, claim status, remark/EOB codes
- Claim Resubmission
- Claim adjustments and voids
- Medicare cross-overs
- Claims payment
- Remittance Advice

Providers will be notified of payment or denial via a Remittance Advice, usually received in electronic format or via the web portal.

Denied claims should be resubmitted only if the reason for the denial has been corrected.

Paid claims cannot be resubmitted; resubmission of a paid claim will result in a denial as a duplicate. Paid claim corrections must be made through the adjustment process. If a paid claim has a line item denial, the individual line charge can be resubmitted.

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information which is now corrected. Providers should never resubmit claims that are currently in process (suspended).

Any claim denied for failure to be submitted or resubmitted consistent with timely filing standards will not be paid. Denied claims that have been corrected must be resubmitted as a new claim transaction on paper, via the web portal, or electronically via EDI.

Use ADA 2006 form for filing claims for dental treatment.

TIMELY FILING

Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper. 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 clients whose NH Medicaid eligibility determination was delayed. The claim should be submitted in the same manner as resubmissions with a note of explanation.

PROCEDURE CODES

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

For dental services, the NH Medicaid Program requires the Current Dental Terminology (CDT) codes.

Claims without the required procedure codes will be denied.

SERVICE AUTHORIZATIONS (SAS)

Providers must obtain pre-approval and a corresponding service authorization (SA) number if required, as outlined in this manual. The claim form allows for entry of a service authorization number. The NH Medicaid Program does not require the service authorization number on the claim form. Providers may choose to enter the SA number on the ADA 2006 claim form in Box 2. If entered, the SA number must be an exact match with the number stored in the MMIS.

REQUIRED CLAIM ATTACHMENTS

Please send all dental claim attachments, such as photographs, radiographs and models, to the Dental Consultant and NOT to Xerox, the Medicaid fiscal agent. Claim attachments are required for the orthodontic and endodontic services, as previously described. Please make certain that all claim attachments are clearly labeled with the patient's name and Medicaid Identification Number.

Send all claim attachments, clearly labeled with patient name and Medicaid ID to:

New Hampshire Department of Health and Human Services
Office of Medicaid Business and Policy
Dental Director's Office
Attn: Dental Consultant
129 Pleasant Street (Brown Building)
Concord, NH 03301

Please do not send dental claim attachments, models, photographs or radiographs to Xerox.

CLAIM COMPLETIONS REQUIREMENTS FOR DENTAL PROVIDER TYPE

Submit claims on a 2006 ADA Dental Claim Form or electronically. Services may not be billed prior to the date the services are actually performed. The patient must be eligible for NH Medicaid on the date of service even if a service authorization request for the treatment had been previously approved.[5] Providers are responsible for determining that the member is NH Medicaid eligible on the date of service.

13. APPENDICES

APPENDIX A: IMPORTANT PHONE NUMBERS

NH Medicaid-enrolled dentistsprovide vital dental care for patients who might otherwise suffer from painful and disfiguring oral disease. The Dental Director's Office greatly values the work of participating dentists and strives to support providers in every way possible. The following resources are available to provide assistance:

Automated Voice Response **1-800-423-8303 (NH & VT, only) or 603-224-1747 (Out of State)** For information on NH Medicaid eligibility, claims status, verification of procedure codes, billing information and assistance with remittance advice, including clarification and explanation of benefit codes
Fiscal Agent: Xerox **603-225-4899 or 1-800-423-8303 (NH & VT only)** To contact a Xerox Provider Relations Representative for information related to provider workshops, on-site training, and to address in-depth billing issues. • For Berlin, Concord, Conway, Laconia, Littleton and Massachusetts regions contact Sue Hammell, Extension 3114 • For Manchester, Nashua regions contact Katherine Davison, Extension 3107 • For Claremont, Keene, Portsmouth, Rochester, Salem, Vermont and Maine regions contact Diane Kemp, Extension 3029 *For information regarding interpreter services, call (603) 224-1747
Fiscal Agent: Xerox Address Information For processing of claims or 1-year overrides, mail documents/forms to: PO Box 2059 Concord, NH 03302-2059

[5] It is unlawful to falsify essential information, such as the date of service, in an effort to receive payment from Medicaid.

For General Correspondences, Provider Enrollment, Provider Relations or Adjustments/Cast Control: mail documents/forms to: PO Box 2059 Concord, NH 03302-2059

Medicaid Dental Director's Office **271-9250 or e-mail to NHSmiles@dhhs.state.nh.us** For NH Medicaid providers in need of assistance related to NH Medicaid dental services or related concerns. Medicaid clients receive service by calling Medicaid Client Services, listed next.
Medicaid Client Services **1-800-852-3345 Extension 4344 (NH & VT) or 603-271-4344 (Out of State)** For Medicaid members in need of assistance with locating a dental provider, transportation assistance to a medical/dental appointment or other benefits related questions.
DHHS Third Party Liability Unit: **603-271-4723** For information related to third party payments.
DHHS SURS Unit **603-271-8029** For information on reporting fraud and abuse of NH Medicaid services.

APPENDIX B: DENTAL CODES AND NH MEDICAID RATES

Dental codes and current NH Medicaid rates for procedures may be found online at:
http://www.nhmmis.nh.gov
(Downloads->Procedure Code ->Accept->Dental 2011)

The following information may be helpful in understanding the listing of dental procedures, limitations by frequency or age, and need for service authorization.

