

**MARYLAND MEDICAL ASSISTANCE**

**EARLY AND PERIODIC SCREENING, DIAGNOSIS,  
AND TREATMENT (EPSDT) PROGRAM  
AUDIOLOGY PROVIDER MANUAL**

**Revised July 01, 2016**

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## **Purpose**

The purpose of this manual is to provide policy and billing instructions for Medical Assistance providers who bill on the CMS 1500/837P claim format and are reimbursed under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Audiology fee schedule. To review regulations for the EPSDT Audiology Services, you may go to: [www.dsd.state.md.us](http://www.dsd.state.md.us) (COMAR 10.09.51).

## **Overview**

Audiologist and hearing aid service coverage is limited to Maryland Medicaid's EPSDT Program population (20 years of age or younger) who are at risk for hearing impairment. At risk for hearing impairment means the condition of a recipient with a suspect or positive hearing screening.

As of November 1999, audiologist and hearing aid dispenser services for the EPSDT population were "carved out" from the managed care organization (MCO) payment system. These services were placed back into Maryland Medicaid's fee-for-service (FFS) system of payment. The recipient *does not* have to receive a preauthorization or referral from the MCO before visiting an audiologist for evaluation and/or treatment. Maryland Medicaid requires preauthorization on certain services. In order to determine which service requires preauthorization, review the attached fee schedule for audiology services.

## **Covered Services**

All services for which reimbursement is sought must be provided in accordance with the Maryland Medical Assistance EPSDT Audiology Services (COMAR 10.09.51).

The Program covers the following medically necessary audiological services for EPSDT recipients who are risk for hearing impairment:

- 1) Audiological assessments;
- 2) Electrophysiological measures such as auditory brainstem response (ABR), otoacoustic emissions, and brainstem auditory evoked response for recipients, when one of the following criteria is met:
  - (a) Failure of the recipient to provide consistent behavioral responses to auditory signals, using procedures appropriate for the recipient's developmental age;
  - (b) Presence of neuromotor involvement or behavioral disorder, or both, which precludes observation of consistent behavioral responses;
  - (c) Failure to respond to test signal intensities appropriate for the recipient's developmental age, using developmentally appropriate test procedures;

(d) Presence of inconsistencies in the results of tests administered during the audiological assessment which suggest, but do not define, a hearing impairment;

(e) The Infant High Risk Questionnaire delineates a need; or

(f) A physician refers the infant for the service;

3) Hearing aid evaluations; and

4) All services as listed on the Audiology Procedure Code and Fee Schedule, Revision 2010 contained in the EPSDT Audiology Provider Manual dated November 1, 2010.

B. Medically necessary hearing aid services, as follows:

1) Hearing aids which are:

(a) Not used or rebuilt, and which meet the current standards set forth in 21 CFR §§801.420 and 801.421, which are incorporated by reference,

(b) Recommended and fitted by an audiologist in conjunction with written medical clearance from a physician who has performed a medical examination within 6 months,

(c) Sold on a 30-day trial basis,

(d) Fully covered by a repair warranty for a period of 2 years, at least 1 year of which is provided by the manufacturer at no cost to the Program, and

(e) Insured for loss or theft for a period of 2 years per hearing aid; and

2) Hearing aid accessories and services, as listed below:

(a) Ear molds,

(b) Batteries,

(c) Chest harnesses or belts,

(d) Replacement receivers and cords,

(e) Tone hooks,

(f) Huggie aids,

(g) Protective coverings for hearing aids,

(h) Battery testers,

(i) Dehumidification kits,

(j) Hearing aid stethoscopes,

- (k) Other amplification-related items recommended by an audiologist,
- (l) Routine follow-ups and adjustments,
- (m) Repairs after all warranties have expired,
- (n) Insurance policies as required by §B(1)(c) and (d) of this regulation, and
- (o) Extended repair warranties.

