DEPARTMENT FOR MEDICAID SERVICES
HEARING PROGRAM MANUAL
Policies and Procedures

Cabinet for Health Services
Department for Medicaid Services
Frankfort, KY 40621

TABLE OF CONTENTS

I. INTRODUCTION..... 4
Introduction... 4
Fiscal Agent... 4
General Information.. 4

II. COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM. ..... 6 - 9
A. Policy. 6
B. Appeal Process for Refund Process .. 7
C. Timely Submission of Claims 8
D. Kentucky Patient Access and Care System (KenPAC) 8
E. Lock-In Program 9
F. Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program 9

III. CONDITIONS OF PARTICIPATION 11 - 12
A. General Information.. 11
B. Licensure 11
C. Clinics 12
D. Freedom of Choice Concept.. 12

IV. PROGRAM COVERAGE 14 - 23
A. Audiology Services 14 - 17
B. Hearing Instrument Services 18 - 23

V. REIMBURSEMENT. 25 - 26
A. Audiologist 25
B. Hearing instrument Dealers... 25
C. Fees – Duplicate or Inappropriate 25
D. Fee Payment by Recipient 26

Appendix I - Diagnosis Codes Frequently Used for Hearing Services

SECTION I

INTRODUCTION

SECTION I – INTRODUCTION

I. INTRODUCTION

A. Introduction

The Kentucky Hearing Medicaid Manual offers providers a tool to be used when delivering services to qualified Medicaid members. This manual contains basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid members.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers non-covered services.

The Kentucky Medicaid Program serves eligible members of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to the Hearing Program shall be specified in the body of this manual in Section IV, Program Coverage.

SECTION II

KENTUCKY MEDICAID PROGRAM

SECTION II – KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid program shall be to ensure the availability and accessibility of quality medical care to eligible program members. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical - expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services prior to billing Medicaid. If a provider receives payment from a member, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid allowable fee.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid covered services in compliance with federal and state statutes age, color, creed, disability, gender, status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Program in accordance with 907 KAR 1:672. From those professionals who have chosen to participate, members may select the provider from whom they wish to receive their medical care.

.

If the Kentucky Department of Medicaid makes payment for a covered service and the provider accepts this payment in accordance with Medicaid's fee structure, the amounts paid shall be considered payment in full; billing for the same services shall not be tendered to the member and a payment for the same service shall not be accepted from the member. The provider may only bill the member for services not covered by Kentucky Department of Medicaid.

The provider's adherence to the application of policies in this manual shall be monitored through either post-payment review of claims by the Department, or

computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and legislative, judiciary and administrative branches.

All services provided to eligible Medicaid members shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All members shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Providers of medical service or authorized representatives attest by their signature (not facsimiles) on the claim form submitted, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment or both. Stamped or computer generated signatures shall not be acceptable.

Claims shall not be allowed for services outside the scope of allowable benefits or licensure within a particular program specialty. Likewise, claims shall not be paid for services that require and were not granted prior authorizations by the Kentucky Medicaid Program. In addition: providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672 and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The members may be billed for non-covered items and services. Providers shall notify members in advance of their liability for the charges for non-medically necessary and non-covered services.

If a member makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a member with spend-down coverage may be responsible for a portion of the medical expenses they have incurred.

B. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the post payment review of claims shall result in a refund request.

If a request occurs subsequent to a post payment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing

clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to:

DIVISION OF HOSPITAL AND PROVIDER OPERATIONS
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH AND FAMILY SERVICES
275 EAST MAIN STREET 6C-B
FRANKFORT, KENTUCKY 40621

If no response (refund or appeal) has been filed with Medicaid by the provider within thirty days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty days, Medicaid shall deduct the refund amount from future payments.

C. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve months of the date of service or six months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define: "Timely submission of claims" **as received** by Medicaid "no later than twelve months from the date of service." Received is defined in 42 CFR 447.45(d) (5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim."

To consider those claims twelve months past the date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve months elapsed between EACH RECEIPT of the aged claim by the Kentucky Department of Medicaid.

D. Kentucky Patient Access and Care System (KENPAC)

KENPAC is a statewide patient care system which provides Medicaid members with a primary care provider. The primary care provider shall be responsible for providing or arranging for the member's primary care and for referral of other medical services. For more information, contact member services at 1-800-635-2570.

