Audiology Services and Hearing Aid Services

Medicaid and Other Medical Assistance Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

July 2016

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Montana Department of Public Health and Human Services

Key Contacts and Websites

See the Contact Us link in the left menu on the Montana Healthcare Programs Provider Information website, http://medicaidprovider.mt.gov/, for a list of contacts and websites.

Montana Department of Public Health and Human Services

Introduction

Thank you for your willingness to serve members of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for providers of audiology services and hearing aid services. Other essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is responsible for reviewing both manuals.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rule references are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office.

Providers are responsible for knowing and following current Medicaid rules and regulations.

The following rules and regulations are specific to the Audiology Services and Hearing Aid Services programs. Additional Medicaid rule references are available in the *General Information for Providers* manual.

- Administrative Rules of Montana (ARM)
  - ARM 37.86.701 – ARM 37.86.705 Audiology Services
  - ARM 37.86.801 – ARM 37.86.805 Hearing Aid Services

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services and supplies provided by **audiology service and hearing aid providers**. Like all healthcare services received by Medicaid members, services rendered by these providers must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Services Provided by Audiologists

Audiologists must hold a current audiology license issued by the Montana Board of Speech Language Pathologists and Audiologists under Title 37, Montana Code Annotated, be enrolled as a Montana Medicaid provider and be the provider of the service. If the provider is serving members outside Montana, he/she must maintain a current license in the equivalent category under the laws of the state in which the services are provided. Audiology services are hearing aid evaluations and basic audio assessments provided to members with hearing disorders within the scope of service permitted by state law.

Services for Children (ARM 37.86.2201–2235)

Members under age 21 will be evaluated under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Well-Child program, which covers all medically necessary services for children under age 21.

Supplier Documentation (ARM 37.86.702)

Audiology services must be referred by a physician or mid-level practitioner. The referral must indicate that an audiological evaluation would be medically appropriate to evaluate the patient's hearing loss. Verbal referrals must be followed up by a written order received by the provider within 30 days. Referrals and orders are valid for Medicaid purposes for no more than 90 days.

Written orders, diagnostic and evaluation reports, and appropriate records that demonstrate compliance with Medicaid requirements, must be current and available upon the request of the Department or its designated representatives at no charge.

The audiologist's written report must document the medical necessity for the service and shall contain the following information:

- The member's name, date of birth, and Medicaid identification number.
- Results of audiometric tests at 500, 1000, 2000 and 3000 hertz for the right and left ears, and word recognition or speech discrimination scores at levels which ensure PB Max.

- A written summary regarding the results of the evaluation indicating, in the provider's professional opinion, whether a hearing aid is required, the type of hearing aid (e.g., in-the-ear, behind-the-ear, body amplifier) and whether monaural or binaural aids are requested.
- The audiologist's name, address and license number in typed or preprinted form.
- The audiologist shall sign and date the form.

The audiologist should give a copy of the report to the member to take to the hearing aid dispenser (if the audiologist is not providing the hearing aid). The audiologist retains the original report in the individual's medical file. The hearing aid dispenser will submit the audiologist's report to the Medicaid Program for approval of the hearing aid before dispensing of the aid.

For additional documentation requirements, see the *General Information for Providers* manual, Provider Requirements chapter.

Request for Prior Authorization

Hearing aids require prior authorization, and a Prior Authorization Request form is required to provide supporting documentation for the member's medical indications.

The PA column of the Montana Medicaid fee schedule indicates whether prior authorization is required. The Prior Authorization Request form is available on the Forms page of the Provider Information website.

Rental/Purchase

Rental of hearing aids is limited to 30 days. Montana Medicaid does not reimburse for a separate dispensing fee on rentals.

Non-Covered Services (ARM 37.85.207 and ARM 37.86.205)

Some services not covered by Medicaid include the following:

- Services considered experimental or investigational.
- Services provided to Medicaid members who are absent from the state, with the following exceptions:
  - Medical emergency.
  - Required medical services are not available in Montana. Prior authorization may be required; see the *Passport to Health* manual and the Prior Authorization chapter in this manual.
  - If the Department has determined that the general practice for members in a particular area of Montana is to use providers in another state.
  - When out-of-state medical services and all related expenses are less costly than in-state services.

