nh healthy families™

Provider Manual



NHhealthyfamilies.com
1-866-769-3085

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Introduction

Welcome

Welcome to NH Healthy Families. We thank you for being part of NH Healthy Families network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. NH Healthy Families works to accomplish this goal by partnering with the providers who oversee the healthcare of NH Healthy Families members.

About NH Healthy Families

NH Healthy Families is underwritten by Granite State Health Plan, a Managed Care Organization (MCO) contracted with the New Hampshire Department of Health and Human Services (DHHS) to deliver a Care Management program to citizens of New Hampshire eligible for Medicaid benefits including members eligible for the Granite Advantage Healthcare Program. NH Healthy Families' parent company, Centene Corporation (Centene), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs since 1984. Centene operates local health plans and offers a wide range of health insurance solutions to individuals. It also contracts with other healthcare and commercial organizations to provide specialty services.

NH Healthy Families is a physician-driven organization that is committed to building collaborative partnerships with providers. NH Healthy Families serves our New Hampshire members consistent with our core philosophy that quality healthcare is best delivered locally.

Mission

NH Healthy Families strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. NH Healthy Families is designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We are happy to have you as part of our network and hope that you will assist NH Healthy Families in reaching these goals.

How to Use This Manual

NH Healthy Families is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to our operations, benefits, and policies and procedures for providers. This provider manual will be posted on the NH Healthy Families website at www.NHhealthyfamilies.com, where providers can review and print it free of charge. Providers will be notified of material changes to the provider manual. To request a hard copy of the provider manual, or if you need further explanation on any topics discussed in the provider manual, please contact the Provider Services Department (Provider Services) at **1-866-769-3085**.

Key Contacts and Important Phone Numbers

The following chart includes several important telephone and fax numbers available to your office. When calling NH Healthy Families, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number
- Member's ID number or Medicaid ID number

Health Plan Information

NH Healthy Families
2 Executive Park Drive, Bedford, NH 03110
Phone: 1-866-769-3085
Fax: 1-877-502-7255
www.NHhealthyfamilies.com

Department	Telephone Number	Fax Number
Provider Services	1-866-769-3085	1-877-502-7255
Member Services	1-866-769-3085 TDD/TYY 1-855-742-0123	1-877-502-7255
Prior Authorization Request Concurrent Review Case Management	1-866-769-3085	1-866-270-8027 1-877-295-7682 1-877-301-8595
Nurse Advice Line (Available 24/7)	1-866-769-3085	
Mental Health Services	1-866-769-3085	1-866-694-3649
Substance Use Disorder Services	1-866-769-3085	1-866-270-8027
Prior Authorization Outpatient/Home Health, Physical, Occupational, Speech Therapy	1-866-769-3085	
To report suspected fraud, abuse or waste to NH Healthy Families	1-866-685-8664	
New Hampshire Department of Health and Human Services (DHHS)	1-844-275-3447	

Paper Claims Submission

NH Healthy Families
ATTN: CLAIMS DEPARTMENT
PO Box 4060
Farmington, MO 63640-3831

Paper Claims Submission for Behavioral Health Services

NH Healthy Families
ATTN: CLAIMS DEPARTMENT
PO Box 7500
Farmington, MO 63640-3831

Claim Disputes Submission

NH Healthy Families
ATTN: CLAIM DISPUTES
PO Box 4060
Farmington, MO 63640-3831

Electronic Claims Submission

Please Note: Payer IDs are different for Behavioral and Medical Services

EDI Payer ID 68069 (Medical Services)
EDI Payer ID 68068 (Behavioral Health Services)

For further questions regarding EDI Submission, please contact our EDI Department using one of the methods below:

NH Healthy Families
c/o Centene EDI Department
Call: 800-225-2573 ext. 25525
E-mail to: EDIBA@centene.com

Provider Services Department

NH Healthy Families' Provider Services Department is dedicated to making each participating provider's experience with NH Healthy Families a positive one.

The Provider Services Department's is available to answer questions for our provider network in the following areas:

- Benefit and Eligibility requests
- Utilization Management process, including whether services have been approved, denied or in process; information on how to appeal any denied service.
- Distribution of the provider manual and provider reference materials. Note: The Provider Manual will be made available to you no later than thirty calendar days after inclusion into the network.

- Assistance with claims inquiries and other administrative services
- Assistance with website navigation and access regarding available web-based tools and functions.

Provider Services can be reached toll free at 1-866-769-3085, 8:00 a.m. to 6:00 p.m. Monday through Friday. Additionally, we can be reached from 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service.

Provider Engagement Department

The goal of the Provider Engagement Department is to develop partnerships with our provider community. Every participating provider within our network is assigned a dedicated, local Provider Engagement Administrator and is available to support you and your staff.

The Provider Engagement team will provide education and training materials regarding NH Healthy Families' administrative processes and tools available to support you in the care of your patients, our members. Your Provider Engagement Administrator will visit you or your designated office representative on a routine basis.

Regularly scheduled in-service meetings are intended to be a proactive way for NH Healthy Families to build a positive relationship, identify issues, trends or concerns quickly; to answer questions; share new information regarding NH Healthy Families; and to address any changes within your practice (ex. change in office staff, new practice location) or scope of service.

Providers and their office staff are encouraged to call or e-mail their dedicated Provider Engagement Administrator for assistance at any time.

Provider Engagement Administrators meet regularly with providers within their designated territories to:

- Coordinate and conduct on-site and ongoing educational programs
- Respond to inquiries and provide clarification related to policies and procedures, contract language and operational issues
- Facilitate problem resolution related to NH Healthy Families processes and tools
- Roster reconciliation
- Share information about special programs available for members and/or providers
- Understand your special programs and areas of opportunity for partnering
- Review your membership list (patient panel) and support reconciliation
- Assist with questions relating to claims or encounter submissions
- Review the processes for web authorizations, claims submissions, and eligibility verification

Another key responsibility of the Provider Engagement Administrator is to monitor network adequacy on a continual basis to ensure NH Healthy Families is in compliance with the State of New Hampshire's access and availability standards and, ultimately, to ensure network sufficiency for members that mirrors community or commercial health plan standards. Your dedicated Provider Engagement Administrator will keep you and your staff apprised of any network changes, new additions or needs within the geographic area you serve, and may - from time to time - survey you regarding your referral network and any preferences you may have with regard to certain providers to target for participation in the NH Healthy Families' provider network.

Product Summary

NH Healthy Families has been providing covered benefits and services for the NH Medicaid Care Management Program since December 2013. We provide managed care services to population groups deemed eligible by the Department of Health and Human Services (DHHS). NH Healthy Families provides integrated medical and behavioral health services, care management and care coordination, various health and disease management programs, and value-added services to the following eligibility categories:

Members	Eligible for Managed Care	Not Eligible for Managed Care (DHHS
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/NonFrail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Medicaid Children Funded through the Children's Health Insurance Program	X	
Medicaid for Employed Adults with Disabilities Non-Dual	X	
Medicaid for Employed Older Adults with Disabilities	X	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

Verifying Eligibility

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

- Log on to the secure provider portal at www.NHhealthyfamilies.com. Using our secure provider website, you can check member eligibility. To verify eligibility, you can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth. The eligibility response will indicate the eligibility category of the member. Please note that you must submit a request to be enrolled with our provider web services in order to access information via the secure provider portal. This may also be done using Availity Essentials at Availity.com.

- Call our automated member eligibility IVR system. Call from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24- hours a day. The automated system will prompt you to enter the member's Medicaid ID and the month of service to check eligibility.

- Call NH Healthy Families' Provider Services. If you cannot confirm a member's eligibility using the methods above, please contact Provider Services at **1-866-769-3085**. Provider Services will need the member name or member Medicaid ID to verify eligibility.

Through NH Healthy Families' secure provider web portal, primary care physicians (PCPs) are able to access a list of eligible members who have selected their services or were assigned to them. The patient list is reflective of all changes made within the last 24-hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. In order to view this list, log on to www.NHhealthyfamilies.com.

Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage; please use one of the above methods to verify member eligibility for each date of service.

All new NH Healthy Families' members receive a NH Healthy Families' member ID card. The member ID card will include the following information:

- The NH Healthy Families' name
- The Member's Name
- The Member's Medicaid ID Number
- The Member's date of birth (DOB)
- The Member Services 24-hour, seven days a week number:**1-866-769-3085**

A new member ID card is issued only when a member reports a card lost, has a name change, requests a new PCP or for any other reason that results in a change to the information disclosed on the member ID card.

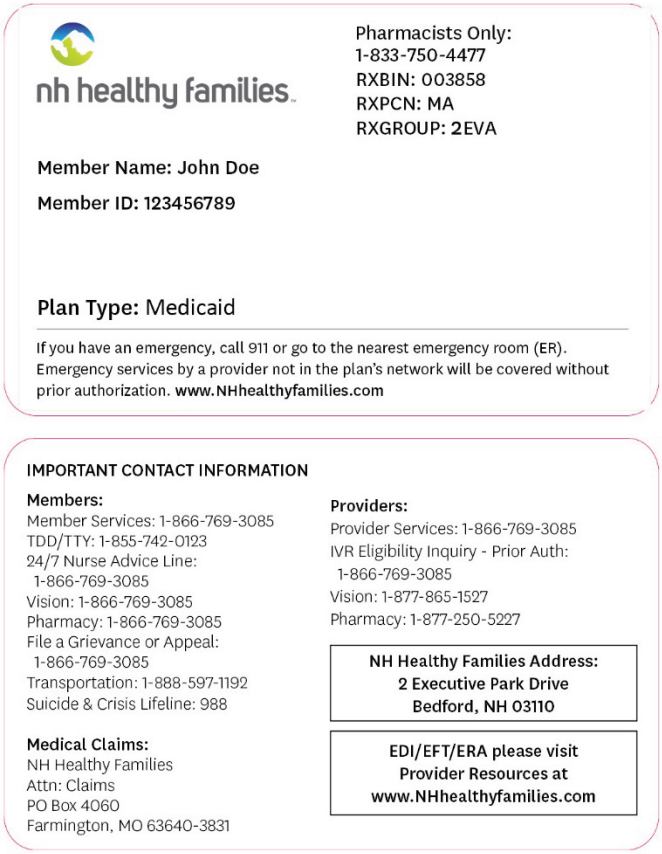
Since member ID cards are not a guarantee of eligibility, providers must verify members' eligibility on each date of service.

Member Identification Card

Whenever possible, in addition to their NH Healthy Families' member ID card, we recommend providers ask members to present a photo ID card each time non-emergency services are rendered. If you suspect fraud, please contact Provider Services at **1-866-769-3085** immediately. Members must keep and present the state-issued Medicaid ID card in order to receive benefits not covered by NH Healthy Families.

Below is a copy of the Member Identification Card for the Standard Medicaid Product & Granite Advantage Program:

Standard Medicaid Product



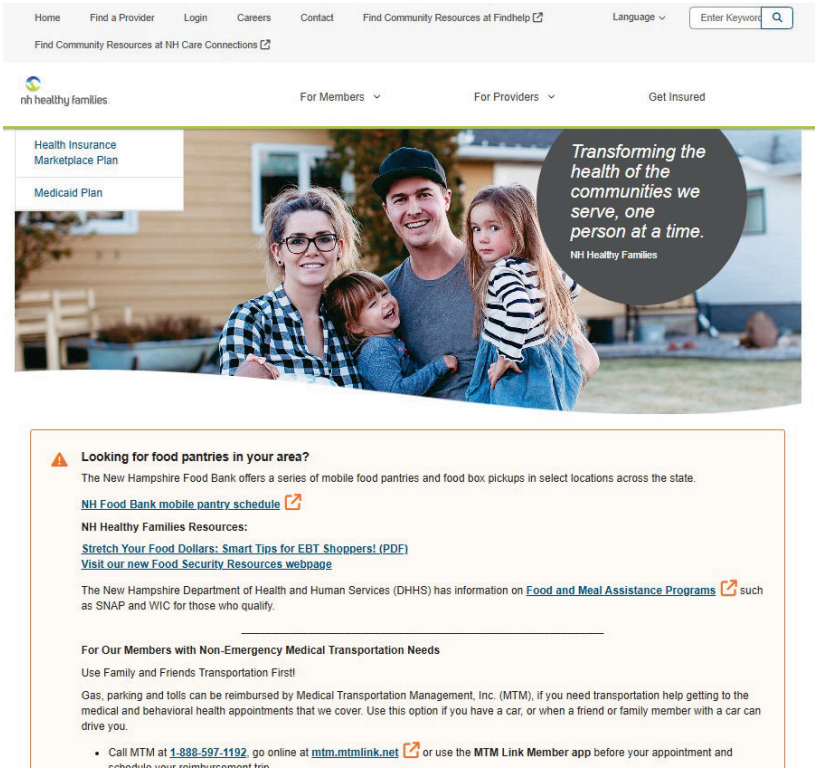
Granite Advantage Program



NH Healthy Families Website

NH Healthy Families Public Website

The NH Healthy Families website can significantly reduce the number of telephone calls a provider will need to make. Utilizing the website allows immediate access to current provider and member information 24-hours, seven days a week. Please contact your Provider Engagement Administrator or our Provider Services department at **866-769-3085** with any questions or concerns regarding the website.



The NH Healthy Families website is located at www.NHhealthyfamilies.com. Providers can find the following information on the public website:

- Provider Manual
- Provider Billing Manual
- Prior Authorization List, and whether prior authorization is required (by entering a CPT, HCPCs or Revenue code)
- Forms
- NH Healthy Families News
- Clinical Guidelines
- Provider Bulletins
- Training Material & Tools
- Provider Newsletters
- Member Handbook Payment Policies

Secure Website

The NH Healthy Families secure provider website enables providers to check member eligibility and benefits, submit and check status of claims, submit claims adjustments, request authorizations, and send messages to communicate with NH Healthy Families staff. NH Healthy Families contracted providers and their office staff have the opportunity to register for our secure provider website quickly and easily. Here, we offer tools which make obtaining and sharing information easy. It's simple and secure. Go to www.NHhealthyfamilies.com to register. On the home page, select the Login link on the top right to start the registration process.

In addition to the features mentioned above, you may also:

- View members health records
- View the PCP panel (patient list)
- View payment history
- View quality scorecard
- Contact us securely and confidentially
- Find member and provider analytics tools
- Find claim trending tools

We are constantly updating our website with the latest news and information, so save our address to your Internet "favorites" list and check our site often. You may sign up as soon as your contract is completed. Once you sign up, there is an instruction manual available on the site to answer any questions you may have.

You may also use **Availity Essentials** as a new provider portal option where you can submit many transactions with ease. Follow these steps to register:

1. Navigate to Availity.com
2. Select Get Started.
3. The Get Started page displays three Account Type options:
    a. Healthcare Provider
    b. Caregiver or atypical provider
    c. Billing Service
4. On the applicable account type, select the training site link.
    a. Availity training site launches and provides details about getting your organization setup with an account.

"Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule."

Primary Care Physician

The primary care physician (PCP) is the cornerstone of NH Healthy Families' service delivery model. NH Healthy Families offers a robust network of primary care providers to ensure every member has access to a medical home within the required travel distance standards: Two providers within forty (40) driving minutes or fifteen (15) driving miles.

Missed Appointments

NH Healthy Families requests that providers contact the NH Healthy Families Member Service department when one of our members misses an appointment so we may contact the member and provide education on the importance of keeping appointments. This outreach can also assist with reducing missed appointments and reduce the inappropriate use of emergency room services. NH Healthy Families prohibits providers from billing members for missed appointments.

Provider Types That May Serve as PCPs

Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistants and advanced registered nurse practitioners. The PCP may practice in a solo or group setting or at an FQHC, RHC or outpatient clinic. NH Healthy Families may allow some specialists to serve as a PCP for members with multiple disabilities or with chronic conditions, if the specialists agree, in writing, and is willing to perform the responsibilities of a PCP as stipulated in this Provider Manual.

Member Panel Capacity

All PCPs may reserve the right to state the number of members they are willing to accept into their panel. NH Healthy Families DOES NOT guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following:

- Physicians –1: 2,500
- Nurse Practitioner-1: 1,000
- Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase by 1,000 per extender.

The panel capacity for Federally Qualified Health Centers will be based upon those standards established by the Health Resources and Services Administration.

If a PCP desires a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Provider Services at **866-769-3085** or their assigned Provider Engagement Administrator.

A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

If a participating provider chooses to close their patient panel for NH Healthy Families members, it must be closed for all patients regardless of insurance carrier. Providers shall notify NH Healthy Families in writing at least forty-five (45) days in advance of his or her inability to accept additional Medicaid covered persons under NH Healthy Families' agreements. In no event shall any established patient who becomes a Covered Person be considered a new patient. NH Healthy Families prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non- Medicaid members.

From an information technology perspective, we offer several applications including **Availity** for our network providers. Our secure **Provider Portal** offers tools that will help support providers in implementing a medical home model of care. These tools include:

- Online Care Gap Notification
- Member Panel Roster including member detail information
- Care Service Plan
- Summary Member Health Record (MHR)
- Provider Overview Report
- Patient full medical history, including care delivered by other providers
- Patients organized into registries to prioritize care management
- Provider and Patient Analytic Tools

Member Attribution

NH Healthy Families offers a robust network to ensure every member has access to a PCP within the required travel distance standards- two PCPs within forty (40) miles or fifteen (15) minutes. For those members who have not selected a PCP during enrollment, NH Healthy Families will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

- **Member history with a PCP.** The algorithm will first look to see if the member is a returning member and attempt to match them to previous PCP. If the member is new to NH Healthy Families, claim history provided by the state will be used to match a member to a PCP that the member had previous relationship where possible.
- **Family history with a PCP.** If the Member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.
- **Geographic proximity of PCP to member residence.** The auto-assignment logic will ensure members are assigned with the required travel distance standard – two PCPs within forty (40) minutes or fifteen (15) driving miles.
- **Appropriate PCP type.** The algorithm will use age, gender, and language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant women assigned to OB/GYNs.

Pregnant women should choose a pediatrician, or an appropriate PCP, for the care of their newborn baby before the beginning of the last trimester. If the pregnant member does not select a pediatrician, or other appropriate PCP, NH Healthy Families will assign one for her newborn.

Primary Care and Prevention Focused Care Model

NH Healthy Families will support the Primary Care and Prevention Focused Care model (PCPFCM) developed by NH MCM through a multi-faceted approach. Providers serving as Primary Care Physicians (PCPs) are enabled with tools and the ability to provide services to our members ensuring the utmost quality of care.

The relevant primary care services supported by the PCPFCM program include:

- Wellness Visits
- Health Risk Assessments
- Lifestyle Counseling
- Preventive Services
- Care Coordination
- Comprehensive Medication Reviews including polypharmacy reviews

Wellness Visits

NH Healthy Families believes preventive services are the cornerstone to healthy living and we have a deep appreciation for the value of an annual wellness visit, and it is current practice that we allow members to have another wellness visit when a member establishes themselves with a new PCP.

Description		CPT code	Billing Provider
Initial new patient preventive medicine evaluation (including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures)	Infant <1 year	99381	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	Early childhood 1-4 years	99382	
	Late childhood 5-11 years	99383	
	Adolescent 12-17 years	99384	
	18-39 years	99385	
	40-64 years	99386	
	≥65 years	99387	
Established patient periodic preventive medicine examination (including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures)	Infant <1 year	99391	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	Early childhood 1-4 years	99392	
	Late childhood 5-11 years	99393	
	Adolescent 12-17 years	99394	
	18-39 years	99395	
	40-64 years	99396	
	≥65 years	99397	

Health Risk Assessments

The Health Risk Assessment (HRA) Screening process will serve as an initial means to identify care coordination and care management needs of members, such as closed-loop referrals for community resources and specialists (e.g. Behavioral Health Providers), promotion of the PCPFCM, and enrollment in NH Healthy Families' care management program for members identified in one or more Required Priority Populations.

Description	CPT code	Billing Provider
Administration and interpretation of patient-focused health risk assessment	96160	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Administration and interpretation of developmental screening (e.g. milestone, speech and language)	96110	
Assessment of emotional and behavioral problems (e.g. ADHD scale, depression inventory)	96127	

HRAs are recommended to be provided once annually. The maximum number of HRAs that can be billed per member is three (3) annually. This service is reimbursable in addition to separate and identifiable services such as a wellness visit.

Lifestyle Counseling

Lifestyle counseling by primary care providers allows an opportunity to educate members about the impact of their health behavior choices and empower them to take control of their health. All providers can offer continuous guidance, motivation, and accountability, helping patients set realistic goals and develop long-term healthy habits while fostering an authentic member-provider relationship.

