NEW YORK STATE
MEDICAID PROGRAM

HEARING AID

PRIOR APPROVAL GUIDELINES

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Section I - Purpose Statement

The purpose of this document is to assist the provider community understand and comply with the New York State Medicaid (NYS-Medicaid) requirements and expectations for:

- Obtaining Prior Approval.
- Field by Field Instructions for Prior Approval Form (eMedNY 283201)

This document is customized for Hearing Aid providers and it should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II – Instructions for Obtaining Prior Approval

Electronic prior approval requests and responses can be submitted on the HIPAA 278 transaction. The Companion Guide for the HIPAA 278 are available on the www.nyhipaadesk.com website. Click on News & Resources, then eMedNY Phase II HIPAA Transactions. Access to the final determinations will be available though eMedNY eXchange messages or by mail. To sign up for eXchange visit www.emedny.org.

Prior approval requests can also be requested via ePACES. ePACES is an internet-based program available to enrolled Medicaid providers. For information about enrolling in ePACES, contact CSC at (800) 522-5518 or (518) 447-9860. A reference number will be returned to your ePACES screen, which can be later used to check the approval status on ePACES. Visit www.emedny.org for more information.

Paper prior approval request forms have been modified to comply with eMedNY requirements. A supply of the new forms is available by contacting CSC at the number above. Paper prior approval forms, with appropriate attachments, should be sent to Computer Sciences Corporation, PO Box 4600, Rensselaer, NY 12144-4600.

The prior approval number format has changed from 8 to 11 digits. Providers will still be allowed to continue using the eight-digit numbers until the units are exhausted.

This section of the manual describes the preparation and submission of the New York State Medical Assistance (Title XIX) Program Order/Prior Approval Request Form (eMedNY 283201). It is imperative that these procedures are used when completing the forms. Request forms that do not conform to these requirements will not be processed by eMedNY.

Services that require prior approval are indicated by a line under the respective procedure code in the New York State Procedure Code and Fee Schedule section of this manual.

Receipt of prior approval does NOT guarantee payments. Payment is subject to client's eligibility and other guidelines.

Requests for prior approval should be submitted before the date of service or dispensing date. However, sometimes unforeseen circumstances arise that delay the submission of the prior approval request until after the service is provided. If this occurs, the prior approval request must be received by the department within 90 days of the date of service, accompanied by an explanation of why the item was dispensed/service was provided before the prior approval request was approved.

A prior approval request will not be processed after 90 days from the date of service unless the provider's request is delayed due to circumstances outside of the control of

the provider. Such circumstances include the following:

- Litigation
- Medicare/third party insurer processing delays
- Delay in the Client's Medicaid eligibility determination
- Administrative delay by the department or other State agency

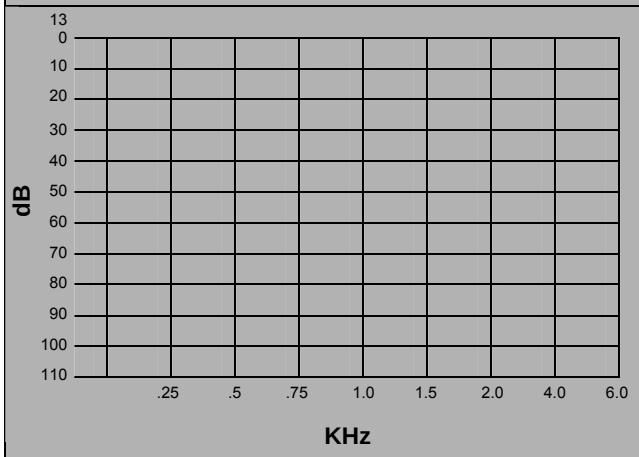
The request must give a detailed explanation for the delay. Requests submitted without an explanation will be returned, without action, to the provider.

To reduce processing errors (and subsequent processing delays), please do not run-over writing or typing from one field (box) into another. The displayed sample Prior Approval Request Form is numbered in each field to correspond with the instructions for completing the request.

NYS MEDICAL ASSISTANCE – TITLE XIX PROGRAM

HEARING AID – ORDER/PRIOR APPROVAL REQUEST

1 ORDER SRC	2 ORDER DATE	3 ID/LICENSE NUMBER	4 PROF CODE	5 ORDERED BY (NAME)	8 CLIENT ID	9 CLIENT NAME
- 5	M M D D C C Y Y			6 TELEPHONE NUMBER		10 ADDRESS
7 ADDRESS					11 DATE OF BIRTH	CITY STATE ZIP CODE



14 PRIMARY DIAGNOSIS		M M D D C C Y Y	12 SEX M F
15 SECONDARY DIAGNOSIS			

	RIGHT	LEFT
16 AIR CONDUCTION PURE TONE AVERAGE	dB	dB
17 RECEPTION THRESHOLD	dB	dB
18 SPEECH DISCRIMINATION	% dB	% dB

19 ☐ REPLACEMENT ☐ THROUGH MEDICAID

MFGR _____

MODEL _____

DISPENSED BY _____

DATE _____

Legend	20 Air Conduction	Masked
RT EAR	O	△
LT EAR	×	□
	21 Bone Conduction	Masked
RT EAR	<	[
LT EAR	>	]

