Audiology Specialty Training

Health First Colorado (Colorado's Medicaid Program)

Navigating This Presentation

- Underlined words or phrases often will link viewers to more information, such as web pages. If you are viewing this presentation in normal mode (not slideshow mode), you may need to press the Ctrl key while you click on the link in order to open it.
- Use color-coded table of contents slides to navigate to specific areas of interest in the presentation.
  - Use back arrows provided in the bottom right corner of some slides to return to table of contents slides.

Agenda

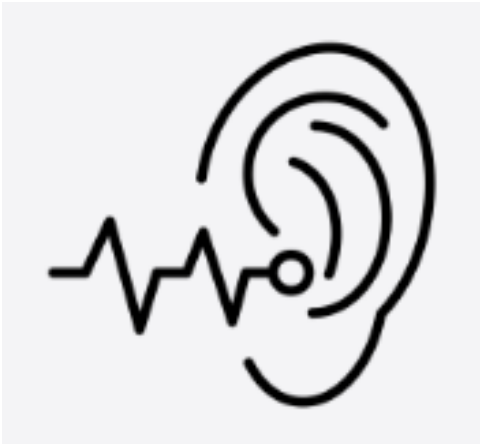
- Introduction
- Provider Enrollment
- Benefit Overview
- Prior Authorization Requests (PARs)
- Billing & Payment
- Resources

Introduction

Introduction
Audiology

- Audiology includes audiology care and supply equipment and appliances for audiology-related services

- Audiology services are billed as fee-for-service claims to Health First Colorado's Fiscal Agent (Gainwell Technologies)



Provider Enrollment

Provider Enrollment
Approved Provider Types

- Approved provider types for Audiology include:
  - Physicians enrolled with an otolaryngology specialty
  - Certified audiologists
    - Must be registered with the Colorado Department of Regulatory Agencies (DORA) in order to dispense hearing aids
  - Colorado Home Intervention Program (CHIP) facilitators credentialed by Health Care Programs for Children with Special Needs (administered by the Colorado Department of Public Health and Environment [CDPHE])

- Any audiology services rendered by a non-licensed audiologist (except for licensed otolaryngologists and enrolled CHIP providers) are **not** covered

Provider Enrollment
Enrollment Requirements

Individuals

- Provider Type 19, Specialty 310: Audiologist
  - Billing Individual
  - Individual Within a Group
  - Ordering, Prescribing and Referring (OPR)

- Must enroll with individual's Social Security Number (SSN)
- National Provider Identifier (NPI), license and malpractice/liability insurance information must be entered in the application

Benefit Overview

Benefit Overview
Member Eligibility

- Audiologists are encouraged to confirm specific coverage types when verifying eligibility. Providers must verify that a member has Health First Colorado benefits before providing any Medicaid services.
  - When viewing eligibility in the Provider Web Portal, Medicaid coverage is listed as "**Medicaid State Plan**" and "**TXIX**" (Title XIX)

Benefit Overview
Ordering, Prescribing, Referring (OPR) Providers

- All services must have a written order, prescription or referral by any of the following Health First Colorado-enrolled providers:
  - Physician (M.D. or D.O.)
  - Physician Assistant
  - Nurse Practitioner
  - An approved Individualized Family Service Plan (IFSP) for Early Intervention Audiology

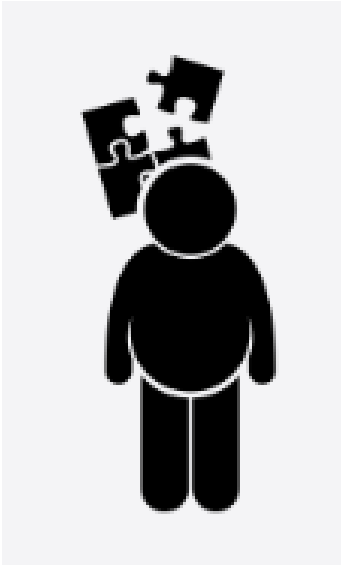
Benefit Overview
Initial Newborn Hearing Screening