KEY:

- The Procedure Codes and description are reflective of the CDT codes as published by the American Dental Association (ADA
- Maximum Units refers to limits set for a given procedure
- PAC Levels describe the pricing structure as follows:
  - PAC 3= Priced as indicated in the "Medicaid Rate" column of this table
  - PAC 5= Priced manually; prices may vary based on individual case
  - PAC 9= The service is not covered by NH Medicaid; payment = $0.00

- Age Limits refer to age restrictions placed on NH Medicaid covered services. The limit includes the indicated age up to the next birthday. For example, an age limit of "20" includes any NH Medicaid member who has not reached the 21st birthday. If no age is indicated, and this is a covered service, then there are no age restrictions placed on this procedure code.
- A "yes" in the "PA required" column indicates that NH Medicaid requires a service authorization request to be submitted and approved service to the procedure being performed.

APPENDIX C: COVERAGE LIMITATIONS

Additional clarification of limits or periodicity of covered services

DIAGNOSTIC (D0100 – D0999)

Clinical Oral Examinations (D0100-D0199)

D0120 Periodic oral evaluation - Reportable once per member 150 days unless medically necessary to determine existence of suspected illness or condition.

D0140 Limited oral evaluation-problem focused - May be reported for either children or adults, allowed at the same time as other procedures. This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as endodontic therapy, orthodontic treatment, or post operative visits.

D0150 Comprehensive oral evaluation - Reportable once per member per provider.

Radiographs (D0210 – D0350)

D0210 Intraoral, complete series, including bitewings – Limited to once every 5 years.

D0220 Intraoral-periapical, first film - Limited to once per date of service.

D0230 Intraoral-periapical, each additional film – Limited to 3 units per date of service.

D0330 Panoramic film – Limited to once every 5 years.

D0340 Cephalometric film – Limited to once per year.

NOTE: Payment for additional periapical radiographs within 60 days of a full mouth series or a panoramic film is not covered unless there is evidence of trauma.

Diagnostic Casts (D0470)

D0470 Diagnostic Casts – Limited to once per member per provider.

PREVENTIVE (D1000 – D1999)

Dental Prophylaxis

D1110 Prophylaxis - adult (age 13 to adult) - Limited to once every 150 days.

D1120 Prophylaxis - child (through age 12) - Limited to once every 150 days.

NOTE: Service authorization may be requested for a second prophylaxis in complex cases, upon documentation, once in a lifetime per member. Toothbrush prophylaxis is not a covered service and codes D110 and D1120 are not to be used for this purpose. The application of topical fluoride is considered a separate part of the prophylaxis treatment and should not be included in the prophylaxis charge.

Topical Fluoride

D1208 Topical application of fluoride (excluding prophylaxis) for a child - Allowed no more frequently than once every 150 days up to age 15.

NOTE: Use of codes D1201, D1204, and D1205 is not appropriate for NH Medicaid claims submission.

Other Preventive Service

D1351 Sealant - per tooth - Reportable on first and second unrestored permanent molars service to age 21 - allowed no more frequently than once every 5 years.

D1515 Space Maintainer-Fixed Bilateral – Limited to 2 units per member (for example, one upper and one lower arch). Space maintainers are covered when medically necessary to replace a prematurely lost deciduous or permanent molar or bicuspid.

RESTORATIVE (D2000 - D2999)

D2335 Amalgam and Resin Based Restorations - Limited to once per surface per tooth per year. Only one reportable restoration per tooth surface allowed per year, irrespective of the number of combinations of restorations placed. Proximal restorations in anterior teeth are considered single surface restorations unless caries extends beyond the line angle.

D2934 Crowns – Limited to once per tooth per year. Crowns require service authorization and are allowable only if the tooth cannot be restored by other means.

D2951 Core Buildup – Limited to once per tooth

ENDODONTICS (D3000 – D3950)

D3330 Endodontic therapy - Limited to once per tooth.

D3410 Apicoectomy/periradicular surgery-anterior – Limited to once per tooth.

D3430 Retrograde filling – Limited to one per tooth

PERIODONTICS (D4000 - D4999)

D4240 Gingival Flap Procedure - Limited to once

NOTE: All peridontic services require service authorization from NH Medicaid.

PROSTHODONTICS (D5000 - D5899 and D6200 - D6999)

NOTE: All prosthodontics, whether removable or fixed, require service authorization from NH Medicaid, excluding repairs, and are limited to 1 per member per 5 years. Removable partial dentures are not normally covered if the member has more than eight (8) occluding posterior teeth, unless one or more anterior teeth are also missing, and unless deemed medically necessary.

ORAL AND MAXILLOFACIAL SURGERY

NOTE: NH Medicaid covers extractions of symptomatic teeth only. Asymptomatic teeth and third molar extractions are only covered with an approved service authorization. The criteria and justification for the extraction must be documented in the dental treatment record. Extractions are limited to once per tooth.

ORTHODONTICS (D8000 - D8999)

D8010-
D8040 Limited Orthodontic Treatment – Limited to once per arch per member per lifetime for any combination of D8010, D8020 and D 8030 for a total of 2 units. A provider is *not allowed* to charge for 2 units for each code for a total of up to 6 payments.

D8050-through
D8060 Interceptive orthodontic treatment - Allowable when member meets dental criteria or when treatment is determined to be medically necessary; requires service authorization. Limited to

one treatment per member per lifetime. Patient must be NH Medicaid eligible on date appliances are placed.

D8070-through
D8090 Comprehensive orthodontics - Allowable when member meets dental criteria or when treatment is determined to be medically necessary; requires service authorization. Limited to one treatment per member per lifetime. Patient must be NH Medicaid eligible on date appliances are placed.

D8660 Pre-orthodontic treatment visit - Included in interceptive or comprehensive orthodontic treatment; not to be billed or paid separately.

D8670 Periodic orthodontic treatment visits (as part of contract) - Used for reporting orthodontic adjustment visits. This code will have limited use as payment for periodic visits is generally included in the payment for comprehensive or interceptive orthodontics.