E. Lock-in Program

The Department shall monitor and review utilization patterns of Medicaid members to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the member. The Department shall investigate all complaints concerning members who are believed to be over-utilizing the Medicaid Program. For more information, contact member services at 1-800-635-2570.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Under the EPSDT program, Medicaid eligible children from birth through the end of the child's birth month of the twenty first year may receive preventative, diagnostic and treatment services by participating providers. More information regarding the EPSDT program can be obtained by calling the EPSDT program within the Department for Medicaid Services.

SECTION III

CONDITIONS OF PARTICIPATION

SECTION III – CONDITIONS OF PARTICIPATION

A. General Information

Historically for the purposes of participation in the Kentucky Medicaid Program, an eight-digit Medicaid provider number was assigned to each provider. Specialist with hearing instruments' provider numbers began with a prefix of "50" and Audiologist provider numbers began with a prefix of "70". After June 4, 2007 regardless of provider type or specialty, all provider numbers issued will be a ten-digit number beginning with a "71" prefix. Providers enrolled prior to June 4, 2007 may continue to use their existing eight-digit provider numbers.

Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated from Kentucky Medicaid participation, services provided to Kentucky Medicaid members after the effective date of termination shall not be payable.

B. Licensure

All Hearing Instrument Dispensers shall have a current, un-revoked and unsuspended license issued by the Kentucky Licensing Board for Specialist Hearing Instruments under requirements set forth in KRS Chapter 334 or hold a current, unrevoked and unsuspended certificate of endorsement. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Provider Enrollment Section, Division of Hospital and Provider Operations or its contracted enrollment and credentialing entity, for providers who desire to remain actively enrolled. All audiologists shall have and be required to submit proof of a current, unrevoked, unsuspended Kentucky audiologist license issued by the State Board of Speech-Language Pathology and Audiology under KRS Chapter 334. Out-of-State audiologists shall be required to submit proof of a Certificate of Clinical Competence issued by the American Speech-Language-Hearing Association (ASHA), as well as appropriate license(s) as required by their state. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Provider Enrollment Section, Division of Hospital and Provider Operations, for providers who desire to remain actively enrolled.

Note: Non-submission of proof of current licensure result loss of eligibility of the provider and denial of claims submitted for payment.

C. Clinics

Kentucky Medicaid shall permit a group of hearing instrument dispensers or audiologists to enroll in the Program as a clinic under certain conditions. A **clinic** shall be defined by Kentucky Medicaid, as a group of several providers who practice cooperatively and collaboratively, and perform a majority of their services in the primary care setting.

Hearing Instrument Dispensers or audiologists who are employed and salaried by a clinic may request that payment for their individual services provided for eligible Kentucky Medicaid members be made directly to the clinic.

D. Freedom of Choice Concept

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program as set forth in 42 CFR 431.51. Providers shall have the freedom to decide whether or not to accept eligible Medicaid members and to bill the program for the medical care provided.

SECTION IV

PROGRAM COVERAGE

SECTION IV – PROGRAM COVERAGE

A. Audiology Services

1. Eligibility Guidelines

Audiology Services shall be covered for Kentucky Medicaid members under twenty-one years of age upon referral by a physician.
Kentucky Members must apply for Medicaid eligibility through their Department for Community Based Services (DCBS) local office. If you have any questions or concerns, you must contact the Kentucky Administrative Agent (KMAA), which is First Health Services Corporation, at 1-800-635-2570, 8:00 a.m. – 6:00 p.m. Eastern Time, Monday through Friday, except Holidays and select the prompt for Member Eligibility. The primary identification for Medicaid eligible members is the *KyHealth Choices* Card. It is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the Member Identification number is the only data displayed on the card. The provider has the responsibility to check identification and eligibility of each member before providing services. (this information can be verified on KyHealth net).

NOTE: Payment cannot be made for services provided to ineligible members, and/or, Possession of a Member Identification card does not guarantee payment for all medical services.

If there is any doubt about the identity of the patient, you may request a second form of identification. Failure to validate the identity of a Medicaid member prior to a service being rendered may result in being out of compliance with 907 KAR 1:671. Any claims paid by Medicaid Services on behalf of an ineligible person may be recouped from the provider.

Limited Audiology and Hearing instrument Services shall be covered for Kentucky Medicaid Program members under twenty-one years of age.

2. Coverage Requirements

a. Prior to the delivery of a covered audiology service, the service shall be determined by the Kentucky Department of Medicaid to be:

(1) Medically necessary; and

(2) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130

b. The requirements established in subsection (a.) of this section shall not apply to an emergency service.