Description		CPT Code	Billing Provider
Individual preventive medicine counseling and/or risk factor reduction intervention(s)	Appx 15 min	99401	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	Appx 30 min	99402	
	Appx 45 min	99403	
	Appx 60 min	99404	
Group preventive medicine counseling and/or risk factor reduction intervention(s)	Approx 30 min	99411	
	Approx 60 min	99412	
Individual smoking and tobacco use cessation counseling	4-10 min	99406	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	>10 min	99407	
Individual brief face-to-face behavioral counseling for alcohol misuse	15 min	G0443	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Individual face-to-face behavioral counseling for obesity	15 min	G0447	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Group (2-10) face-to-face behavioral counseling for obesity	30 min	G0473	
Face-to-face transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge	At least moderate level of medical decision making during the service period, within 14 calendar days of discharge	99495	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	High level of medical decision making during the service period, within 7 calendar days of discharge	99496	

These services are reimbursable in addition to separate and identifiable services such as a wellness visit and health risk assessment.

Preventive Services

Preventive screenings allow early identification and detection of diseases when treatment is most effective, thereby preventing complications that can lead to morbidity and mortality. Providers are encouraged to track and offer preventive screenings at age-appropriate and risk-factor intervals in alignment with all A- and B-level United States Preventive Services Task Force (USPSTF) guidelines.

Description		Recommended CPT Code	Billing Provider
Individual alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT, DAST) and brief intervention (SBI)	15 to 30 min	99408	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	>30 min	99409	
Individual annual alcohol misuse screening	5 to 15 min	G0442	
Individual annual depression screening	5 to 15 min	G0444	

This service is reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, and lifestyle counseling.

Care Coordination

Care coordination ensures that all providers and organizations provide the right care at the right time, leading to a continuous, cohesive, and consistent care while incorporating the member's goals and preferences. Care coordination is to be distinguished from "Care Management," which involves a direct contact between NH Healthy Families and a NH Healthy Families member. NH Healthy Families, not the Providers, are responsible for delivering care management services to target priority populations: DCYF-involved children, infants with low birthweight and Neonatal Syndrome, previously incarcerated populations, and members in the community who have had a behavioral health inpatient admission.

Description		Recommended CPT Code	Billing Provider
Extended office or other outpatient service by clinical staff	First hour (List separately in addition to code for outpatient Evaluation and Management service)	99415	Clinical staff incident to physician (supervision) within any clinical discipline
	Each additional 30 min (List separately in addition to code for prolonged service)	99416	
Care management services for a single high-risk disease, with the following elements:	First 30 minutes provided personally by qualified health care	99424	Providers (MD, DO), PA/NP; Incident-to Care Coordination performed by

One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care	professional, per calendar month		staff under the supervision of a Physician.
	Each additional 30 min provided personally by qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	99425	
	First 30 min of clinical staff time directed by health care professional, per calendar month	99426	
	Each additional 30 min of clinical staff time directed by health care professional, per calendar month (List separately in addition to code for primary procedure)	99427	
Care management services for multile (two or more) chronic conditions with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored	First 20 min of clinical staff time directed by health care professional, per calendar month	99490	Physicians (MD, DO), PA/NP; Incident-to Care Coordination performed by staff under the supervision of a Physician.
	Additional 20 min of clinical staff time directed by health care professional, per calendar month (List separately in addition to code for primary procedure)	99439	
	First 30 min provided personally by health care professional, per calendar month	99491	
	Additional 30 min provided personally by health care professional, per calendar month (List separately in addition to code for primary procedure)	99437	
Complex chronic care management services with the following required elements:	First 60 min of clinical staff time directed by health care	99487	Physicians (MD, DO), PA/NP; Incident-to Care Coordination performed by

Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making	professional, per calendar month		staff under the supervision of a Physician.
	Each additional 60 min of clinical staff time directed by health care professional, per calendar month (List separately in addition to code for primary procedure)	99489	
Care management services for behavioral health conditions, with the following required elements: Initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.	20 min or more clinical staff time directed by health care professional	99484	Physicians (MD, DO), PA/NP; Incident-to Care Coordination performed by staff under the supervision of a Physician.
Comprehensive assessment of and care planning for patients requiring chronic care management services	(List separately in addition to code for primary procedure)	G0506	Physicians (MD, DO), PA/NP; Incident-to Care Coordination performed by staff under the supervision of a Physician.

This service is reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, lifestyle counseling, and preventive services.

Comprehensive Medication Review

A Comprehensive Medication Review (CMR) is a detailed evaluation of medications including prescription drugs, over-the-counter medications, herbal supplements, and vitamins to identify and resolve potential medication-related problems such as polypharmacy, dosing errors, and contraindications. By administrating CMRs, providers and pharmacists can assess adherence and provide counseling and education.

Description		CPT Code	Billing Provider
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	(List separately in addition to the code for primary procedure)	90863 with Modifier 33	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
New patient outpatient visit, which requires a medically appropriate history and/or examination and medical decision making	15-29 min	99202 with Modifier 33	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP); Incident-to Pharmacist performed by staff under the supervision of a Physician
	30-44 min	99203 with Modifier 33	
	45-59 min	99204 with Modifier 33	
	60-74 min	99205 with Modifier 33	
Outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional		99211 with Modifier 33	
Established patient office or other outpatient visit, which requires a medically appropriate history and/or examination and medical decision making	10-19 min	99212 with Modifier 33	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP); Incident-to Pharmacist performed by staff under the supervision of a Physician
	20-29 min	99213 with Modifier 33	
	30-39 min	99214 with Modifier 33	
	40-54 min	99215 with Modifier 33	
Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided	New patient; Initial 15 min	99605	Community Pharmacist
	Established patient; Initial 15 min	99606	
	Additional 15 min (List separately in addition to code for primary service)	99607	

This service is reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, lifestyle counseling, preventive screening and care coordination.

Primary Care Physician (PCP) Responsibilities

The PCP shall serve as the member's initial and most important contact. PCP's responsibilities include, but are not limited, to the following:

- Provide applicable primary care services identified in the Primary Care and Prevention Focused Care model including Wellness Visits, Health Risk Assessments, Lifestyle Counseling, Preventive Services, Care Coordination with closed-loop referrals and Comprehensive Medication Reviews including polypharmacy reviews
- Establish and maintain hospital admitting privileges sufficient to meet the needs of all associated NH Healthy Families members, or entering into an arrangement for management of inpatient hospital admissions of members
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions
- Educate members on maintaining healthy lifestyles and preventing serious illness
- Provide screenings, well care and referrals to community health departments and other agencies in accordance with the New Hampshire DHHS requirements and public health initiatives
- Based on provider assessment, conduct a behavioral health screen to determine whether the member needs behavioral health services
- Coordinate with providers for behavioral health services as needed
- Maintain continuity of each member's healthcare by serving as the member's medical home
- Offer hours of operation that are no less than the hours of operating hours offered to commercial and fee for service patients
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide
- Ensure follow-up and documentation of all referrals including services available under the State's fee for service program
- Collaborate with NH Healthy Families' case management program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and to other support services as needed
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services
- Adhere to the EPSDT periodicity schedule for members under age 21
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care
- Share the results of identification and assessment for any member with special healthcare needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated
- Actively participate in and cooperate with all NH Healthy Families quality initiatives and programs
- Ensure coordination with community mental health programs, including obtaining consent from members to release information regarding primary care.

PCPs may have a formalized relationship with other PCPs to see their members when circumstances like vacation dictate. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them, regardless of any additional PCP engagement.

Member Transfer of Care

Under certain circumstances, a PCP may remove a Member from his/her panel. A PCP may find that a satisfactory Patient/Provider relationship cannot be developed with a particular Member. The PCP may request a Member be transferred to another practice for any of the following reasons:

- Repeated disregard of medical advice
- Repeated disregard of Member responsibilities
- Ongoing personality conflicts between Physician and/or staff with the Member
- Disruptive behavior that impairs the Provider's ability to provide service to the Member

Reasonable efforts should be made to establish a satisfactory provider and member relationship. The providers should include adequate documentation in the member's medical record to support his or her efforts to develop and maintain a satisfactory relationship. The PCP may remove a Member from his/ her care only under the above circumstances, and only after NH Healthy Families receives appropriate notification and the provider and NH Healthy Families completes the steps outlined below. First, the PCP must send a request, in writing, using the PCP Change Form – located on the NH Healthy Families website under Provider Resources – Manuals, Forms & Resources to remove a Member from his or her practice stating the reasons for the proposed disenrollment to:

NH Healthy Families Network Operations
2 Executive Park Drive
Bedford, NH 03110

After NH Healthy Families receives notification from the Provider, the PCP must provide written notice to the Member and send a copy of the notice to the Provider Engagement Department. The PCP must provide at least a sixty (60) day notice to the Member for a transition of care and to allow time for the Member Services Department to contact the Member and assist them in selecting another PCP. The PCP is obligated to provide covered services to the Member until the change is completed and written notice is received from NH Healthy Families stating that the Member has been transferred from the provider's practice. NH Healthy Families will provide a listing of other available PCPs to the Member.

A PCP should never request a Member be dis-enrolled for any of the following reasons:

- Adverse change in the Member's health status or utilization of services, which are medically necessary for the treatment of a Member's condition.
- On the basis of the Member's age, gender, race, color, religion, national origin, ancestry, marital status, sexual orientation, income status, physical or mental condition or disability, pre-existing condition, occupation, and/or need for health care services.

Referrals

It is NH Healthy Families' preference that the PCP coordinates a Member's healthcare services. However, PCPs are encouraged to refer a Member when medically necessary care is needed that is beyond the scope of what the PCP can provide. This includes referring Members for mental health services. Electronic/

Paper referrals are not required. The PCP must obtain Prior Authorization from NH Healthy Families for referrals to certain specialty providers as noted on the Prior Authorization list found elsewhere in the Provider Handbook and on the NH Healthy Families website. All Out of Network service requests require Prior Authorization, and may be approved only if the requested services are not available timely within NH Healthy Families' Provider Network. NH Healthy Families, at its discretion, will determine which OON Provider a Member will be authorized to see when an OON service is required. A Provider is also required to promptly notify NH Healthy Families when prenatal care is rendered. In accordance with State Law, Providers are prohibited from making referrals to healthcare entities with which the Provider or a member of the Providers' family has a financial relationship.

Referral Process for Medical and Behavioral Health Services

After assessing the Member's service and/or care needs, providers should offer brief education about available care options and support the Member in connecting to appropriate services. Referrals should be timely, person-centered, and based on the Member's preferences, clinical needs, safety needs, and applicable benefit requirements.

Coordination with Behavioral Health Providers

PCPs are encouraged to coordinate care with behavioral health providers involved in a member's treatment. Coordination may include communication regarding diagnoses, medications, treatment plans, referrals, and follow-up needs, consistent with applicable federal and state confidentiality regulations and member consent requirements. PCPs should collaborate with behavioral health providers, CMHPs, CCBHCs, substance use disorder treatment providers, and other treating practitioners, as appropriate, to support comprehensive, whole-person care. Coordination of care activities must comply with all applicable federal and state confidentiality requirements, including HIPAA and 42 CFR Part 2, where applicable.

Behavioral Health Referrals and Transitions of Care

Providers are encouraged to utilize referral processes that promote timely access to care and communication between treating providers. Whenever feasible, providers should support closed-loop referral processes that confirm referral completion and facilitate follow-up regarding treatment engagement. When clinically appropriate, providers should utilize warm handoff practices during care transitions, including from inpatient, institutional, emergency department, residential, withdrawal management, or Substance Use Disorder treatment settings, to improve member engagement and continuity of treatment.

Referral Process

1. Assess the Member's service, care coordination, behavioral health, Substance Use Disorder, safety, and/or health-related social needs.
2. Provide brief education about available care options and discuss the Member's preferences for the next steps.
3. Review service and care options with the Member, including medical, behavioral health, Substance Use Disorder, CCBHC/CMH, crisis, community-based, and health-related social needs resources, as applicable.
4. Obtain a Release of Information when required for information sharing and document consent-related actions.
5. Explain what information may be shared, with whom, and for what care coordination or referral purpose, consistent with applicable privacy requirements.
6. Provide the Member with referral information and/or assist the Member with outreach to connect with the service resource or health care provider.

7. Use closed-loop referral practices when feasible, including confirming the referral was received, following up on whether the Member connected to services, and coordinating additional support if the Member was unable to access care.
8. Document the referral, Member preference, information shared, follow-up actions, and referral outcome when known.

Additional Referral Considerations

Referral planning should be culturally and linguistically appropriate, trauma-informed, recovery-oriented, and accessible. Providers should consider the Member's clinical urgency, safety needs, preferences, disability-related accommodation needs, and ability to access the referred service. Providers should ensure Members have access to interpretation, translation, auxiliary aids, reasonable accommodations, and accessible formats when needed. Providers should share screening results, clinical information, discharge information, and other relevant care coordination information with treating practitioners or providers when necessary and legally permissible to support coordination and continuity of care.

Providers may use the following resources to support referral planning, as appropriate:

- Social service referral resources: https://uniteus.com/
- New Hampshire Certified Community Behavioral Health Clinics: https://www.dhhs.nh.gov/programs-services/health-care/behavioral-health/certified-community-behavioral-health-clinics
- CCBHC locator/resource information: https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-locator/

To connect a Member to the NH Healthy Families Care Management program, call **1-866-769-3085** or email **NHHFCareManagement@centene.com** .

Behavioral Health Screening and Assessment Tools

Overview

NH Healthy Families encourages providers to use validated, evidence-based, and age-appropriate screening and assessment tools to support early identification, referral, treatment planning, care coordination, and ongoing monitoring of behavioral health conditions, substance use disorders, suicide risk, trauma-related needs, pediatric behavioral health concerns, and perinatal behavioral health needs. Screening results should be interpreted within the context of a comprehensive clinical assessment and should not be used as the sole basis for diagnosis, level-of-care determination, or treatment planning. Positive screens should prompt clinically appropriate follow-up assessment, safety planning when indicated, referral, care coordination, and documentation consistent with professional standards, Member needs, and applicable requirements.

How to Use This Tool Set

Providers should select screening tools based on the Member's age, presenting concerns, clinical setting, cultural and linguistic needs, disability-related accommodation needs, and the provider's scope of practice. The tools listed below are organized to support routine screening, targeted assessment, referral, and monitoring when clinically indicated.

NH Healthy Families recommends distinguishing between Core Screening Tools and Targeted Assessment or Monitoring Tools:

- **Core Screening Tools** are recommended for routine or commonly occurring screening workflows across primary care, behavioral health, pediatric, perinatal, and substance use settings.

- **Targeted Assessment or Monitoring Tools** may be used when a positive screen, presenting concern, diagnosis, risk factor, or clinical judgment indicates the need for additional assessment, triage, monitoring, or referral support.

Screening Tool	Clinical Focus	Population	Use Category	Verified Resource Link
PHQ-2 / PHQ-9	Depression Screening & Monitoring	Adolescents & Adults	Core Screening Tool	https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf
GAD-7	Anxiety Screening	Adolescents & Adults	Core Screening Tool	https://www.hiv.uw.edu/page/mental-health-screening/gad-7
C-SSRS	Suicide Risk Screening	Children, Adolescents & Adults	Core Screening Tool	https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/
C-SSRS Screener (PDF)	Suicide Risk Screening	Children, Adolescents & Adults	Core Screening Tool	https://www.cms.gov/files/document/cssrs-screen-version-instrument.pdf
SAFE-T	Suicide Risk Assessment & Triage	Adolescents & Adults	Targeted Assessment / Triage Tool	https://library.samhsa.gov/product/safe-t-suicide-assessment-five-step-evaluation-and-triage/pep24-01-036
ASQ	Brief Suicide Risk Screening	Youth & Adults	Core Screening Tool	https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
AUDIT-C / AUDIT	Alcohol Use Screening	Adults	Core Screening Tool	https://nida.nih.gov/sites/default/files/files/AUDIT.pdf
DAST-10	Drug Use Screening	Adults	Core Screening Tool	https://www.sbirt.care/pdfs/tools/DAST.PDF
DAST-20	Drug Use Screening	Adolescents & Adults	Targeted Assessment / Monitoring Tool	https://adai.uw.edu/instruments/pdf/Drug_Abuse_Screening_Test_105.pdf
CRAFFT	Adolescent Substance Use Screening	Adolescents	Core Screening Tool	https://crafft.org/
NIDA Quick Screen	Substance Use Risk Screening	Adults	Core Screening Tool	https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
SBIRT	Screening, Brief Intervention, and Referral to Treatment for Substance Use	Children, Adolescents & Adults	Core Screening and Referral Framework	https://www.samhsa.gov/substance-use/treatment/sbirt
ASSIST	Substance Use Screening (multi-substance)	Adolescents & Adults	Targeted Assessment / Monitoring Tool	https://www.who.int/publications/i/item/978924159938-2

PC-PTSD-5	PTSD Screening	Adults	Core Screening Tool	https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp
PCL-5	PTSD Symptom Severity & Monitoring	Adults	Targeted Assessment / Monitoring Tool	https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
ACE Questionnaire	Adverse Childhood Experiences / Trauma History	Adults	Core Screening Tool	https://www.cdc.gov/violenceprevention/aces/index.html
PEARLS	Pediatric ACEs & Related Life Events	Children & Adolescents	Core Screening Tool	https://www.acesaware.org/learn-about-screening/screening-tools/
EPDS	Perinatal Depression Screening	Pregnant & Postpartum Members	Core Screening Tool	https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf
TWEAK	Alcohol Use Screening in Pregnancy / Perinatal Risk	Pregnant & Postpartum Members	Core Screening Tool	https://www.camh.ca/-/media/professionals-files/treating-conditions-and-disorders/alcohol-use/tweak-screener-pdf.pdf
T-ACE	Alcohol Use Screening in Pregnancy	Pregnant Members	Core Screening Tool	https://www.cdc.gov/alcohol-pregnancy/hcp/alcoholsbi/index.html
MDQ	Bipolar Disorder Screening	Adults	Targeted Assessment / Monitoring Tool	https://ibpf.org/wp-content/uploads/2016/11/MDQ.pdf
PSC-17	Pediatric Psychosocial Screening	Children & Adolescents	Core Screening Tool	https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist
Vanderbilt	ADHD Screening & Symptom Monitoring	Children & Adolescents	Targeted Assessment / Monitoring Tool	https://www.nichq.org/resource/nichq-vanderbilt-assessment-scales
T-ACE	Alcohol Use Screening in Pregnancy	Pregnant Members	Core Screening Tool	https://www.cdc.gov/alcohol-pregnancy/hcp/alcoholsbi/index.html

Screening and Referral Considerations

Use of validated screening tools should support, but does not replace, required clinical assessment, care coordination, referral, and follow-up activities. Providers should ensure that screening workflows are connected to appropriate next steps, including:

- **Wellness Visit and primary care screening:** Screening for depression, mood, suicidality, and SUD should be incorporated into applicable preventive and primary care workflows.

- **Health Risk Assessment and Comprehensive Assessment:** Screening results should inform identification of behavioral health needs, SUD needs, trauma and ACEs, suicide risk, functional needs, health-related social needs, and care management or referral needs.
- **Suicide risk and Zero Suicide alignment:** Positive suicide risk screens should prompt appropriate risk assessment, safety planning, crisis response, referral, follow-up, and documentation based on Member risk and clinical urgency.
- **Substance Use Disorder referral and ASAM considerations:** Substance use screening is not a substitute for ASAM Level of Care Assessment when SUD treatment need is identified. Members who screen positive for SUD needs should receive timely follow-up, referral, interim services when applicable, and closed-loop referral support consistent with applicable requirements.
- **Pediatric screening:** Pediatric behavioral health, developmental, substance use, suicide risk, and trauma/adversity screening should be age-appropriate and aligned with EPSDT and Bright Futures expectations.
- **Perinatal screening:** Pregnant and postpartum Members should receive clinically appropriate screening for depression, substance use, and alcohol-related risk, with timely referral and care coordination when needs are identified.
- **Closed-loop referrals:** When screening identifies a need for behavioral health, SUD, CCBHC/CMH, crisis, specialty, community-based, or health-related social needs services, providers should initiate and document referral, follow-up, and care coordination activities.
- **Accessibility and equity:** Screening activities should be conducted in a culturally and linguistically appropriate and accessible manner.

