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TO: **Arkansas Medicaid Health Care Providers – Hearing Services**

DATE: **April 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 49**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000 – 202.100	10-13-03	201.000 – 202.200	4-1-05
213.000	10-13-03	213.000	4-1-05
242.100 – 242.110	Dates Vary	242.100 – 242.110	4-1-05
242.310 – 242.400	10-13-03	242.310 – 242.400	4-1-05

Explanation of Updates

Section 201.000 has been revised and reformatted.

Section 202.000 has been revised and renamed. This section sets forth the current requirements for participation in the Arkansas Medicaid Hearing Services Program.

Section 202.100 has been revised.

Section 202.200 is a new section explaining that audiologists are not required to participate in the Title XVIII Medicare Program in order to participate in the Medicaid Program.

Section 213.000 is included to discuss some new services available in the Hearing Services Program. Effective April 1, 2005, licensed audiologists may provide vestibular testing, aural rehabilitation and aural habilitation services to their patients. Information was also added in this section to explain that a primary care physician referral is required for hearing services.

Section 242.100 is included because new procedure codes have been added.

Section 242.110 has been revised and reformatted. All references to local codes and their descriptions were deleted.

Section 242.310 is included to explain that on the CMS-1500 Claim Form, field number 17, a primary care physician referral is required for hearing services. Also, field number 29 has been revised. References concerning private insurance co-pay information have been deleted. The recipient is no longer responsible for co-pay.

Section 242.400 is included only to remove obsolete information.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

201.000 Arkansas Medicaid Participation Requirements for Hearing Aid Dealers 4-1-05

Hearing aid dealers must meet the following criteria to participate in the Arkansas Medicaid Program.

A. Hearing aid dealers/physicians/audiologists must be licensed in their states as Hearing Aid dealers. However, audiologists licensed in Arkansas may render both audiology service and the dispensing of hearing aids with their audiologist license. A current copy of the hearing aid license must accompany the provider application and Medicaid contract.

1. A copy of subsequent state licensure renewal must be forwarded to Provider Enrollment within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional final 30 days to comply.

2. Failure to timely submit verification of license renewal will result in termination of enrollment in the Arkansas Medicaid Program.

B. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).

C. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid Providers.

View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).

202.000 Participation Requirements for Individual Audiologists 4-1-05

Audiologists are eligible for participation in the Arkansas Medicaid Program if they meet the following criteria:

A. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

B. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid Providers.

C. Audiologists must be licensed in their states as audiologists. Audiologists with an Arkansas license may also dispense hearing aids as per Act 1171-1991.

1. A copy of the current state license must accompany the provider application and Medicaid contract.

2. A copy of subsequent state licensure renewal must be forwarded to Provider Enrollment within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional final 30 days to comply.

3. Failure to timely submit verification of license renewal will result in termination of enrollment in the Arkansas Medicaid Program.

202.100 Group Providers of Audiology Services in Arkansas and Bordering States 4-1-05

Group providers of Audiology Services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program.

A. In order for a group of audiologists to receive Arkansas Medicaid reimbursement, the group and each individual audiologist must enroll in Arkansas Medicaid.

1. Each audiologist member of the group who intends to treat Medicaid recipients must enroll in accordance with the requirements in section 202.000.

2. The group must also enroll in the Arkansas Medicaid Program by completing and submitting to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

3. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid Providers.

B. All group providers are "pay to" providers only. The service must be performed and billed by the performing licensed and enrolled audiologist with the group.

NOTE: An audiologist licensed outside the state of Arkansas who has a Hearing Aid Dealer License and an Audiology License must enroll under both programs. A provider application and Medicaid contract must be completed for each program, and two (2) separate Medicaid provider numbers will be assigned.

202.200 Optional Enrollment in the Title XVIII (Medicare Program) 4-1-05

Audiologists have the option of enrolling in the Title XVIII Medicare Program as providers of audiology services. When a recipient is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse for those services if Medicare has not been billed prior to Medicaid billing. The recipient cannot be billed for the charges. Claims filed by Medicare "non-participating" providers do not automatically cross over to Medicaid for payment of deductibles and coinsurance.

NOTE: Providers enrolled to participate in the Title XVIII Medicare Program must notify the Provider Enrollment Unit of their Medicare provider number. **View or print Medicaid Provider Enrollment Unit contact information.**

213.000 Scope 4-1-05

The Utilization Review Section of the Division of Medical Services is responsible for authorizing hearing aid services for eligible Medicaid recipients under age 21. Services are provided as a result of a referral from the recipient's primary care physician (PCP). If the recipient is exempt from the PCP process, then the attending physician must make the referral. Licensed audiologists may provide vestibular testing, aural rehabilitation and aural habilitation services.

