

Hearing Aid Services

Provider Manual
Volume II

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Medicaid



Table of Contents

1.	NH MEDICAID PROVIDER BILLING MANUALS OVERVIEW	1
	Intended Audience	1
	Provider Accountability	1
	Document Disclaimer/Policy Interpretation.....	1
	Notifications & Updates.....	2
	Description of Change Log	2
	Contacts for Billing Manual Inquiries.....	2
2.	PROVIDER PARTICIPATION & ONGOING RESPONSIBILITIES	3
3.	COVERED SERVICES & REQUIREMENTS	4
	Service Limits	6
4.	NON-COVERED SERVICES	7
5.	SERVICE AUTHORIZATION (SA)	8
	Requesting Service Authorization.....	8
	Approval or Denial of Service Authorization Requests.....	8
6.	DOCUMENTATION.....	10
7.	SURVEILLANCE AND UTILIZATION REVIEW (SURS) PROGRAM INTEGRITY.....	11
8.	ADVERSE ACTIONS	12
9.	MEDICARE/THIRD PARTY COVERAGE	13
10.	PAYMENT POLICIES	14
11.	CLAIMS.....	15
	Timely Filing.....	16
	Diagnosis & Procedure Codes.....	16
	Service Authorizations (SAs).....	16
	Required Claim Attachments	17

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes, which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and complies with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The Appendices section encompasses a wide range of supplemental materials such as Fee Schedules, Contact Information, Provider Type List, Sample Forms and Instructions, as well as other general information.
- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for health care providers, their staff, and provider-designated billing agents.

These manuals are *not* designed for use by NH Medicaid members (hereinafter referred to as members).

Provider Accountability

Providers should maintain both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to NH Medicaid providers by the Communications staff of Xerox, the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between Xerox and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media, including provider bulletins, provider notices, memos, letters, web site updates, newsletters and/or updated pages to the General Billing Manual – Volume I and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their billing agents and staff.

Billing Manual updates are distributed jointly by the Department and Xerox. Providers receive notification of manual updates through a message sent to each provider's message center inbox via the web.

Description of Change Log

All changes made to this manual are under change control management and are approved by Department and/or its associated organizations. The change log is located at the front of this document.

Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the Xerox Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the Xerox Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

To receive payments from NH Medicaid for hearing aid services, the provider must be an enrolled NH Medicaid provider.

To enroll in NH Medicaid, the hearing aid services provider must be either:

1. An audiologist licensed in accordance with RSA 137-F:11 or licensed by the state in which he or she practices; or
2. A hearing aid dealer registered in accordance with RSA 137-F:8 or credentialed in accordance with applicable law in the state in which he or she practices.

3. Covered Services & Requirements

Hearing aid services covered under the NH Medicaid program shall include:

1. The following services and items:
 - a. The hearing aid evaluation or a hearing aid consultation, which shall be limited to one service every 2 years since the last date of service for members age 21 or over and as needed for members under age 21;
 - b. The ear mold(s);
 - c. The least costly hearing aid(s) or pocket talker as determined by the audiologist or hearing aid dealer to achieve appropriate access to speech in all of the member's communication settings;
 - d. The dispensing/fitting of the hearing aid(s) or pocket talker, including real ear verification for conventional hearing aids, adjustment and instruction;
 - e. Follow-up to include verification of hearing aid or pocket talker performance, if not completed at the fitting, and monitoring of hearing thresholds, as needed; and
 - f. The audiogram
2. Monaural hearing aids:
 - a. For members under 21 years of age when:
 - i. The audiogram indicates a unilateral hearing loss of one or more thresholds of 25 decibels (dB) hearing level (HL) or poorer at any frequency from 1000 hertz (Hz) to 4000 Hz, and
 - ii. The audiologist or hearing aid dispenser deems the loss communicatively significant, and
 - b. For members 21 years of age or over when the audiogram indicates a bilateral hearing loss with an average threshold of 35 dBHL or poorer for 1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz by pure tone air conduction
3. Binaural hearing aids:
 - a. For members under 21 years of age when:
 - i. The audiogram indicates a bilateral hearing loss of one or more thresholds of 25 dBHL or poorer at any frequency from 1000 Hz to 4000 Hz, and
 - ii. The audiologist or hearing aid dispenser deems the loss communicatively significant, and
 - b. For members 21 years of age or over, when:
 - i. A service authorization has been requested and obtained from the Department in advance of the hearing aid(s) being rendered, and
 - ii. The coverage criteria for monaural hearing aids in #2 above and one of the following criteria have been met:
 1. The member is attending post-secondary school at any educational level for the purpose of obtaining employment or is receiving vocational training, and the provider maintains supporting records to include a letter from the member's school verifying attendance or documentation confirming the member is receiving vocational training, or