Provider Office Standards

NH Healthy Families requires the following:

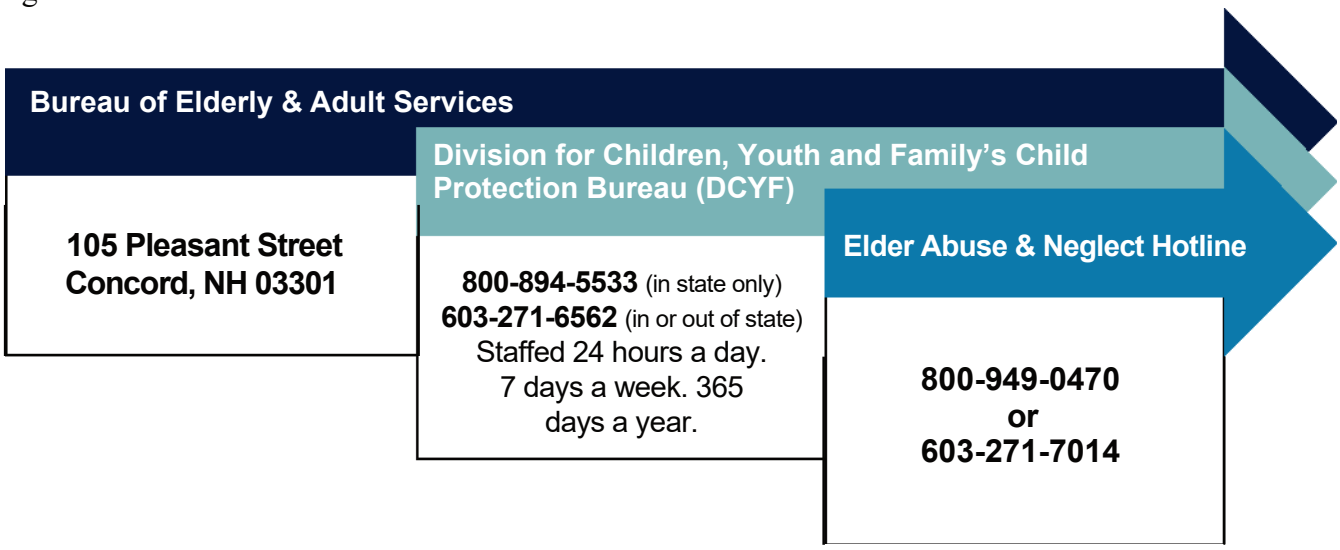
- Office must be professional and secular
- Signs identifying office must be visible
- Office must be clean, and free of clutter with unobstructed passageways
- Office must have a separate waiting area
- Waiting area must have adequate seating to support the current member volume
- Clean restrooms must be available
- Office environment must be physically safe
- Providers must have a professional and fully-confidential telephone line and twenty-four (24) hour availability
- Member records and other confidential information must be locked up and out of sight during the work day
- Medication prescription pads and sample medications must be locked up and inaccessible to members
- ADA compliant

The Provider's office must have evidence of the following:

- Child Abuse and HIPAA Privacy posters are posted in the Provider's waiting room/reception area
- The Provider has a complete copy of the Patient's Bill of Rights and Responsibilities, available upon request by a member, at each office location
- The Provider's waiting room/reception area has a consumer assistance notice prominently displayed in the reception area.

Abuse and Neglect Reporting

Providers are required to report all incidents that may include abuse and neglect consistent with the Department of Human Services Act, the Adults with Disabilities Domestic Abuse Intervention Act and the Abused and Neglect Child Reporting Act. Reports regarding elderly Enrollees who are over the age of 60 will be reported to the Bureau of Elderly & Adult Services (BEAS) by using the Elder Abuse & Neglect Hotline number.



DHHS Immunization Program

Vaccines are available at no charge to public and private providers for eligible children ages newborn through 18 years through the DHHS Immunization Program (NHIP). DHHS requires Providers who administer immunizations to qualified DHHS eligible children to enroll in the NHIP program. Providers should contact the DHHS at:

Immunization Program
Division of Public Health Services
New Hampshire Department of Public Health Services
29 Hazen Drive
Concord, NH 03301

Phone Number: 800-852-3345 ext. 4482 TDD Access Relay: 800-735-2964
Fax: 603-271-3850
Vaccine Shipping: 800-852-3345 ext. 4463 Vaccine Shipping Fax: 603-271-4932
http://www.dhhs.state.nh.us/dphs/immunization/contact.htm

NH Healthy Families participating providers who administer vaccines must enroll in this program through the DHHS. Participating providers must utilize the NHIP program for NH Health Families' members.

NH Healthy Families will reimburse an administration fee per dose to providers who administer the free vaccine to eligible members. Please refer to the NH Healthy Families Provider Billing Manual for instructions on how to submit claims.

Specialist Responsibilities

NH Healthy Families encourages all specialists, including mental health providers, to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the member's care and ensure the referred specialty physician is a participating provider within the NH Healthy Families network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following the NH Healthy Families referral guidelines.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from NH Healthy Families Medical Management Department (Medical Management) if needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24-hours a day for management of Member care
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all NH Healthy Families quality initiatives and programs

Emergency admissions will require notification to the NH Healthy Families Medical Management Department within one business day of admission to conduct medical necessity review.

All non-emergency inpatient admissions require notification to NH Healthy Families Medical Management Department five business days prior to admission. Prior authorization will not be required unless the service itself is one that required prior authorization.

NH Healthy Families Providers should refer to their contract for complete information regarding provider obligations and mode of reimbursement or contact their Provider Engagement Administrator with any questions or concerns.

Mainstreaming

NH Healthy Families considers mainstreaming of its Members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a NH Healthy Families Member a covered services or availability of a facility
- Providing a NH Healthy Families Member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay Members or based upon the NH Healthy Families program under which the Member is enrolled (examples: different waiting rooms or appointment times or days)
- Subjecting a NH Healthy Families member to segregation or separate treatment in any manner related to covered services.

Appointment Accessibility Standards

NH Healthy Families follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. NH Healthy Families monitors compliance with these standards on an annual basis through a Provider Survey. It is the expectation that all providers will comply with the survey request. We will use the results of appointment standards monitoring to ensure adequate appointment availability, and reduce unnecessary emergency room utilization. Network Providers should call the NH Healthy Families Provider Services department at 1-866-769- 3085 if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new members or meet the access standards can result in suspension and/or termination from the network. All changes in a Network Provider's status will be considered in the recredentialing process.

Type of Appointment	Scheduling Time Frame
Transitional care after inpatient stay (medical or behavioral) – PCP, Specialist or CMHC	Within 2 business days of discharge when part of a member's discharge plan from inpatient care
Transitional care after inpatient stay (medical or behavioral) – Home care	Within 2 calendar days of discharge – must be ordered by PCP, specialty care provider or as part of discharge plan
PCP non-symptomatic office visit	Within 45 calendar days of request
PCP non-urgent, symptomatic visits	Within 10 calendar days of request
PCP or other provider Urgent, symptomatic office visits	Within 48 hours
Obstetrics and gynecological	care shall be available within fifteen (15) calendar days from the date of the Member's appointment request
Mental Health Providers	Care within 6 hours, or direct member to crisis center or ER For a non-life threatening emergency Care within 48 hours for urgent care appointment within 10 business days for a routine office visit

Post Discharge from New Hampshire Hospital	Contact with community mental health center within 48 hours of psychiatric discharge from a New Hampshire Hospital and follow-up appointment to occur within 7 calendar days
Private Hospital Psychiatric Discharge	Follow-up appointment within 7 calendar days
Emergency Providers (medical and behavioral)	Immediately (24 hours a day, 7 days a week) and without prior authorization

All providers must offer hours of operation that are no less than the hours of operation offered to commercial and fee for service patients.

Covering Providers

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another NH Healthy Families network provider.

Telephone Arrangements

PCPs and Specialists must:

- Answer the Member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a Member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After-hours telephone care for non-emergent, symptomatic issues within 30minutes
  - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the Member's medical record
- Provide for a system or service to address calls made after office hours.
- During after-hours, a provider must have arrangement or:
  - Access to a covering physician
  - An answering service
  - Triage service, or a voice message that provides a second phone number that is answered
  - Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members

24- Hour Access

PCPs and specialty providers within the NH Healthy Families network are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, seven days a week.

Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to Member receiving urgent or emergent care.NH Healthy Families will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement program ("QIP").

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message
- Returning after-hours calls outside thirty minutes

The selected method of 24-hour coverage chosen by the provider must connect the Member or caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

NH Healthy Families monitors providers offices through scheduled and unscheduled visits conducted by NH Healthy Families Provider Engagement staff.

Hospital Responsibilities

NH Healthy Families utilizes a network of hospitals to provide services to NH Healthy Families Members. Hospital services providers must be qualified to deliver services under the New Hampshire Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after a Member's emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify NH Healthy Families' Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, DOS, and member's phone number.
- Notify NH Healthy Families' Medical Management department of all admissions within one (1) business day.
- Notify NH Healthy Families' Medical Management department of all newborn deliveries within one business day of the delivery.
- Prior to admission to NH Hospital or other State determined institution for mental diseases (IMDs) for mental illness, a crisis team consultation must be completed for all members evaluated by a licensed physician or psychologist.
- In assessing eligibility for emergency involuntary admission to NH Hospital, a face-to-face evaluation by a mandatory pre-screening agent must be conducted to assess eligibility for emergency involuntary admission to NH Hospital and determine whether all available less restrictive alternative services and supports are unsuitable.
- Notify NH Healthy Families' Medical Management department within one business day of a Member discharging from an inpatient admission

Marketing Requirements

All marketing materials utilized by NH Healthy Families must be approved by DHHS prior to distribution to members. Additionally:

- NH Healthy Families nor its contracted providers will offer anything of value as an inducement to enrollment, including the sale of other insurance to attempt to influence enrollment.
- Neither NH Healthy Families nor its contracted providers will directly or indirectly conduct door-to- door, telephonic or other cold-call marketing of enrollment.

NH Healthy Families or its contracted providers may not make any written or oral statements in marketing materials that a potential member must enroll with NH Healthy Families in order to obtain benefits or in order not to lose benefits.

- NH Healthy Families may not make any assertion or statement in marketing materials that NH Healthy Families is endorsed by CMS, the Federal or State government or similar entity.
- NH Healthy Families providers should not create and distribute any marketing materials to NH Healthy Families members' without prior approval by NH Healthy Families and DHHS. Should you have any questions regarding these marketing requirements, please feel free to contact NH Healthy Families' Provider Services or your Provider Engagement Administrator.

Advance Directives

NH Healthy Families is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. NH Healthy Families is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to NH Healthy Families' members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

NH Healthy Families recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive and the member's response should be documented in the medical record
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request in the member's medical record
- An advance directive should be included as a part of the member's medical record and include mental health directives

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. If possible, a copy of the advance directive should be collected and placed in members' chart. Any such discussion should be documented in the medical record.

Interpreter Services

NH Healthy Families will make oral or sign interpretation services available free of charge for each member or potential member. Members shall not be charged for interpretation services.

Voluntarily Leaving the Network

Providers must give NH Healthy Families notice of voluntary termination following the terms of their participating agreement with our health plan. Providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to NH Healthy Families or the member.

NH Healthy Families will notify affected members in writing of a provider termination.

The notice shall be provided the later of thirty (30) calendar days prior to the effective date of the termination or fifteen (15) calendar days after the receipt or issuance of a termination notice. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. If the terminating provider is a PCP, NH Healthy Families will request that the member elect a new PCP within fifteen (15) business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP, NH Healthy Families will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of sixty (60) days, the anniversary date of the member's coverage, or until NH Healthy Families can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, NH Healthy Families will reimburse the provider for the provision of covered services for a period of up to ninety (90) days from the provider's termination date. In addition, NH Healthy Families will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from NH Healthy Families

NH Healthy Families will also provide written notice to a member within seven (7) days, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

Cultural Competency

Cultural Competency within the NH Healthy Families Network is defined as, "a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members."

NH Healthy Families is committed to the development, strengthening, and sustaining of healthy provider/ member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare

services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

The NH Healthy Families vision for culturally competent care is:

- Care is given with the understanding of, and respect for, the member's health related beliefs and cultural values.
- NH Healthy Families staff respect health related beliefs, interpersonal communication styles and attitude of the members, families and communities they serve.
- Each functional unit within the organization applies a trained, tailored approach to culturally sensitive care in all member communications and interactions.
- All NH Healthy Families providers and practitioners support and implement culturally sensitive care models to NH Healthy Families members.
- The NH Healthy Families goal for culturally sensitive care is:
- To support the creation of a culturally sensitive behavioral health system of care that embraces and supports individual differences to achieve the best possible outcomes for individuals receiving services.

Providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them
- Care is provided with consideration of the member's race/ethnicity and language and its impact/ influence on the member's health or illness
- Office staffs that routinely come in contact with members have access to and participate in cultural competency training and development
- The office staff responsible for data collection makes reasonable attempts to collect race and language specific member information
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process
- Office sites have posted and printed materials in English, Spanish, or other prevailing languages within the region

Health Disparity Facts

- Government-funded insurance consumers face many barriers to receiving timely care
- Households headed by Hispanics are more likely to report difficulty in obtaining care
- Consumers are more likely to experience long wait times to see healthcare providers
- African American Medicaid consumers experience longer waits in emergency departments and are more likely to leave without being seen
- Consumers are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality
- Consumers that are children are less likely to receive childhood immunizations
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare
- Health disparities come at a personal and societal price

Understanding the Need for Culturally Competent Services
Research indicates that a person has better health outcomes when they experience culturally appropriate interactions with providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Providers should note that the experience of a member begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Member's feelings of being insulted or treated rudely
- Member's reluctance and fear of making future contact with the Provider's office
- Member's confusion and misunderstanding
- Non-compliance by the member
- Member's feelings of being uncared for, looked down upon and devalued
- Parents' hesitance to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Providers misdiagnosis due to lack of information sharing
- Wasted time for the member and Provider; and/or
- Increased grievances or complaints

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. NH Healthy Families is committed to helping you reach this goal.

Take the following into consideration when you provide services to members:

- What are your own cultural values and identity?
- How do/can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?

Cultural competency training is available at the following link https://cccm.thinkculturalhealth.hhs.gov/.

Benefit Explanation and Limitations

NH Healthy Families Benefits

NH Healthy Families' network of participating providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Manual, please contact Provider Services at 866-769-3085, Monday through Friday. A Provider Services Representative will assist you in understanding the benefits.

NH Healthy Families covers, at a minimum, those core benefits and services specified in our Agreement with the New Hampshire DHHS. ***NH Healthy Families members may not be charged or balance billed for covered services or missed appointments.***

Preferred Drug List (PDL)

The NH Healthy Families Preferred Drug List (PDL) contains information for pharmaceutical management procedures including: A list of covered pharmaceuticals, including restrictions and preferences, copayment information – if applicable.

- How to use the pharmaceutical management procedures including the prior authorization process, limits on refills, doses, prescriptions.
- How to submit an exception request.
- The process for generic substitution, therapeutic interchange and step-therapy protocols.

Providers may call 866-769-3085 to receive a copy of the pharmaceutical management procedures by mail, fax or email. The PDL can also be found on NH Healthy Families provider portal.

NH Healthy Families follows the general rules He-W 500 for covered services, limitations and exclusions. This following list is not intended to be an all-inclusive list of covered services. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

Covered Services	Limits or Requirements	Comments
Adult Day Care	Limited to age 18 and above.	
Allergy Services		
Ambulatory Surgery Center	Some services require prior authorization.	
Anesthesia Services		
Audiology Services		
Bariatric Surgery	Prior authorization required.	
Behavioral Health Services	Some services require prior authorization.	Services may include: • Inpatient Services • Outpatient Services • Psychological Services
Community Mental Health Center Services and Certified Community Based Health Clinics		
Birthing Centers, including Free Standing Birth Centers	Prior authorization required.	
Chemotherapy		

Covered Services	Limits or Requirements	Comments
Dental Services	For persons age 21 and over, coverage limited to the medical services provided for treatment of acute pain or infection. Covered dental services for members under age 21 are those rendered in a physician's office as part of the standard EPSDT exam.	
Diabetes Self-Management		
Dialysis at Designated Receiving Facilities		
Disease Management	Asthma Weight Management Program Diabetes Congestive Heart Failure (CHF) Heart Disease COPD Smoking Cessation Puff Free Pregnancy TeleCare Management Program	
Durable Medical Equipment (DME)	Some items require prior authorization.	
Early Periodic Screening Diagnosis and Treatment	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are designed to provide preventative health care, diagnostic services, and early detection and treatment of disease or abnormalities to Medicaid eligible individuals under age 21. Some items require prior authorization.	
Emergency Room Services	No authorization required	
Enteral & Parenteral Nutrition for Home Use	Some items require prior authorization.	
Family Planning		
Fluoride Varnish	For members up to age 5, limited to twice per year.	(PCP/Pediatrician visit)
FQHC & RHC Services		

Covered Services	Limits or Requirements	Comments
Gender Reassignment Surgery		Treatment will not be denied or limited on the basis of race, color, national origin, sex, age, or disability. Health Services will not be denied or limited because they are ordinarily available to a different sex than the individual requesting them. Services will not be denied or limited for be denied or limited for a transgender individual. Health Services will not be excluded or limited that are related to gender transition.
Hearing Aids and Related Services	For members age 21 and over, hearing aid evaluations & consultations are limited to one service every 2 years. These services are covered as needed for Members under the age of 21. Hearing aids are covered if criteria is met.	
High Cost Radiology	Prior authorization required.	(MRA, MRI, CT, PET Scan)
Home Health Care Services	Prior authorization required.	
Hospice Care	Prior authorization required.	
Hospital Services: Inpatient	Prior authorization required.	
Hospital Services: Outpatient	Some services require prior authorization.	
Hysterectomy	Not covered if performed for the purpose of an individual permanently incapable of reproducing;	**Consent Form Required**
Infertility	Limited Coverage	Includes coverage for determining cause of, and treating, medical condition causing infertility
Interpreter services – telephonic / face to face	Covered upon request free of charge	
Laboratory Services	Some services require prior authorization.	
Maternity Care Services	Some services require prior authorization	Includes: • Nurse mid-wife and certified non-nurse midwife services • Pregnancy related services • Services for conditions that might complicate pregnancy

Covered Services	Limits or Requirements	Comments
Physician and Nurse Practitioner Services		
Podiatrist Services		
Private Duty Nursing	Prior authorization required.	
Personal Care Services	Prior authorization required.	For members 18 and over who are chronically wheelchair bound, living in a non-institutional setting and able to self-direct their care.
Prescription Drugs	**Please refer to PDL for covered medications** Co-pays may apply Some exclusions apply	
Preventative Care	Certain limitations may apply	
Radiology and x-rays		
Rehabilitative Services Post Hospital Discharge		
Sterilization Procedures Age 21 and over		**Consent Form Required**
Substance Use Disorder	Prior authorization may be required. For ASAM 3.5 (H0018), ASAM 3.1 (H2034), ASAM 2.5 (H2036), and ASAM 2.1 (H0015) levels of care: First five (5) calendar days are automatically approved with initial PA submission. Additional days require concurrent review with clinical documentation. Please refer to the Substance Use Disorder Treatment Request Form found on our website www.nhhealthyfamilies.com under Provider Resources/Forms.	Services may include: • Screening, brief intervention, and referral to treatment (SBIRT) • Substance use screenings • Individual, group, and family therapy • Intensive outpatient SUD services • Partial hospitalization • Medically monitored outpatient withdrawal management • Crisis intervention • Peer recovery support • Non-peer recovery support • Continuous recovery monitoring • Inpatient acute or psychiatric hospital services • Opioid treatment services • Medication assisted treatment • Medically monitored residential withdrawal management • Residential treatment services, including specialty services for pregnant and postpartum women.