- Hearing screening for newborns was established by Colorado House Bill 97-1095 [25-4-1004.7(VI)(b)]
  - Hearing Conservation Program (HCP) Audiology Regional Coordinators provide consultation information, technical assistance and referral services for families of children with special health care needs

- Reimbursement for a newborn hearing screening is included in the hospital Diagnosis Related Group (DRG) for inpatient hospital deliveries and in the birth center payment for freestanding birthing center deliveries
  - Codes for hearing screening cannot be billed for dates on or during the date span of the delivery stay
  - Refer to the Obstetrical Care billing manual

Benefit Overview
Subsequent Newborn Hearing Screening

- Follow-up testing for newborns who fail initial screening may be billed if it occurs on dates of service outside of the date span for delivery



Benefit Overview
Cochlear Implants

- Unilateral and bilateral cochlear implants are covered for members ages 12 months through 20 years
- Replacement components of existing implants is a benefit for all ages when current components are no longer functional and cannot be repaired
  - Upgrading an existing cochlear implant system or component if the existing unit is properly functioning is **not** covered

Benefit Overview
Hearing Aids

- Hearing aids are a covered benefit for members ages 20 and under

- Each hearing aid must be listed on a separate line on the claim form and include a modifier to note the ear for which it is fitted when billing for a pair
  - RT = right
  - LT = left
- Billing for two (2) units of a hearing aid on the same line without the appropriate modifier will result in a denial

- A trial rental period is included in the purchase reimbursement
  - Use the last day of the rental period as the date of service

Benefit Overview
Hearing Aids

- Replacement of hearing aids is covered for members ages 20 and under
- Hearing aids are expected to last 3-5 years
- Hearing aids may be replaced when they no longer fit, have been lost or stolen or the current hearing aid is no longer medically appropriate for the child

- Hearing aids for adults are **not** a covered benefit
  - Hearing exams and evaluations are a benefit only when a concurrent medical condition exists
- Hearing aid insurance is **not** a covered benefit

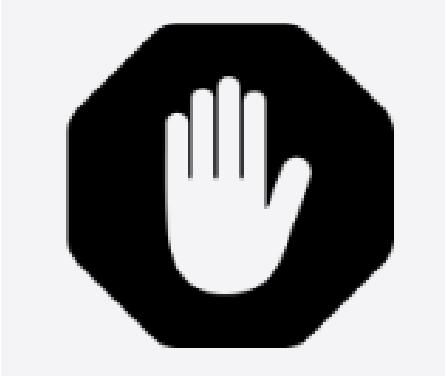
Benefit Overview
Softbands

- Softbands (including Bone-Anchored Hearing Aids [BAHAs]) are a covered benefit for members ages 20 and under
  - Require Prior Authorization Request (PAR) that is accompanied by a signed letter from physician documenting medical necessity
- Claims do not require attached invoice

Covered Softband/BAHA Procedure Code Details					
Code	**Description**	**PAR**	**Required PAR and Claim Modifier**	**Allowed Billing Provider Types**	**Allowed Rendering Provider Types**
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment.	Always	NU	Physician, Pharmacy, Supply, Clinics, Osteopath, Audiologist.	Physician, Osteopath, Audiologist
L8691	**Replacement.** Auditory osseointegrated device, external sound processor.	Always	NU		

Benefit Overview
Services NOT Covered

- In addition to those listed in previous slides, the following services are **not** covered by the audiology benefit:
  - Any service not documented in the member's plan of care
  - Training or consultation provided by an audiologist to an agency, facility or other institution
  - Ear molds for the purpose of noise reduction or swimming are not covered



Prior Authorization Requests (PARs)

Prior Authorization Requests (PARs)
ColoradoPAR Program

- Prior authorizations are not required for most audiology services
  - The following Common Procedural Terminology (CPT) codes: 92507, 92508, 92526, 92609, L8691, L8692 require a Prior Authorization Request (PAR)

- Prior authorization is not needed when a primary payer, such as commercial insurance, pays

When is a PAR Required?	When is a PAR *Not Required*? *
The primary insurance did not pay on the claim.	TPL or Medicare paid on the claim for the services billed.
The TPL PAR is partially denied by the primary payer.	TPL covers ***all*** the services requested.
The member does not have Medicare or TPL.	