### **Service Limitations**

A. Covered audiology and postoperative cochlear implant services are limited to:

- (1) Recipients under 21 years old who are referred for the service or have had cochlear implant surgery;
- (2) One audiological assessment per year, unless the time limitations are waived by the Program;
- (3) One monaural or binaural hearing aid every 3 years unless the Program approves more frequent replacement;
- (4) Replacement of hearing aids that have been lost, stolen, or damaged beyond repair, after all warranties and insurance policies have expired;
- (5) Repairs and replacements that take place after all warranties and insurance policies have expired;
- (6) A maximum of 48 batteries per recipient per year for a monaural hearing aid, or 96 batteries per recipient per year for a binaural hearing aid, purchased from the Department not more frequently than every 6 months, and in quantities of 24 or fewer for a monaural hearing aid, or 48 or fewer for a binaural hearing aid;
- (7) A maximum of 476 disposable batteries for a cochlear implant per calendar year, purchased every 6 months in quantities of 238 or fewer.
- (8) Two replacement cochlear implant component rechargeable batteries per 12-month period;
- (9) Two cochlear implant replacement transmitter cables per 12-month period;
- (10) Two cochlear implant replacement headset cables per 12-month period; and
- (11) Charges for routine follow-ups and adjustments which occur more than 60 days after the dispensing of a new hearing aid.

B. Services which are not covered are:

- (1) Services not medically necessary;
- (2) Hearing aids and accessories not medically necessary;
- (3) Cochlear implant services and external components not medically necessary;
- (4) Cochlear implant audiological services and external components provided less than 90 days after the surgery or covered through initial reimbursement for the implant and the surgery;
- (5) Spare or backup cochlear implant speech processors;
- (6) Upgrades to new generation hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;
- (7) Replacement of hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;
- (8) Spare or backup hearing aids, equipment, or supplies;
- (9) Repairs to spare or backup hearing aids, equipment, or supplies;
- (10) Investigational, experimental, or ineffective services or devices, or both;
- (11) Educationally or socially needed services or equipment;
- (12) Replacement of improperly fitted ear mold or ear molds unless:
  - (a) Replacement service is administered by someone other than the original provider; and
  - (b) Replacement service has not been claimed before;
- (13) Additional professional fees and overhead charges for a new hearing aid when a dispensing fee claim has been made to the Program; and
- (14) Loaner hearing aids.

## **Eligibility Verification System – (EVS)**

The Eligibility Verification System (EVS) is a telephone inquiry system that enables health care providers to verify quickly and efficiently a Medicaid recipient's current eligibility status. Medicaid eligibility should be verified on EACH DATE OF SERVICE *prior* to rendering services. Although Medicaid eligibility validation via the Program's EVS system is not required, it is to your advantage to do so to prevent the rejection of claims for services rendered to a canceled/non-eligible recipient. ***Before rendering a Medicaid service, verify the recipient's eligibility on the date of service via the Program's Eligibility Verification System (EVS) 1-866-710-1447.***

If you need additional EVS information, please call the Provider Relations Unit at 410-767-5503 or 800-445-1159. EVS is an invaluable tool that is fast and easy to use.

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application, is now available at [www.emdhealthchoice.org](http://www.emdhealthchoice.org). The provider must be enrolled in eMedicaid in order to access the web EVS system. For additional information view the website or contact 410-767-5340 for provider application support.

## **Preauthorization Requirements**

A. The Department shall issue preauthorization for EPSDT Audiology Services when the provider:

- (1) Meets Program procedures and limitations; and
- (2) Submits to the Department adequate documentation demonstrating that the services to be preauthorized are necessary, as stated in COMAR 10.09.23.07.

B. The Program requires preauthorization for the following audiology services:

- (1) Certain hearing aids;
- (2) Unlisted hearing aid accessories; and
- (3) Unlisted post-cochlear implant external components.

C. Preauthorization for audiology services expires 6 months from the authorized span of time that is issued by the Department and is valid if the recipient is eligible at the time the service is rendered to the recipient.

D. The following written documentation shall be submitted by the provider with each new hearing aid that requires preauthorization:

- (1) Audiology report;
- (2) Audiogram; and
- (3) Written medical approval by a physician.