Covered Services	Limits or Requirements	Comments
Telemedicine		
Therapy (OT, PT, ST) Services (Outpatient)	Covered-20 visits per therapy type combined Habilitative & Rehabilitative	Prior authorization is required after the initial evaluation.
Transitional Housing Program Services and Community Based Residential Services with Wrap-Around Services and Supports (beginning 1/1/2020)		
Transplant Service	Prior authorization required.	
Transportation (Emergency Ambulance)		
Transportation (Non-Emergency Medical)	Must be transportation to Medicaid-covered services or required by EPSDT	
Vision Services and Eyewear	Treatment for routine vision care, includes one routine eye examine with refraction and eyewear once per calendar years. Eyewear includes one pair of eyeglasses when there is a 1/2 diopter change in vision.	NH Healthy Families will offer members their choice of glasses from a standard set of frames or will give them a credit towards the frames of their choice.
Wheelchair Van Service		

Services That are Excluded and Not Covered:

(Please keep in mind that this may not be an all-inclusive list)

Non-Covered Services	Additional Detail	Comments
Abortions (Voluntary)		**Not Covered**
Alternative Medicine	Acupuncture, Biofeedback	**Not Covered**
Cosmetic or plastic surgery		**Not Covered**
Chiropractic Care		**Not Covered**
Experimental procedures, drugs and equipment		**Not Covered**
Personal Comfort Items		**Not Covered**
Non-Medical Equipment		**Not Covered**
Physical exams required for employment, insurance or licensing.		**Not Covered**
Radial Keratotomy		**Not Covered**
Services not allowed by federal or state law		**Not Covered**

Non-Covered Services	Additional Detail	Comments
Weight reduction and control services	This includes: weight loss drugs or products, gym memberships or equipment for the purpose of weight reduction.	**Not Covered**
Intermediate Care Facility MR		**Covered by New Hampshire Medicaid**
Medicaid to Schools Services		**Covered by New Hampshire Medicaid**

Non-Covered Services	Additional Detail	Comments
Dental Benefit Services		**Covered by New Hampshire Medicaid**
Acquired Brain Disorder Waiver Services		**Covered by New Hampshire Medicaid**
Developmentally Disabled Waiver Services		**Covered by New Hampshire Medicaid**
Choices for Independence Waiver Services		**Covered by New Hampshire Medicaid**
In Home Supports Waiver Services		**Covered by New Hampshire Medicaid**
Skilled Nursing Facility		**Covered by New Hampshire Medicaid**
Skilled Nursing Facility Atypical Care		**Covered by New Hampshire Medicaid**
Inpatient Hospital Swing Beds, SNF		**Covered by New Hampshire Medicaid**
Intermediate Care Facility Nursing Home		**Covered by New Hampshire Medicaid**
Intermediate Care Facility Atypical Care		**Covered by New Hampshire Medicaid**
Inpatient Hospital Swing Beds, ICF		**Covered by New Hampshire Medicaid**
Glencliff Home		**Covered by New Hampshire Medicaid**
Developmental Services Early Supports and Services		**Covered by New Hampshire Medicaid**
Home Based Therapy – DCYF		**Covered by New Hampshire Medicaid**
Child Health Support Service – DCYF		**Covered by New Hampshire Medicaid**
Intensive Home and Community Services – DCYF		**Covered by New Hampshire Medicaid**
Placement Services – DCYF		**Covered by New Hampshire Medicaid**
Private Non-Medical Institution For Children – DCYF		**Covered by New Hampshire Medicaid**

Value Added Benefits

Value Added Benefits	Details
My Health Pays	Dollar amounts rewarded to NH Healthy Families members for the completion of healthy behaviors. To start receiving rewards the member must complete their Health Needs Assessment and complete a wellness visit with their PCP.
Start Smart for Your Baby®	Program design to support pregnant mothers. This program offers educational materials and personalized care management for those members with complex health conditions. We seek to provide our members helpful information and services as early as possible in pregnancy. If you verify pregnancy of a member, please complete a notice of pregnancy (NOP) form (available on our website) to start the process of important supports as soon as possible.
MemberConnections	Representatives trained to promote preventive health and to help members get connected to community services. MemberConnections representatives will even visit members in their homes, when needed. For your NH Healthy Families members who need this type of assistance, complete a referral form, or reach out to our call center at 1-866-769-3085.
Health Coaching	Services to help members manage their chronic health conditions. This includes health coach services for asthma and diabetes. Health coaches can also help members quit smoking.
Transitioning Youth Program/Future is Now	The Foster Care Transitioning Youth Program/Future is Now, is designed to identify those youth who are approaching their 18th birthday and need assistance/support as they age out of Foster Care. This program is at no cost to the Member and will assist youth transitioning from the Foster Care System by implementing three main strategies: • Link transitioning youth to the health resources identified in their Community- Based Care (CBC) Transitional Independent Living Assessment/Plan; • Enhance the education youth receive when transitioning to include how to access care through the Medicaid system, healthcare benefits available to them, and improving attitudes toward living a healthy life style; • Expand options for transitioning youth to connect to transitional independent living support programs located in their communities.
Post Discharge Meals	The Post Discharge Meals program is a transitional care management referred program. Members discharged from an inpatient stay with chronic conditions or social health needs will receive up to 14 healthy, home-delivered discharge meals.

Enhanced Non-Emergent Medical Transportation	Enhanced Transportation is a care management referred program where Members in recovery can receive transportation services for recovery and sobriety programs Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Medication Assisted Recovery Anonymous (MARA). Enhanced Transportation is also available to Members enrolled in Care Management program for obtaining food at food banks or pantries, attending appointments at Community Action Programs to complete applications, or WIC appointments for pregnant women.
Alternative Therapies Program	The Alternative Therapies program is available to Members enrolled in the Care Management HALO® program. This program provides access to alternative therapies such as massage, acupuncture, and chiropractic services for Members with chronic pain and potential or history of substance misuse disorder. Limited to 12 combined visits annually for all modalities. Transportation is available for Members to these appointments under the Enhanced Transportation benefit.
YMCA Self-Management Programs	The Diabetes Self-Management Program is care management program where Members can participate in a 3-month Diabetes Self-Management program receiving educating on nutrition, exercise, self-monitoring, medication management, and community resources to improve and maintain their diabetes. The Blood Pressure Self-Monitoring program is a 4-month program designed to help members with hypertension and educates them on healthy eating and hydration, increasing physical activity, reducing sodium and stress, and identifying risk factors for heart disease. Both programs include a 12-month membership to the Granite YMCA to utilize their facilities to maintain their physical activity, receive continued support and education.

Substance Use Disorder Benefits (SUD)

As of July 1, 2016, substance use disorder benefits became effective in New Hampshire for Medicaid members. Increased coverage to help support those needing help to get to recovery includes:

- Initial Assessments
- Crisis Intervention
- Individual, family, and group counseling
- Withdrawal management
- Suboxone and methadone administration & services
- Intensive outpatient and partial levels of care
- Inpatient rehabilitative services
- Peer recovery support

This new coverage will be added to the stable of existing services that are already in existence to address the needs of people in or trying to get to recovery:

- Integrated Care Management
- Provider Support and Referral Services
- Support for the Homeless
- Naloxone (Narcan) Training Support

Beginning July 15, 2026, NH Healthy Families will automatically approve the first five (5) calendar days of certain substance use disorder (SUD) services when the provider notifies the plan and submits a prior authorization (PA) request.

This applies to the following levels of care:

- ASAM 3.5 (Residential) – H0018
- ASAM 3.1 (Residential) – H2034
- ASAM 2.5 (Partial Hospitalization) – H2036
- ASAM 2.1 (Intensive Outpatient) – H0015

Providers must submit a PA request that includes the first five (5) days of treatment. These days are automatically approved and do not require clinical review before services begin. After the first five (5) days, NH Healthy Families will complete a concurrent review to determine if additional days are medically necessary. Providers must submit a new PA request with clinical documentation to support continued treatment.

This change does not apply to detoxification services (ASAM 3.7 – H0010). Providers should continue to follow current prior authorization requirements for detox services.

Prior authorization is not required for SUD services delivered by a Community Mental Health Center (CMHC) or Certified Community Behavioral Health Clinic (CCBHC).

SUD Care Management
NH Healthy Families staffs specially-trained Care Managers who help providers easily access information, options for treatment, and tools necessary for your patient's recovery.

Care Managers are available to provide you support in real time and directs you to the information or resources appropriate for the patient's treatment. Care Managers may provide any or all of the following services and resources:

- A fast assessment of your current patient's situation to determine the correct level of care. NH Healthy Families supports and has resources in-network for all four ASAM levels of treatment.
- Care Managers can help providers quickly connect members to treatment. While providers can begin the referral process right away, a prior authorization request must be submitted for certain SUD services.
- Optional conversations on the spot with the patient if needed.
- The ability to coordinate a direct conversation with the Behavioral Health Medical Director
- A link to access educational material from Providers' Clinical Support System for Opioid Therapies (https://pcssnow.org), National Resource
- Continuing coordination of care with inpatient or outpatient specialists or facilities
- Assistance with bridging the patient to an appropriate program

Depending on the needs of your patient, you may choose to follow a path independently with the patient or further engage the Care Manager to assist in choosing the right therapy or treatment. If clinically appropriate, the member will have an opportunity to enroll into NH Healthy Families' Integrated Care Management program to receive support and help with care coordination on an on-going basis

ASAM Treatment Levels
The SUD Case Manager can coordinate or assist with obtaining the following types of care for your patient:

- ASAM Level 1: Outpatient therapy
- ASAM Level 2: Outpatient program at a facility
- ASAM Level 3: Inpatient services at a facility
- ASAM Level 4: Admission to an acute level of care

My Health Pays®
The goal of the My Health Pays program is to increase appropriate utilization of preventive services by rewarding members for practicing a targeted healthy behavior. The program will strengthen the relationship with the medical home as members regularly access preventive services, and will promote personal responsibility for and ownership of the member's own healthcare. My Health Pays also benefits members because it provides them with credits to purchase healthcare items, such as over-the-counter medications that they might otherwise not be able to afford. Services that will qualify for rewards through the program include completion of, annual adult well visits, EPSDT visits, certain disease- specific screenings, and completion of postpartum care.

How does it work? Upon completion of the Health Risk Assessment Screening, located inside the members Welcome Packet, the member will receive a prepaid My Health Pays card. Credit will be added to the account balance once the member receives certain screenings or preventive care. Members may use the cards to purchase approved healthcare goods and services at certain stores and pharmacies. My Health Pays goods and services are those recognized by the Internal Revenue Service as healthcare expenses for

flexible spending accounts. In addition to the aforementioned goods and services, members may use the cards to pay for licensed childcare services, utilities, public transportation, and telecommunication services (i.e. SafeLink if available, cell/home phones).

My Health Pays Program Rewards

Reward Type	Description	Frequency	Exempt from $250* Limit	Reward Amount
Wellness Visit				
Adult Wellness Visit	**Health Hero** reward for Adult Members who receive an annual preventive care visit with their Primary Care Provider.	Once annually	✓	$40
Child/Adolescent Wellness Visit	**Health Hero** reward for Child Members (24 months-21 years) who receive an annual preventive care visit with their Primary Care Provider.	Once annually	✓	$40
Infant Wellness Visit (0-15)	**Health Hero** reward for Infant Members (0-15 months) who receive an annual preventive care visit with their Primary Care Provider.	Up to 6 visits annually	✓	$40
Infant Wellness Visit (15-30)	**Health Hero** reward for child Members (15-30 months) who receive an annual preventive care visit with their Primary Care Provider.	Up to 2 visits annually	✓	$40
Wellness Screening				
Health Risk Assessment Screening	**Health Hero** reward for members who complete an annual HRA with their Primary Care Provider, a plan of care is established, and the Primary Care Provider submits a claim for the HRA completion.	Once annually	✓	$10
Diabetes HbA1c	**Health Hero** reward for any members with Diabetes in completing at least 1 Hemoglobin A1C test.	Once annually	✓	$10
Diabetic Retinopathy	**Health Hero** reward for completing Retinopathy Screening (Dilated Eye Exam) each year.	Once annually	✓	$10
Diabetic Kidney Testing	**Health Hero** reward for any member with Diabetes in completing kidney test and screening for members aged 18-85.	Once annually	✓	$10
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	**Health Hero** reward for members with Schizophrenia or Bipolar Disorder who receive Diabetes screening for members aged 18-64.	Once annually	✓	$10

Prenatal Visits- 1st Trimester	**Health Hero** reward for all newly pregnant Members who receive a prenatal visit within the first trimester (12 weeks) for female members aged 9-55.	Once per pregnancy	✓	$150
Notification of Pregnancy (NOP)	**Health Hero** reward for all newly pregnant Members who complete the NOP.	Once per pregnancy	✓	$10
Lead Screening 1YO	**Health Hero** reward for members up to age 1 who obtain a lead screening from their Primary Care Provider.	1 per lifetime	✓	$25
Lead Screening 2YO	**Health Hero** reward for members up to age 2who obtain a lead screening from their Primary Care Provider.	1 per lifetime	✓	$20
Lead Screening Parent/Guardian Incentive	Reward for the Parent/Guardian of toddlers up to age 2 receives their lead screening test will be entered into a monthly raffle to win a $50.00 Amazon Gift Card.	1 per lifetime		$50*
Lead Screening Kicks for Kids	**Health Hero** reward for members up to age 2 are eligible for a gift card to Walmart to purchase a pair of shoes when they receive a Lead Screening test from their Primary Care Provider.	1 per lifetime		$50*
Cervical Cancer Screening	**Health Hero** reward for receiving a receiving a cervical cancer screening once per calendar year for female members aged 21-64 years.	Once annually	✓	$10
Colorectal Cancer Screening	**Health Hero** reward for receiving a colorectal screening once per calendar year for members aged 45-75.	Once annually	✓	$10
Breast Cancer Screening	**Health Hero** reward for receiving a mammogram once per calendar year for Members aged 40 to 74 years.	Once annually	✓	$10
Healthy Behaviors				
In-home Assessment	**Health Hero** reward for certain qualifying Adult Members who complete an In-Home Assessment to close open risk and care gaps, aged 18-64.	1 per lifetime	✓	$25
Care Management Engagement	Reward for certain care management qualifying members who stay engaged in Care Management activity.	Once annually		$10*
Tobacco Cessation	**Health Hero** reward for completing 6 Health Coaching sessions for tobacco, vaping, and e-cigarette cessation for Members 12-year-old and up.	Once annually	✓	$10
Flu Vaccine	**Health Hero** reward for receiving annual Flu vaccine any time between September and April at participating pharmacies.	Once annually	✓	$10
*Some restrictions and limitations apply. Each member can earn up to $250 for certain cash and non-cash goods and services through June 30 each year. Rewards for preventive screenings and services do not apply to the $250 maximum.				

Infant Flu Vaccine	**Health Hero** reward for infant Members who receive a Flu vaccine at a pharmacy or qualifying provider for Members aged 0-24 months.	Once per lifetime	✓	$20
Human Papilloma Vaccine	**Health Hero** reward for receiving the series of the HPV vaccine for male and female adolescents ages 11 and 12 years old.	1 per lifetime	✓	$10
Shingles Vaccine	**Health Hero** reward for Members who receive the Pneumococcal vaccine for members aged 50 and over.	Once per vaccine series	✓	$10
Pneumococcal Vaccine	**Health Hero** reward for Members who receive the Pneumococcal vaccine for members aged 50 and over.	Once per vaccine series	✓	$10
Welcome Call Reward	**Health Hero** reward for new members who complete a welcome call to include PCP verification, initial screening, and Primary Care Provider appointment scheduling within the first 90 days from enrollment to the plan.	1 per lifetime		$30*
Mental Health Champion	Reward for youth for engaging in training, volunteer work or peer support related to BH needs in their communities.	1 per lifetime		$10*
Ready for My Recovery (30-days)	Reward for members for engaging in recovery services for their full first month-30 days.	Once per lifetime		$25*
Ready for My Recovery (6-months)	Reward for members for engaging in recovery services for a continuous 6-month period.	Once per lifetime		$30*
Ready for My Recovery (Annually)	Reward for members for engaging in recovery services continuously for 1 full year.	Once annually		$30*
The Future Is Now	Reward for Members aged 15-17, particularly Foster Care, who will be transitioning into adulthood. This 3-part education module will provide life skills and education to members regarding Health Care, Finances, and Life Skills. Member will receive a $50 reward for completing 1 course, up to $150 for completing all 3 courses.	1 per lifetime		Up to $150*
Welcome Home Kit	Cash and non-cash social health needs program for home displaced Members in Care Management*. The Welcome Home Kit provides household necessities and a $50 Walmart gift card to assist members in becoming established in a home. *The member must be enrolled in Care Management to participate in this incentive.	1 per lifetime		Valued up to $150*
*Some restrictions and limitations apply. Each member can earn up to $250 for certain cash and non-cash goods and services through June 30 each year. Rewards for preventive screenings and services do not apply to the $250 maximum.				

In Lieu of Services (ILOS) are medically appropriate and cost-effective alternatives to standard Medicaid State Plan services. Authorized under federal regulation (42 CFR § 438.3(e)), ILOS allow Medicaid Managed Care Organizations (MCOs) to offer substitute services or settings that meet the same clinical objectives as traditional care, with the goal of improving outcomes and reducing costs. In Lieu of Services are designed to address health-related social needs (HRSNs) such as housing instability, food insecurity, or transportation barriers, provide preventive or transitional care that reduces the need for emergency department visits, inpatient admissions, or long-term institutionalization, and support step-down care from higher acuity settings, such as using partial hospitalization instead of inpatient psychiatric care. ILOS are clinically appropriate, effective substitutes for Medicaid State Plan Services and are reviewed and approved by the Centers for Medicare and Medicaid Services and the NH Department of Health and Human Services.

In Lieu of Services are provided at no cost to the Member and available with practitioners or providers who participate with NH Healthy Families. ILOS are voluntary. Providers may recommend ILOS based on patient needs, but the patient retains the right to choose traditional Medicaid services over the In Lieu of Services offering. The chart below describes the ILOS offerings provided by NH Healthy Families, including approved billing codes, eligibility, and prior authorization requirements.

In Lieu of Service	Description	Eligible Population	Limitations	Billing Codes
Partial hospitalization for youth with behavioral health diagnoses	**Partial hospitalization** is a daily program that helps members get better from behavioral health disorders. It gives strong support every day to help them safely move from staying in a hospital to living at home again. The goal is to help people heal in a safe place without needing to stay in the hospital full-time. It's a step between serious care and regular care. With partial hospitalization, you get treatment for part or all of the day, and then you go home at night.	Individuals up to 21 years old with a behavioral health diagnosis eligible to transition safely from an inpatient level of care to their community.	Prior authorization is required	H0035 S0201 Rev 0912 Rev 0913

In Lieu of Service	Description	Eligible Population	Limitations	Billing Codes
Partial hospitalization for eating disorders	**Partial hospitalization** is a daily program that helps members get better from eating disorders. It gives strong support every day to help them safely move from staying in a hospital to living at home again. The goal is to help people heal in a safe place without needing to stay in the hospital full-time. It's a step between serious care and regular care. With partial hospitalization, you get treatment for part or all of the day, and then you go home at night.	Individuals who experience abnormal eating behaviors leading to physiological effects from overeating or insufficient food intake and eligible to transition safely from an inpatient level of care to their community.	Prior authorization is required	Rev 0912 Rev 0913
Diabetes Self-Management	**Diabetes Self-Management** is a program that helps members learn how to stay healthy and feel more in control of your diabetes. The goal is to teach you how to keep your blood sugar at a healthy level. This can help you avoid needing more medicine, going to the emergency room, or staying in the hospital.	Individuals who are newly diagnosed with diabetes or others with diabetes who are unable to control their diabetes, blood sugar levels, or lower their A1C.	No prior authorization required	G0108 G0109

In Lieu of Service	Description	Eligible Population	Limitations	Billing Codes
Medical Nutrition Therapy (MNT)	**Medical Nutrition Therapy** is a special kind of care that uses healthy eating and support to help people feel better and stay healthy. The goal is to teach you healthy eating habits to treat or prevent health problems like diabetes, heart disease, or kidney problems. This kind of care gives you the tools and support you need to take charge of your health—one meal at a time.	Individuals of all ages with a medical condition that requires medical nutrition and/or counseling support (e.g., individuals with diabetes, renal disease or after a kidney transplant, individuals unable to meet daily nutritional requirements using traditional foods alone due to injury or illness); medical nutrition therapy for children with special health care needs or medical conditions (e.g., low birth weight, premature birth, malabsorption, or other condition with a nutritional impact).	No prior authorization required	97802 97803 97804

Non-Emergency Medical Transportation

NH Healthy Families partners with Medical Transportation Management (MTM) to administer the non-emergency transportation program. If a Member does not have access to transportation, or is unable to cover the cost of transportation to Medicaid-covered services, transportation can be provided. If a Member has access to a car, or a friend or family member with a car, the Member can enroll in the Friends and Family Mileage Reimbursement Program.

To enroll in this program or request transportation, Members should call MTM at (888) 597-1192. Members should refer to the Member Handbook for more information regarding transportation coverage and limitations. For more information, contact MTM at (888) 597-1192.

Prescription Drug Copayments

A copayment may be required for each prescription

NH Healthy Families members may be charged a copayment at the pharmacy for covered prescription drugs, unless the prescription category is exempted or the member is included in the member exempt categories, as described below (see Members who are exempt from copayments).

A "copayment" or "copay" is the fixed amount the member may pay each time they fill and refill a prescription. Prescription drug copayment amounts are subject to change.