- When Montana makes adoption assistance or foster care maintenance payments for a member who is a child residing in another state.

- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments.
  - Mileage and travel expenses for providers.
  - Preparation of medical or insurance reports.
  - Service charges or delinquent payment fees.
  - Telephone services in home.
  - Remodeling of home.
  - Plumbing service.
  - Car repair and/or modification of automobile.
- Warranty fee/replacement fee and/or deductible for replacing a lost hearing aid within the two-year warranty period.

Verifying Coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. Use the fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT and HCPCS coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Fee schedules are available on the Provider Information website.

Coverage of Specific Services

The following are specific criteria for certain items/services Medicaid covers that are either in addition to Medicare requirements or are services Medicare does not cover.

Basic Audio Assessments and Hearing Aid Evaluations

Basic audio assessments (BAA) must include at a minimum, for each ear, under ear phones in a sound-attenuated room:

- Speech discrimination (word recognition) test under pb max conditions.
- Speech reception thresholds.
- Pure tone air conduction thresholds (at the frequencies of .5, 1, 2, 3, and 4 KHZ).
- Either pure tone bone thresholds at the above frequencies or tympanometry including tympanogram with acoustic reflexes and static compliance.

Hearing aid evaluation (HAE) includes those procedures necessary to determine the acoustic specifications most appropriate for the individual's hearing loss.

Reimbursement for BAA or HAE includes all related supplies and items used in the performance of the assessment or evaluation.

Hearing Aids

For a hearing aid to be covered, the member must be referred by a physician or mid-level practitioner for an audiological exam, and the physician or mid-level practitioner must have determined that a hearing evaluation would be medically appropriate to evaluate the patient's hearing loss.

A hearing aid will be covered if the examination by a licensed audiologist results in a determination that a hearing aid or aids are needed, and either of the following criteria is met:

- For persons age 21 and older, the audiological examination results show that there is an average pure tone hearing loss of at least 40 decibels for each of the frequencies of 500, 1,000, 2,000 and 3,000 Hertz in the better ear and word recognition or speech discrimination scores are obtained at a level to ensure pb max.
- Persons age 20 and under are evaluated under the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) Services Well-Child program. The Department or its designee determines after review of the audiology report that the hearing aid would be appropriate for the person. For more information on the EPSDT program, see the *General Information for Providers* manual.

Medicaid payment covers the manufacturer's invoice price (excluding warranty charges) of the hearing aid. The invoice must contain the hearing aid model and serial number. Medicaid also will pay a dispensing fee. (See the Hearing Aid Fitting section below.)

Monaural Hearing Aids

Monaural hearing aids are covered for invoice cost up to $400.

Binaural Hearing Aids

For coverage of binaural hearing aids for adults ages 21 and older, **all** of the following criteria must be met:

- The two-frequency average at 1 HKHZ and 2 KHZ must be greater than 40 decibels in both ears;
- The two-frequency average at 1 KHZ and 2 KHZ must be less than 90 decibels in both ears;
- The two-frequency average at 1 KHZ and 2 KHZ must have an interaural difference of less than 15 decibels;

- The interaural word recognition or speech discrimination score must have a difference of not more than 20%;
- Demonstrated successful use of a monaural hearing aid for at least six (6) months; and
- Documented need to understand speech with a high level of comprehension based on an educational or vocational need.

Binaural hearing aids are covered for invoice cost up to $800.

Use the fee schedule for your provider type to verify coverage for specific services.

Hearing Aid Fitting

The provider may bill Medicaid for a dispensing fee as specified in the fee schedule, in addition to the invoice price for the purchase of the hearing aid or aids. Hearing aid fitting must include either sound field testing in an appropriate acoustic environment or real ear measurements to determine that the hearing aid adequately fits the member's needs. It also must include at least one follow-up visit and warranty coverage for the hearing aid for a period of at least two years.

Hearing Aid Replacement

For members age 21 or over, a hearing aid purchased by Medicaid will be replaced no more than once every five years and only if:

- The original hearing aid has been lost or irreparably broken after the warranty period;
- The provider's records document the loss or broken condition of the original hearing aid; and
- The hearing loss criteria specified in this manual continue to be met; or
- The original hearing aid no longer meets the needs of the individual and a new hearing aid is determined to be medical necessary by a licensed audiologist.