A preauthorization request for EPSDT audiologist or hearing aid dispenser service is submitted on form DHMH 4525. The provider must complete, sign (original signature from the audiologist or hearing aid dispenser is required) and mail to the address listed on the form *prior* to rendering the service to the recipient to ensure coverage. It is imperative that correct procedure codes be placed on the request form. Incorrect or omitted information will result in a rejected request.

Determination of authorization is issued via a letter after the receipt and review of the request (form DMHM-4525) has taken place. A copy of the notification letter is sent to the provider as well as to the recipient.

### **Billing Information**

Services such as developmental screens or pure tone audiologic screening tests provided by a physician or nurse practitioner to identify children who need a referral for further evaluation are not billable to the Medical Assistance Program. These screening tests remain the responsibility of the child's MCO and need to be provided within the MCO'S guidelines. Newborn hearing screens, in or out of the hospital, also remains under the MCO payment system.

### **Payment Procedures**

Providers shall submit requests for payment for Audiology services as stated in COMAR 10.09.36. A copy of the EPSDT: Audiology Services Procedure Code and Fee Schedule can be viewed by visiting the following Program website:

[www.dhmf.maryland.gov/providerinfo](http://www.dhmf.maryland.gov/providerinfo)

- A. Providers shall submit requests for payment for audiology services as stated in COMAR 10.09.36.04.
- B. The Audiology Procedure Code and Fee Schedule, Revision July, 2016 is incorporated by reference and is contained in the EPSDT Audiology Provider Manual revised July 1, 2016.
- C. Audiologists, audiological centers, and hearing aid dispensers shall charge the Program usual and customary charges, not exceeding those charged to the general public for similar professional services.
- D. The provider shall charge the Program the acquisition cost for certain hearing aids, accessories, external cochlear implant accessories, and supplies.
- E. The provider shall itemize all hearing aid and external cochlear implant charges including accessories, supplies, shipping or handling, or both, insurance, and warranties.
- F. The provider shall submit the request for payment on the form designated by the Department.
- G. The provider may not bill the Department for:
  - (1) Completion of forms and reports;

- (2) Broken or missed appointments;
- (3) Professional services rendered by mail or telephone; and
- (4) Services provided at no charge to the general public.

H. Audiological centers licensed as a part of a hospital may charge for and be reimbursed according to rates approved by the Health Services Cost Review Commission (HSCRC), set forth in COMAR 10.37.03.

I. The provider shall refund to the Program payment for hearing aids, supplies, or both, that have been returned to the manufacturer.

J. The provider shall give the Program the full advantage of any and all manufacturer's warranty and trade-ins offered on hearing aids, equipment, or both.

K. The Program shall reimburse for covered services at the lower of:

- (1) The provider's usual and customary charge to the general public; or
- (2) The Program's fee schedule; or
- (3) The provider's acquisition cost.

### **The Health Insurance Portability and Accountability Act Of 1996(HIPAA) and NPI**

**HIPAA is the** Health Insurance Portability and Accountability Act. HIPAA requires that standard electronic health transactions be used by health plans, including private, commercial, Medicaid and Medicare, healthcare clearinghouses and health care providers. The intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes. More information on HIPAA can be found at:

<http://dhmh.maryland.gov/hipaa/Pages/Home.aspx> .

The National Provider Identifier (NPI) is a 10 digit, numeric identifier that does not expire or change. It is administered by CMS and is required by HIPAA. The NPI will replace all of your existing provider numbers that you use to bill Medicaid, Medicare and other health care payers.

If you have not applied for your NPI, please do so at once and report it to us. You should be using the NPI as the primary identifier and your Medicaid Provider number as the secondary identifier on all paper and electronic claims.