Prescription drug copayments are:

- $4 copayment for all prescription drugs up to a 30-day supply. A $4 copayment for a 90-day supply. $0 copayment will be applied for family planning products, Clozaril (Clozapine) prescriptions, Pre-Exposure Prophylaxis (PrEP) drugs, or nicotine cessation products.
- To request approval of a non-formulary drug please submit rationale via prior authorization request form to Centene Pharmacy Services (fax 833-645-2738)

Members who are exempt from copayments

NH DHHS determines whether a member is exempt from prescription copayments. Members do not have to pay a copayment if they:

- Fall under the designated income threshold (100% or below the federal poverty level)
- Are under age 18 years
- Are in a nursing facility or in an intermediate care facility for individuals with intellectual disabilities;
- Participate in one of the Home and Community Based Care (HCBC) waiver programs
- Are pregnant and receiving services related to your pregnancy or any other medical condition that might complicate your pregnancy
- Are receiving services for conditions related to your pregnancy and your prescription is filled or refilled within 60 days after the month your pregnancy ended
- Are in the Breast and Cervical Cancer Program
- Are receiving hospice care; or
- Are a Native American or Alaskan Native.

Members who qualify for any of these exemptions and are charged a copayment, may contact NH DHHS Customer Service Center toll-free at **1-844-ASK-DHHS** (TDD Relay Access: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

Network Development and Maintenance

NH Healthy Families will ensure the provision of covered services as specified by the State of New Hampshire. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the New Hampshire DHHS network adequacy requirements for the Managed Care Organization networks. NH Healthy Families will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with New Hampshire DHHS access and availability requirements. NH Healthy Families may not require a provider or provider group to enter into an exclusive contracting arrangement with NH Healthy Families as a condition for network participation.

NH Healthy Families offers a network of PCPs to ensure every member has access to a medical home within the required travel distance standards. Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistant and advanced registered nurse practitioners. In addition, NH Healthy Families will have available, at a minimum, the following specialists for members on at least a referral basis:

- Allergy
- Behavioral Health (Mental Health/SUD)
- Cardiology
- Dermatology
- Endocrinology
- Family Medicine
- Gastroenterology
- General practice
- Hematology/Oncology
- Internal Medicine
- Infectious Disease
- Nephrology
- Neurology
- Obstetrics and Gynecology
- Ophthalmology
- Optometry
- Orthopedics
- Otolaryngology
- Pediatric (General)
- Pediatric (Subspecialties)
- Physical Medicine and Rehabilitation
- Podiatry
- Psychiatrist-Adult/General
- Psychiatrist- Child/Adolescent
- Psychologists/Other Therapies
- Pulmonary Disease
- Rheumatology
- Surgery (General)
- Urology
- Vision Care/Primary Eye Care

In the event NH Healthy Families network is unable to provide medically necessary services required under the contract, NH Healthy Families shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a NH Healthy Families' member, please contact our Medical Management team at 866-769-3085 and we will identify a provider to make the necessary referral.

Tertiary Care

NH Healthy Families offers a network of tertiary care inclusive of level one and level two trauma centers, Hemophilia Centers, Neonatal intensive care units, perinatology services, comprehensive cancer services, comprehensive cardiac services and pediatric subspecialties available 24-hours per day in the geographical service area. In the event the NH Healthy Families network is unable to provide the necessary tertiary care services required, NH Healthy Families shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

Population Health and Clinical Operations

Overview

NH Healthy Families' Population Health and Clinical Operations department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m. (excluding holidays). After normal business hours, our 24 Hour Nurse Advice Line staff is available to answer questions about prior authorization. Population Health services include the areas of utilization management, care management, health coaching, and quality review. The department's clinical services are overseen by the NH Healthy Families' medical director ("Medical Director"). The Vice President of Population Health has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Population Health contact:

Population Health Phone: 1-866-769-3085
Prior Authorizations: 1-866-270-8027
Concurrent Review: 1-877-295-7682 http://www.NHhealthyfamilies.com

Utilization Management

The NH Healthy Families Utilization Management Program (UMP) is designed to ensure members of NH Healthy Families network receive access to the right care, at the right place, at the right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care and ancillary care services.

NH Healthy Families' UMP seeks to optimize a member's health status, sense of wellbeing, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under-utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or disease management for members with complex healthcare needs or those at risk for significant healthcare expenses
- Development of an infrastructure to ensure that all NH Healthy Families members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self- management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

Referrals – In support of the Medical Home healthcare delivery model, PCPs should coordinate the healthcare services for NH Healthy Families members. PCPs can refer a member to an in network specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, **paper referrals *are not* required.** To better coordinate a member's healthcare, NH Healthy Families encourages specialists to communicate with the PCP the need for a referral to another specialist rather than making such a referral themselves.

Notifications – A provider is required to promptly notify NH Healthy Families when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Prior Authorizations – Some services require prior authorization from NH Healthy Families in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, please use the Code Checker tool at http://www.NHhealthyfamiles.com or contact Population Health at 866-769-3085.

Prior Authorization requests may be submitted electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically contact:

> NH Healthy Families c/o Centene EDI Department 1-800-225-2573, extension 25525 Or by e-mail at: EDIBA@centene.com

Self-Referrals

The following services do not require prior authorization or referral:

- Emergency services including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women's health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified Medicaid family planning provider
- General optometric services (preventative eye care) with a participating provider

Note: Except for emergency and family planning services, the above services must be obtained through the NH Healthy Families provider network.

Prior Authorization and Notifications

Prior Authorization is a request to the NH Healthy Families' Utilization Management (UM) department for approval of services on the Prior Authorization list, before the service is delivered. Authorization must be obtained prior to the delivery of certain elective and scheduled services.

Routine Prior authorization should be requested at least five calendar days before the scheduled service delivery date or as soon as the need for service is identified. Services that require authorization by NH Healthy Families are listed in the *Benefits and Services Requiring Authorization* Table as contained in this Provider Manual. The PCP must contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization and will require NH Healthy Families' Medical Director review and approval. Below is a Table reflecting those services that require prior authorization.

Most services require prior authorization before they are provided. However, substance use disorder (SUD) services follow a different process. For ASAM 3.5, 3.1, 2.5, and 2.1 levels of care, the first five (5) calendar days are automatically approved when the provider notifies NH Healthy Families and submits a PA request that includes those days. After the first five (5) days, a concurrent review is required. Providers must submit a new PA request with clinical documentation to support continued services.

All other services, including detox (ASAM 3.7), must follow standard prior authorization requirements.

This list is not all-inclusive. Please visit http://www.NHhealthyfamilies.com and use the prior Authorization Prescreen Tool or contact the utilization management team at 866-769-3085 for assistance.

Non-emergency, out of Network services are not covered unless the requested services are not able to be obtained timely within the NH Healthy Families Provider Network. All Out-of-Network (OON) services require Prior Authorization and will require NH Healthy Families Medical Director review and approval. NH Healthy Families, in its discretion, will determine which OON provider a member will be authorized to see when an OON service is determined by NH Healthy Families to be required.

Authorization requests for non-emergency Out of Network care must be submitted to NH Healthy Families at least ten (10) calendar days prior to the proposed date of service, (inclusive of all clinical information needed to make a coverage determination). If a non-emergency OON service request is received without at least 10 calendar days of lead time, services provided that are determined to be medically necessary by NH Healthy Families will be reimbursed at no more than one hundred percent (100%) of the NH Medicaid fee schedule. A Prior Authorization requests must be submitted to the NH Healthy Families UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. Below is a Table reflecting those services that require prior authorization. This list is not all-inclusive. Please visit www.NHhealthyfamilies.com and use the Prior Authorization Prescreen Tool or contact the medical management at 866-769-3085 for assistance.

Procedures/Services	Inpatient Notification	Ancillary Services
V All procedures and services performed by out of network providers (except ER, urgent care and family planning)	V All elective/scheduled admissions at least 5 business days prior to the scheduled date of admit	V Air Ambulance Transport(non-emergent fixed wing airplane)
V Potentially Cosmetic including but not limited to: blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures, reconstructive or plastic surgery	V All services performed in out of network facility	V DME - *certain services may require authorization. Please use the Prior Authorization Prescreen Tool at http://www.NHhealthyfamilies.com to verify what dual medical equipment requires prior authorization
V Experimental or investigational	V Hospice care	V Home healthcare services including, home infusion, skilled nursing, and therapy • Home Health Services • Private Duty Nursing • Hospice • Furnished Medical Supplies & DME
V High Tech Imaging (i.e. CT, MRI, PET)	V Rehabilitation facilities	V Orthotics/Prosthetics billed with an "L" code - Please use the Prior Authorization Prescreen Tool
V Bariatric surgery	V Skilled nursing facility	V Therapy Services Occupational Physical Speech. Includes Habilitation and Rehabilitative services

Procedures/Services	Inpatient Notification	Ancillary Services
V Obstetrical Ultrasound – two allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists. *For urgent/emergent ultrasounds, treat using best clinical judgment and it will be reviewed retrospectively.*	V Transplants, including evaluation	V Hearing Aid devices including cochlear implants
V Oral Surgery	V Observation Stays exceeding 24 hours require Inpatient Authorization	V Genetic Testing
V Pain Management	V Notification for all Urgent/ Emergent Admissions: • Within 1 business following date of admission • Newborn Deliveries must include birth outcomes	V Quantitative Urine Drug Screen
V Certain Bio Pharmaceuticals and Specialty Injections (please refer to website for complete list)		

Emergency room and post stabilization services never require prior authorization. Providers must notify NH Healthy Families of post stabilization services such as, but not limited to, the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one (1) business day of the service initiation. Providers should **notify NH Healthy Families of emergent inpatient admissions within one business day** of the admission for ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. NH Healthy Families providers are contractually prohibited from holding any NH Healthy Families member financially liable for any service administratively denied by NH Healthy Families for the failure of the provider to obtain timely authorization.

Authorization Determination Timelines

NH Healthy Families decisions are made as expeditiously as the member's health condition requires. For standard service authorizations the decision and notification will be made no more than seven (7) calendar days from receipt of the request (unless an extension is requested). "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information within forty-eight (48) hours of the request can result in an administrative denial of the requested service. For urgent/expedited pre-service requests, a decision and notification is made within seventy two (72) hours of the receipt of the request, unless sufficient information is not provided. For urgent concurrent review of ongoing inpatient admission, decisions are made within seventy two (72) hours of receipt of the request, and other services such as outpatient rehabilitation, home care or ongoing specialty care decisions are made within twenty four (24)

hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date.

Second Opinion

NH Healthy Families will reimburse for a second opinion from a qualified health professional within the provider network or arrange for the member to obtain a second opinion outside the network. Medical Management may be contacted to assist in the coordination of second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

Clinical Information

Authorization requests may be submitted by fax, phone, secure web portal or Availity. Authorization determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a NH Healthy Families' nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

NH Healthy Families' clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NH Healthy Families is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

NH Healthy Families affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. NH Healthy Families does not reward practitioners or other individuals for issuing denials of service or care. Financial incentives for UM decision makers does not encourage decisions that result in underutilization.

Participating providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. If the clinical decision is a medical necessity denial, the provider has the option for a Peer-to-Peer conversation and may also appeal the denial decision. A request for a Peer-to-Peer review must be submitted by the provider within 3 business days from the verbal notice of denial by contacting the Medical Director Peer-to-Peer Review line at 1-855-735-4397.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the NH Healthy Families Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Medical Necessity

Medical necessity is defined by NH Healthy Families as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

For member's twenty one (21) years of age and older the following definition of medical necessity shall be used: "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a member for the purpose of evaluating, diagnosing, preventing or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

- Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the member's illness, injury, disease, or its symptoms
- Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider
- No more costly than other items or service which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms
- Not experimental, investigative, cosmetic, or duplicative in nature

For ESPDT services, the following definition of medical necessity shall be used: "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a)

of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

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, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service.

Review Criteria

NH Healthy Families has adopted utilization review criteria developed by InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the full criteria used to make a specific adverse determination by contacting the Utilization Management Department at 866-769-3085. Examples of criteria that may be utilized are Centene/ NH Healthy Families Clinical Policies and InterQual® criteria appropriate to clinical condition and member's unique needs (e.g. Adult, Geriatric, Child, Adolescent, and Behavioral Health/Psychiatry). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling NH Healthy Families main toll-free phone number and asking for the Medical Director. A case manager may also coordinate communication between the Medical Director and requesting practitioner.

Members, or healthcare professionals with the member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

NH Healthy Families
Grievance & Appeals Coordinator
2 Executive Park Drive
Bedford, NH 03110
Phone: 1-866-769-3085
Fax: 1-866-270-9943

New Technology

NH Healthy Families evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the NH Healthy Families' population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-866-769-3085.

Notification of Pregnancy

Members that become pregnant while covered by NH Healthy Families may remain a NH Healthy Families member during their pregnancy. The managing or identifying physician should notify the NH Healthy Families' prenatal team by completing the Notification of Pregnancy (NOP) form within five days from the confirmation of pregnancy. Providers are expected to identify the estimated date of confinement and delivery facility.. See the Care Management section for information related to our Start Smart for Your Baby® program. The NOP forms can be located at https://www.nhhealthyfamilies.com/providers/resources/forms-resources.html.

Plan of Safe Care

According to the State of New Hampshire Department of Health and Human Services, medical providers are responsible for developing the Plan of Safe Care (POSC) with their patients. It must be put into place prior to discharge after birth.

NH Healthy Families is ready to assist you with developing a POSC for NH Healthy Families members by:

- Providing you an overview of the law, helping you plan and providing resources
- Helping patients who are NH Healthy Families members develop the POSC
- Fostering coordination of Medicaid services and supports to help families
- Educating members on Start Smart for Baby® care management and reward program for mother and baby
- Educating members about Ready for My Recovery program

Concurrent Review and Discharge Planning

Nurse Case Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The Care Manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date. Providers must notify NH Healthy Families of a Member discharging from an inpatient level of care after discharge.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review. However, the hospital must notify NH Healthy Families within two business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to NH Healthy Families was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their New Hampshire Medicaid card or otherwise indicated New Hampshire Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within thirty (30) calendar days following receipt of the request.

Speech Therapy and Rehabilitation Services

NH Healthy Families offers our members access to all covered, medically necessary outpatient and home health physical, occupational and speech therapy services. NH Healthy Families is committed to ensuring that physical medicine services provided to our members are consistent with nationally recognized clinical guidelines. This prior authorization program is managed by E Therapies Management Program.

Program Details

Physical, occupational and speech and language services will be reviewed via prior authorization to determine whether the services meet NH Healthy Families policy criteria for medically necessary and medically appropriate care. These determinations are based on a review of the objective, contemporaneous, clearly documented clinical records.

Prior authorization is required for all providers after an initial evaluation of therapy services. The Service limit for each therapy type is twenty (20) visits.

Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of twenty (20) visits for each type of therapy shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for habilitative purposes directed at functional impairments.

To request a Prior Authorization (PA) for medically necessary services in excess of the service limit submit a completed PA form in one of the following ways:

1. Phone: 1-866-769-3085
2. Web: www.RadMD.com
3. Fax: 866-270-8027

Under terms of the agreement between NH Healthy Families and EVOLENT, NH Healthy Families will oversee the EVOLENT Therapies Management program and continue to be responsible for claims adjudication. If EVOLENT therapy peer reviewers determine that the care provided fails to meet the NH Healthy Families' criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

Radiology and Diagnostic Imaging Services

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, NH Healthy Families is using National Imaging Associates (EVOLENT) to provide prior authorization services and utilization. EVOLENT focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT / CTA
- MRI / MRA
- PET Scan KEY

PROVISIONS:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach EVOLENT and obtain authorization, please call 866-769-3085 and follow the prompt for radiology authorizations. EVOLENT also provides an interactive website which may be used to obtain online authorizations. Please visit http://www.RadMD.com for more information or call our Provider Services department at 866-769-3085.

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections
- Spinal Cord Stimulators

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through NH Healthy Families. To obtain authorization through Evolent, visit RadMD.com or call 800-327-0641.

Musculoskeletal Care Management (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to NH Healthy Families members, NH Healthy Families has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for NH Healthy Families members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant
- Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder

- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair
- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair
- Shoulder Surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical

- Cervical Anterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement – Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar

- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels
- Lumbar Artificial Disc – Single & Multiple Levels

Sacroiliac

- Sacroiliac Joint Fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the “Solutions” tab on the Evolent home page (https://www.RadMD.com) for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines.

Should you have questions, please contact Evolent at 866-769-3085

Early and Periodic Screening, Diagnostic and Treatment

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of twenty one (21), provision of which is mandated by state and federal law. EPSDT services include periodic screening with a valid screening tool; vision, dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

NH Healthy Families and its providers will provide the full range of EPSDT services as defined in, and in accordance with, New Hampshire state regulations and New Hampshire Department of Health and Human Services' policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and developmental history (including assessment of both physical and mental development, as well as for Substance Use Disorders)
- Comprehensive unclothed physical examination
- Appropriate behavioral health and substance abuse screening
- Screening for developmental delay at each visit through the fifth (5th) year using a validated screening tool
- Screening for Autism Spectrum Disorders per American Academy of Pediatrics (AAP)
- Immunizations appropriate to age and health history
- Laboratory tests, including blood lead screening appropriate for age and risk factors; Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Health education, counseling and anticipatory guidance for both the child and caregiver based on age and health history

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member.

NH Healthy Families requires that providers cooperate to the maximum extent possible with efforts to improve the health status of New Hampshire citizens, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. NH Healthy Families will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

Provider shall participate in the DHHS Immunization Program (NHIP). **Vaccines must be billed with the appropriate administration code and the vaccine detail code.**

Emergency Care Services

NH Healthy Families defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairments of bodily functions, or (3) serious dysfunction of any bodily organ or part as per 42 CFR438.114(a).

Members may access emergency services at any time without prior authorization or prior contact with NH Healthy Families. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or NH Healthy Families' 24 hour Nurse Triage Line (24 Hour Nurse Advice Line) at 866-769-3085 for assistance; however, this is not a requirement to access emergency services. NH Healthy Families contracts with emergency services providers as well as non-emergency providers who can address the member's non- emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by NH Healthy Families when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by NH Healthy Families. Emergency services will cover and reimburse regardless of whether the provider is in NH Healthy Families provider network and will not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition
- A representative from the Plan or a network provider instructs the member to seek emergency services

Once the member's emergency medical condition is stabilized, NH Healthy Families requires notification for hospital admission or prior authorization for follow-up care as noted elsewhere in this handbook.

24 Hour Nurse Advice Line is our twenty four (24) hour, seven day per week nurse line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the 24 Hour Nurse Advice Line service.

Members may use the 24 Hour Nurse Advice Line to request information about providers and services available in the community after hours, when the NH Healthy Families Member Services department ("Member Services") is closed. The 24 Hour Nurse Advice Line staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or 24 Hour Nurse Advice Line at 866-769-3085.

Women's Healthcare

NH Healthy Families will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive healthcare services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization. In addition, members will have the freedom to receive family planning services and related supplies from an out of network provider without any restrictions. Family planning services include but are not limited to:

- Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations and sexually transmitted diseases
- Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases
- Provision of contraceptive procedures and contraceptive supplies by those qualified to do sounder the laws of the State in which services are provided
- Referral of members to physicians or health agencies for consultation, examination tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases as indicated
- Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B, HPV vaccine and chlamydia immunizations
- Abortions will only be considered a covered benefit in the following situations: 1) If the pregnancy is the result of an act of rape or incest and 2) In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed in accordance with 42 CFR 441.202.

NH Healthy Families will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

Clinical Practice Guidelines

NH Healthy Families clinical and quality programs are based on evidence based preventive and clinical practice guidelines. NH Healthy Families adopts guidelines based on the health needs of the membership and opportunities for improvement identified as part of the Quality Improvement program. The Guidelines are based on valid and reliable clinical evidence formulated by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Clinical Practice Guidelines are reviewed annually and updated to reflect the current standard of care. Practice Guidelines may be reviewed and updated off-cycle when nationally recognized updates are published. All guidelines are reviewed and approved annually by NH Healthy Families' Quality Improvement Committee. These guidelines are used for both preventive services as well as for the management of chronic diseases. NH Healthy Families providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by NH Healthy Families.