Hearing Aid Miscellaneous Codes

When a provider bills with a miscellaneous code, a description of the item is required or payment will be denied.

Prior Authorization

What Is Prior Authorization? (ARM 37.85.410 and ARM 37.86.1806)

Prior authorization is one of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular member.

If a service requires prior authorization, the requirement exists for all Medicaid members. When prior authorization is granted, the provider is issued a prior authorization number which must be on the claim.

To ensure federal funding requirements are met, certain items/services are reviewed before delivery to a Medicaid member. These items/services are reviewed for appropriateness based on the member's medical need. In determining medical appropriateness of an item/service, the Department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

If an item/service is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item/service to the member.

When requesting prior authorization, remember:

- Only Medicaid-enrolled providers may request prior authorization for items/services.
- Documentation must support medical necessity.
- Documentation must coincide with other documentation provided by those involved with the member.
- Documentation must be complete, including appropriate signatures and dates.
- Member must be eligible for Medicaid.
- Use current correct coding.

To request prior authorization for an item/service:

- Submit a completed Request for Prior Authorization Form.
- Submit a completed Certificate of Medical Necessity.
- Include appropriate supporting documentation with the request. See the Prior Authorization Criteria table on the next page.
- Fax or mail the request and supporting documentation to the Department. See the Prior Authorization Criteria table on the next page.

- Upon completion of the review, the member and the requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call Provider Relations. No prior authorization is required for hearing aid services and supplies or the handling fee for hearing aid repairs or batteries.

Prior Authorization Criteria

Covered Service	Prior Authorization Contact	Requirements

Hearing Aid and Dispensing Fee
Hearing Aid for Members under 21 Years of Age
	Health Policy and Services Division
	Medicaid Services Bureau
	DPHHS
	P.O. Box 202951
	Helena, MT 59620-2951
	406-444-1861Fax
		Medical necessity documentation must include all of the following:
		• Completed Request for Prior Authorization form.
		• Completed CMN form.
		• Supporting documentation, which must include, at a minimum:
		  • A copy of the physician or mid-level practitioner's referral.
		  • An audiogram.
		  • A report from the licensed audiologist.

Montana Department of Public Health and Human Services

Billing Procedures

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the applicable CPT and HCPCS coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January and July. Fee schedules are available on the Provider Information website.

Place of Service

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Date of Service

The date of service for hearing aids or repairs is the day the hearing aid or repair is ordered from the manufacturer.

Using Modifiers

- Review the guidelines for using modifiers in the applicable CPT manual and/or HCPCS coding book.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.
- The Medicaid claims processing system recognizes only three pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- The HCPCS codes for monaural hearing aids require the use of modifiers to identify whether the aid is for the left (LT) or right (RT) ear. Use of the modifiers is mandatory for payment of monaural hearing aids. **Monaural hearing aids billed without the LT or RT modifier will be denied.**

Billings Tips for Specific Services

Hearing Aids

The provider bills for hearing aids using two separate procedure codes: one for the hearing aid and one for the dispensing fee. Valid diagnosis codes are mandatory on hearing aid claims. Providers may contact the physician or mid-level practitioner for the appropriate diagnosis code in a particular case. Also, a copy of the invoice must be attached to the claim. No other attachments are required.

Handling Fee for Repairs

Submit claims for hearing aid repairs with one charge for each service or supply item provided, and one charge for a handling fee.

Batteries

The maximum number of hearing aid batteries is four cells per month per hearing aid. The eight cells per month limit cannot be exceeded unless prior authorization has been received from the Medicaid Services Bureau.

Hearing Aid Rentals

Maximum rental is 30 days. Montana Medicaid does not reimburse for a separate dispensing fee on rentals.

How Payment Is Calculated

Overview

Although providers do not need the information in this chapter in order to submit claims to Montana Medicaid, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

The RBRVS Fee Schedule

Most services by provider types covered in this manual are reimbursed for using the Department's Resource-Based Relative Value Scale (RBRVS). The fee schedule includes several thousand CPT codes and HCPCS codes. Within the CPT coding structure, only anesthesia services (00100–01999) and clinical lab services (almost the entire 80000–89999 range) are not reimbursed for using the RBRVS fee schedule.