2. The member is employed and is likely to be determined as unable to meet the audiometric requirements of the job without the use of binaural hearing aids, and the provider maintains supporting records to include (a) a statement from the member's employer verifying the member's employment status, including the employer's audiometric requirements for the particular position in which the member is employed, (b) a statement from the audiologist that the member cannot meet the employer's audiometric requirements in (a) without the use of binaural hearing aids, and (c) an audiogram which supports the audiologist's statement in (b), or
 - iii. The member meets the definition of statutory blindness as defined in Sections 216(i) (1) and 1614(a) (2) of the Social Security Act, 42 USC 416 and 42 USC 1382c, an audiogram indicates a unilateral hearing loss with an average threshold of 35 dBHL or poorer for 1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz by pure tone air conduction, and any other required audiological and medical data to document the required criteria is obtained.
4. Hearing aid batteries for the life span of the hearing aid(s)
5. Replacement of hearing aids:
 - a. If there is an increase in the member's hearing loss, as established by the most recent audiogram, which makes the existing hearing aid ineffective
 - b. If an audiologist or hearing aid dealer determines that the hearing aid can no longer be repaired, or that it is not cost effective to do so, or
 - c. If the replacement is due to loss and is coverable under He-W 546 for members under age 21
6. Hearing aid repairs, which shall not require:
 - a. A physician referral
 - b. An initial purchase by NH Medicaid
7. FM systems for members under age 21, when a hearing aid on its own does not meet the member's personal amplification needs, or when a traditional hearing aid is not an appropriate option, as determined by an audiologist
8. Pocket talkers, to accommodate hearing loss and enhance communications, when:
 - a. The audiogram indicates that a member has a bilateral hearing loss with an average threshold of 35 dBHL or poorer for 1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz by pure tone air conduction, and
 - b. A hearing aid has not also been covered by NH Medicaid
9. Replacement of a pocket talker:
 - a. With hearing aid(s) or a more effective pocket talker if there is an increase in the member's hearing loss, as established by the most recent audiogram, which makes the existing pocket talker ineffective, or
 - b. Once every 5 years
10. Replacement of a headset, ear buds, or neck loop for a pocket talker once every year if an audiologist determines that such accessories are malfunctioning

Service Limits

Hearing aid evaluations or hearing aid consultations are limited to one service every 2 years since the last date of service for members age 21 or over and as needed for members under age 21.

4. Non-Covered Services

Non-covered services are those services for which a NH Medicaid program will not make payment.

There may be non-covered services directly associated with your provider type (such as those listed below or those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the “Non-Covered Services” section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, **prior to** delivery of the service, that it is non-covered by NH Medicaid and that, should the member still choose to receive the service, then the member will be responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that s/he understands that the service is non-covered and that s/he agrees to pay for the service

Non-covered hearing services shall include:

- Replacement of hearing aids due to loss, misuse, or abuse, except as noted under “Covered Services and Requirements” above;
- FM systems, if the systems are for the sole purpose of member use in an educational setting and are coverable under He-M 1301, the Medicaid in the Schools Program;
- Repair of hearing aids which are covered under a warranty;
- Pocket talker repairs, batteries, accessories, except those listed under “Covered Services and Requirements” above, and optional telelinks;
- A pocket talker if a hearing aid is already covered by NH Medicaid;
- A hearing aid if a pocket talker is already covered by NH Medicaid, unless the criteria under “Covered Services and Requirements” above are met; and
- Binaural hearing aids for members 21 years of age and older unless the criteria under “Covered Services and Requirements” above are met.

5. Service Authorization (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization of payment for a specific item or service.

Service authorizations are reviewed by a service authorization agent under contract with the Department. Because the service authorization agent can vary depending on the type of service provided, the Contact information in the Appendices or on any SA related forms should be consulted for the name and method of contact.

A service authorization does not guarantee payment. Providers should verify the following before providing a service:

- The member is eligible on the date(s) of service;
- The performing and billing NH Medicaid providers are actively enrolled providers on the date(s) of service; and
- The procedure code(s) and billing modifier(s) are active codes and valid combinations for billing under NH Medicaid.

Requesting Service Authorization

Service authorizations are required for binaural hearing aids for members 21 years of age or over. Service authorizations must be submitted in writing to the Department's service authorization agent and include:

- The member's name;
- The member's Medicaid identification number;
- The member's diagnosis;
- The provider's Medicaid ID number;
- Clinical documentation that addresses how the request for binaural hearing aids meets the criteria outlined under the "Covered Services and Requirements" section; and
- Signature of the provider

Approval or Denial of Service Authorization Requests

The service authorization agent will make a decision on the service authorization request based on whether or not the request demonstrates that the required criteria for coverage have been met. Once a decision is made, the service authorization agent will either:

- Grant approval no longer than ten business days after the request for service authorization has been made, by mail, by facsimile, or via the service authorization agent's web site; or
- Issue a denial.