**FREQUENTLY REQUESTED TELEPHONE NUMBERS**

<b>Audiology Policy/Coverage Issues</b>	<b>(410) 767-1903</b>
<b>Healthy Start/Family Planning Coverage</b>	<b>(800) 456-8900</b>
<b>MD Medicaid Children's Services</b>	<b>(410) 767-1903</b>
<b>REM Program</b>	<b>(800) 565-8190</b>
<b>Eligibility Verification System (EVS)</b>	<b>(866) 710-1447</b>
<b>BD of Audiologists/Hearing Aid Dispensers/Speech Language Pathologists</b>	<b>(410) 764-4725</b>
<b>Provider Enrollment P.O. Box 17030 Baltimore, MD 21203</b>	<b>(410) 767-5340</b>
<b>Provider Relations P.O. Box 22811 Baltimore, MD 21203</b>	<b>(410) 767-5503 (800) 445-1159</b>
<b>Missing Payment Voucher/Lost or Stolen Check</b>	<b>(410) 767-5503</b>
<b>Third Party Liability/Other Insurance</b>	<b>(410) 767-1771</b>
<b>Recoveries</b>	<b>(410) 767-1783</b>

**AUDIOLOGY PROCEDURE CODES AND FEE SCHEDULE JULY 1, 2016****KEY**

- \* REQUIRES PREAUTHORIZATION FOR ALL RECIPIENTS  
 \*\* REQUIRES PREAUTHORIZATION FOR RECIPIENTS 3 YEARS OLD AND OLDER  
 A/C ACQUISITION COST TO THE PROVIDER [PROVIDER MUST BILL ACQUISITION COST]  
 B/R BY REPORT-ATTACH AUDIOLOGY REPORT, AUDIOGRAM, MEDICAL CLEARANCE & INVOICE TO CLAIM  
 I/C INDIVIDUAL CONSIDERATION

**AUDIOLOGY SERVICES**

<b>PROCEDURE CODE</b>	<b>BRIEF DESCRIPTION</b>	<b>MAXIMUM FEE</b>
92550	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS (DO NOT REPORT 92567 OR 92568 IN ADDITION TO 92550)	\$35.00
92551	SCREENING TEST, PURE TONE, AIR ONLY	\$7.82
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	\$ 18.58
92557	COMPREHENSIVE AUDIOMETRY- PURE TONE, AIR AND BONE, AND SPEECH THRESHOLD AND DISCRIMINATION - <b>ANNUAL AUDIOLOGICAL ASSESSMENT</b> ( <i>annual limitation may be waived if medically necessary and appropriate</i> )	\$ 46.80
92567	TYMPANOMETRY (IMPEDANCE TESTING) (DO NOT REPORT 92550 OR 92568 IN ADDITION TO 92567)	\$ 20.00
92568	ACOUSTIC REFLEX TESTING; threshold (DO NOT REPORT 92550 OR 92567 IN ADDITION TO 92568)	\$ 16.22
92570	ACOUSTIC IMMITTANCE TESTING (INCLUDES TYMPANOMETRY ACOUSTIC REFLEX THRESHOLD AND ACOUSTIC REFLEX DECAY TESTING)	\$50.00
92585	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR) <u>COMPREHENSIVE</u>	\$140.00
92586	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR)- <u>LIMITED</u>	\$70.00
92587	EVOKED OTOACOUSTIC EMISSIONS; <u>LIMITED</u> (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCTS)	\$50.00
92588	EVOKED OTOACOUSTIC EMISSIONS; <u>COMPREHENSIVE</u> (COMPARISON OF TRANSIENT AND/OR DISTORTION PRODUCT OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND FREQUENCIES)	\$75.00
92601	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, PATIENT UNDER 7 YEARS OF AGE; WITH PROGRAMMING	\$140.40
92602	SUBSEQUENT REPROGRAMMING (DO NOT REPORT 92602 IN ADDITION TO 92601)	\$ 96.30
92603	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, AGE 7 YRS OR OLDER, WITH PROGRAMMING	\$108.84
92604	SUBSEQUENT REPROGRAMMING (DO NOT REPORT 92604 IN ADDITION TO 92603)	\$65.33
92620	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT; INITIAL 60 MINUTES	\$50.00