RBRVS was developed for the Medicare program, which first implemented it in 1992. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid implemented its RBRVS-based fee schedule in 1997. It is based largely on the Medicare model, with a few differences that will be described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the research performed by the federal government and national associations of physicians and other healthcare professionals. RBRVS-based payment methods are widely used across the U.S. by Medicaid programs, Blue Cross and Blue Shield Plans, workers' compensation plans and commercial insurers.

Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

Fee Calculation

Each fee is the product of a relative value times a conversion factor.

Basis of Relative Values

For almost all services, Medicaid uses the same relative values as Medicare in Montana. Nationally, Medicare adjusts the relative values for differences in practice costs between localities, but Montana is considered a single locality.

For fewer than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values.

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge.
- Modifiers. (See Other Modifiers in this chapter;)
- Provider type. (See Professional Differentials in this chapter.)
- Place of service. (See Site of Service Differential in this chapter.)
- Date of service. (Fees for services may change over time.)
- Check for cost sharing and Medicare or TPL payments, which are shown on the remittance advice.

Composition of Relative Values

For each code, the relative value is the sum of a relative value for the work effort (including time, stress, and difficulty), the associated transitional practice expense, and the associated malpractice expense.

Site of Service Differential

The Medicare program has calculated two sets of relative values for each code: one reflects the practitioner's practice cost of performing the service in an office and one reflects the practitioner's practice cost of performing the service in a facility.

Medicaid typically pays a lower fee if the service is provided in a facility because Medicaid typically also pays the facility.

Conversion Factor

The Department sets the conversion factor for the state fiscal year (July through June) and it is listed on the fee schedule.

Policy Adjuster

To encourage access to maternity services and family planning services, the Department increases fees for these codes using a policy adjuster that increases the fee. The fee listed on the fee schedule includes the policy adjuster.

Payment for Audiology Services

Medicaid payment for audiology services will be the lower of the provider's usual and customary charge for the service or 100% of the published RBRVS fee schedule.

Payment for Hearing Aid Services

Medicaid payment for covered hearing aid services and items will be the lower of the provider's usual and customary charge for the service or item, the submitted price on the invoice, or the Department's fee schedule.

How Cost Sharing Is Calculated on Medicaid Claims

Member cost sharing for services provided by audiology services and hearing aid services providers is $4.00/day per visit. The member's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount. (See the Remittance Advices and Adjustments chapter in the *General Information for Providers Manual).*

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability (TPL). In these cases, the other insurance is the primary payer and Medicaid makes a payment as the secondary payer. For example, a Medicaid member who also has insurance through her job receives a monaural hearing aid to wear behind her right ear (V5060RT). The invoice amount is $375.00. The member's other insurance is billed first and pays $200.00. The Medicaid allowed amount for this item is the invoice amount up to $400.00. The amount the other insurance paid ($200.00) is subtracted from the Medicaid allowed amount ($375), leaving a balance of $175.00.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the Medicare co-insurance and deductible amounts not to exceed the Medicaid fee for the service for these dually eligible individuals. See the How Payment Is Calculated chapter in the *Physician-Related Services* manual for details on how payment is calculated on Medicare crossover claims.

Professional Differentials

For some services within the scope of RBRVS payment methods, mid-level practitioners are paid differently. Audiologists are paid at 100% of the fee schedule.

Charge Cap

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider's charge.

Payment by MSRP

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at 75% of the amount submitted, which is the manufacturers suggested retail price (MSRP) or, when no MSRP is available, the provider's acquisition cost.

Appendix A: Forms

For the forms listed below and others, see the Forms link in the left menu on the Provider Information website.

- Individual Adjustment Request
- Paperwork Attachment Cover Sheet
- Hearing Aid Request for Prior Authorization
- Hearing Aid Certificate of Medical Necessity

Definitions and Acronyms

For definitions and acronyms, see the Definitions and Acronyms link in the left menu on the Provider Information website.

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