When a service authorization request is denied, written notice of the denial is mailed to the member, and a copy of the denial is mailed to the requesting provider to include the following:

- Reason for and the legal basis of the denial
- Information on how the member can file an appeal
- Information that a denial may be appealed by the member within 30 calendar days from the date the denial was issued or

A written confirmation of approval will be sent to the requesting service provider only.

6. Documentation

Hearing service(s) providers must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement. Please see the “Record Keeping” section of the General Billing Manual – Volume I, for documentation requirements.

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer.

Supporting documentation should include:

1. An audiogram;
2. Audiological and medical data documenting the required coverage criteria, that supports the request for the hearing aid(s) or pocket talker;
3. For those members 21 years of age or over requesting binaural hearing aids in accordance with the service authorization requirements, the following as applicable:
 - A statement from the member’s employer verifying the member’s employment status and including the employer's audiometric requirements for the particular position in which the member is employed; a statement from the audiologist that the member cannot meet the employer’s audiometric requirements without the use of binaural hearing aids; and an audiogram which supports the audiologist's statement; or
 - A letter from the member’s school verifying attendance or documentation confirming the member is receiving vocational training, if applicable.

7. Surveillance and Utilization Review (SURS) Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Program Integrity Unit is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse. These utilization review activities are required and carried out in accordance with Federal regulations at 42 CFR 455 and 42 CFR 456, and they are done to ensure that accurate and proper reimbursement has been made for care, services and/or supplies that have been provided to a member, and for which a provider has received payment.

Utilization review activities may be conducted prior to payment, following payment, or both. These activities include, but are not limited to, conducting provider reviews. These reviews may be selected at random, generated from member complaints, other providers, anonymous calls, or from the SURS reporting system.

There are various outcomes that may result from Program Integrity review activities. They include, but are not limited to:

- Recovery of erroneous and improper provider payments;
- Provider education regarding appropriate documentation to support the submission and payment of claims;
- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid Program;
- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG);
- Potential termination from the NH Medicaid Program; or
- Other administrative actions.

If a provider is found to have abused the NH Medicaid Program requirements, the provider may be restricted, through suspension or otherwise, from participating in the NH Medicaid Program for a reasonable period of time. In addition, the provider may also have their claims placed on a prepayment pend or hold status for additional review by the Program Integrity Unit.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the Medicaid program is the *payer of last resort*. All third party obligations must be exhausted before claims can be submitted to Xerox in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume I. Providers who receive payment in full from a third party are not required to file zero-payment claims with NH Medicaid.

A provider must first submit a claim to the third party within the third party's time limitations. If a third party or primary insurance plan does not pay at or in excess of the applicable NH Medicaid program reimbursement level, a provider may submit a claim to NH Medicaid which is processed based on the applicable reimbursement rate minus any payment received from all other resources. Commercial health insurance coverage often provides a higher payment than does NH Medicaid.

When a third party denies a claim, for any reason, a copy of the notice of denial from the third party **must be included** behind the claim submitted to the NH Medicaid program. When Medicare denies a claim, a copy of the Explanation of Medicare Benefits must be attached behind the claim that is submitted. For claims not submitted on paper, the Medicare or third-party denial is considered a claim attachment.

Detailed Medicare/Third Party Liability (TPL) information is found in the General Billing Manual, including handling discrepancies in TPL resource information, correcting erroneous TPL information, and exceptions to third party filing requirements.

When a member is also covered by Medicare, the provider must bill Medicare for all services before billing NH Medicaid. The provider must accept assignment of Medicare benefits in order for the claim to “cross over” to the NH Medicaid program. The crossover process works only for Medicare approved services; Medicare denied services and Medicare non-covered services are addressed in this section. NH Medicaid pays crossover claims only if the service is covered by NH Medicaid.

Certain services that are not covered by Medicare *may* be covered by NH Medicaid for dually eligible members. Services identified in the Medicare billing manual and HCPCS coding manuals as non-covered by Medicare may be billed directly to NH Medicaid, who will determine whether or not the service is covered and can be reimbursed by NH Medicaid.

This does not apply to QMB Only members whose benefits are limited to the Medicare premiums and payment toward the Medicare deductible and coinsurance. Therefore, if Medicare does not cover the service, there is no NH Medicaid payment available for QMB members.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

Payment for hearing aid services is made in accordance with a fee schedule established by the Department.

