ARKANSAS DEPARTMENT OF HUMAN SERVICES

# Division of Medical Services
## Program Planning & Development

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

**DATE:** **September 1, 2009**

**SUBJECT:** **Provider Manual Update Transmittal #84**

| **REMOVE** | | **INSERT** | |
|---|---|---|---|
| **Section** | **Date** | **Section** | **Date** |
| 202.200 | 4-1-05 | 202.200 | 9-1-09 |
| 204.000 | 7-1-04 | 204.000 | 9-1-09 |
| 211.000 | 10-13-03 | 211.000 | 9-1-09 |
| 212.000 | 10-13-03 | 212.000 | 9-1-09 |
| 213.000 | 4-1-05 | 213.000 | 9-1-09 |
| 214.000 | 7-1-04 | 214.000 | 9-1-09 |
| 214.100 | 7-1-04 | 214.100 | 9-1-09 |
| 242.100 | 4-1-05 | 242.100 | 9-1-09 |
| 242.110 | 10-1-06 | 242.110 | 9-1-09 |

**Explanation of Updates**

Section 202.200 is updated to delete outdated information and to include location references regarding joint Medicare/Medicaid eligible beneficiaries.

Section 204.000, 211.000, 212.000, 213.000, 214.000 and 214.100 are updated to change the term “recipient” to the correct Medicaid term “beneficiary.”

Section 242.100 is updated to delete a code that is no longer payable under Arkansas Medicaid and relocate information from Section 242.110 that is more suited to this Section. Other minor wording changes have been included for program clarity.

Section 242.110 is updated to include information regarding the requirement for paper/manual billing and to delete information relocated to Section 242.100.

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 have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

*TOC REQUIRED*

## 202.200 Enrollment in the Title XVIII (Medicare Program) 9-1-09

For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. See Section III for instructions on filing joint Medicare/Medicaid claims.

## 204.000 The Hearing Services Provider's Role in the Child Health Services (EPSDT) Program 9-1-09

The Arkansas Medical Assistance Program includes a Child Health Services (Early and Periodic Screening, Diagnosis and Treatment or EPSDT) Program for eligible individuals under age 21. The purpose of this program is to detect and treat health problems in their early stages.

If you are a Child Health Services (EPSDT) provider, please refer to the Child Health Services (EPSDT) manual for additional information.

Hearing Services providers interested in the Child Health Services (EPSDT) Program should contact the Child Health Services (EPSDT) Office. **View or print the Child Health Services Office (EPSDT) contact information.**

Hearing Services providers must bill Child Health Services (EPSDT) on the DMS-694 claim form when billing on paper. If billing electronically, use the professional claim format. Current billing information must be obtained from the Child Health Services (EPSDT) provider manual. Ancillary charges, such as lab and X-ray, associated with Child Health Services (EPSDT) should be listed on the claim. **View a sample DMS-694 form.**

Any enrolled Arkansas Medicaid provider who provides services that are not covered by the Arkansas Medicaid Program to a participant in the Child Health Services (EPSDT) Program who has been referred for services as a result of an EPSDT screen will be reimbursed for the services provided they are medically necessary and permitted under Federal Medicaid regulations.

When a provider performs a Child Health Services (EPSDT) screen and refers the patient to another provider for services not covered by Arkansas Medicaid, the referring provider must give the beneficiary a prescription for the services. The prescription must indicate that the services being prescribed are due to a Child Health Services (EPSDT) screen. The beneficiary must present this prescription to the provider. The beneficiary may take this prescription to the provider of his or her choice. The prescription for services must then be retained in the beneficiary's medical record for audit purposes by the provider who provides the services. If the beneficiary is then referred to another provider, the same procedure must be followed. A provider who performs a Child Health Services (EPSDT) screen may also provide services resulting from the screen, if appropriate.

**In order for the non-covered service to be eligible for Medicaid payment, the referral documentation must be available for review.**

The prescription for services must be dated by the provider referring the patient. The prescription for the non-covered service is acceptable if services were prescribed and the prescription is dated within the applicable periodicity schedule, not to exceed a maximum of 12-months.

## 211.000 Introduction 9-1-09

The Arkansas Medicaid Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual.

## 212.000 Coverage 9-1-09

Arkansas Medicaid covers hearing services for eligible Medicaid beneficiaries under age 21 in the Child Health Services (EPSDT) Program when prescribed by a physician.

## 213.000 Scope 9-1-09

The Utilization Review Section of the Division of Medical Services is responsible for authorizing hearing aid services for eligible Medicaid beneficiaries under age 21. Services are provided as a result of a referral from the beneficiary's primary care physician (PCP). If the beneficiary 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 beneficiary, 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 beneficiary 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 beneficiary 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.

## 214.000 Limitations and/or Exclusions 9-1-09

There is a one-year warranty period during which all necessary adjustments, parts and replacements to the transmitter and receiver are provided at no cost to the beneficiary or to the Medicaid Program. At the expiration of the warranty period, the dealer will be reimbursed at the lesser of 75% of charges billed to private patients or the Title XIX maximum charge allowed for necessary repairs and replacements.

Repairs and replacements to the transmitter or receiver of hearing aids not purchased through the Medicaid Program may be authorized in the same manner as aids purchased through the Program. Medicaid will make no reimbursement for this equipment during the one-year warranty period.

Replacements are not covered under the Medicaid Program one-year warranty period. Reimbursement is made by Medicaid at 68% of charges billed to private pay patients.

In cases of equipment abuse, no payment will be made by the Medicaid Program. The beneficiary (or parent or guardian) is encouraged to purchase hearing aid insurance from the dealer to cover the cost of repairs or replacements.

### 214.100 Extension of Benefits 9-1-09

The hearing services provider may request an extension of benefits by sending a letter to the Utilization Review Unit requesting prior authorization for additional services. The request must be accompanied by the Medicaid beneficiary's medical record. **View or print the Utilization Review Section contact information.**

Providers are encouraged to use Form DMS-686, Amplification/Assistive Technology Recommendation Form, to request hearing aid services that require approval. Providers are not required to use DMS-686. However, all the information contained in DMS-686 must be submitted in writing to the reviewer. **View or print form DMS-686.**

### 242.100 Audiology Procedure Codes 9-1-09

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 | 92590 | 92591 |
| 92594 | 92595 | 92626 | 92627 | 92630 | 92633 | | |

Use the following procedure code for hearing screenings for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

| **HCPCS Procedure Code** | **Modifier** |
|---|---|
| V5008 | EP |

### 242.110 Hearing Aid Procedure Codes 9-1-09

Use the following procedure codes for hearing aid equipment for beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Medicaid covers up to 2 hearing aids

per beneficiary each six-months. Hearing aid procedure codes may be billed electronically or on a paper claim form.

| **HCPCS Procedure Codes** | | | | | | | |
|---|---|---|---|---|---|---|---|
| V5014* | V5030 | V5040 | V5050 | V5060 | V5120 | V5130 | V5140 |
| V5170 | V5180 | V5210 | V5220 | V5267** | V5299 | | |

*Repairs require prior authorization
**Accessories