The guidelines:

- Consider the needs of the Members
- Are adopted in consultation with Network Providers
- Are reviewed and updated periodically, as appropriate

Preventive and chronic disease guidelines and recommendations include, but are not limited to:

- Guidelines for Adult, Adolescent, Pediatric Preventive Care
- Guidelines for Diagnosis and Management of Asthma
- Clinical Practice Guidelines and Standards for Diabetes Care
- Guidelines for the Diagnosis and Evaluation of the Child with Attention Deficit Hyperactivity Disorder (ADHD)
- Hypertension
- Clinical Practice Guideline for the Treatment of patients with Major Depressive Disorder
- Recommendations for Routine Perinatal Care

The website provides access to new clinical practice guidelines as well as any updates or revisions to existing guidelines. Practitioners are provided information on how to access or receive copies of the guidelines through this Provider Manual, the NH Healthy Families' website, and in the Provider newsletters, Provider Report. For links to the most current version of the guidelines adopted by NH Healthy Families, visit our website at http://www.NHhealthyfamilies.com. If you would like more information or want to request a paper copy, please contact the Quality Improvement Department at 866-769-3085. The following is a sample of the clinical practice guidelines adopted by NH Healthy Families.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC):Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

Care Management Program

NH Healthy Families recognizes that a PCP is the best person to manage a member's care. For those members not assigned or not established with a PCP, NH Healthy Families will complete a screening with the Member on the initial welcome call that will serve to identify potential care coordination and care management needs of the member. The Care Management team will review the results of this screening and make outreach to support the member until care can be established with a primary care provider within the guidelines of the Primary Care & Prevention Focused Care Model. This support includes assisting in arranging appointments, reminding members of gaps in care, and arranging for transportation, as necessary. If during that interaction a member is identified as falling into one or more required Priority Populations a referral for the Plan's Care Management Program will also be created.

NH Healthy Families supports the NH Care Connection, a statewide closed-loop referral system that enhances collaboration between providers and community-based organizations (CBOs) in meeting the needs of Members in a systematic and efficient manner.

A care management team is available to help all providers manage their NH Healthy Families' members. Below are programs and components of special services that are available and can be accessed through the care management team. We look forward to hearing from you about any NH Healthy Families' members that you think can benefit from the addition of a NH Healthy Families' care management team member.

High Risk Pregnancy Program

The OB Care Management Team (CM) will implement our **Start Smart for Your Baby® (Start Smart) program**, which incorporates care management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing care management to high and moderate risk members through the postpartum period and infants through the first year of life. A care manager with obstetrical nursing experience will serve as lead care manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. All members are asked to completed a screening for depression (Edinburg) post-partum. The Care Managers will share the results of the screens with providers and assist in referrals as necessary. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to NH Healthy Families' Medical Director on obstetrical care standards and use of newer preventive treatments.

Complex Teams

These teams will be led by clinically licensed nurses or licensed behavioral health clinicians with either adult or pediatric expertise, as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The NH Healthy Families complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special healthcare needs are at special risk and are also eligible for enrollment in Care management. NH Healthy Families will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to NH Healthy Families Care Management department for assessment and Care Management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

Special Needs

In addition to care managers, NH Healthy Families has a **Special Needs Coordinator** who is able to provide support and coordination for members who may have special healthcare needs. All members who have special healthcare needs should be referred to the NH Healthy Families Care management department for assessment and Care management services. NH Healthy Families considers members who have one or more of the following conditions (but not limited to) as requiring special healthcare needs:

- Chronic illness such as asthma, diabetes, heart failure, chronic obstructive pulmonary disease;
- Children with Special Needs
- HIV/AIDS
- Foster care needs or receiving services the Department of Child, Youth and Families(DCYF)
- Homeless

To contact a care manager call:

NH Healthy Families
Care Management Department
Phone: 866-769-3085
Fax: 877-502-7255

MemberConnections® Program

MemberConnections is the NH Healthy Families outreach program designed to provide education to our Members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our care management program in order to link NH Healthy Families and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of NH Healthy Families within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who phone NH Healthy Families to talk with the NH Healthy Families Member Services department may be referred for more personalized discussion on the topic about which they are inquiring. Care Managers may identify Members who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the Connections Representative or their assigned Care Manager. Community groups may request that a Connections Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: Connection Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what NH Healthy Families, an overview and it's services, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and NH Healthy Families.

Home Connections: Connection Representatives are available on a full-time basis whenever a need or request from a member or provider arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include an overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections: Connection Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

Connections Plus®: Connections Representatives work together with the high risk OB team or case management team for high risk members who do not have safe, reliable phone access. When a member qualifies, a Connections Representative visits the member's home and gives them a free cell phone. Members may use this cell phone to call the health plan care manager, PCP, specialty physician, 24 Hour Nurse Advice Line, 911, or other members of their healthcare team.

To contact the MemberConnections Team call:

NH Healthy Families
Phone: 866-769-3085

Chronic Care/Health Coaching Programs

As a part of the NH Healthy Families suite of services, Chronic Care Management Programs (CCMP) is offered to members. Chronic Care Management/Health Coaching is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care. Health Coaching supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

NH Healthy Families' Health Coaching Program, will promote a coordinated, proactive, disease specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. NH Healthy Families' programs include but are not limited to: asthma, obesity, back pain, diabetes and congestive heart failure.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High- risk members with co-morbid or complex conditions will be referred for Care management program for evaluation.

To refer a Member for the disease management program call:

NH Healthy Families
Health Coach
1-866-769-3085

Or NHHFCAREMANAGEMENT@centene.com

Billing and Claims Submission

General Guidelines

This Provider Manual describes general billing and claim submission guidelines. Please visit our website at http://www.NHhealthyfamilies.com for NH Healthy Families complete Provider Billing Manual. NH Healthy Families processes its claims in accordance with applicable State prompt pay requirements. Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with NH Healthy Families for payment of covered services. It is important that providers ensure NH Healthy Families has accurate billing information on file. Please confirm with the Provider Engagement department that the following information is current in our files:

- Provider name (as noted on current W-9form)
- National Provider Identifier(NPI)
- Tax Identification Number(TIN)
- Taxonomy code
- Physical location address (as noted on current W-9form)
- Billing name and address

If a rendering provider is required providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja when a rendering provider is required, to avoid possible delays in processing. Claims missing the requirements will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

We recommend that providers notify NH Healthy Families as soon as possible, but no later than 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form to nh_providernetworkoperations@centene.com. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member's contract on the date of service
- Referral and prior authorization processes were followed, when applicable

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual and the Provider Billing Manual located at http://www.NHhealthyfamilies.com.

Provider Payment Guidelines

Payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding. They are used to help identify whether health care services are correctly coded for reimbursement. Each payment rule is sourced by a generally accepted coding principle. They may include, but are not limited to, claims processing guidelines referenced by the Centers of Medicare and Medicaid (CMS), the CMS National Correct Coding Initiative policy manual (procedure-to-procedure coding combination edits and medically unlikely edits), Current Procedural Technology guidance published by the American Medical Association (AMA) for reporting medical procedures and services, health plan clinical policies based on the appropriateness of health care and medical necessity, and at times, state-specific claims reimbursement guidance.

Both payment and clinical policies are located under the Provider Resources section at http://www.NHhealthyfamilies.com.

Clean Claim Definition

A clean claim is defined as a claim received by NH Healthy Families for adjudication, in a nationally accepted format in compliance with standard coding guidelines and can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the NH Healthy Families's claims system. The following exceptions apply to this definition: (a) a claim for which fraud or abuse is suspected; (b) a claim under review for medical necessity; and (c) a claim for which a Third Party Resource should be responsible.

Paper claims must be typed or printed with 10 or 12 size Times New Roman font with NO highlighting, italics, or bold text, as supported by NUCC/CMS guidelines. All characters must fit into appropriate fields without extending outside of the fields. Original Red and White form must be used and not a copy,

Incomplete Claim Definition

An incomplete claim is defined as a claim that is denied for the purpose of obtaining additional information from the provider. The errors or omissions in the claim may result in

- A request for additional information from the provider or other external sources to resolve or correct data omitted from the claim
- The need for review of additional medical records
- The need for other information necessary to resolve discrepancies. In addition, incomplete claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Timely Filing

Claims will not be accepted for payment after one hundred and twenty (120) days from the date of service. When NH Healthy Families is the secondary payer, the claims must be received within one hundred and twenty (120) days from the date of disposition (final determination) of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

Electronic Claims Submission

Network providers are encouraged to participate in the NH Healthy Families electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and what clearinghouses NH Healthy Families has partnered with, contact:

NH Healthy Families
c/o Centene EDI Department
1-800-225-2573, extension 25525 or
by e-mail at: EDIBA@Centene.com

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Please note: Payer IDs are different for Behavioral and Medical Claims. See EDI Payer ID numbers below:

EDI Payer ID 68069 (Medical Services)
EDI Payer ID 68068 (Behavioral Health Services)

- NH Healthy Families works with the following clearinghouses: Change Healthcare, formerly Emdeon (Renamed, November 2015)
- Gateway
- SSI
- Availity
- Relay Healthy

Paper Claims Submission

All claims and encounters should be submitted as follows:

First time claims, corrected claims, claim disputes and requests for reconsideration:

NH Healthy Families
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4060
Farmington, MO 63640-3831

Behavioral Health Paper Claims should be submitted as follows:

NH Healthy Families
ATTN: CLAIMS DEPARTMENT
P.O. BOX 7500
Farmington, MO 63640-3831

Claim Dispute: *Claim disputes must be accompanied by the Request for Claim Review Form located at http://www.NHhealthyfamilies.com

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

NH Healthy Families is pleased to partner with PaySpan® for Electronic Funds Transfers (EFT's) and Electronic Remittance Advices (ERA's). Through this service, providers can take advantage of EFTs and

ERAs to settle claims electronically at no cost to providers. As a Provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at http://www.NHhealthyfamilies.com. If further assistance is needed, please contact Provider Services at 866-769-3085.

Claim Payment

For Dates of Service Prior to September 1, 2019:

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- Ninety-five percent (95%) of clean claims within 30 calendar days of receipt or receipt of additional information
- One hundred percent (100%) of all claims within sixty 60 calendar days of receipt

Effective September 1, 2019 Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- Ninety-five percent (95%) of clean claims within thirty (30) calendar days of receipt or receipt of additional information
- Ninety-nine percent (99%) of all clean claims within ninety (90) calendar days of receipt or receipt of additional information.

Interest will be paid at the interest rate published in the Federal Register in January of each year, for the Medicare program, on any clean claim not adjudicated within thirty (30) days from the date of the claim receipt.

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

NH Healthy Families is always the payer of last resort. NH Healthy Families' providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to NH Healthy Families members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform NH Healthy Families that efforts have been unsuccessful. NH Healthy Families will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, NH Healthy Families will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Claim Requests for Reconsideration, Claim Appeals and Corrected Claims

Claim requests for reconsideration and corrected claims must be submitted within 180 days from the original date of notification of payment or denial but not to exceed fifteen (15) months from the original date of service.

If a provider has a question or is not satisfied with the information s/he has received related to a claim, there are five effective ways in which the provider can contact us:

- Review and submit the correction for claim in question on the secure Provider Portal
- Submit a corrected claim in Availity
- Contact Provider Service Representative at866-769-3085
- Submit an Adjusted or Corrected Claim to NH Healthy Families, Electronic or Paper
- Submit a "Request for Reconsideration" to NH Healthy Families
- Submit a "Claim Review Form" to NH Healthy Families

Please refer to the NH Healthy Families Provider Billing Manual for detailed information on submitting claim disputes, reconsiderations, corrected claims or viewing claims in the secure provider portal.

NH Healthy Families shall process, and finalize all corrected claims, requests for reconsideration, and disputed claims to a paid or denied status in accordance with State law and regulation.

As noted above, the provider has a right to file an appeal for a denied claim for services rendered that have not been filed as a Member appeal. All requests for claim appeals must be received within 60 calendar days of receiving the Explanation of Payment which serves as a Notice of Adverse Action or the last adverse notice, not to exceed 15 months from the date of service. Requests received outside of this timeframe will not be considered and the original determination will be upheld, unless a qualifying circumstance is offered by the provider and appropriate documentation is submitted.

Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster. Staffing education or attrition is not a valid event.
- Mechanical or administrative delays or errors by NH Healthy Families or the New Hampshire Department of Health and Human Services.
- The member was eligible, however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
  - The provider's records document that the member refused or was physically unable to provide their ID card or information.
  - The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered
  - The provider can substantiate that a claim was filed within 180 days of discovering Plan eligibility
  - The provider has not filed a claim with NH Healthy Families for this member prior to the filing of the claim under review

To file a Claim Appeal, the provider should complete and submit the Request for Claim Review Form. The Request for Claim Review Form is located under Provider Resources on the NH Healthy Families website at www.NHhealthyfamilies.com.

The Request for Claim Review Form may be submitted by mail or via the secure Provider Portal. If submitting by mail, please mail the "Request for Claim Review Form" and all other attachments to:

NH Healthy Families
Attn: Claim Appeal
PO Box 4060
Farmington, MO 63640-3831

Please note that failure to submit to the correct address may result in delays or incorrect processing.

NH Healthy Families will send the provider written acknowledgement of their appeal receipt within 10 business days. All provider appeals are determined by an administrative or clinical professional with expertise in the subject of the appeal. We ensure through our policies and procedures that the decision makers involved in the provider appeals process and their subordinates – whether administrative claims staff or clinical staff – were not involved in previous levels of review or decision making of the provider's adverse action.

NH Healthy Families will provide written notice of resolution of the provider appeal within 30 calendar days of receipt of the request (or, if an extension is granted to allow additional documentation to be submitted by the provider, within 90 days from our receipt of the provider's appeal submission).

Our Resolution Notices include:

- Our decision
- The specific reason(s) for our decision
- The provider's right to request a State Fair Hearing in accordance with RSA 126-A:5,VIII
- Contact person for questions and next steps

The provider must exhaust the NH Healthy Families provider appeal process before pursuing a State Fair Hearing. If the appeal is related to a medical necessity denial, NH Healthy Families offers peer-to-peer review

support with a like clinician, upon request before the provider seeks recourse through the State Fair Hearing process. Instructions on how to request a peer-to-peer consultation are outlined in the Provider Appeal Acknowledgement letter which will be sent to the provider within 10 business days of the appeal receipt.

If the Resolution Notice indicates an overturned appeal, NH Healthy Families will take all steps to reverse the Adverse Action within 10 calendar days.

Providers may also appeal adverse credentialing determinations, as well as contract and program integrity-related decisions. When provider appeals are received for these reasons, they are addressed by NH Healthy Families' Credentialing Committee, Contracting and Network Department, Compliance Department, and Special Investigations Unit (SIU), respectively. The provider will receive a written resolution letter within thirty (30) calendar days as required.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are other effective ways to contact NH Healthy Families.

1. Review the claim in question on the secure Provider Portal:

    - Participating providers, who have registered for access to the secure provider portal, can access claims to obtain claim status, submit claims, submit a corrected claim, and submit a claim appeal.

2. Contact a NH Healthy Families Provider Service Representative at1-866-769-3085:

    - Providers may inquire about claim status, payment amounts or denial reasons. A provider may also make a simple request for further claim review by clearly explaining the reason the claim is not adjudicated correctly and expected payment amount

Contractual Terms

This Provider Manual is incorporated by reference into the provider agreement and includes all policies in this manual, as well all Plan policies, which are referenced in the manual.

NH Healthy Families reimburses providers for covered services and supplies provided to members according to the contractual terms in individual provider agreements.

General conditions of payment:

Submitting cost and pricing information does not guarantee payment at the submitted rate. Rates are based on:

- Established reimbursement rates based on the provider agreement
- Compliance with NH Healthy Families administrative guidelines, including prior authorization and claim submission guidelines
- Verification of medical necessity
- Verification that the service is a covered service
- Eligibility of the member on date of service
- Adherence to proper Current Procedural Terminology and Healthcare Common Procedure Coding System (CPT/HCPCS) and other national coding guidelines
- Reimbursement Policy terms, which may reduce or deny payment based on standard editing rules (such as National Correct Coding Initiative claim edits)

Encounters

What is an Encounter Versus a Claim?

An *encounter* is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for a NH Healthy Families' member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a "proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. **It is mandatory that your office submits encounter data.** NH Healthy Families utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A *claim* is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be provided to the provider who submitted the original claim. Claims will generate an EOP. You are required to submit either an encounter or a claim for each service that you render to a NH Healthy Families' member.

Procedures for Filing a Claim/Encounter Data

NH Healthy Families encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters.

Billing the Member

NH Healthy Families reimburses only services that are medically necessary and covered through the New Hampshire Department of Health and Human Services' MCO. In-network and out-of- network providers may not charge, or balance bill members for covered services except for any applicable copayments. NH Healthy Families prohibits providers from billing members for missed appointments.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the member stating,

I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under NH Healthy Families Network program as being reasonable and medically necessary for my care. I understand that NH Healthy Families, through its contract with the New Hampshire Department of Health and Human Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

For more detailed information on NH Healthy Families' billing requirements, please refer to the Provider Billing Manual available on the website http://www.NHhealthyfamilies.com.

Credentialing and Recredentialing

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by NH Healthy Families, as well as government regulations and standards of accrediting bodies. Upon written request, the MCO makes all application and credentialing verification policies and procedures available for review to the applying health care professional.

Note: In order to maintain a current provider profile, providers are required to notify NH Healthy Families of any relevant changes to their credentialing information in a timely manner, typically within thirty days if advance notice cannot be provided.. Changes can be submitted to nh_providernetworkoperations@centene.com.

Physicians must submit at a minimum the following information when applying for participation with NH Healthy Families:

- Complete signed and dated New Hampshire Standardized Credentialing application or authorize NH Healthy Families access to the CAQH (Council for Affordable Quality Health Care).Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation.
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with New Hampshire regulations regarding malpractice coverage or alternate coverage.
- Copy of current New Hampshire Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of New Hampshire.
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of Medicare Certification

NH Healthy Families will verify the following information submitted for Credentialing and/or Re-credentialing:

- Current participation in New Hampshire FFS Medicaid
- New Hampshire license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five year work history
- Review federal sanction activity individual, managing employee, business interests and business with transactions over $25,000 against the EPLS and LEIE databases.

Once the application is completed, the NH Healthy Families' Credentialing Committee (Credentialing Committee) will render a final decision on acceptance following its next regularly scheduled meeting.

It is important to know that individual providers within a group will become effective as each completes his or her credentialing. Providers will receive a letter confirming when he or she has passed credentialing. Prior to your effective date you must request a Prior Authorization to see a NH Healthy Families Member.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site visits are performed at practitioner offices within sixty (60) days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than eighty (80) percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

Re-Credentialing

To comply with accreditation standards, NH Healthy Families conducts the re-credentialing process for re-credentialing providers at least every thirty six (36) months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the NH Healthy Families network.

In between credentialing cycles, NH Healthy Families conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate New Hampshire State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry ensures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, NH Healthy Families reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the NH Healthy Families Credentialing Committee that credentialing requirements are no longer being met.

Right to Review and Correct Information

All providers participating within the NH Healthy Families network have the right to review information obtained by NH Healthy Families to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies.

This does not allow a provider to review references, personal recommendations, or other information that is peer review protected such as references, personal recommendations, or other information. Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, the practitioner has the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the NH Healthy Families credentialing department. Upon receipt of this information, the provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to the. The NH Healthy Families Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join NH Healthy Families have the right to be informed of the status of their application upon request. To obtain status, contact the NH Healthy Families' Provider Services department at 866-769-3085.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request an appeal of the decision in writing within sixty (60) calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the NH Healthy Families' network. Appeals will be reviewed by the Credentialing Committee and written notice of the decision will be issued within thirty (30) calendar days from the receipt of the appeal request, or if an extension is granted to the Provider to submit additional documentation, from the date on which the additional documentation is received. A provider may be granted an extension of up to sixty (60) calendar days to submit additional documentation. With an extension in place, the resolution notice will be no later than ninety (90) calendar days from the date of the initial appeal request.

Exclusion List Monitoring and Reporting Requirements

Providers are required to screen all employees, contractors, temporary staff, volunteers, and any individuals involved in the provision of services under their agreement with the MCO against all applicable federal and state exclusion lists prior to contracting with the MCO and monthly thereafter. At a minimum, providers must screen against the U.S. Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), available at the OIG Exclusions Database.

If a provider identifies that any staff member appears on an applicable exclusion list, the provider must:

- Notify the MCO within three (3) business days of becoming aware of the exclusion;
- Immediately remove the individual from providing any services or performing any activities under the MCO agreement;
- Take appropriate corrective action to ensure continued compliance with all applicable federal and state requirements.

Providers are responsible for maintaining documentation of all exclusion list screenings and must make such documentation available to the MCO upon request. This requirement applies throughout the duration of the provider's participation with the MCO and is intended to ensure compliance with applicable federal and state program integrity requirements.