11. Claims

All providers participating in NH Medicaid must submit claims to the fiscal agent in accordance with NH Medicaid guidelines. Providers should note that NH Medicaid claim completion requirements may be different than those for other payers, previous fiscal agents, or fiscal agents in other states.

Providers participating in NH Medicaid are responsible for timely and accurate billing. If NH Medicaid does not pay due to billing practices of the provider which result in non-payment, the provider cannot bill the member

Claim completion guidelines in this manual should be followed for instructions on specific fields. The NH Specific Companion Guide, which can be found at www.nhmmis.nh.gov, (see provider manuals under the provider tab), should be used for electronic claim filing instructions. While field-by-field requirements are shown for paper claims; the same required data is captured through web portal claim entry and through electronic submissions to EDI. Web portal submissions feature step-by-step claim completion instructions as well as tools such as Online Help to assist providers in correct claim completion.

Regardless of the method claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

The following claim-related topics are found in the General Billing Manual – Volume I:

- Claims Submission via EDI, web portal, paper
- Claims processing – edits & audits, transaction control numbers, line item vs. header processing, claim status, remark/EOB codes
- Claim Resubmission
- Claim adjustments and voids
- Medicare cross-overs
- Claims payment
- Remittance Advice

Providers will be notified of payment or denial via a Remittance Advice, usually received in electronic format or via the web portal.

Denied claims should be resubmitted only if the reason for the denial has been corrected.

Paid claims cannot be resubmitted; resubmission of a paid claim will result in a denial as a duplicate. Paid claim corrections must be made through the adjustment process. If a paid claim has a line item denial, the individual line charge can be resubmitted.

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information which is now corrected. Providers should never resubmit claims that are currently in process (suspended).

Any claim denied for failure to be submitted or resubmitted in accordance with timely filing standards will not be paid. Denied claims that have been corrected must be resubmitted as a new claims transaction on paper, via the web portal, or electronically via EDI.

Timely Filing

In accordance with federal and state requirements, all providers must submit all initial claims within one year following the earliest date of service on the claim.

Except as noted below, NH Medicaid will **not** pay claims that are **not** submitted within the one-year time frame.

Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper along with Form 957x, “Override Request,” located on the NH MMIS Health Enterprise Portal web site at www.nhmmis.nh.gov. A copy of the RA with the original billing date and the denial circled must also be attached. This resubmission **must** be received **within 15 months** of the date of service. If this time frame is not met, the claim will be denied.

The only other circumstance eligible for consideration under the one-year override process is for claims for NH Medicaid covered services for clients whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above.

Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis and procedure codes. One procedure code must be provided for each charge billed.

For medical services, NH Medicaid requires use of the most current published editions of the current procedural terminology (CPT) and/or the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

ICD-9-CM diagnosis codes are required for all services billed on medical claims forms (CMS-1500).

Claims without the required diagnosis or procedure codes will be denied.

Service Authorizations (SAs)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, NH Medicaid does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

Required Claim Attachments

All attachments must be submitted in hardcopy or via fax. Providers that submit claims on paper claims should have the claim attachment stapled behind the claim form. Providers that submit claims electronically or via the NH MMIS Health Enterprise Portal must first submit the claim and obtain a Transaction Control Number (TCN) for the line requiring the attachment. Attachments in hard-copy format must then be sent to the fiscal agent with a cover sheet identifying the TCN for the claim. Failure to provide the TCN on the submitted attachments could result in claim denial due to missing or incomplete information.

When submitting a claim via the NH MMIS Health Enterprise Portal, providers must indicate in the claim form if there is an attachment to support the claim. Providers should answer yes to the question “Does this claim have attachments?” and click “Add Attachment” **Note:** Please select Delivery Method “by Mail” or “by Fax” to submit attachments.

Type Attachment ▼	Delivery Method ▲	Attachment Control # ▼
No Data		

Following claim submission a confirmation page will generate. Please print the confirmation page and submit it as a cover page with the claim attachments. If you are unable to print the confirmation page please write the 17 digit TCN on the attachment.

- **Please mail claim attachments to:**
 Xerox Claims Unit
 PO Box 2003
 Concord, NH 03302

- **Please fax claim attachments to:**
 (888) 495-8169

If you are submitting EDI claims, paper attachments to Electronic 837P claims are indicated in the 2300 PWK segment, the 2400 PWK segment, or both. The hard copy attachment is submitted via fax or on paper and linked to the related claim by means of an Attachment ID (your TCN).

Examples of , but not inclusive of, when a claim attachment is required are when another insurer is primary and has denied coverage for the service or a 957x form is required because the filing limit was not met.