**NH Department of Health and Human Services (DHHS)** **105 Pleasant St.**
**Division of Long Term Supports and Services** **Concord, NH 03301**
**Bureau of Developmental Services**

| **STATE OF NEW HAMPSHIRE<br>BDS GENERAL MEMORANDUM (GM)** | |
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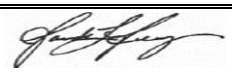
| **DATE:** | June 29, 2023 |
| **TO:** | Designated Area Agencies, Service Coordination Agencies, all In Home Supports, Developmental Disabilities, and Acquired Brain Disorder Waiver Service Providers |
| **FROM:** | Sandy Feroz, Bureau Chief, Bureau of Developmental Services (BDS) |
| **SIGNATURE:** |  |
| **SUBJECT:** | Provider Billing |
| **GM NUMBER:** | GM#23-011 |
| **EFFECTIVE DATE:** | July 1, 2023 |
| **REGULATORY GUIDANCE:** | This memo is a communication tool circulated for informational purposes only. The goal is to provide information and guidance to the individuals to whom it is addressed. The contents of this memo and the information conveyed are subject to change. This communication is not intended to take the place of or alter written law, regulations or rule. |

**MEMORANDUM SUMMARY**

The purpose of this memorandum is to:

- Provide standard processes for submitting Medicaid claims for providers delivering 1915(c) waiver services for individuals with developmental disabilities.

All providers participating in NH Medicaid must submit claims to the fiscal agent in accordance with NH Medicaid guidelines. Providers should note that NH Medicaid claim completion requirements may be different than those for other payers, previous fiscal agents, or fiscal agents in other states. Providers participating in the NH Medicaid Program are responsible for timely and accurate billing. In accordance with federal and state requirements, all providers must submit all initial claims within 15 months following the earliest date of service on the claim.

## I. Medicaid Management Information System (MMIS) Web Portal Claim Entry

If an organization chooses to submit claims through the MMIS web portal without vendor software or a third-party agent, the following steps must be followed.

TIP: User IDs become inactive after 30 days without logging in and are removed after 60 days of inactivity. Set a calendar notice to log into your MMIS web portal account monthly to avoid inactivation.

The provider must be enrolled with NH Medicaid and have access to the MMIS web portal.

1. Log into the NH MMIS Health Enterprise Portal as a provider. If you do not currently have access to the MMIS Portal:

a. Complete the Change of Provider Information Form and complete the NH MMIS Health Enterprise Portal Registration section.

   i. An authorized representative that is on the provider record must sign the form.

   ii. Send the completed form to NH Medicaid:
   Via secure fax: 866-446-3318
   Via encrypted email: NHProviderRelations@Conduent.com

   iii. Once your form has been processed, you will be sent an encrypted email to the email address that you listed on the form. The email will contain your User ID and Password.

2. Ensure you have the Claims role and Eligibility role added to your User ID.

   a. Navigate to the Manage Users screen.

   b. Search for your User ID either by your name or by the User ID.

   c. Add the "Provider-Claims" role and the "Provider-Eligibility" role to the selected roles and select save.

3. Check client eligibility on the MMIS web portal before providing service.

4. Make sure that the billing claims match the prior service authorization information received from DHHS.

5. Navigate to the claims tab in the MMIS web portal and start entering your claims.

## II. Trading Partner/ Billing Agent (TP/BA)

If an organization chooses to submit claims using a Trading Partner or a Billing Agent, the following steps must be followed. A Trading Partner is any entity, or agent acting on behalf of the provider, who transmits electronic transaction data to the NH MMIS. These organizations provide claim submission services to providers.

The provider and Trading Partner must:

1. Ensure that the Trading Partner (TP) is enrolled in NH MMIS and has an active Trading Partner ID affiliated to the provider account.

   a. If they do not have an active Trading Partner ID (TP ID), then the TP/BA will need to submit an application to NH Medicaid from the MMIS and include the following documents:

      i. Trading Partner Agreement Signature Page;

      ii. Electronic Remittance Advice (ERA) Application; and

      iii. Billing Agent Agreement.

   b. The Trading Partner must complete Electronic Data Interchange (EDI) testing with the Department before billing.

   c. If the Trading Partner is enrolled in NH MMIS, but not affiliated to the provider account, the provider must complete the following documents:

      i. Electronic Remittance Advice (ERA) Application; and

      ii. Billing Agent Agreement.