Prior Authorization Requests (PARs)
ColoradoPAR Program

- All audiology Prior Authorization Requests (PARs) and revisions must be processed by the ColoradoPAR Program
  - Acentra Health is the Utilization Management (UM) vendor
  - Refer to the Colorado Utilization Manual (UM) Provider Manual

- When submitting a PAR:
  - Request number of units, not number of services
  - Include appropriate modifiers
  - Answer clinical questions on the portal
  - Attach relevant clinical documentation
  - Select "Medical" type from the drop-down menu (Selecting "DME" will result in denial)

Prior Authorization Requests (PARs)
ColoradoPAR Program

- All Prior Authorization Requests (PARs) for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines
- Do not render or bill for services until the PAR has been processed

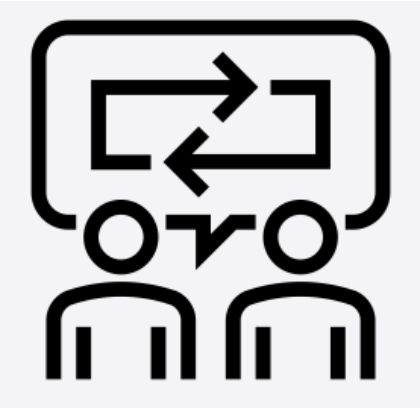


Prior Authorization Requests (PARs)
ColoradoPAR Program

- Final Prior Authorization Request (PAR) determination letters are mailed to members
- Letter inquiries should be directed to ColoradoPAR
- Providers can review requests via the Provider Web Portal
- Services may not be denied because a Prior Authorization Request is denied due to Lack of Information (LOI) on the request

Prior Authorization Requests (PARs)
Denials

- Prior Authorization Requests (PARs) that are denied may go through a peer-to-peer review with the provider who originally requested the Prior Authorization Request (PAR)
- Providers can request reconsideration (second opinion) of PARs that have been denied after peer-to-peer review
- If the PAR is denied for medical necessity, the reconsideration will be performed by a different physician, including an appropriate specialist
- Members can also submit appeals for PAR reconsiderations