Rights and Responsibilities

Member Rights

NH Healthy Families Members have the following **rights**:

- To be treated with respect and with due respect and recognition of his/her dignity and right to privacy
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- To participate with practitioners in making decisions regarding his/her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions
- To a candid discussion of appropriate or medically necessary treatment options for their specific condition, regardless of cost or benefit coverage to seek second opinions
- To obtain information about available experimental treatments and clinical trials and how such research can be accessed
- To obtain assistance with care coordination from the PCP's office
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To voice complaints or appeals about NH Healthy Families or the care it provides, and receive a response in a reasonable period of time.
- To receive information, or make recommendations, including changes about NH Healthy Families and services, the NH Healthy Families network of providers, and member rights and responsibilities
- To file a complaint with New Hampshire Insurance Department if physical and behavioral health services received were not provided fairly
- To obtain medical necessity criteria for mental health and substance use disorder benefits upon request
- To be able to request and receive the plan NH Healthy Families uses to offer incentives to providers the NH Healthy Families network
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected as specified in 45 CFR 164 and 42 CFR 438.100. To implement an advance directive as required in 42.CFR
- The right to implement an advance directive as required in 42CFR§438.10(g)(2)
- To choose his/her health professional to the extent possible and appropriate, in accordance with 42 CFR §438.6(m)
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition

- Freedom to exercise the rights described herein, without any adverse effect on the member's treatment by NH Healthy Families, its providers or contractors
- To receive information about NH Healthy Families, including: its services and utilization plans, practitioners and providers, the plan structure and operations and member rights and responsibilities. As well as, enrollment notices, informational materials, instructional materials, available treatment options and alternatives.—in a manner and format that may be easily understood as defined in the Provider Agreement and the Member Handbook
- To receive assistance from both the New Hampshire Department of Health and Human Services and the Enrollment Broker in understanding the requirements and benefits of NH Healthy Families
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent
- To be notified that oral interpretation is available and how to access those services
- To receive sign language with oral interpretation services
- To follow plans and instructions for care that you have agreed to with your practitioners

Member Responsibilities

NH Healthy Families Members have the following **responsibilities**:

- To supply information (to the extent possible) that the organization and its practitioners or providers need in order to provide care
- To understand your health problems and participate in developing mutually agreed upon treatment goals with your provider to the degree possible
- Make their primary care provider their first point of contact when needing medical care:
- Follow appointment scheduling processes
- To follow plans and instructions for care that you have agreed to with your practitioners

Provider Rights

NH Healthy Families Providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against NH Healthy Families and/or a member
- File a grievance with NH Healthy Families on behalf of a member, with the member's consent.
- Have access to information about NH Healthy Families quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact NH Healthy Families' Provider Services with any questions, comments, or problems,
- Collaborate with other healthcare professionals who are involved in the care of members

Provider Responsibilities

NH Healthy Families Providers have the **responsibility** to:

- Help Members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self-administered
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options; or for the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- Allow Members to use their New Hampshire State Medicaid ID card as proof of enrollment in NH Healthy Families until the member receives their NH Healthy Families ID card
- Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give Members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide Members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow Members to request restriction on the use and disclosure of their personal health information
- Provide Members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a Member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect Members' advance directives and include these documents in the members' medical record
- Allow Members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow Members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in NH Healthy Families data collection initiatives, such as HEDIS® and other contractual or regulatory programs

- Review clinical practice guidelines distributed by NH Healthy Families
- To provide timely updates when information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) about your practice, your locations, or your practitioners changes, etc.
- To provide timely updates through our contracted vendors who perform regular audits of our provider directories.
- To provide timely updates of demographic updates to their enrollment and credentialing information.
- Comply with NH Healthy Families' Medical Management program as outlined in this handbook
- Disclose overpayments or improper payments to NH Healthy Families
- Provide Members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Allow NH Healthy Families to capture and use practitioner/provider performance data to manage health care access, costs, quality of care, and member experience
- Obtain and report to NH Healthy Families information regarding other insurance coverage
- Notify NH Healthy Families in writing if the provider is leaving or closing a practice
- Contact NH Healthy Families to verify member eligibility or coverage for services, if appropriate
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide Members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Not be excluded, penalized, or terminated from participating with NH Healthy Families for having developed or accumulated a substantial number of patients in the NH Healthy Families with high cost medical conditions
- Coordinate and cooperate with other service providers who serve Medicaid members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Primary Care Providers (PCP) and all Specialty Care Providers are willing to provide consultation to DCYF regarding medical and psychiatric matters for members who are children in State custody/guardianship.
- Disclose to NH Healthy Families , on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between NH Healthy Families and the physician or physician group
- Provide services to children, youth members and their families in accordance with RSA 135-F– System of Care for Children's Mental Health
- In order to best serve Members, PCPs and other Providers should use a BH screening tool approved by DHHS, as well as other mechanisms to facilitate early identification of behavioral health needs. This requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary. All PCPs and BH Providers are to

incorporate the following domains into their screening and assessment process:

  - Demographic,
  - Medical,
  - Substance Use Disorder,
  - Housing,
  - Family & support services,
  - Education,
  - Employment and entitlement,
  - Legal, and
  - Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

- With all children, Pediatric Providers are to use a standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

  - Depression screening (e.g., PHQ 2 & 9); and
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

Grievances and Appeals Process

Member Grievances

A Member grievance is defined as any member expression of dissatisfaction about any matter other than an "adverse action". Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

The grievance process allows the Member, (or the Member's authorized representative family member, etc. acting on behalf of the Member or provider acting on the Member's behalf with the member's written consent), to file a grievance either orally or in writing. NH Healthy Families shall acknowledge receipt of each grievance in writing within ten (10) business days of receipt of the grievance. Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making.

In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, NH Healthy Families shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 CFR § 438.406] NH Healthy Families values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. NH Healthy Families will provide assistance to both members and providers with filing a grievance by contacting our Member/Provider Services Department at 866-769-3085.

Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. The Grievance Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within ten (10) business days of receipt.

Grievance Resolution Time Frame

Grievance Resolution will occur as expeditiously as the member's health condition requires, not to exceed forty-five (45) calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the Grievance Coordinator, in coordination with other NH Healthy Families staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the member, representative or provider filing the grievance. Expedited grievance reviews will be available for members in situations deemed urgent and will be resolved within seventy-two (72) hours of receipt. NH Healthy Families may extend the timeframe for disposition of a grievance for up to fourteen (14) calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's best interest.

If the health plan extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay.

Notice of Resolution

The Grievance Coordinator will provide written resolution to the Member, Representative or Provider within the timeframes noted above.

The grievance response shall include, but not be limited to, the decision reached by NH Healthy Families, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for ten years. Grievances may be submitted by written notification to:

NH Healthy Families
Grievance Coordinator
2 Executive Park
Drive Bedford, NH 03110
Phone: 1-866-769-3085
Fax Number: 1-866-270-9943

Member Appeals

An appeal is the request for review of an adverse action. An adverse action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the NH Healthy Families network. The review may be requested in writing or orally. Members, or someone on their behalf (such as their treating provider) with the Member's written consent, may request that NH Healthy Families review the adverse action to verify if the right decision has been made. Appeals must be made within sixty (60) calendar days from the date on NH Healthy Families notice of action.

NH Healthy Families shall acknowledge receipt of each standard appeal in writing within ten (10) business days after receiving an appeal. NH Healthy Families shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed thirty (30) calendar days from the date NH Healthy Families receives the appeal. NH Healthy Families may extend the timeframe of the standard for resolution of the appeal up to fourteen (14) calendar days if the member requests the extension or NH Healthy Families demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, NH Healthy Families shall provide written notice to the member of the reason for the delay. NH Healthy Families will provide assistance to both members and providers with filing an appeal by contacting our Member/Provider Services Department at 866-769-3085.

Expedited Appeals

Expedited appeals may be filed when either NH Healthy Families or the Member's provider determines that the time expended in a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. In instances where the Member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals and NH Healthy Families will make reasonable attempts to give the Member oral notification of the denial and follow up with a written notice within two (2) calendar days.

Decisions for expedited appeals are issued as expeditiously as the Member's health condition requires, not exceeding seventy-two (72) hours after initial receipt of the appeal. NH Healthy Families may extend the seventy- two (72) hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the health plan justifies a need for additional information and how the extension is in the member's interest. NH Healthy Families will also make reasonable efforts to provide oral notice. Within two (2) calendar days, NH Healthy Families will give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision.

Notice of Resolution

Written notice shall include the following information:

- The decision reached by NH Healthy Families;
- The date of decision
- Reason for determination
- Written statement of the clinical rationale, including how the requesting provider or member may obtain clinical review or decision-making criteria
- For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the NH Healthy Families decision

NH Healthy Families will make reasonable efforts to provide oral resolution notices for an expedited appeal. A written resolution notice will also be provided.

Call, fax or mail member appeals to:

NH Healthy Families
Grievance & Appeals Coordinator
2 Executive Park Drive
Bedford, NH 03110
Phone: 866-769-3085
Fax: 866-270-9943

Effective September 14, 2026, for pharmacy/drug authorization appeals:

Centene Pharmacy Services
NH Pharmacy Appeals Department
P.O. Box 31398
Tampa, FL 33631-3398
Phone: 866-769-3085
Retail Pharmacy Appeals Fax: 888-865-6531
Medical Pharmacy (Buy and Bill) Appeals Fax: 844-235-5091

State Fair Hearing Process

NH Healthy Families will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the New Hampshire Department of

Health and Human Services. The member has the right to appeal to the New Hampshire Department of Health and Human Services only after exhausting all appeal rights with NH Healthy Families. A member may request a state fair hearing within one hundred and twenty (120) calendar days from NH Healthy Families notice of resolution of the appeal. An appeal that is not resolved wholly in favor of the member by NH Healthy Families may be appealed by the member or the member's authorized representative to the New Hampshire Department of Health and Human Services for a fair hearing conducted in accordance with 42 CFR 431 Subpart E. Adverse actions include reductions in service, suspensions, terminations, and denials. NH Healthy Families denial of payment for New Hampshire Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the NH Healthy Families or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, NH Healthy Families will authorize the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. Additionally, in the event that services were continued while the appeal was pending, NH Healthy Families will provide reimbursement for those services in accordance with the terms of the final decision rendered by the DHHS and applicable regulations.

To File A Medicaid State Hearing:

New Hampshire Department of Health and Human Services
Administrative Appeals Unit
105 Pleasant Street
Concord, NH 03301-6521
Phone: 800-852-3345 ext. 4292
TDD Access: 800-735-2964

Provider Complaints and Appeals

A **Complaint** is a verbal or written expression by a provider which indicates dissatisfaction or dispute with NH Healthy Families' policy, procedure, claims, or any aspect of NH Healthy Families functions. NH Healthy Families logs and tracks all complaints whether received verbally or in writing. A provider may file a complaint within 90 calendar days of the date of dissatisfaction by contacting our Provider Services Department at 866-769-3085. A complaint may also be submitted in writing to: NH Healthy Families, Grievance Coordinator, 2 Executive Park Drive, Bedford, NH 03110; Fax Number: 866-270-9943. NH Healthy Families will acknowledge receipt of all provider complaints within 10 business days of receipt. Upon receipt, the Grievance Coordinator initiates an investigation, which may include obtaining additional information from the provider and gathering related documentation and assistance from other NH Healthy Families' departments or subcontractors. If a complaint is related to claims payment or denial, the Grievance Coordinator verifies the provider appeal process has been exhausted. NH Healthy Families resolves all provider complaints through written notice within forty-five (45) calendar days of receipt. Clinically urgent complaints are resolved no later than seventy-two (72) hours after receipt.

An Appeal is the mechanism which allows providers the right to appeal actions of NH Healthy Families such as a claim denial, or any other adverse decision made by NH Healthy Families.

Please refer to the Claim Reviews, Appeals, and Corrected Claims section of this manual for instructions on submitting an appeal for a claim denial, and the Credentialing and Re-credentialing section for instructions on appealing an adverse credentialing determination. For all other appeals, please contact our Provider Services Department at 866-769-3085 or follow the appeal instructions noted on your adverse action letter.

Fraud, Waste and Abuse

Fraud, Waste and Abuse (FWA) System

NH Healthy Families takes the detection, investigation, and prosecution of fraud, waste and abuse very seriously, and has a fraud, waste and abuse (FWA) program that complies with New Hampshire and federal laws. NH Healthy Families, in conjunction with its management company, Centene, successfully operates a fraud, waste and abuse unit. NH Healthy Families performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims section of this manual. The Special Investigation Unit (SIU) performs prospective and retrospective audits which, in some cases, may result in taking actions against those providers, individually or as a practice. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution

Some of the most common FWA practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered
- Claims for services that are not medically necessary

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call OIG's Hotline at 800-HHS-TIPS (1-800-447-8477), directly to a Medicaid Fraud Control Unit (MFCU), or our anonymous and confidential WAF hotline at 1-866-685-8664. NH Healthy Families and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

Please Note: *Due to the evolving nature of fraudulent, wasteful and abusive billing practices, NH Healthy Families and Centene may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of fraudulent, wasteful and abusive billing patterns.*

Authority and Responsibility

The NH Healthy Families' Director of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. NH Healthy Families is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The NH Healthy Families' provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

Quality Improvement

NH Healthy Families' culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and service in such areas as preventive health, acute and chronic care, behavioral health, over- and under- utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

The program directs activities designed to improve the health for all its enrolled Members, meet the cultural and linguistic needs of its diverse membership, and serve those with complex and special needs.

NH Healthy Families recognizes its legal and ethical obligation to provide Members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, NH Healthy Families will provide for the delivery of quality care with the primary goal of improving the health status of its Members. Where the Member's condition is not amenable to improvement, NH Healthy Families will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Member. The QAPI program includes identification of Members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the NH Healthy Families' QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its Members.

Program Structure

The NH Healthy Families' Board of Directors (BOD) oversees the development, implementation and evaluation of the QAPI Program and has the ultimate authority and accountability for the oversight of the quality and safety of clinical care and service provided to members. The BOD delegates the operating authority of the QAPI Program to the Quality Improvement Committee (QIC) and has established various committees and ad-hoc committees to monitor and support the QAPI Program.The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly

accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes. This may include the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the Quality Improvement (QI), Utilization Management (UM), and Credentialing programs. The following sub-committees report directly to the Quality Improvement Committee:

- Credentialing Committee
- Clinical Policy Committee
- National Continuity and Coordination of Care Work Group
- Patient Safety/Quality of Care Work Group Committee
- Pharmacy and Therapeutics Committee
- Performance Improvement Team
- Peer Review Committee (Ad Hoc Committee)

The following subcommittees report to the Performance Improvement Team:

- Quality Measures Steering Committee
- Member Advisory Board
- Provider Advisory Board

Practitioner Involvement

NH Healthy Families recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through Provider representation. NH Healthy Families encourages PCP, Behavioral Health, Specialty, and OB/GYN representation on key quality committees such as but not limited to, the:

- Quality Improvement Committee
- Credentialing Committee
- Pharmacy & Therapeutics Committee
- Select ad-hoc committees

NH Healthy Families also encourages provider engagement through participation in its Provider Advisory Board.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and services provided to the NH Healthy Families members, , including medical, behavioral health, vision care and dental (when applicable). The QAPI Program incorporates all demographic groups, ~~lines of business,~~ benefit packages, care settings, and services in quality improvement activities, including preventive care, emergency care primary care, specialty care, acute care, short-term care, long term care (depending upon the product), and ancillary services. NH Healthy Families' primary QAPI Program goal is to improve Members' health status, through a variety of meaningful quality improvement activities, implemented across all care

settings and aimed at improving quality of care and services delivered. To that end, the NH Healthy Families QAPI Program monitors the following:

- Compliance with preventive health and clinical practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and re-credentialing)
- Behavioral healthcare
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and overutilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider access and appointment availability
- Provider and Health Plan after-hours telephone accessibility
- Member experience
- Provider experience
- Member grievance, complaints and appeals
- Provider Complaints System
- Member enrollment and disenrollment
- PCP Changes
- Department performance and service
- Patient safety and quality of care
- Marketing practices
- NCQA Accreditation status
- Performance improvement activities and progress towards goals
- Pharmacy services

Patient Safety and Quality of Care

Patient Safety is a key focus of the NH Healthy Families' QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the Health Plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care (QOC) issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. NH Healthy Families' employees (including medical management staff, member services staff, provider services, grievance coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The NH Healthy Families QIC reviews and adopts an annual QAPI Program and Work Plan that aligns with NH Healthy Families' strategic vision and goals and appropriate industry standards. The QI Department implements performance/quality improvement activities as required by the state contract and accreditations needs. The QIC utilizes traditional quality/risk/utilization management approaches to identify activities that are relevant to NH Healthy Families programs or a specific member population and that describe an observable, measurable, and manageable issue. Most often, initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non- clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow NH Healthy Families to monitor improvement overtime.

On an annual basis, NH Healthy Families reviews and adopts an annual QAPI Work Plan that aligns with NH Healthy Families' strategic vision and goals and appropriate industry standards. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

NH Healthy Families communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the Member Newsletter, Provider Newsletter and the NH Healthy Families website at http://www.NHhealthyfamilies.com.

At any time, NH Healthy Families providers may request a printed copy of our program material, additional information on the health plan programs including a description of the QAPI Program and a report on NH Healthy Families' progress in meeting the QAPI Program goals by contacting the Quality Improvement department at 866-769-3085.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans. HEDIS® performance measures give purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS® reporting is a required part of NCQA Health Plan Accreditation and the New Hampshire State Medicaid contract.

As both the New Hampshire and Federal governments move toward a healthcare industry that is driven by quality, HEDIS® performance rates are becoming increasingly important, not only to the health plan, but to the individual provider as well. New Hampshire purchasers of healthcare use the aggregated HEDIS® rates to evaluate the effectiveness of a Health Insurance Company's ability to

demonstrate an improvement in preventive and clinical health outreach to its members. Physician specific scores are being used to measure
provider practices preventive and clinical efforts for delivering quality care and services. HEDIS® rates serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality HEDIS® indicators.

How are HEDIS® rates calculated?

HEDIS® rates can be calculated in three ways: administrative data, an Electronic Clinical Data System (ECDS) or hybrid data.

Administrative Data: Consists of claim and encounter data submitted to the health plan. Examples of measures calculated by using administrative data include well child visits, annual chlamydia screening, appropriate treatment of asthma, eye exams for patients with diabetes, cardiac rehabilitation, initiation & engagement of substance use disorder, etc.

Hybrid Data: Consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data or for measures where the measured value is not reported anywhere but the medical record. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see NH Healthy Families website and HEDIS® guide for more information on HEDIS® and what codes can be used to reduce medical record reviews). Examples of measures requiring medical record review are well child visits that include BMI percentile, counseling for nutrition and physical activity, glycemic status assessment for patients with diabetes, controlling high-blood pressure, prenatal care and postpartum care, etc.

ECDS data is the newest method for HEDIS® rate reporting and is quickly replacing traditional administrative and hybrid methodology. ECDS reporting aligns with the broader shift in healthcare towards interoperability and digital health data reporting. Examples of measures that are collected via ECDS methodology are breast cancer screening, immunizations for adolescents, metabolic monitoring for children and adolescents on antipsychotics, and cervical cancer screening.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS®?

NH Healthy Families continues to conduct the medical record reviews for HEDIS® data abstraction but the timeframe for data collection is changing in response to ECDS. While many medical record review audits for HEDIS® are still conducted between February through May each year, charts are now also collected year-round to ensure we are accurately reporting the care your patients received. If you receive a call and/or a fax from the NH Healthy Families QI staff member requesting medical records for patients in regard to HEDIS® measures, your cooperation is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient.

What can be done to improve my HEDIS® scores?

- Understand the HEDIS® specifications established for each HEDIS® measure.
- Submit claim/encounter data for every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS®. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS® rate calculation.
- Ensure chart documentation reflects all services provided. Bill CPT II codes related to HEDIS® measures such as , Glycemic status assessment for patients with diabetes and Controlling Blood Pressure measures.

If you have any questions, comments, or concerns related to the annual HEDIS® project or the medical record reviews, please contact the Quality Improvement department at 1-866-769-3085.

Provider Satisfaction Survey

NH Healthy Families conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by NH Healthy Families, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider-related quality improvement initiatives.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The CAHPS® survey is a member experience survey that is included as a part of HEDIS® and NCQA accreditation. The CAHPS® survey is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with the health care system, including their care from the health plan and their practitioners and gives a general indication of how well the health care system is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

Medical Records Review

Medical Records

NH Healthy Families Practitioners and Providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable NH Healthy Families to review the quality and appropriateness of the services rendered.

To ensure the member's privacy, medical records should be kept in a secure location. NH Healthy Families requires providers to maintain all records for members for at least 10 years. Only authorized personnel have access to records. Staff receive periodic training in member information confidentiality. See the Member Rights section of this handbook for policies on member access to medical records.

Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x- rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults
- Evidence that preventive services/risk screening and services are offered in accordance with NH Healthy Families' practice guidelines
- Appropriate subjective and objective information pertinent to the members' presenting complaints is documented in the history and physical
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses and, discharge summaries
- Member physicals
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documentation of clinical findings and evaluation for each visit
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented

- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of member information and records protected
- Evidence that an advanced directive has been offered to adults 18 years of age and older
- Confidentiality of medical records includes: secure record storage, only authorized personnel have access to the records and staff receive periodical training on member confidentiality practices

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the member or a member's legal guardian or authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis. Providers and community mental health programs must obtain written consent from the member to release information to coordinate care regarding primary care and mental health services or substance abuse services or both.

Providers shall provide documentation of all instances in which consent was not given, and if possible, the reason why, and submit this information to NH Healthy Families on each occurrence but no later than thirty (30) calendar days following the end of the fiscal year.

Sharing Medical Records

NH Healthy Families will share medication record information, as appropriate with network providers and care coordinators.

Medical Records Transfer for New Members

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned NH Healthy Families' members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

NH Healthy Families may conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of

specialists, as well as the outcome of such services also may be assessed during a medical record audit. NH Healthy Families will provide written notice prior to conducting a medical record review.

Access to Records and Audits by NH Healthy Families

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit NH Healthy Families or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by NH Healthy Families or its designated representative, but not more than sixty (60) days following such written notice.

EMR Access

Provider will grant NH Healthy Families access to Provider's Electronic Medical Record (EMR) system to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the NH Healthy Families for this access.

Behavioral Health Services

This section describes the delivery and coordination of Behavioral Health Services and supports for mental health, Serious Mental Illness, Substance Use Disorders, and Serious Emotional Disturbances, delivered to children, youth and transition-aged youth/young adults, and adults.

Continuum of Behavioral Health Services

The continuum of Behavioral Health Services will include the following categories of Providers approved by the Department for providing one or more types of services under the State Medicaid Plan, certain Administrative Rules, and under contracts with the Department when necessary to ensure Member access to higher levels of care for Serious Mental Illness, Substance Use Disorder, Serious Emotional Disturbance, and I/DD:

- Mental Health Services, including but not limited to psychotherapy, psychological evaluation and testing, authorized in the Medicaid State Plan under Attachment 3.1-A for Medical, Remedial Care and Services. These services will be provided by appropriately licensed and certified Providers who are not providing the service on behalf of or under agreement with a Community Mental Health Program (also known as Community Mental Health Center) or a Community Mental Health Provider.
- Community Mental Health Services (CMH Services), authorized in the Medicaid State Plan under Attachment 3.1-A for Other Diagnostic, Screening, Preventative and Rehabilitative Services, which represents services at a higher level of care for Members with current He-M 401 eligibility and which are provided by:
    - Community Mental Health Programs (CMH Programs), also known as Community Mental Health Centers (CMHC) that are currently approved by the Department pursuant to He-M 403; there are ten such programs in NH; or by

    - Community Mental Health Providers (CMH Providers) that have been previously approved by the Commissioner of the Department of Health and Human Services to provide Community Mental Health Services identified in He-M 426.07-He-M 426.17 for which they have received approval to provide pursuant to He-M 426.04 and remain in compliance with the requirements specified in He-M 426.04.
- Certified Community Behavioral Health Clinic (CCBHC) Services, a Covered Service provided by state-certified clinics that deliver, directly or through Designated Collaborating Organizations, the full required array of crisis, assessment, treatment planning, outpatient, case management, rehabilitation, and peer/family support services; NH Healthy Families' Participating Provider network shall include all certified CCBHCs in New Hampshire.
- Substance Use Disorder Services authorized in accordance with the Medicaid State Plan, He-W 513, and where applicable, He-A 304 for Opioid Treatment Programs (OTP).

Member Treatment Requirements and Covered Behavioral Health Continuum

Providers must ensure that Behavioral Health Services will be delivered in a manner that is both clinically and developmentally appropriate, and that considers the Member, parents, caregivers, and other networks of support the Member may rely upon. The delivery of service will be Member-centered and align with the principles of system of care, recovery, and resiliency. Behavioral Health Services should be provided in accordance with all applicable State and federal laws and regulations. Providers must ensure a full continuum of physical health and behavioral health services will be provided, as authorized under the State’s Medicaid State Plans and in accordance with the applicable NH Administrative Rules specific to Behavioral Health Services; ensuring continuity and coordination of care between covered physical health and Behavioral Health Services Providers; and requiring collaboration between physical health and Behavioral Health Providers.

Integrated Care Coordination

NH Healthy Families supports an integrated, whole-person approach to care that promotes coordination between physical health, behavioral health, and substance use disorder treatment providers. Providers are encouraged to collaborate, as appropriate, to address a member's physical health, mental health, substance use, and social support needs. Behavioral health providers, Primary Care Providers (PCPs), Community Mental Health Programs (CMHPs), Certified Community Behavioral Health Clinics (CCBHCs), substance use disorder providers, care managers, and other treating providers should work collaboratively to support continuity of care and improve health outcomes.

Trauma-Informed and Recovery-Oriented Services

NH Healthy Families supports trauma-informed, person-centered, and recovery-oriented approaches to service delivery. Providers are encouraged to consider the impact of trauma on health outcomes

and deliver services in a manner that promotes member engagement, resilience, recovery, and self-determination.

Recovery and Peer Supports

NH Healthy Families supports recovery-oriented services that recognize each member's individual strengths, goals, culture, preferences, and stage of readiness for change. Providers are encouraged to engage members in person-centered planning that promotes hope, self-direction, resilience, community connection, and sustained recovery. Peer support services may help members build recovery skills, navigate services, strengthen natural supports, and connect with community-based recovery resources. When appropriate and available, providers should consider peer supports as part of a coordinated behavioral health or substance use disorder treatment approach.

Screening, Assessment, and Early Identification

Providers should use a BH screening tool approved by DHHS, as well as other mechanisms to facilitate early identification of behavioral health needs. This requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary. All PCPs and BH Providers are to incorporate the following domains into their screening and assessment process:

- Demographic,
- Medical,
- Substance Use Disorder,
- Housing,
- Family & support services,
- Education,
- Employment and entitlement,
- Legal, and
- Risk assessment including suicide risk and functional status (ADL, IADL,cognitive functioning).

With all children, Pediatric Providers are to use a standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

- Depression screening (e.g., PHQ 2 & 9); and
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

Behavioral Health Crisis Response and Emergency Services

Providers must ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services. Emergency Services should be accessible to Members anywhere in the region served by the CMH Program. CMH Program-delivered emergency services that are not delivered by mobile crisis teams, such as for use in determining whether involuntary emergency admission is required and applying an existing client's crisis safety plan in an office setting, are also included in the meaning of emergency services, and should be provided within the CMH Program's applicable CMH region only. Emergency Services teams must employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention and who have access to a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

Behavioral Health Medical Management

Our behavioral health services comply with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Accessing behavioral health services does not require a physician's referral from a PCP. However, some services do require prior authorization. Services that require authorization by NH Healthy Families are listed in the Benefits and Services Requiring Authorization Table as contained in this Provider Manual. For substance use disorder (SUD) treatment, NH Healthy Families uses a modified prior authorization process. The first five (5) calendar days of certain levels of care are automatically approved when the provider submits an initial PA request. Providers must submit clinical information for review of any continued services after day five.

When making coverage determinations, NH Healthy Families utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. NH Healthy Families has adopted utilization review criteria developed by InterQual® to determine medical necessity for healthcare services. Behavioral health utilization managers use

InterQual® criteria for psychiatric levels of care and American Society of Addiction Medicine (ASAM) criteria for substance use disorder levels of care; for behavioral health community-based services state service definitions are applied.

Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual® criteria is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director reviews all potential medical necessity denials and makes decisions in accordance with currently accepted medical or healthcare practices. This includes taking into account special circumstances of each case that may require deviation from the screening criteria.

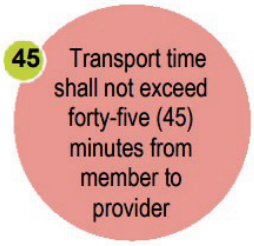
Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department. Practitioners also have the opportunity to discuss any medical or pharmaceutical utilization management adverse determination with a physician or other appropriate

reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Please see the Appeals section for more detail.

Naloxone Requirement

Providers will prescribe and/or dispense Naloxone for Members receiving a one hundred (100) mg,or more, morphine equivalent dose for ninety (90) calendar days or more.

Provider Access and Density Standards



NH Healthy Families must ensure that provider accessibility is maintained so that there is a standard of coverage for members throughout the state. The provided standards have been established by NH Healthy Families for the State of New Hampshire.NH Healthy Families members may access mental health, substanceuse disorder services, and specialty therapy & rehabilitative services through several mechanisms. Members do not need a referral from their Primary Care Physician (PCP) to access covered mental health, substance use disorder services, and specialty therapy & rehabilitative services. Caregivers or medical consenters may self-refer members for behavioral health services. If assessment is required, NH Healthy Families must approve the assessment.

NH Healthy Families adheres to National Commission for Quality Assurance (NCQA) and State accessibility standards for member appointments. Provider shall meet and maintain compliance with the State's waiting times for appointments with Medicaid Covered Persons as set forth herein, or as otherwise amended by the State. Providers must make every effort to assist NH Healthy Families in providing appointments within the provided timeframes.

Network Providers shall ensure that services provided are available on a basis of twenty-four (24) hours a day, seven (7) days a week, as the nature of the member's behavioral health condition dictates.

Network Providers will offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees and shall ensure members with disabilities are afforded access to care by ensuring physical and communication barriers do not inhibit members from accessing services.

Clinical Training

NH Healthy Families offers a variety of clinical training opportunities to providers that support their ability to provide quality services to members.

The Clinical Training program is committed to achieving the following goals: promote provider competence and opportunities for skill-enhancement; promote Recovery and Resiliency; promote Trauma-Informed models of care; promote assessment and treatment of Substance Use; to sustain and expand the use of Evidence Based and Best practices (Trauma Focused Cognitive Behavioral Training: TF-CBT, Motivational Interviewing); and to assist in providing at least two (2) hours annually to all CMHC, Hospital ED and reception staff related to suicide risk assessment, prevention and post-intervention strategies.

Clinical trainings for providers will be offered at various times throughout the year and network providers can also contact NH Healthy Families to request additional clinical trainings or topics specific to your organization. Clinical trainings may be offered live or webinar format. NH Healthy Families will work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to a program and/or Provider staff at a minimum annually.

Community Mental Health (CMH) Program and Provider Requirements

Community Mental Health Programs (CMH Programs) and Community Mental Health Providers (CMH Providers) must maintain complete, accurate, legible, chronological, and retrievable records that support the Community Mental Health Services delivered. Documentation must demonstrate compliance with the Medicaid State Plan, applicable New Hampshire Administrative Rules, the MCM Agreement, and applicable federal and State confidentiality requirements.
Community Mental Health Services must be:

- Limited to services for which the furnishing CMH Program or CMH Provider is currently approved by the Department;
- Provided only to members who have current eligibility for Community Mental Health Services under He-M 401;
- Delivered in the least restrictive, community-based setting appropriate to the member's needs;
- Based on person-centered planning that considers the member's strengths, needs, preferences, personal recovery goals, and, when appropriate, the involvement of the member's family or other authorized supports; and
- Supported by documentation sufficient to establish the medical necessity, scope, frequency, duration, and delivery of the service.

General Clinical Record Requirements

The member's clinical record must include, as applicable:

- The member's current eligibility for Community Mental Health Services;
- The Comprehensive Assessment and subsequent reassessments;
- Diagnoses, medications, functional status, identified risks, strengths, needs, and recovery goals;
- The current Care Plan or Individual Service Plan, including measurable goals, objectives, interventions, responsible providers, and anticipated timeframes;
- Evidence of the member's participation and, when authorized, participation by family members, caregivers, or other supports;

- The service provided and the related Care Plan or Individual Service Plan goal or objective;
- The date, location, modality, start and stop time, or duration of the service, as applicable;
- The intervention delivered, the member's response, and progress toward identified goals and objectives;
- Changes in the member's clinical condition, risk, diagnosis, treatment, medication, level of care, or service needs;
- Referrals, consultations, care-coordination activities, and follow-up outcomes;
- Crisis, safety, transition, and discharge planning, when applicable; and
- The author's name, professional title or credentials, signature, and date.

Eligible members must be offered supports for illness self-management and recovery and must receive coordinated care when entering or leaving a designated receiving facility. The clinical record must document supports offered and relevant care-coordination, transition-planning, and follow-up activities.

CMH Programs and CMH Providers must protect member information in accordance with HIPAA, 42 CFR Part 2 when applicable, and other applicable federal and State confidentiality requirements. Records must be available to NH Healthy Families for quality monitoring, utilization review, audits, and program-integrity activities, consistent with applicable confidentiality protections.

Requirements Specific to Community Mental Health Programs

Initial and updated Care Plans maintained by a CMH Program must be based on a Comprehensive Assessment completed by the CMH Program using the New Hampshire Child and Adolescent Needs and Strengths Assessment (CANS), the Adult Needs and Strengths Assessment (ANSA), or another evidence-based assessment tool approved by the Department.

A CMH Program may use another evidence-based assessment tool only when the tool has been approved by the Department in accordance with the MCM Agreement.
CMH Programs must ensure that clinicians using the approved assessment tool:

- Complete required certification within one hundred twenty (120) calendar days following the Department's implementation of the applicable web-based training and certification system;
- Use the approved assessment tool for newly evaluated members following certification; and
- Use the approved assessment tool for existing members no later than the member's first Community Mental Health Services eligibility-renewal determination following certification.

CMH Programs must also:

- Complete and document quarterly assessment of each member's housing status and risk of homelessness;
- Maintain Care Plans that reflect findings from the Comprehensive Assessment and the member's current strengths, needs, risks, and goals;
- Document periodic review of the member's progress and continued need for services; and

- Participate in required quality-monitoring, audit, data-sharing, care-coordination, reporting, and program-review activities.

Requirements Specific to Community Mental Health Providers

A CMH Provider may furnish only those Community Mental Health Services identified in He-M 426.07 through He-M 426.17 for which the CMH Provider has received and maintains Department approval under He-M 426.04.

Before furnishing Community Mental Health Services, the CMH Provider must ensure that:

- The member has been identified by the regional CMH Program as currently eligible for Community Mental Health Services under He-M 401;
- A documented process is in place for collaborative service planning and service delivery with the regional CMH Program; and
- The member's Individual Service Plan has been jointly developed and approved by the CMH Provider and the regional CMH Program, as applicable.

The CMH Provider's record must document:

- Verification of the member's current Community Mental Health Services eligibility;
- The CMH Provider's contributions to the development, review, and implementation of the Individual Service Plan;
- Communications and coordination with the regional CMH Program;
- Services delivered in accordance with the jointly approved Individual Service Plan;
- Relevant changes in the member's clinical condition, eligibility, service needs, or level of care;
- Referrals, follow-up activities, and transitions between providers or settings; and
- Coordination with the regional CMH Program when the member enters or leaves a designated receiving facility.

Substance Use Disorder Accessibility Standards

Initial Contact and Screening

Providers under contract to deliver Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible, but no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible. Ideally, the initial eligibility screening will take place at the time of first contact (face-to-

face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency. However, it should not be later than two (2) business days following the date of first contact.

ASAM Assessment and Clinical Evaluation

Members who have screened positive for substance misuse/Substance Use Disorder services shall receive an American Society of Addiction Medicine (ASAM) Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment (but no later than three (3) business days after admission).

Timely Access to Treatment

Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed. Members should start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

Interim Services and Referrals

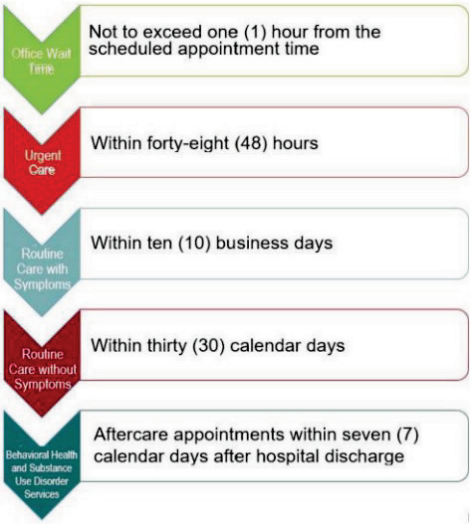
If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the Provider delivers interim Substance Use Disorder services until such time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering Provider, and the ordering provider does not make a referral for the Covered Services within three (3) business from initial contact, then the provider must contact NH Healthy Families who will work with the care team to make a closed-loop referral for the identified level of care, and to the applicable Doorway Program location within three (3) business days thereafter. NH Healthy Families will ensure the member has access to interim Substance Use Disorder services until such time that the Member is accepted and starts receiving services by the receiving agency.

When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member’s choice, Members receiving interim services shall be reassessed for ASAM level of care.

Priority Access Population

Pregnant women are to be admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment.

If the Provider is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the Provider and NH Healthy Families shall assist the pregnant woman with identifying alternative Providers, and accessing services from these Providers. This assistance shall include actively reaching out to identify Providers on the behalf of the Member, and provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week, recovery support services as needed by the Member, and daily calls to the Member to assess and respond to emergent needs.



Compliance with Access Standards

Network Providers should call the NH Healthy Families Provider Services department at 1-866-769¬3085 if they are unable to meet these access standards on a regular basis. Repeated inability to accept new members or meet the access standards outlined above can result in suspension and/or termination from the network. All changes in a Network Provider's status will be considered in the re-credentialing process.

Substance Use Disorder Clinical Standards

ASAM Criteria and Dimensional Assessment

The ASAM (American Society of Addiction Medicine) Criteria – Treatment criteria for Addictive, Substance Related and Co-Occurring conditions provides the criteria used to create treatment plans and evaluate level of care needed

The ASAM levels of service and criteria were updated through collaboration of ASAM clinical leadership and the Steering Committee of the Coalition for National Clinical Criteria (CNC)

ASAM Criteria should be utilized to:

1. Assign the appropriate level of service and level of care
2. Do effective treatment planning and documentation
3. Make decisions about continued service or discharge by ongoing assessment and review of progress notes

Covered Services Requirements

Credentialed providers delivering substance use disorder (SUD) services must comply with the Covered Services requirements set forth in He-W 513.05, as applicable to their provider type, including Opioid Treatment Programs (OTPs), SUD treatment providers, and recovery support service providers.

Opioid Treatment Programs must also comply with all applicable state and federal requirements, including He-A 304 and 42 CFR Part 8.

New Hampshire Administrative Rules governing substance use disorder services and Opioid Treatment Programs are available at:

- https://gc.nh.gov/rules/state_agencies/he-w500.html
- https://gc.nh.gov/rules/state_agencies/he-a300.html

Documentation Requirements for Substance Use Disorder (SUD) Providers

The recipient's individual record shall include at a minimum:

- The recipient's name, date of birth, address, and phone number
- A copy of the evaluation described in He-W513.05(u)(3) if the service is an outpatient substance use disorder program or a comprehensive Substance Use Disorder program

Supporting documentation shall include:

- A complete record of all physical examinations, laboratory tests, and treatments including drug and counseling therapies, whether provided directly or by referral
- Progress note for each treatment session, including
    - The treatment modality and duration
    - The signature of the primary therapist for each entry
    - The primary therapist's professional discipline
    - The date of each treatment session
- A copy of the treatment plan that is:
    - Based on clinical evaluation data within 3 business days of the clinical evaluation (or 3 sessions, if the member is meeting with an outpatient treatment provider no more than once per week), that addresses problems in all ASAM domains which justify the Member's admittance to a given level of care and that includes goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).
    - Includes the member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions
    - Updated at least every 4 sessions or 4 weeks, whichever is less frequent, if the service is an outpatient substance use disorder program or a comprehensive Substance Use Disorder program
    - Signed by the provider and the recipient prior to treatment being rendered
    - Signed by the clinical supervisor, prior to treatment being rendered, if the service is an outpatient, substance use disorder program or comprehensive Substance Use Disorder program

Treatment plans shall be updated based on any changes in any ASAM domain and at minimal intervals as described by ASAM for each level of care. Treatment plan updates shall include:

- Documentation of the degree to which the Member is meeting treatment plan goals and objectives;
- Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives, as appropriate;
- The Provider's assessment of whether or not the Member needs to move to a different level of care based on ASAM continuing care, transfer and discharge criteria; and
- The signature of the Member and the Provider agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.



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