D8692 Replacement of broken or lost retainer - A service authorization request is required. Replacement is limited to once per arch when the patient is a currently enrolled NH Medicaid member; the replacement is not a result of member neglect, wrongful disposal, intentional misuse or abuse; and the request is within 3-years of the treatment being completed. All other replacement costs are the responsibility of the patient.

NOTE: Payments for all orthodontic evaluations, radiographs and other means used by the provider to assess the course of orthodontic treatment, is included in the interceptive or comprehensive orthodontic treatment fee and cannot be billed separately. If a request for interceptive or comprehensive orthodontic treatment has been denied, extractions, radiographs and any other procedures that are ancillary to the denied treatment are not billable to NH Medicaid. Orthodontic services require service authorization from NH Medicaid, except limited orthodontic treatment procedure codes 08010 - 08040 and 08210 - 08220.

ADJUNCTIVE GENERAL SERVICES (09000 - 09999)

D9110 Palliative (emergency) treatment of dental pain - minor procedures – Reportable with brief description - does not include prescription writing.

D9230 Analgesia - nitrous oxide.

D9310 Consultation - Does not include discussion of treatment plan.

APPENDIX D: DOCUMENTATION OF MEDICAL NECESSITY FOR EXTRACTIONS

Include this form along with all Service Authorization Requests for extraction of any third molars, asymptomatic teeth and extractions related to orthodontic treatment.

Patient Name:_____ Date of Birth:_____

NH Medicaid ID #:_____ Parent or Guardian, If Minor_____

Provide the diagnosis and rationalefor medical necessity of the extraction(s) (i.e., the specific diagnosis and the medical necessity for the extraction requested). The rationale must be supported by the patient's clinical and/or medical record. **Include radiographs and other records as required to support the medical necessity of the extraction.**

List of Tooth/Teeth by Number(s) To Be Extracted and Diagnosis/Rationale for Medical Necessity of Extraction of Each Tooth

If the extractions are requested as a part of an orthodontic treatment plan please provide the following information:

Name of Treating Orthodontist: _____

Please Print Name of Dentist/Oral Surgeon Performing Extraction(s):

_____

Signature of Treating Dentist/Oral Surgeon:

_____**Date**_____

Please submit this form and radiographs along with Service Authorization Request to:
NH Department of Health and Human Services
Medicaid Dental Consultant
Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301

APPENDIX E: ORTHODONTIC FORMS

APPENDIX E-1: CHECKLIST FOR PA REQUESTS FOR ORTHODONTIC TREATMENT

I. **He-W 566: Comprehensive Orthodontic Treatment (D8070, D8080, D8090)**: Submit the following when requesting Service Authorizations for comprehensive orthodontic treatment**:**

ADA 2006 claim form
Criteria Form for Comprehensive Orthodontic Treatment (Appendix E.2) indicating criteria to be considered for approval of coverage
Orthodontic Treatment Plan Form (Appendix E.4)
Orthodontic Treatment Plan Acknowledgement Form (Appendix E.5)
Current Diagnostic Models demonstrating conditions meeting criteria for approval of coverage
Current Radiographs

II. **He-W 566: Interceptive Orthodontic Treatment (D8050, D8060):** Submit the following when requesting Service Authorizations for interceptive orthodontic treatment:

ADA 2006 claim form
Criteria Form for Interceptive Treatment (Appendix E.3) indicating criteria to be considered for approval of coverage

Orthodontic Treatment Plan Form (Appendix E.4)
Orthodontic Treatment Plan Acknowledgement Form (Appendix E.5)
Current Radiographs or photographs demonstrating the criteria to be considered for approval of coverage

III. **He-W 546: Medically Necessary Orthodontic Treatment Not Meeting Criteria for Severe Handicapping Malocclusion:** Please submit the following in addition to information described in the manual:

ADA 2006 claim form
PA Request Form for Coverage of Comprehensive or Interceptive Orthodontic Treatment Based on Medical Necessity (Appendix E.6)
Criteria Form for Comprehensive Orthodontic Treatment (Appendix E.2) or for Interceptive Orthodontic Treatment (Appendix E3), as appropriate
Orthodontic Treatment Plan Form (Appendix E.4)
Orthodontic Treatment Plan Acknowledgement Form (Appendix E.5)
Current Diagnostic Models
Current Radiographs

All information submitted for review must be current and have sufficient detail and quality to enable the Medicaid Dental Director's Office to evaluate the request.

NH Department of Health and Human Services
Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301
Attn: Dr. W. Blackey

APPENDIX E-2: CRITERIA FORM FOR COMPREHENSIVE ORTHODONTIC TREATMENT (D8070, D8080, D8090)

NH Medicaid Recipient's Information	
Last Name:	First Name:
Treating Dentist's Information:	
Name **(Print, please)**	NH Medicaid Provider ID#:
Address	Phone/fax #(s):
Criteria For Comprehensive Orthodontic Treatment:	

As per He-W 566, this patient exhibits a severe handicapping malocclusion that limits function and if left untreated would result in damage to the dental structures or surrounding tissue due to the following condition(s): ***(Please check all that apply and indicate actual measurements)***

Crowding of teeth greater than 12mm in a single arch
The actual measurement is _____mm
A deep impinging overbite with destruction of tissue
A cross bite of anterior teeth with destruction of tissue
An overjet greater than 9mm
The actual measurement is _____mm
A reverse overject greater than 3.5 mm
The actual measurement is _____mm
Severe traumatic deviations demonstrated by gross pathology (Briefly explain pathology:

OR

I have completed a thorough examination and have determined that this patient does not exhibit the criteria necessary for comprehensive orthodontic treatment in accordance with He-W 566.05(a)

I have completed a thorough examination and have determined that this patient does not exhibit the criteria necessary for comprehensive orthodontic treatment in accordance with He-W 566.05(a); nonetheless, as per He-W 546, orthodontic treatment is required as part of a condition that is medically necessary to treat and documentation from all treating providers is attached.