Prior to providing hearing aid services to an eligible Medicaid recipient, a medical clearance must be obtained from a physician. This clearance must indicate if there are any medical or surgical indications contrary to fitting the recipient with a hearing aid. An audiological exam must be made by a certified audiologist or a physician. Arkansas Medicaid will not reimburse for a hearing test performed by a State-licensed hearing aid dispenser unless the hearing aid dispenser is also a licensed physician or licensed audiologist. The hearing evaluation must include the audiologist's or physician's recommendations regarding the brand name and model of the hearing aid to be dispensed and the name of the Medicaid dealer the patient has chosen to provide the hearing aid. The cost of the hearing aid should be provided if available. The medical clearance and hearing evaluation and a copy of the audiogram must be forwarded to the Division of Medical Services Utilization Review (UR) Section and must reach the UR Section within 6 months from the date the above evaluations were performed. **View or print the Division of Medical Services Utilization Review Section contact information.** After reviewing the medical clearance from the physician and the audiological evaluation from the audiologist or the physician, a letter of authorization is sent from the Utilization Review Section to the Medicaid provider dispensing the hearing aid.

Fitting and servicing the hearing aid is performed by a licensed dispenser. The dealer must submit his or her claim for payment to EDS with the charges and serial numbers of the aid dispensed. Please refer to Section 240.000 of this manual for billing instructions and procedure codes regarding hearing aids.

The recipient is entitled to three follow-up visits to the dealer who dispensed the aid for the purpose of learning proper operation and care of the aid. The Medicaid Program does not reimburse the provider an additional amount for these three visits.

242.100 Audiology Procedure Codes 4-1-05

Use the following procedure codes for audiological function tests.

CPT Codes				
92506	92507	92508	92541	92542
92543	92544	92545	92551	92552
92553	92555	92556	92557	92559
92560	92561	92562	92563	92564
92565	92567	92568	92569	92571
92572	92573	92575	92576	92577
92579	92582	92583	92584	92585
92586	92587	92588	92589	92590
92591	92594	92595	92700	

242.110 Hearing Aid Procedure Codes 4-1-05

Use the following procedure codes for hearing aid equipment for recipients under age 21 in the EPSDT program. Hearing aids are limited to two appliances per six-month period.

HCPCS Codes				
V5030	V5040	V5050	V5060	V5120
V5130	V5140	V5170	V5180	V5210
V5299				

National Code	Required Modifier(s)
V5008	EP
V5008	EP, U1
V5014	—
V5267	—

242.310 Completion of CMS-1500 (formerly HCFA-1500) Claim Form 4-1-05

Field Name and Number	Instructions for Completion
1. Type of Coverage	This field is not required for Medicaid.
1a. Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2. Patient's Name	Enter the patient's last name and first name.
3. Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
Sex	Check "M" for male or "F" for female.
4. Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5. Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name (post office box or RFD), city name, state name and ZIP code.
6. Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7. Insured's Address	Required if insured's address is different from the patient's address.
8. Patient Status	This field is not required for Medicaid.
9. Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
b. Other Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
c. Employer's Name or School Name	Enter the employer's name or school name.
d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10. Is Patient's Condition Related to:	
a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d. Reserved for Local Use	This field is not required for Medicaid.

11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is required for Hearing Services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19.	Reserved for Local Use	Not applicable to Hearing Services.
20.	Outside Lab?	This field is not required for Medicaid
21.	Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22.	Medicaid Resubmission Code	Reserved for future use.
	Original Ref No.	Reserved for future use.
23.	Prior Authorization Number	Enter the prior authorization number, if applicable.

24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 242.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 242.100 through 242.110.
Modifier	Use applicable modifier.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.
K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25. Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.

26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Field 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

242.400 Special Billing Procedures 4-1-05

Requests for hearing aids, accessories and repairs must be completed on Form CMS-1500 (formerly HCFA-1500) prior to being submitted to the Utilization Review Section.

The following documentation must accompany each request for a hearing aid:

A. Medical Clearance (within the last six (6) months, by an orologist or ENT specialist)

B. Audiogram (by certified audiologist) and Evaluation

All hearing aid providers should use code **V5014** (Hearing Aid Repair and Service) when billing for hearing aid repairs. Code **V5014** will require authorization prior to payment. All prior authorization requests should be submitted to the Hearing Aid Consultant, Division of Medical Services. **View or print the Division of Medical Services Hearing Aid Consultant contact information.**

Please use code **V5267** when billing for hearing aid accessories.