3. Services Not Covered by the Kentucky Audiology Program

Services not covered by the Kentucky Medicaid Audiology Program shall include the following:

- Routine screening of individuals or groups for identification of hearing problems. Program coverage extends only to those hearing evaluations performed when the member has been referred to the audiologist or hearing clinic by a physician or when there ~~is~~ has been some indication of hearing loss prior to the evaluation.
- Hearing therapy is not covered except as covered through the six month adjustment counseling following the fitting of a hearing instrument.
- Lip reading instructions except as covered in six month adjustment counseling following fitting of a hearing instrument.
- Services for which the member has no obligation to pay and for which no other person has a legal obligation to provide or to make payment (e.g. transportation of equipment for testing fee).
- Telephone calls
- Services associated with investigational research

4. Hearing Evaluations

a. Upon physician referral, one hearing evaluation per year shall be covered for eligible Kentucky Medicaid Program members under twenty-one years of age.

b. Upon physician referral, one hearing instrument evaluation per year when indicated as a result of the hearing evaluation shall be covered for eligible Kentucky Medicaid Program members.

5. Follow-Up Services

a. After a hearing instrument has been fitted as a result of a hearing evaluation, three follow-up visits within six months shall be allowed for eligible Kentucky Medicaid members. To insure that the member has become properly adjusted to the hearing instrument the follow-up care shall include counseling and instructing the member and family as to proper use and care of the aid, plus attention to any psycho-social problems resulting from loss of hearing and the wearing of the aid.

b. After the final fitting of the hearing instrument, a required six month follow-up visit to the audiologist or hearing instrument clinic shall be allowed for eligible Kentucky Medicaid members.

6. Equipment Guidelines

Equipment utilized in performance of tests shall meet National Standard Institute (ANSI) Standards and Specification.

The audiometer shall be checked at least once per year to assure proper functioning. Proof of calibration and repairs shall be available for review. The audiometer shall be checked periodically by the individual who uses the testing equipment, as that individual shall be familiar with the levels of appropriate hearing responses.

7. Audiology Procedure Codes (upon Physician referral only)

Following are the audiology procedures covered by the department and which shall be covered only if a recipient is referred to the licensed audiologist by a physician:

CODE	PROCEDURE DESCRIPTION
92552	Pure Tone audiometry (threshold); air only
92555	Speech audiometry threshold
92556	Speech audiometry threshold; with speech recognition
92557	Comprehensive audiometry eval
92567	Tympanometry
92568	Acoustic reflex testing
92579	Visual reinforcement audiometry
92585	Auditory evoked potentials
92587	Evoked otoacoustic emissions
92588	Comp. or diagnostic eval (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and freq.)
92541	Spontaneous nystagmus test
92542	Positional nystagmus test
92543	Caloric vestibular test
92544	Optokinetic nystagmus test
92545	Oscillating tracking test
92546	Sinusodial vertical axis rotational testing
92547	Use of vertical electrodes

Kentucky Medicaid shall provide audiology services **only by physician referral** for members under twenty-one years of age.

8. Hearing Instrument Recommendations

If a hearing instrument is needed as a result of the Comprehensive Hearing Test and the Assessment for Hearing Instrument for a Kentucky Medicaid member, the audiologist shall request that a hearing instrument be fitted for that member. Upon the request of a hearing instrument for a Kentucky Medicaid member, the member must be provided with the following documentation:

a. Signed and dated statement of medical necessity from the examining physician and
b. A signed and dated recommendation for a hearing instrument to include the type and style of the hearing instrument device. The member shall be instructed to take the documentation to a Kentucky Medicaid participating specialist in hearing instruments to obtain the appropriate hearing equipment.

9. Hearing Instrument Replacement

Reimbursement to Kentucky Medicaid participating audiologists or hearing clinics for a complete re-evaluation of a hearing loss shall be made when loss of or extensive damage to a hearing instrument purchased through the Medicaid Program necessitates replacement of the instrument.

a. If replacement of a hearing instrument becomes necessary within twelve months of the original fitting, the second instrument shall be fitted upon the signed and dated recommendation from the audiologist but coverage shall not exceed $800.00 benefit limit per ear every thirty six months.

b. If replacement of a hearing instrument becomes necessary one year or more of the original fitting, the member shall be examined by a physician and the hearing loss re-evaluated by an audiologist but coverage shall not exceed $800.00 benefit limit per ear every thirty six months.

c. If medical, physical, or other conditions pertinent to the member's hearing loss change to an extent that the use of a hearing instrument other than the aid originally fitted is indicated, the Kentucky Medicaid Program shall reimburse the audiologist or center for a complete re-evaluation of the hearing loss if the required signed and dated statement of medical clearance from the

examining physician states the condition but coverage shall not exceed $800.00 benefit limit per ear every thirty six months.