Treating Dentist's Signature _____ Date _____

Appendix E-3: CRITERIA FORM FOR INTERCEPTIVE ORTHODONTIC TREATMENT (D8050, D8060)

NH Medicaid Recipient's Information	
Last Name:	First Name:
NH Medicaid ID #:	DOB:
Treating Dentist's Information:	
Name (Print)	NH Medicaid Provider ID#:
Address	Phone/fax #(s):
Criteria For Interceptive Orthodontic Treatment:	

The patient demonstrates the following conditions (check all that apply):

A constricted palate
A deep impinging overbite with demonstration of destruction of tissue
An anterior crossbite
A posterior traumatic crossbite
Dentition exhibiting results of harmful habit(s) (List habits:

OR

I have completed a thorough examination and have determined that this patient does not exhibit the criteria necessary for interceptive orthodontic treatment in accordance with He-W 566.05(b)

I have completed a thorough examination and have determined that this patient does not exhibit the criteria necessary for interceptive orthodontic treatment in accordance with He-W 566.05(a); nonetheless, as per He-W 546, orthodontic treatment is required as part of a condition that is medically necessary to treat and documentation from all treating providers is attached.

_____

Treating Dentist's Signature Date

Appendix E-4: TREATMENT PLAN FOR COMPREHENSIVE OR INTERCEPTIVE ORTHODONTICS (D8050, D8060, D8070, D8080, OR D8090)

Name of Patient:
Print General/Referring Dentist's Name:General/Referring Dentist's Chief Complaint:
Orthodontic Treatment Plan:
Diagnosis of Malocclusion or Pathology To Be Treated: Treatment Plan and Duration of Treatment: List elements of the malocclusion that result in severe handicapping malocclusion (Refer to

criteria as per He-W566) Specific treatment objectives that DESCRIBE THE RESULT OF TREATMENT RELATIVE TO EACH ELEMENT OF THE MALOCCLUSION LISTED ABOVE:
The chief complaint expressed by the the patient and/or guardian:
Other conditions to be considered:
Are deciduous teeth present? Yes No Are there permanent teeth not erupted? Yes No If yes, what is the justification for early treatment?
Will extractions be required as part of this treatment plan? If yes, please list by Tooth #: Yes No To Be Determined
Will surgery be needed as part of treatment? If yes, briefly describe. Yes No To Be Determined
Plan for comprehensive oral care during treatment:

Appendix E-5: ORTHODONTIC TREATMENT PLAN ACKNOWLEDGEMENTS FORM FOR COMPREHENSIVE AND INTERCEPTIVE ORTHODONTIC TREATMENT (D8050, D8060, D8070, D8080, OR D8090)

Treating Dentist's Acknowledgements:
I attest that the following are true statements: • The requested treatment is the least restrictive, most cost effective treatment for the malocclusion • The member has received an oral examination and was found to be free of untreated oral disease or other conditions that may make orthodontic treatment unsuccessful or harmful • The member demonstrates oral hygiene habits consistent with being able to prevent inflammation and dental decay during orthodontic treatment • Sealants are in place on all of the recipient's un-restored erupted molars.
Treating Dentist's Signature Date Please Print Treating Dentist's Name:
Member's Acknowledgements:
I understand and agree to all of the following: • adhere to the treatment plan • comply with an oral hygiene regiment as instructed • attend all scheduled appointments

- properly wear and maintain the appliances

I am aware that:

- the provider is permitted to discontinue treatment for non-compliance
- NH Medicaid will not pay for the cost of treatment beyond my 21st birthday

NH Medicaid will not cover the cost of orthodontic treatment more than once if treatment is terminated due to non-compliance

Member/Legal Guardian Signature Date

Please Print Name of Member Signing Above:

Submit request to:

NH Department of Health and Human Services
Medicaid Dental Director's Office
Orthodontist Consultant
129 Pleasant Street (Brown Building)
Concord, NH 03301

APPENDIX E-6: PA REQUEST FORM FOR COVERAGE OF COMPREHENSIVE OR INTERCEPTIVE ORTHODONTIC TREATMENT BASED ON MEDICAL NECESSITY UNDER HEW 546, NOT MEETING CRITERIA LISTED UNDER HE-W 566

NH Medicaid Member's Information	
Last Name:	First Name:
Address:	
NH Medicaid ID #:	DOB:
Treating Provider's Information:	
Name	NH Medicaid Provider ID#:
Address	Phone/fax #(s):
Justification for request of Medical Necessity (To be completed by all providers treating the diagnosed condition requiring orthodontic treatment not meeting the criteria under He-W 566.)	
Is the diagnosis a pre-existing condition or a presenting condition?	
Describe the recipient's diagnosis and prognosis including the effect non-treatment will have on the member:	
Provide a summary of any previous treatment plans, including outcomes, which were used to treat the diagnosed condition for which the request is being made	
Describe the reasons that orthodontia is necessary for the effective treatment of the condition that is medically necessary to treat:	
Describe the expected outcome of providing orthodontic treatment relative to the condition that is medically necessary to treat: :	
When is treatment recommended to begin and how long will it take before the desired outcome is achieved?	
Is the requested service the least restrictive, most cost-effective service availability to meet the recipient's needs?	
Provide the names and addresses of individuals or agencies to whom the member is being referred or by whom the member is being treated for the diagnosed condition requiring orthodontic treatment not meeting the criteria under He-W 566. :	
Please include a signed statement and medical records from the following indicating they are treating the condition that is medically necessary to treat, and for which effective treatment orthodontia is required (1) treating physician or primary care provider; (2) treating advanced registered nurse practitioner; or (3) primary treating psychotherapist:	