<b>PROCEDURE CODE</b>	<b>BRIEF DESCRIPTION</b>	<b>MAXIMUM FEE</b>
92550	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS (DO NOT REPORT 92567 OR 92568 IN ADDITION TO 92550)	\$35.00
92551	SCREENING TEST, PURE TONE, AIR ONLY	\$7.82
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	\$ 18.58
92557	COMPREHENSIVE AUDIOMETRY - PURE TONE, AIR AND BONE, AND SPEECH THRESHOLD AND DISCRIMINATION - <b>ANNUAL AUDIOLOGICAL ASSESSMENT</b> ( <i>annual limitation may be waived if medically necessary and appropriate</i> )	\$ 46.80
92567	TYMPANOMETRY (IMPEDANCE TESTING) (DO NOT REPORT 92550 OR 92568 IN ADDITION TO 92567)	\$ 20.00
92568	ACOUSTIC REFLEX TESTING; threshold (DO NOT REPORT 92550 OR 92567 IN ADDITION TO 92568)	\$ 16.22
92570	ACOUSTIC IMMITTANCE TESTING (INCLUDES TYMPANOMETRY ACOUSTIC REFLEX THRESHOLD AND ACOUSTIC REFLEX DECAY TESTING)	\$50.00
92585	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR) <u>COMPREHENSIVE</u>	\$140.00
92586	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR)- <u>LIMITED</u>	\$70.00
92587	EVOKED OTOACOUSTIC EMISSIONS; <u>LIMITED</u> (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCTS)	\$50.00
92588	EVOKED OTOACOUSTIC EMISSIONS; <u>COMPREHENSIVE</u> (COMPARISON OF TRANSIENT AND/OR DISTORTION PRODUCT OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND FREQUENCIES)	\$75.00
92601	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, PATIENT UNDER 7 YEARS OF AGE; WITH PROGRAMMING	\$140.40
92602	SUBSEQUENT REPROGRAMMING (DO NOT REPORT 92602 IN ADDITION TO 92601)	\$ 96.30
92603	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, AGE 7 YRS OR OLDER, WITH PROGRAMMING	\$108.84
V5299	HEARING SERVICE, MISCELLANEOUS (Procedure not listed; service not typically covered, request for consideration. Documentation demonstrating medical necessity required– to be submitted with preauthorization request.)	I/C*

**HEARING AID AND COCHLEAR IMPLANT CODES AND SUPPLIES**

<b>PROCEDURE CODE</b>	<b>BRIEF DESCRIPTION</b>	<b>MAXIMUM FEE</b>
92590	HEARING AID EXAMINATION AND SELECTION; MONAURAL	\$78.00
92591	HEARING AID EXAMINATION AND SELECTION; BINAURAL	\$78.00
92592	HEARING AID CHECK; MONAURAL	\$42.00
92593	HEARING AID CHECK, BINAURAL	\$42.00
L8614	COCHLEAR DEVICE/SYSTEM (LIMITED EXTERNAL REPLACEMENT COMPONENTS)	B/R*
L8615	COCHLEAR IMPLANT HEADSET/HEADPIECE, REPLACEMENT	\$450.00
L8616	COCHLEAR IMPLANT MICROPHONE, REPLACEMENT	\$288.00
L8617	COCHLEAR IMPLANT TRANSMITTING COIL, REPLACEMENT	\$126.00
L8618	COCHLEAR IMPLANT TRANSMITTER CABLE, REPLACEMENT	\$28.00
L8619	COCHLEAR IMPLANT EXTERNAL SPEECH PROCESSOR (LIMITED TO NON-REPAIRABLE OUT OF WARRANTY CASES)	A/C*
L8621	COCHLEAR IMPLANT, BATTERY, ZINC AIR, REPLACEMENT	\$ 1.56
L8622	COCHLEAR IMPLANT, BATTERY, ALKALINE, REPLACEMENT	\$ 1.56
L8623	COCHLEAR IMPLANT SPEECH PROCESSOR LITHIUM ION BATTERY, (REPLACEMENT)	\$150.00
L8624	COCHLEAR IMPLANT SPEECH PROCESSOR LITHIUM ION BATTERY, EAR (REPLACEMENT)	\$150.00
V5030	BODY WORN, AIR CONDUCTION HEARING AID	B/R
V5040	BODY WORN, BONE CONDUCTION HEARING AID	\$2500
V5050	MONAURAL, IN THE EAR	\$350.00
V5060	MONAURAL BEHIND THE EAR AIDS (SPECIFY)	\$350.00
V5080	GLASSES, BONE CONDUCTION	A/C*
V5100	BODY WORN, BILATERAL	B/R
V5120	BODY, BINAURAL	B/R
V5130	IN THE EAR, BINAURAL	\$700.00
V5140	BEHIND THE EAR, BINAURAL (SPECIFY)	\$700.00
V5150	GLASSES, BINAURAL	A/C*
<b>V5160</b>	<b>DISPENSING FEE, BINAURAL</b>	<b>\$175.00</b>
V5170	CROS, IN THE EAR	\$1600.00
V5180	CROS, BEHIND THE EAR	\$1190.00
V5190	CROS, GLASSES	A/C*
<b>V5200</b>	<b>DISPENSING FEE, CROS</b>	<b>\$106.00</b>
V5210	BICROS, IN THE EAR	\$1190.00
V5220	BICROS, BEHIND THE EAR	\$1190.00
V5230	BICROS, GLASSES	A/C*