B. Hearing Instrument Services

1. Eligibility Guidelines

Hearing Instrument Services shall be -covered for eligible Kentucky Medicaid members under twenty-one years of age. Kentucky Members must apply for Medicaid eligibility through their Department for Community Based Services (DCBS) local office. If you have any questions or concerns, you must contact the Kentucky Administrative Agent (KMAA), which is First Health Services Corporation, at 1-800-635-2570, 8:00 a.m. – 6:00 p.m. Eastern Time, Monday through Friday, except Holidays and select the prompt for Member Eligibility. The primary identification for Medicaid eligible members is the *KyHealth Choices* Card. It is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the Member Identification number is the only data displayed on the card. The provider has the responsibility to check identification and eligibility of each member before providing services. (this information can be verified on KyHealth net).

NOTE: Payment cannot be made for services provided to ineligible members, and/or, Possession of a Member Identification card does not guarantee payment for all medical services.

If there is any doubt about the identity of the patient, you may request a second form of identification. Failure to validate the identity of a Medicaid member prior to a service being rendered may result in being out of compliance with 907 KAR 1:671. Any claims paid by Medicaid Services on behalf of an ineligible person may be recouped from the provider.

a. Reimbursement to a Kentucky Medicaid participating specialist in hearing instruments for hearing instruments provided to an eligible member shall be made by Kentucky Medicaid after a licensed physician has examined the member and after a licensed audiologist has verified the member's hearing loss and recommended that a hearing instrument is necessary to improve the member's hearing ability. Examinations by the physician and recommendations by the audiologist shall be provided within ninety days prior to the hearing instrument fitting. (This ninety day period begins on the date of the physician's examination or the audiologist's evaluation, whichever is earlier.) The specialist in hearing instruments shall provide the member with hearing instruments specifically recommended by the audiologist. Hearing

instrument coverage is limited to members under age twenty-one and shall not exceed $800.00 per ear every thirty-six months.

b. If a member loses a hearing instrument purchased through the Medicaid Program or an instrument is damaged to an extent which makes effective repair impossible, Kentucky Medicaid **can** make payment for a replacement hearing instrument but coverage shall not exceed $800.00 per ear every thirty six months. In case of extensive damage, written verification shall be obtained from the manufacturer attesting to the impossibility of repair of the instrument.

1. If replacement of a hearing instrument becomes necessary within one year of the original fitting, the member shall return to an audiologist for consultation and specific instrument recommendation if other than the instrument is replaced.

2. If replacement of a hearing instrument becomes necessary after one year or more, a hearing examination of the member by a physician and an audiologist re-evaluation and hearing instrument recommendation shall be required prior to fitting of the replacement aid.

c. If medical, physical or other conditions pertinent to the members loss change to an extent that use of a hearing instrument other than the instrument fitted is indicated, Medicaid shall reimburse the specialist in hearing instruments for the second hearing instrument if the member has been examined by a physician for the hearing loss and recommendations for fitting of the replacement instrument have been received from an audiologist.

1. Replacement of a hearing instrument shall not be covered upon only the request by the member.

2. Replacement of a hearing instrument for the purpose of incorporating recent improvements or innovations in instruments shall not be covered, unless the replacement will result in appreciable improvement in the member's hearing ability, as determined by evaluation of an audiologist. In these cases, an audiologist's explanation shall accompany the specialist in hearing instruments' billing for the fitting.

Note: Kentucky Medicaid Program reimbursement for hearing instruments shall be considered payment in full for the initial, successful operation of the instrument, plus general service for the instrument for a period of one year. General services shall include any cleaning, repairs to the instrument, which do not necessitate return of the instrument to the manufacturer. If Program payment is requested, the specialist in hearing instruments shall agree to accept this payment as "payment in full" for the items and services, even though the amount of Program reimbursement is less than usual and customary charge for the hearing instrument. A claim shall not be submitted to Kentucky for additional payment. Members shall not be billed for any difference in costs.