Appendix E-7: TWELVE-MONTH ORTHODONTIC TREATMENT PROGRESS REPORT FORM (TO ACCOMPANY CLAIM FOR 12 MONTH PAYMENT OF COMPREHENSIVE ORTHODONTIC TREATMENT (D8070, D8080, D8090)

NH Medicaid Member's Information	
Last Name:	First Name:
NH Medicaid ID #:	Service Authorization #:
Treating Dentist's Information:	
Printed Name	NH Medicaid Provider ID#:
Address	Phone/fax number(s):
Progress Summary	
Date Appliances Were Applied:	
Number of actual patient visits since date of application of appliances:	
Number of missed or cancelled appointments since date of application of appliances: :	
Specific treatment objectives originally described that have been achieved to date:	
Assessment of member's compliance/cooperation :	
Comments (Especially note specific areas of non-compliance that may have a negative impact of efficacy of treatment)	

Treating Dentist's Signature Date

Return complete form to:

Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301

Appendix E-8:.REPORT FORM FOR NON-COMPLIANCE WITH COMPREHENSIVE OR INTERCEPTIVE ORTHODONTIC TREATMENT PLAN

NH Medicaid Member's Information	
Last Name:	First Name:
NH Medicaid ID #:	Service Authorization #:
Treating Dentist's Information:	
Name	NH Medicaid Provider ID#:
Address	Phone/fax number(s):
Patient Compliance:	
Date Appliances Were Applied:	
Number of actual patient visits since date of application of appliances:	
Number of missed or cancelled appointments since application of appliances:	

Patient is not complying with treatment plan as noted below: (check all that apply)

Patient is not brushing/flossing teeth, gums, appliances as instructed
Patient is not wearing elastics as required
Patients is not wearing headgear or elastics for the prescribed number of hours
Patient is not wearing or caring for removable appliances as instructed
Patient is eating foods or engaging in activities that repeatedly break, loosen or cause loss of orthodontic appliances
Patient is not keeping scheduled appointments
Other: _____

Deficiencies in compliance as noted above have reached a point that they are likely to interfere with achieving the goals of treatment.

Does it seem likely that the non-compliance will result in early termination of treatment?

Please indicate the action, if any, you would like the Dental Director to take in response to this report.

Treating Dentist's Signature Date

Return completed form to:

Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301

Appendix E-9: ORTHODONTIC TREATMENT COMPLETION REPORT FORM TO REQUEST THIRD PAYMENT FOR COMPREHENSIVE ORTHODONTIC TREATMENT (D8070, D8080, D8090)

NH Medicaid Recipient's Information	
Last Name:	First Name:
NH Medicaid ID #:	Service Authorization #:
Treating Dentist's Information:	
Name	NH Medicaid Provider ID#:
Address	Phone/fax number(s):
Post-Treatment Report:	
Date of Removal of Appliances/Treatment Completion:	
Specific Treatment Objectives as listed on original request for service authorization:	
Please list final results of treatment relative to each Specific Treatment Objective above:	
Assessment of member compliance/cooperation during the course of treatment: Comments:	

Enclosed: diagnostic models or post treatment photographs of the dentition in centric relation from center, right and left sides demonstrating that the specific treatment objectives have been achieved.

Treating Dentist's Signature Date

Return to:

Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301

APPENDIX E-10: REPORT OF ORTHODONTIC TREATMENT TERMINATION NOTIFICATION FORM

NH Medicaid Member's Information	
Last Name:	First Name:
NH Medicaid ID #:	Service Authorization #:
Treating Dentist's Information:	
Name	NH Medicaid Provider ID#:
Address	Phone/fax number(s):
Termination Summary	
Date of Application of Appliance:	
Estimated months needed to complete treatment:	
Date of termination:	
Reason for termination (check appropriate box and attach any supporting documentation) Member moved out of State Member commenced treatment by another provider (specify name of new provider, if known) Member non-compliance as follows: ▪ Failure to adhere to oral hygiene expectations o Missed appointments o Failure to properly wear or maintain appliances o Other (specify) Patient has refused treatment I have removed appliances and fabricated retainer(s)	
Comments:	

Treating Dentist's Signature Date

Return completed form to:

Medicaid Dental Director's Office
NH Department of Health and Human Services
129 Pleasant Street (Brown Building)
Concord, NH 03301

APPENDIX F: INSTRUCTIONS FOR COMPLETING ADA FORM 2006 TO SUBMIT A SERVICE AUTHORIZATION REQUEST

Mail Service Authorization Requests and Supporting Attachments To:

NH Department of Health and Human Services
Medicaid Dental Director's Office
129 Pleasant Street (Brown Building)
Concord, NH 03301
Attn: Dental Consultant

Providers are required to submit service authorization (SA) requests using CDT codes that best describe the level and complexity of the services proposed. Submit SA requests on a 2006 ADA Dental Claim Form as follows:

Header Information

Box 1 - Type of Transaction:
Check the box for "Request for Predetermination/Preauthorization"
Check the box for "EPSDT/NH Medicaid"

Insurance Company/Dental Benefit Plan Information

Box 3 – Company/Plan Name, Address, City, State, Zip Code
Fill in with the address of NH Medicaid Fiscal Agent:

ACS Provider Relations
PO Box 2059
Concord, NH 03302-2059

Policyholder/Subscriber Information

Box 12 – Policyholder/Subscriber
Write in the patient's last, first, middle names as it appears on his/her NH Medicaid (card.
NOTE: Do not enter the name of the parent or guardian.

