

3 Audiology Services Guidelines

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3.1 Audiology Services Policy

3.1.1 Introduction

This section covers all Medicaid services provided by hearing aid and audiology service providers as deemed appropriate by the Idaho Department of Health and Welfare (IDHW). It addresses the following:

- Claims payment.
- Prior authorization (PA).
- Electronic and paper claims billing.

3.1.2 Payment

Medicaid reimburses hearing aid and audiology services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

3.1.3 Participant Eligibility

All Medicaid participants are eligible for audiological function testing unless they are participating in a restricted program.

Participants enrolled in the following restricted programs are not eligible for audiology services:

- Pregnant women (PW).
- Presumptive eligibility (PE).
- Ineligible aliens.
- Qualified Medicare beneficiary (QMB).

3.1.3.1 *Healthy Connections (HC)*

Check eligibility to see if the participant is enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, there are guidelines that must be followed to ensure reimbursement for providing Medicaid covered services. See *Section 1.5 Healthy Connections (HC), General Provider & Participant Information*, for more information.

3.1.4 Audiometric Testing

All audiometric testing must be physician ordered. Testing payment is limited to once each calendar year (January to December). Audiometric testing by a certified audiologist and/or licensed physician does not require PA. The comprehensive audiometric exam is over and above basic audiometry and must be ordered in writing by a physician prior to performing the testing.

Audiometric testing, CPT codes **92551 - 92597**, as described in the *Audiologic Function Tests with Medical Diagnostic Evaluation* subsection of the *Current Procedural Terminology® Manual*, is reimbursable for audiology services. Idaho Medicaid uses the most current CPT version available.

The audiometric test implies the use of calibrated electronic equipment. Other hearing tests, such as whispered voice or tuning fork, are considered part of the general otorhinolaryngologic services and are not reported separately. All services include testing of both ears.

3.1.5 Visits

Only one charge may be made for each visit. Two hearing aid checks are allowed after the exam and selection of the hearing aid. A hearing check is not allowed on the same day as an exam or selection of the aid.

These visits are intended as a mechanism for the provider to check the hearing aid after the initial issuance. It is understood the hearing aid will be checked and be in proper functioning order when it is issued.

3.1.6 Hearing Aid Purchase

One hearing aid (monaural), per participant, is covered by Medicaid for adult participants 21 years of age and older.

Medicaid considers purchases of medically necessary, binaural hearing aids only for children under age 21, in cases where it is documented that, without a binaural hearing aid, the child's ability to learn would be severely restricted.

The following components are separately billable from the hearing aid:

- Ear mold.
- Exam and selection.
- Batteries.

3.1.7 Hearing Aid Warranty and Insurance

Medicaid requires a two year of warranty or insurance be provided, The cost of warranty or insurance is included in the reimbursement rate of the hearing aid.

3.1.8 Hearing Aid Follow-Up

The following services may be covered in addition to the purchase of the hearing aid:

- Additional ear molds that are purchased after the initial six months to one year period may be billed for participants age 21 and under, if medically necessary.
- Up to twenty batteries may be purchased each month. Medicaid reimburses this cost up to the Medicaid maximum allowable amount for HCPCS code **V5266**. 1 unit = 1 battery.
- Follow-up hearing aid testing and repairs resulting from normal use may be allowed after the second year. Hearing aid testing and repairs during the first two years after purchase are included as part of the initial hearing aid purchase.
- Refitting of an adult hearing aid or additional ear molds are allowed once every 48 months.
- Lost, misplaced, stolen, or destroyed hearing aids are the responsibility of the participant. Medicaid will not pay for hearing aid repairs as a result of neglect, abuse, or misuse.

3.1.9 Payment Procedures

Payment amount for hearing aids is determined by Medicaid.

3.1.10 Physician Orders

The vendor must keep the following documentation in its files for a period of five years:

Physician's signed and dated order that includes:

- The participant's diagnosis.
- The results of the basis comprehensive audiometry exam.
- Brand name, model, and type needed, including any options or accessories.

3.1.11 Program Abuse

Medical equipment items, including hearing aids, used by or provided to an individual other than the participant for whom the items were billed are prohibited. Violators are subject to strictly enforced penalties for program fraud and abuse.

Medicaid has no obligation to repair or replace any item or supply that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the item.

3.1.12 Place of Service (POS) Codes

Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field when billing electronically.

- 11 Office
- 12 Patient's home
- 21 Inpatient hospital
- 22 Outpatient hospital
- 32 Nursing facility
- 71 State or local public health clinic
- 72 Rural health clinic

3.1.13 Prior Authorization (PA) Requests

Approved PAs are valid only for the period between the start date and stop dates. PA numbers must be included on the claim or the authorized service will be denied.

For HC participants, PA will be denied if the requesting provider is not the primary care provider (PCP) or a referral has not been obtained.

Requests for hearing aids for children beyond one per lifetime must be sent to the Durable Medical Equipment (DME) Unit for PA.

Requests must include the following information:

- A completed Idaho Medicaid DME/Supplies Request form.
- A copy of the audiometric test results.
- Make/model of the hearing aid, including any option or accessories.
- Justification for the options or accessories.
- Physician prescription.

Attach the invoice or quote to the PA request form for consideration. The authorized reimbursement will be entered on the PA approval letter.

See *Section 2.3.2 Medicaid Prior Authorization (PA), General Billing Information*, for more information.

The Idaho Medicaid DME/Supplies Request form can be found in *Appendix D; Forms*. Use it to make copies as needed.

Send completed PA request form to:

Division of Medicaid
Medical Care Unit
Attn: DME
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax: (800) 352-6044

3.2 Claim Billing

3.2.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other Health Insurance Portability and Accountability Act (HIPAA) compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.2.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission, General Billing Information*, for more information.

3.2.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the transaction.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3* in the *Physicians Guidelines* for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.2.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006, is entered as 07042006.

3.2.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field **24A** (Date(s) of Service From/To) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.
- You can bill with a date span (Date(s) of Service From/To) only if the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature-on-file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.2.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.2.3.3 Completing Specific Fields of CMS-1500

Consult the Use column in the following table to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field 11d is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items 9a-9d .
14	Date of Current: Illness, Injury, or Pregnancy (LMP)	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier 1D followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier 1D followed by the 9-digit HC referral number. Note: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit National Provider Identifier (NPI) number. Note: The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the internal control number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis, and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.

Field	Field Name	Use	Directions
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	Date(s) of Service From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003, becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield (1 - 4) for the diagnosis code entered in field 21.
24F	\$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening Diagnosis and Treatment (EPSDT) Program Screen; see <i>Section 1.6 Child Wellness Exams</i> for more information.
24I	ID. Qual	Required, if legacy ID	Enter qualifier 1D followed by the 9-digit Idaho Medicaid provider number in 24J.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the 1D qualifier was entered in 24I. Note: If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. Note: Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See <i>Section 1.1.4 Signature-on-File Form</i> for more information.

Field	Field Name	Use	Directions
33	Billing Provider Info and Ph #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or remittance advice (RA). Note: If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. Note: NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier 1D followed by the provider's 9-digit Idaho Medicaid provider number. Note: All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.2.3.4 Sample Paper Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/>														
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)					2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____														
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY														
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #												
1											NPI													
2											NPI													
3											NPI													
4											NPI													
5											NPI													
6											NPI													
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ _____													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____			32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____			33. BILLING PROVIDER INFO & PH. # () a. NPI _____ b. _____																		

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