Kentucky Medicaid Program reimbursement to a specialist in hearing instruments for hearing instrument repairs, replacement of a hearing instrument and hearing instrument replacement cords shall be contingent upon the member's eligibility for Medicaid benefits on the date of service or date the item is supplied. If a member is not eligible on the date of service, reimbursement for the service provided shall not be made. However the provider can bill for non-covered services but they **can not** balance bill to member. (Can the provider bill the member for the service?)

2. Hearing Instrument Cords

Hearing instrument cords necessary for proper functioning of the hearing instrument shall be payable by Kentucky Medicaid.

3. Hearing Instrument Repairs

Kentucky Program reimbursement to the hearing instrument shall be made only for necessary repairs to the hearing instrument, if repairs entail replacement of vital components of the instrument and necessitate return of the instrument the manufacturer. Reimbursement shall not be made for repairs normally covered by the manufacturer's guarantee.

4. Eyeglass Hearing Instruments

If the member is diagnosed with refractive error and the audiologist recommends an eyeglass hearing instrument, Kentucky Medicaid Program reimbursement shall be made for the hearing instrument and the eyeglass temples **only.** Other financial arrangements for payment of incurred cost of eyeglass fronts and lenses shall be made by the provider.

5. Hearing Instrument Procedure Codes

The following procedure codes and descriptors for instruments and hearing instrument parts shall be reimbursable to specialist in hearing instruments by the Kentucky Medicaid Program and shall be used when submitting claims for reimbursement.

Code	Procedure
V5010	Assessment for Hearing Instrument
V5011	Fitting/Orientation/Checking of Hearing Instrument
V5014	Repair/Modification of Hearing Instrument
V5015	Hearing Instrument Repair Professional Fee
V5020	Conformity Evaluation
V5030	Hearing Instrument, Monaural, Body Aid Conduction
V5040	Hearing Instrument, Monaural, Body Worn, Bone Conduction
V5050	Hearing Instrument, Monaural, In the Ear Hearing,
V5060	Hearing Instrument, Monaural, Behind the Hearing
V5070	Glasses; Air Conduction
V5080	Glasses; Bone Conduction
V5090	Dispensing Fee, Unspecified Hearing Instrument
V5095	Semi-implantable Middle Ear Hearing Prosthesis
V5100	Hearing Instrument, Bilateral, Body Worn
V5120	Binaural; Body
V5130	Binaural; In the Ear
V5140	Binaural; Behind the Ear
V5150	Binaural; Glasses
V5160	Dispensing Fee, Binaural
V5170	Hearing Instrument, Cros, In the Ear
V5180	Hearing Instrument, Cros, Behind the Ear
V5190	Hearing Instrument, Cros, Glasses
V5200	Dispensing Fee, Cros
V5210	Hearing Instrument, Bicros, In the Ear
V5220	Hearing Instrument, Bicros, Behind the Ear
V5230	Hearing Instrument, Bicros, Glasses
V5240	Dispensing Fee, Bicros
V5241	Dispensing Fee, Monaural Hearing Instrument, Any type
V5242	Hearing Instrument, Analog, Monaural, CIC (Completely In the Ear Canal)
V5243	Hearing Instrument, Analog, Monaural, ITC (In the Canal)
V5244	Hearing Instrument, Digitally Programmable Analog, Monaural, CIC
V5245	Hearing Instrument, Digitally Programmable, Analog, Monaural, ITC

V5246	Hearing Instrument, Digitally Programmable Analog, Monaural ITE (In the Ear)
V5247	Hearing Instrument, Digitally Programmable Analog, Monaural, BTE (Behind the Ear)
V5248	Hearing Instrument, Analog, Binaural, CIC
V5249	Hearing Instrument, Analog, Binaural, ITC
V5250	Hearing Instrument, Digitally Programmable Analog, Binaural, CIC
V5251	Hearing Instrument, Digitally Programmable Analog, Binaural, ITC
V5252	Hearing Instrument, Digitally Programmable, Binaural, ITE
V5253	Hearing Instrument, Digitally Programmable, Binaural, BTE
V5254	Hearing Instrument, Digital, Monaural, CIC
V5255	Hearing Instrument, Digital, Monaural, ITC
V5256	Hearing Instrument, Digital, Monaural, ITE
V5257	Hearing Instrument, Digital, Monaural, BTE
V5258	Hearing Instrument, Digital, Binaural, CIC
V5259	Hearing Instrument, Digital, Binaural, ITC
V5260	Hearing Instrument, Digital, Binaural, ITE
V5261	Hearing Instrument, Digital, Binaural, BTE
V5262	Hearing Instrument, Disposable, Any Type, Monaural
V5263	Hearing Instrument, Disposable, Any Type, Binaural
V5264	Ear mold (one ear mold per year per ear if medically necessary)
V5266	Hearing Instrument Battery (Limit 4 per aid when billed with a new hearing instrument or a replacement aid.)
V5267	Hearing Instrument Supplies/Accessories
V5299	Hearing Service Misc. (may be used to bill warranty replacement hearing instruments but MUST be Prior Authorized.)