Box 13 – Date of Birth
Enter the patient's date of birth in MM/DD/YYYY format.

Box 15 – Policyholder/Subscriber ID
Enter the patient's NH Medicaid 11-digit NH Medicaid Identification number (MID)

Patient Information

Box 29 - Procedure Code
Enter the applicable 5-character CDT dental procedure code. Repeat for any additional services/procedures rendered (up to 10 procedures per form)
When submitting for Comprehensive Orthodontic treatments, be sure to indicate the number of periodic visits (D8670s) being requested.

Box 30 – Description
Enter the description of the procedure according to the CDT guidelines.

Box 31 – Fee
Enter the treating dentist's *usual and customary*" charges in a valid currency format of DD.CC (eg. 24.00). NOTE: Do not enter the NH Medicaid reimbursement fee.

Box 33 – Total Fee

Enter the summed total charges in a valid currency format of DD.CC (eg 24.00). The total must equal the totals of all fees entered in Box 31
If there is more than one page, total each page separately

Missing Teeth Information: (if applicable)

Indicate missing teeth information when applicable to the treatment being requested.

Ancillary Claim/Treatment Information

Box 39 – Number of Enclosures
Indicate the number of radiographs, images and molds enclosed with the form

Box 40 - Is treatment for Orthodontics?
Check the appropriate box.

Billing Dentist or Dental Entity

Box 48 – Name and Address
Enter the name and address of the billing NH Medicaid enrolled dentist.
The name entered here must be the same that is entered when submitting the claim for payment. If there is a mismatch, NH Medicaid will not pay the claim.

Box 49 – NPI (optional if Provider ID number is provided in Box 52a below)
Enter the 10-digit billing provider's NPI (National Provider Identifier)

Box 52 – Phone number
Enter the billing provider's phone number

Box 52a – Additional Provider ID (optional if NPI provided in Box 49 above)
Enter the billing dentist or dental entity's 8-digit NH Medicaid Provider Identification Number (PIN)
The PIN here must be the same that is entered when submitting the claim for payment. If there is a mismatch, NH Medicaid will not pay the claim.

Treating Dentist and Treatment Location Information

Box 53 – Signature/Date
Enter the signature or name of the treating dentist. The performing provider's name must match that which is on file with NH Medicaid
Enter the date in MM/DD/YYYY format (e.g. 12/01/2008).

APPENDIX G: INSTRUCTIONS FOR COMPLETING ADA 2006 CLAIM FORM AND SUBMITTING FOR PAYMENT

Providers are required to bill for services using the CDT codes that best describe the level and complexity of the services rendered. All claims must be submitted on a 2006 ADA Dental Claim form or electronically using the provider portal. The following are instructions for completing the 2006 ADA claim form for payment:

Header Information

Box 1 - Type of Transaction:
Check the box for "Statement of Actual Services"
Check the box for "EPSDT/Medicaid" (if applicable)

Box 2 – Predetermination/Preauthorization Number
Enter the assigned Service Authorization number (if applicable)

Insurance Company/Dental Benefit Plan Information

Box 3 – Company/Plan Name, Address, City, State, Zip Code
Fill in with the address of NH Medicaid Fiscal Agent:

ACS Provider Relations
PO Box 2059
Concord, NH 03302-2059

Box 4 – Other Dental or Medical Coverage?
Check Yes or No. If yes, complete Box 11

Box 11 – Other Insurance Co. /Dental Benefit Plan
Indicate "other insurance plan(s)" 4-digit carrier code(s)
Enter up to 3 carrier codes (one per carrier) and separate each code with a space or comma
Carrier codes can be found on the Provider Services website at www.nhmmis.nh.gov or contact the Provider Relations Unit at 1-866-291-1674 (NH & VT only) or 603-223-4774.

Policyholder/Subscriber Information

Box 12 – Policyholder/Subscriber
Write in patient's last, first, middle names as it appears on his/her NH Medicaid (NH Medicaid) card
To verify the correct spelling of a name, please contact the Provider Relations Unit at 1-866-291-1674 (NH & VT only) or 603-223-4774

Box 13 – Date of Birth
Enter the patient's date of birth
Date must be entered in MM/DD/YYYY format

Box 15 – Policyholder/Subscriber ID
Enter the patient's NH Medicaid (NH Medicaid) 11-digit NH Medicaid Identification number (MID)

Patient Information

Box 23 – Patient ID/Account # (Optional)

If you enter the patients account number, it will be reported back on the remittance advice (RA)
The number can be any combination of alpha characters or number up to 12 characters.

Box 24 – Procedure Date
Enter the date of the service
Must be in mmddccyy format, for example 01012010

Box 27 – Tooth number(s) or letter(s)
Enter tooth surface, as applicable
Must be no more than two (2) characters

Box 28 – Tooth Surface
Enter tooth surface, as applicable
Up to five (5) surfaces, one character each

Box 29 - Procedure Code
Enter the applicable 5-character CDT procedure code, beginning with "D"
Repeat for any additional services/procedures rendered (up to 10 procedures per form)

Box 30 – Description
Enter the description of the procedure according to the CDT guidelines

Box 31 – Fee
Enter your "usual and customary" charges and not the NH Medicaid reimbursement fee.
Dollar amounts must be in a valid currency format of DD.CC (eg. 24.00)

Box 33 – Total Fee
Enter the total "usual and customary" charges for charges listed on that page (If more than one page, total each page separately)
The total must equal the totals of all fees entered in Box 31
Dollar amounts must be in a valid currency format of DD.CC (eg 24.00)

Missing Teeth Information

Box 34

When submitting a claim for a space maintainer (DD1510-D1555), indicate here the number of the missing tooth that is being replaced.