<b>PROCEDURE CODE</b>	<b>BRIEF DESCRIPTION</b>	<b>MAXIMUM FEE</b>
<b>V5240</b>	<b>DISPENSING FEE, BICROS</b>	<b>\$106.00</b>
V5242	ANALOG, MONAURAL, CIC (COMPLETELY IN THE EAR CANAL)	A/C*
V5243	ANALOG, MONAURAL, ITC (IN THE CANAL)	A/C*
V5244	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, CIC	A/C*
V5245	DIGITALLY PROGRAMMABLE ANALOG MONAURAL, ITC	A/C*
V5246	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, ITE (IN THE EAR)	A/C*
V5247	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, BTE (BEHIND THE EAR)	\$900.00
V5248	ANALOG, BINAURAL, CIC	A/C*
V5249	ANALOG, BINAURAL, ITC	A/C*
V5250	DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, CIC	A/C*
V5251	DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, ITC	A/C*
V5252	DIGITALLY PROGRAMMABLE, BINAURAL, ITE	\$1900.00
V5253	DIGITALLY PROGRAMMABLE, BINAURAL, BTE	\$1900.00
V5254	DIGITAL, MONAURAL, CIC	A/C*
V5255	DIGITAL, MONAURAL, ITC	A/C*
V5256	DIGITAL, MONAURAL, ITE	\$950.00
V5257	DIGITAL, MONAURAL, BTE	\$950.00
V5258	DIGITAL, BINAURAL, CIC	A/C*
V5259	DIGITAL, BINAURAL, ITC	A/C*
V5260	DIGITAL, BINAURAL, ITE	\$1900.00
V5261	DIGITAL, BINAURAL, BTE	\$1900.00
V5160	DISPENSING FEE+, BINAURAL	\$175.00
V5200	DISPENSING FEE+, CROS	\$106.00
V5240	DISPENSING FEE+, BICROS	\$106.00
V5241	DISPENSING FEE +, MONAURAL	\$106.00
V5264	EAR MOLD, NOT DISPOSABLE, (LIMITATION = UP TO 2 PER MONAURAL/4 PER BINAURAL PER YEAR)	\$ 27.00
V5266	REPLACEMENT BATTERY FOR USE IN HEARING DEVICE MAXIMUM 48 PER YEAR FOR MONAURAL MAXIMUM 96 PER YEAR FOR BINAURAL	\$ 1.56
V5267	HEARING AID SUPPLIES /ACCESSORIES <i>(Medically necessary and effective services. Note: prophylactic ear protection - a copy of the signed Rx from the primary care doctor, and a documented history of tympanostomy tube must be on file.)</i>	A/C*
V5014	REPAIR/MODIFICATION OF A HEARING AID	\$250.00