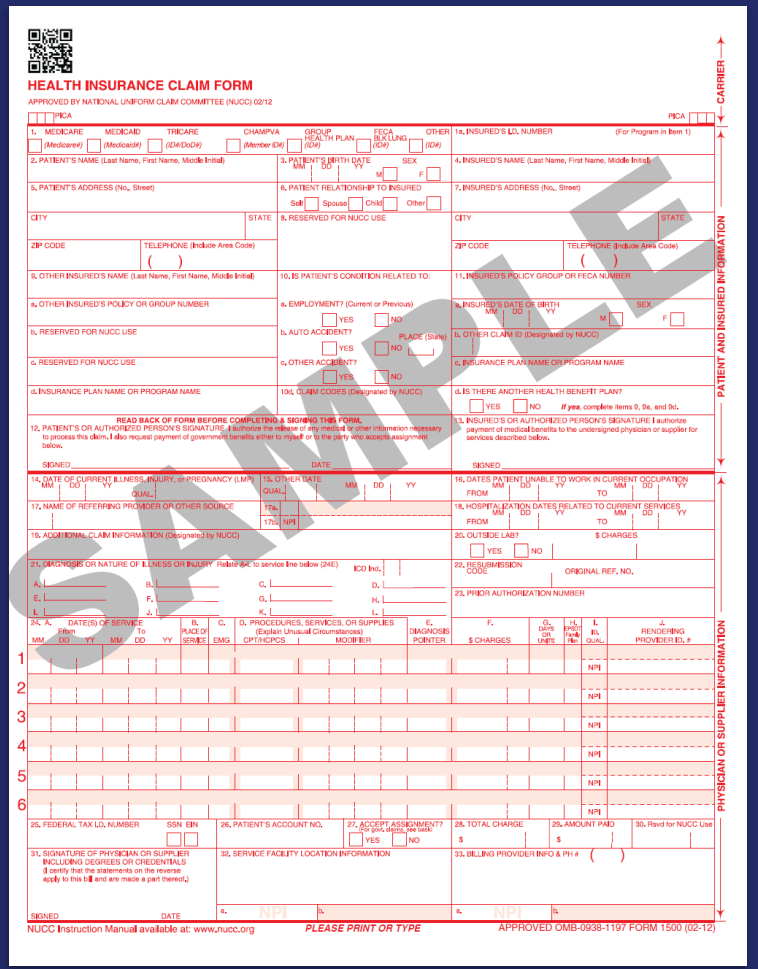
Billing & Payment

Billing
Claims Submission

Audiology services must be billed using the CMS 1500 professional claims form or the 837 Professional (837P) transaction, which requires using Rendering; Billing; and Ordering, Prescribing and Referring (OPR) National Provider Identifiers (NPIs)

Claims should be submitted to the Fiscal Agent (Gainwell Technologies)

Audiology supply claims cannot be submitted as Durable Medical Equipment (DME)/supply


HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (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 F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Billing
Codes & Modifiers

- Refer to the Audiology Billing Manual for a list of covered codes and modifiers

- Current Procedural Terminology (CPT) codes describe medical procedures and professional services
- CPT is a numeric coding system maintained and copyrighted by the American Medical Association
  - Code books are available from a variety of bookstores

Billing
Places of Service

Place of Service (POS)	Code Description
02	Telemedicine- not provided in patient's home. Refer to the Telemedicine Billing Manual.
03	School - (non-public) services provided in or during public school must be billed by the school district only
10	Telehealth- provided in patient's home. Refer to the Telemedicine Billing Manual.
11	Office
12	Home
13	Assisted Living Facility
99	Other - (Community Based Organization)

- Telemedicine is available only for specific procedure codes found in the Telemedicine Billing Manual

Billing
Ordering, Prescribing and Referring (OPR)

- A Health First Colorado-enrolled Ordering, Prescribing and Referring (OPR) provider's National Provider Identification (NPI) number must be included on the claim form (CMS 1500 field 17b)
  - Physician (M.D. or D.O.)
  - Physician Assistant
  - Nurse Practitioner

- Claims without a valid OPR NPI which are paid will be subject to recovery
  - "Valid" means the NPI is registered to a provider that legitimately orders, prescribes or refers the audiology service being rendered

- Medical documentation must be kept on file to substantiate the order, prescription or referral for audiology services

Billing
Ordering, Prescribing and Referring (OPR)

- The Early Intervention Service Broker may list their National Provider Identifier (NPI) as the rendering and referring NPI for early intervention services ordered through an Individualized Family Service Plan (IFSP)
  - Must include modifier TL on the procedure line to denote service ordered by an approved IFSP and delivered with the time span noted in the IFSP

Billing
Common Denial Reasons

Member Not Eligible for Title XIX

Check to make sure that:
- Correct Member ID is listed on the claim
- Member was eligible for Health First Colorado benefits on the date of service

Coverage needs to be listed as “Medicaid State Plan” or “TXIX” on the Provider Web Portal

Billing
Common Denial Reasons

Prior Authorization (PAR) Not on File
(Member does not have commercial insurance as primary payer)

Check to make sure that:
- Prior Authorization Request (PAR) is on file for the member for the date of service
- Member ID on the claim matches what is listed on the PAR
- Units on the claim match what is listed on the PAR
- All billing dates on the claim match what is listed on the PAR
- Modifiers listed on the claim match what is on the PAR