Box 35 – Remarks (if applicable)
Left side of box:
Label as "non-covered by other insurance" and state the reason why.
Right side of box:

- Enter any payments made by another plan, if applicable.
- If more than one payment is made by other plans, add total payments together and enter as one amount.
- Subtract other insurance payment from total fee in Box 33 for the balance to NH TitleXIX (NH Medicaid) program.
- Dollar amounts must be in a valid currency format of DD.CC (eg 24.00)

Ancillary Claim/Treatment Information

Box 38 – Place of Treatment
Check the appropriate box. One box must be checked

Box 39 – Number of Enclosures (Optional)
DO NOT send radiographs with claims for payment!

Box 40 - Is treatment for Orthodontics
Check Yes or No. One box must be checked

Box 41 – Date Appliance Placed (if applicable)

Enter the date the appliance was applied in mmddccyy format, for example 01012010

Box 42 – Months of Treatment Remaining (if applicable)

Enter the number of treatments remaining. The number must not more than 2 characters long

Box 43 – Replacement of Prosthesis

Check Yes or No. One box must be checked

Box 44 – Date Service Placement (if applicable)

Enter date of service placement in mmddccyy format, for example 01012010

Box 45 – Treatment Resulting from (if applicable)

Check appropriate box if the treatment Is the result of an occupational illness/injury, auto accident, or other accident

If box is checked, enter date in Box 46

Box 46 – Date of Accident

If Box 45 is checked, enter date of occupational illness/injury, auto or other accident in mmddccyy format, for example 01012010

Billing Dentist or Dental Entity

Box 48 – Name and Address

Enter the name of either the billing individual or group NH Medicaid enrolled dentist. The provider name entered in this field is the provider name that services will be reimbursed to and under which the monies will be reported to the Internal Revenue Service

If service was Service Authorized, the name and provider ID number used here must match the one on the Service Authorization!!

The provider name must be entered the same way the provider is enrolled in the NH Medicaid program.

Enter the address of the billing individual or group NH Medicaid enrolled dentist. This address must match the enrollment records with NH Medicaid as this address will be used to facilitate the cross-walk from NPI to the NH Medicaid Provider ID Number (PIN).

Box 49 – NPI (optional if PIN provided in Box 52a below)

Enter the 10-digit billing provider's NPI (National Provider Identifier)

Box 51– SSN or TIN

Enter the Billing Dentist's or Dental Entity's Social Security Number or Tax Identification Number

This number must match what NH Medicaid has in your enrollment file

Box 52 – Phone number

Enter the billing provider's phone number

Box 52a – Additional Provider ID (optional if NPI provided in Box 49 above)

Enter the billing dentist or dental entity's 8-digit NH Medicaid Provider Identification Number (PIN)

The PIN entered in this field must be for the provider that services will be reimbursed to and under which monies will be reported to the Internal Revenue Service

Treating Dentist and Treatment Location Information

Box 53 – Signature/Date

Enter the signature or name of the treating dentist. The performing provider's name must match what is on file with NH Medicaid

Enter the date in MM/DD/YYYY format (e.g. 12/01/2008). Date must be on or after the date of service

Box 54 – NPI (optional field if a PIN is included in Box 58)

Enter the 10-digit performing dental provider's National Provider Identifier (NPI)

Box 56 – Address (optional)

Enter the address of the treating dentist

Box 56a - Provider Specialty Code (optional)

If an NPI is in Box 54, enter the corresponding 10-digit taxonomy code

Strongly suggested that the taxonomy code be provided when an NPI is in Box 54

The NPI number and corresponding taxonomy code must be on file with the Fiscal Agent (HP)

Box 57 – Phone number (optional)

Enter the phone number that the NH Medicaid can call if there are any questions regarding the completed form

Box 58 – Additional Provider ID (optional if a NPI is included in Box 54)

Enter the NH Medicaid Provider Identification Number (PIN). Performing provider must be cross-referenced with the NH Medicaid billing provider's PIN.

MAIL CLAIMS TO:
Xerox Provider Relations
PO Box 2059
Concord, NH 03302-2059

14. Terminology

APPENDIX H: RA HEADINGS, ACRONYMS AND DESCRIPTIONS

ADJUSTMENT REASON: A text field that explains why the adjustment took place.

A/L NUM: The number assigned to the provider's ledger to account for the transaction.

ALW AMT: The NH Medicaid allowed reimbursement rate.

BALANCE: The remaining balance to be exhausted by future financial cash transactions (amount still owed against the receivable or payable). This value is equal to the Original Amount less the Transaction Amount.

BLD AMT: The amount charged for the service by the provider.

CARRIER CODE: The carrier code of the insurance carrier listed above.

CCN: The *Cash Control Number* of the financial transaction. The first two digits of the number indicate the type of financial transaction.

CLAIMS PAID AMOUNT (CURRENT): The dollar amount paid for claims processed during the past week.

CLAIMS PAID AMOUNT (YTD): The dollar amount paid for claims processed this calendar year. This figure is equal to the sum of the Dollar Amount Processed fields on each RA year-to-date.

CREDIT ITEMS (CURRENT): The dollar amount relating to any credit items for the past week. Credit items are all NH Medicaid void transactions, State void transactions, and refund transactions.

CREDIT ITEMS (YTD): The total dollar amount relating to any credit items for the calendar year. Credit items are all NH Medicaid void transactions, State void transactions, and refund transactions. This figure is equal to the sum of the Credit Items fields on each RA year-to-date.

DNUM: The detail number.

DVER: The version of the detail. The original detail paid is version 00. The first adjustment to any payment is version 01, etc.