PROCEDURE CODE	BRIEF DESCRIPTION	MAXIMUM FEE
	<i>(Extended warranty period for aid has expired. Note: Regulations stipulate that new aids be fully covered by a repair warranty and insured for loss or theft for a period of 2 years per hearing aid.)</i>	
X0103	HEARING AID INSURANCE/WARRANTY	\$150.00
99002	HANDLING/CONVEYANCE SERVICE FOR DEVICES	\$15.00

## MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE PREAUTHORIZATION REQUEST FORM AUDIOLOGY SERVICES

### SECTION I - Patient Information

Medicaid Number | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ |

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
 (Last) (First) (MI)

Address \_\_\_\_\_

### SECTION II - Preauthorization General Information

Pay to Provider Number | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ |

Name \_\_\_\_\_ Request Date \_\_\_\_\_

Address \_\_\_\_\_

Contact \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Provider's Signature \_\_\_\_\_

### SECTION III - Additional Preauthorization Information

Prescribing Audiologist | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ |

Provider Number

Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

### SECTION IV - Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE		REQUESTED UNITS	REQUESTED AMOUNT	DATES OF SERVICE		AUTHORIZED	
	CODE	MOD			FROM	THRU	UNITS	AMOUNT
_____	_____	_____	_____	\$ _____	____/____/____	____/____/____	_____	_____
_____	_____	_____	_____	\$ _____	____/____/____	____/____/____	_____	_____
_____	_____	_____	_____	\$ _____	____/____/____	____/____/____	_____	_____

PREAUTHORIZATION NUMBER  
Eligibility Services

SUBMIT TO: Office of Operations and

Division of Claims Processing  
P.O. Box 17058  
Baltimore, Maryland 21203

\_\_\_\_\_

DOCUMENT CONTROL NUMBER  
(STAMP HERE)

DHMH 4525 Rev.3/97  
SEE REVERSE SIDE  
PA- 1

**MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL  
HYGIENE  
PREAUTHORIZATION REQUEST FORM  
AUDIOLOGY SERVICES**

SECTION V - Specific Program Preauthorization Information

Patient Location: Home\_\_\_ Nursing Home \_\_\_ Hospital Inpatient\_\_\_ Discharge Date \_\_\_\_\_

Address where equipment will be used (if different from Above):

Period of time required:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

MFGR

MODEL/PRODUCT

SINGLE UNIT

AMT. PKG

_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

Diagnosis and Present Physical Condition \_\_\_\_\_

Prognosis \_\_\_\_\_

Treatment Plan \_\_\_\_\_

Expected Therapeutic Effect \_\_\_\_\_  
\_\_\_\_\_

SECTION VI (DHMH USE ONLY)

\_\_\_\_\_ Approved                      \_\_\_\_\_ Denied

REASON (S) \_\_\_\_\_

Medical Consultant's Signature \_\_\_\_\_ Date \_\_\_\_\_

PA-2



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										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)										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					8. RESERVED FOR NUCC USE										CITY					STATE														
ZIP CODE					TELEPHONE (Include Area Code) ( ) ( )					9. RESERVED FOR NUCC USE										ZIP CODE					TELEPHONE (Include Area Code) ( ) ( )														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																			
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																																							
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.										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 _____										SIGNED _____																													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										15. OTHER DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
QUAL. _____										QUAL. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
										17b. NPI _____																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind. _____										23. PRIOR AUTHORIZATION NUMBER _____																			
A. _____		B. _____		C. _____		D. _____		E. _____		F. _____		G. _____		H. _____		I. _____		J. _____																					
E. _____		F. _____		G. _____		H. _____		I. _____		J. _____		K. _____		L. _____																									
I. _____		J. _____		K. _____		L. _____																																	
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/HCP/CS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																					
1																																							
2																																							
3																																							
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER					SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Rsvd for NUCC Use									
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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ( )																			
SIGNED _____ DATE _____										a. NPI _____					b. _____					a. NPI _____					b. _____														

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

#### **REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND TRICARE PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### **BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

#### **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)**

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

#### **NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

#### **MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.