2. The Trading Partner will upload 837 Claim files either to the NH MMIS Web Portal or to the Secure File Transfer Portal.

## III. Vendor Software/ Trading Partner Self

If an organization chooses to submit claims using vendor software, the following steps must be followed.

The provider must:

1. Have vendor software that can create X12 files.
2. Be enrolled as a trading partner "self" and have NH MMIS web portal access. If the provider is not enrolled as a trading partner "self":
    a. Log into the NH MMIS web portal as a provider.
    b. Select Trading Partner Enrollment after logging in. Complete the enrollment application.
    c. Complete the following documents after submitting the application:
        i. Trading Partner Agreement Signature Page; and
        ii. Electronic Remittance Advice (ERA) Application.
3. Have the EDI role on their User ID.
4. Complete EDI testing with the Department before submitting files.
5. Upload X12 files to the NH MMIS web portal.

## IV. Paper Claims

If an organization chooses to submit paper claims to Medicaid, the following steps must be followed by the rendering provider.

1. Enter claim information (typed) on an original red and white CMS 1500 form.
    a. Do not use highlighters, enter information using script font, or laser cut information onto the form.
    b. Use only black or blue ink.
2. Do not use staples, do not staple the CMS 1500 form or any attachments.
3. Submit required claim attachments behind the claim form. Required attachments vary by situation.
4. Ensure that the data entered is aligned properly with the fields of the page. Avoid misalignment due to printer settings.
5. Ensure that the CMS 1500 form is signed and dated on or after the last date of service.
6. Mail the completed claim to:
    Conduent Claims Unit
    P.O. Box 2003
    Concord, NH 03301

## V. Billing Documentation

Providers must maintain electronic and paper billing records in support of claims for at least six years from the date of service. Records may need to be maintained for longer periods of time for claims related to personal actions, such as disputes. Such records must be originals and must accurately and completely document the extent of the services provided. Fiscal and/or medical/clinical records relating to the provision of billed services must be furnished to the Department, or designated representatives, when such information is requested.

Providers delivering services to individuals with developmental disabilities must adhere to record retention requirements outlined in He-M 503, He-M 522, and He-M 524.

## VI. Claim Review/ Processing

The NH MMIS systematically reviews all submitted claims to ensure compliance with NH Medicaid policies, administrative rules, and billing guidelines. Claims submitted via the portal are adjudicated in real-time, i.e., immediately upon submission. Claims submitted via EDI or on paper require overnight batch processing prior to adjudication.

The Remittance Advice (RA), issued weekly, provides payment or denial information on each claim processed by NH Medicaid. It is intended to assist the provider in maintaining accurate records of claims submitted and serves as notification of the action taken on each NH Medicaid claim processed. The RA includes a listing of claims paid, claims denied, and newly suspended claims. The RA also reflects voids and adjustments, if applicable.

1. **Paid Claims**
    a. Each paid claim will be listed on the RA along with the total amount paid for each claim.
    b. An individual line may be denied. If a line is denied, the reason for the denial will be listed.
2. **Suspended Claims**
    a. Suspended claims require further research, evaluation, or other action before they can be paid or denied.
    b. Providers should not submit duplicate claims for claims that have been suspended.
3. **Denied Claims**
    a. Denied claims constitute the termination of the transaction between the Department and the provider for the services billed.
    b. Possible reasons for denial include but are not limited to:
        i. The service for which reimbursement is claimed is not a covered service.
        ii. The patient was not an eligible NH Medicaid member when the service was rendered.
        iii. The provider failed to obtain a required service authorization.
        iv. The limit for the type of service billed was exceeded.
        v. The claim was not completed according to NH Medicaid requirements.