Claims submitted for the above referenced covered hearing instrument and hearing instrument parts shall reflect the actual cost of the materials. The physician statement of medical necessity, the audiologist hearing instrument recommendation, and invoice verifying the actual costs of materials shall be attached to the claims submitted for payment. Reimbursement shall be provided by Kentucky Medicaid **only** for members under twenty one years of age and shall not exceed the members benefit of $800.00 per ear every 36 months.

6. Services Not Covered by the Kentucky Medicaid Hearing Instrument Program

Services not covered by the Kentucky Medicaid Hearing Instruments Program shall include the following:

a. Replacement batteries are not covered.
b. Telephone switches, unless built in by manufacturer as standard part of hearing instrument **and** included in standard charge for hearing instrument.
c. Devices for listening to radio and television.
d. Other accessories not usually part of a standard hearing instrument and unnecessary for basic operation of a hearing instrument.
e. Preparations for cleaning hearing instruments.
f. Ointments and drops for relief of irritation caused by wearing the hearing instrument.
g. Hearing and audiology services for eligible members who are over twenty-one years of age.
h. Duplicate services.
i. Any procedures not approved by Kentucky Department of Medicaid.

SECTION V

REIMBURSEMENT

SECTION V – REIMBURSEMENT

A. Audiologist

Reimbursement of audiologist shall be in accordance with 907 KAR 1:039.

B. Specialist in Hearing Instruments

Reimbursement for specialists in hearing instruments shall be in accordance with 907 KAR 1:039.

C. Fees-Duplicate or Inappropriate

Effective July 1, 1994, the Kentucky Medicaid Program implemented comprehensive, computerized auditing system for provider claims submitted for payment. The auditing system was designed to evaluate billing information and coding accuracy on claims submitted for payment to prevent duplicate or inappropriate payment. Based on coding criteria and protocols in the Physician's Current Procedural Terminology (CPT) code book and published annually by the American Medical Association, this system of checking claims shall be utilized to detect miscoding **and** irregularities, unbundling which involves billing two or more individual codes that may be combined under a single code and charge, mutually exclusive procedures, incidental or integral procedures, etc. The logic of this oversight system shall supersede any Kentucky Medicaid audits or edits previously implemented. As complex developments in medical technology are introduced and require more specific coding, this automated, claim-checking system shall be updated to assist in the processing and payment of claims for Kentucky Medicaid providers in a way more consistent CPT and International Classification of Diseases (ICD-9) criteria.

Any duplicate or inappropriate payments issued by Kentucky Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Kentucky Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and sent to the fiscal agent.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud or abuse, and therefore, subject to prosecution.

D. Fee Payment By Member

Participants in the program shall report **ALL** payments or deposits made toward a member’s account, regardless of the source of payment. If the provider receives

payment from an eligible Medicaid Program member for a Medicaid covered service, the Medicaid Program regulations preclude payment being made by the program for that service unless documentation is received that the payment has been refunded to the member. This policy shall not apply to payments made by member for spend down or non-covered services.

Members approved for Medicaid benefits on a spend down basis shall be obligated to pay fees to health care providers as assigned by their local Department for Community Based Services (DCBS) Office where eligibility is established. These fees shall be paid to the providers by the member and shall satisfy the excess income for the period of eligibility. The providers shall report these fee payments by the members on the claim as payments from other sources.

Any item(s) or service(s) provided for Medicaid members non-covered by Kentucky Medicaid may be billed to the member or any other responsible party. Providers shall not collect fees from member for covered item(s) or service(s) for which Kentucky Medicaid has made payment. Any payment made by Kentucky Medicaid shall be accepted by the provider as payment in full for a service.

If a member has retroactive eligibility in which the individual receives a back-dated *KyHealth Choices* card, the provider of service shall maintain the option to accept the *KyHealth Choices* card. If the provider agrees to accept the card, any payments made to the provider by the member for services during the retroactive eligible period will require a 100 percent refund to the member before the program may be billed.