Billing
Common Denial Reasons

Prior Authorization (PAR) Not on File
(Member has commercial insurance as primary payer)

Check to make sure that:
- Paid amount from the commercial insurance has been entered on the claim
- If commercial insurance paid zero and applied all charges to the deductible, the third-party liability Explanation of Benefits (EOB) is attached to the claim

If a third-party liability pays at zero due to applying all charges being applied to the deductible, providers must attach the EOB so the claim can be manually reviewed and paid
- *This is the only reason for attaching a primary payer's EOB*

Billing
Common Denial Reasons

Rendering Provider ID is Not on File *or*
Provider Not Authorized to Perform or Provide Service Requested

Check to make sure that:

- An individual National Provider Identifier (NPI) is listed on the claim in the "rendering provider" field: 24j on the CMS 1500 claim form (e.g., audiologist, licensed otolaryngologist)

Even if the billing provider has revalidated, claims will deny if an individual provider has not revalidated as a Health First Colorado provider

Billing
Common Denial Reasons

Referring, Ordering, Prescribing Provider is Missing or Not Enrolled *or* Valid Enrolled Prescribing/Referring/Ordering Provider NPI is Required

Check to make sure that:

- An individual National Provider Identifier (NPI) is listed on the claim in the "referring provider" field: 17b on the CMS 1500 claim form (e.g., physician, physician assistant, nurse practitioner)

Even if the billing and rendering providers have revalidated, claims will deny if an Ordering, Prescribing and Referring (OPR) provider has not revalidated as a Health First Colorado provider

Resources

Resources

For Our Providers web pages: https://hcpf.colorado.gov/our-providers

The **General Provider Information Manual** is an overview of the program, including billing and policy information

The **Audiology Billing Manual** provides specific guidance for the benefit

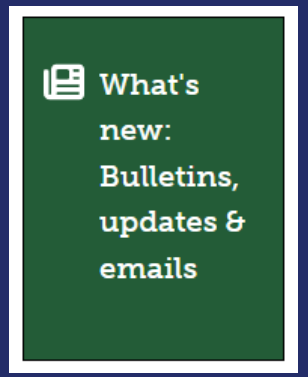
Fee Schedule web page

Provider Contacts web page

Reminders

- Remember to sign up for Department of Health Care Policy & Financing communications by visiting the website and clicking “For Our Providers” and then “What’s new: Bulletins, updates & emails.” Be sure to sign up for Provider Types 00 and 19.

- Interested in more training? Sign up or view training materials by visiting the website and clicking “Provider Resources” and then “Provider Training.” Presentations are listed under the calendar in the “Billing Training – Resources” section.



hcpf.colorado.gov/our-providers

Where can I find…?

For Our Providers

- Enrollment forms
- Revalidation dates spreadsheet
- National Provider Identifier (NPI) information
- Provider types

- Fee schedules
- General Provider Information manual
- Billing manuals & appendices
- Forms
  - Prior Authorization Requests (PARs)
  - Load letters
  - Request to use paper claim form

- Newsletters
- What's New?

Why should you become a provider?	Provider enrollment	Provider services: Forms, rates, & billing manuals	What's new: Bulletins, updates & emails
CBMS: CO Benefits Management System	Long-Term Services and Supports	Web portal	
Revalidation	Provider contacts: Who to call for help	Provider resources: Quick guides, known issues, EDI, & training	

Where can I…?

- Check member eligibility
- Submit claims
- Review Prior Authorization Requests (PARs)
- Receive Remittance Advices (RAs)
- Complete provider maintenance requests

- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
  - Accountable Care Collaborative & RAEs
  - Co-Pays
  - EVV

COLORADO
Department of Health Care Policy & Financing

COVID-19 Provider Information	Resources for HCBS Providers		
SAVE System	ColoradoPAR	DDDWeb	Value Based Payments

Thank you!