FDOS: The *From Date of Service* as it appears on the claim.
FINANCIAL ITEMS REASON CODE DESCRIPTIONS: A list of all financial reason codes and their descriptions referenced in the above section for the provider.

GROUP: The group number that the insurance policy falls under. This field is only populated if the recipient's insurance policy is a group policy.

HVER: The version number of the claim. The original claim paid for the services rendered is version 00. The first adjustment to any payment is version 01, etc.

LIAB AMT: The amount for which the patient is responsible, excluding co-pay.

LIEN AMOUNT WITHHELD (CURRENT): The dollar amount withheld as a result of lien transactions occurring during the past week.

LIEN AMOUNT WITHHELD (YTD): The dollar amount withheld as a result of lien transactions for the calendar year. The figure is the sum of the Lien Amount Withheld on each RA year-to-date.

M1: The primary modifier as it appears on the claim.

M2: The secondary modifier as it appears on the claim.

MANUAL PAYMENT AMOUNT (CURRENT): The dollar amount paid out through manual checks during the past week.

MANUAL PAYMENT AMOUNT (YTD): The total dollar amount paid out through manual checks for this calendar year. This figure is equal to the sum of the Manual Payout Amount fields on each RA year-to-date.

MEDICARE: This field indicates the Medicare type. Possible values are 'PART A' and 'PART B'.

MEDICARE ID: The Medicare ID of the member, if applicable.

MID: The recipient's NH Medicaid identification number.

NET ADJUSTMENT AMOUNT: This field indicates the net effect the adjustment had on the provider. The value is equal to the difference between the Original Claim Paid Amount and the Adjusted Paid Amount.

NET ADJUSTMENT AMOUNT (CURRENT): The total net adjustment amount from adjusted claims processing during the past week. This figure is equal to the sum of the Net Adjustment Amount fields located in the Adjustments section of the RA for each adjusted claim.

NET ADJUSTMENT AMOUNT (YTD): The total net adjustment from adjusted claims processing for the calendar year. This figure is equal to the sum of the Net Adjustment fields for each RA year-to-date.

NET 1099 ADJUSTMENT (CURRENT): The net 1099 adjustment incurred from financial transactions during the past week. This figure is equal to the net sum of all positive and negative 1099 transactions during the past week.

NET 1099 ADJUSTMENT (YTD): The total net 1099 adjustment incurred from financial transactions for the calendar year. This figure is equal to the net sum of the NET 1099 Adjustment fields on each RA year-to-date.

NET EARNINGS (CURRENT): The net earnings for the past week. This figure is calculated as follows: Dollar Amount Processed + System Payout Amount + Manual Payout Amount - Recoup Amount Withheld - Credit Items +/- Net 1099 Adjustment (may be positive or negative = Net Earnings

NET EARNINGS (YTD): The total net earnings for the calendar year. This figure is equal to the sum of all the Net Earnings fields on each RA year-to-date.

NO OF CLAIMS PROCESSED (CURRENT): The total number of claims processed during the past week. This figure includes all paid, denied, in process, and adjusted claims appearing on the RA.

NO OF CLAIMS PROCESSED (YTD): The total number of claims processed this calendar year. This figure includes all paid, denied, in process, and adjusted claims appearing on the RA; it is equal to the sum of the Number of Claims Processed fields on each RA year-to-date.

OI AMT: The amount paid by insurance for this claim or detail.

ORIG AMT: The original amount to be exhausted by financial transactions.

OTHER INSURANCE: The name and address of the insurance carrier with whom the member has other insurance coverage.

PT ACCT: The patient account or medical record number as it appeared on the claim or adjusted claim.

PD AMT: The amount paid for this claim.

PEND AMT: The amount pended for each TCN listed.

POLICY: The policy number of the insurance policy that the member holds with the insurance carrier.

POLICY NAME: The name of the person who holds the insurance policy.

PROC: The procedure code as it appears on the claim.

PT ACCT: The patient account or medical record number is reported as it appeared on the pended claim.

MEMBER NAME: Member names listed in alphabetical order. The names appear in last name, first name format.

RECOUP AMOUNT WITHHELD (CURRENT): The dollar amount withheld as a result of recoupment financial transactions during the past week.

RECOUP AMOUNT WITHHELD (YTD): The dollar amount withheld as a result of recoupment financial transactions for this calendar year. This figure is equal to the sum of the Recoup Amount Withheld Amount fields on each RA year-to-date.

RELATIONSHIP DESCRIPTION: The relationship between the member and the policy holder.
RSN CD: This field describes why the transaction was performed.

SETUP AMT: The dollar amount corresponding to the transaction. This is the actual amount of money included or withheld from the payment and applied to the original amount.

SETUP DATE: This field indicates the date the transaction was entered and logged in the provider's account ledger.

SYSTEM PAYOUT AMOUNT (CURRENT): The dollar amount paid out as a result of system generated financial transactions during the past week.

SYSTEM PAYOUT AMOUNT (YTD): The dollar amount paid out as a result of system generated financial transactions for this calendar year. This figure is equal to the sum of the System Payout Amount fields on each RA year-to-date.

TCN: The *Transaction Control Number*; a unique 15-digit identifying number assigned to each claim.

TDOS: The *To Date of Service* as it appears on the claim.

TOS: The *Type of Service* as it appears on the claim.

TOTAL CHECK AMOUNT (CURRENT): The total dollar amount paid for claims submitted and financial transactions incurred.

TOTAL CHECK AMOUNT (YTD): The total dollar amount paid for claims submitted and financial transactions incurred for the calendar year. This figure is equal to the sum of the Payment Amount fields on each RA year-to-date.

TOTAL FINANCIAL ITEMS: The total number of financial items (transactions) for the provider processed during the past week.

QTY BLD: The number of units of service as it appears on the claim.