SOUND FIELD SP. AUDIOMETRY	NO AID E	NO AID D	WITH RECOMMENDED AID EXAMINER	WITH RECOMMENDED AID DISPENSER
22 RECEPTION THRESHOLD			27	
23 DISCRIMINATION @ 35dBHL			28	
24 DISCRIMINATION @ 50dBHL			29	
25 DISC. IN NOISE			30	
26 EAR(S) FITTED			L R I I R B	

33

☐ CHANGE IN CLINICAL STATUS

☐ REPLACEMENT ☐ *LOST

☐ *STOLEN ☐ *DAMAGED

*ATTACH STATEMENT

34 RECOMMENDATION ☐ NO ☐ YES

PRESCRIPTION ☐ YES, SPECIFY BELOW BY ITEM CODE

35 Possible Disability		36 Accident	
Y	N	Y	N

37 EAR MOLD

☐ CROS
☐ BICROS
☐ BINAURAL
☐ RIGHT
☐ LEFT
☐ BOTH

38 SERVICING PROVIDER NAME

39 TELEPHONE NUMBER

☐ SINGLE SOUND TREATED ROOM ☐ AUDIOLOGIST

31 ☐ TWO ROOM SOUND SUITE 32 ☐ OTOLARYNGOLOGIST

40 SERVICING PROVIDER ID	41 PROVIDER ADDRESS	42 PROVIDER SIGNATURE	43 LOC CODE	44 ID/LICENSE NUMBER	45 EXAMINER SIGNATURE
	CITY STATE ZIP				

	46 ITEM CODE	47 DESCRIPTION	48 QUANTITY REQUESTED	49 TOTAL AMOUNT REQUESTED
1			.	.
2			.	.
3			.	.
4			.	.

50 PA REVIEW OFFICE CODE

DO NOT STAPLE IN BARCODE AREA

[redacted]

↑

← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

Section III - Field by Field (eMedNY 283201) Instructions

ORDER SRC (Field 1)

Enter the code letter from the list below, indicating where the test was done:

CODE		ORDER SOURCE
A	-	Hospital Outpatient Department
B	-	Inpatient Hospital Service
C	-	Treatment and Diagnostic Center
D	-	Residential Health Care Facility
E	-	Adult Home
G	-	Practitioner's (Prescriber's) Office
H	-	Patient's Home
J	-	P.H.C.P. Approved Speech and Hearing Center
K	-	P.H.C.P. Approved Amputee Center

ORDER DATE (Field 2)

Indicate the month, day, and year on which the hearing evaluation tests were conducted.

Example: October 7, 2005 = 10072005

ORDER DATE							
1	0	0	7	2	0	0	5

ID/LICENSE NUMBER (Field 3)

Enter the ordering provider's MMIS provider number as shown in the example below. Right justify the information in this field.

Example:

ID/LICENSE NO.								
		0	1	2	3	4	5	6	7

When the ordering provider is a non-enrolled, private-practicing otolaryngologist or audiologist, enter the orderer's state license number. When entering the license number, leave the first two spaces at the left side of the box blank, enter two zeros then begin the license number. Right justify the information in this field as shown in the example below.

Example:

ID/ LICENSE NUMBER									
		0	0	2	3	4	5	6	7

If entering an out-of-state license number, the two-digit United States Post Office state abbreviation should be entered in place of the two zeros as in the example below.

Example:

ID/ LICENSE NUMBER									
		N	J	2	3	4	5	6	7

PROF CODE (Field 4)

When the ordering provider is a non-enrolled private practicing otolaryngologist or audiologist, enter the three-digit code from below to indicate the profession of the orderer who performed the testing and completed the recommendation/prescription.

	CODE
Otolaryngologist	060
Audiologist	057

ORDERED BY (NAME) (Field 5)

Enter the last name followed by the first name of the prescribing provider. For PHCP Centers and Article 28 facilities, this will be the name the facility enrolled under for MMIS.

TELEPHONE NUMBER (Field 6)

Enter the ordering provider’s telephone number.

ADDRESS (Field 7)

Enter the provider's address including name of facility, where appropriate.

CLIENT ID (Field 8)

For a district of fiscal responsibility, including County Code 97 (OMH Administered) and County Code 98 (OMR/DD Administered), enter the client's eight-character

alphanumeric Welfare Management System (WMS) ID number.

Example:

CLIENT ID NUMBER
A A 1 2 3 4 5 X

CLIENT NAME (Field 9)

Enter the last name followed by the first name of the client as it appears on the Medicaid ID Card.

ADDRESS (Field 10)

Enter the client's street number, P.O. Box number, city, state, and zip code.

DATE OF BIRTH (Field 11)

Enter the month, day, and year of the client's birth.

Example: April 5, 1940 = 04051940

DATE OF BIRTH
0 4 0 5 1 9 4 0

SEX (Field 12)

Place an X on M for Male or F for Female to indicate the client's gender.

PURE TONE AUDIOGRAM (Field 13)

The ordering provider or the audiologist completes the audiogram that represents test results of air conduction and bone conduction thresholds of the right ear and left ear. Masked threshold levels shall also be recorded where appropriate. Enter on the audiogram the applicable symbols from the legend.

PRIMARY DIAGNOSIS (Field 14)

Enter the ICD-9-CM diagnosis code that represents the condition or symptom which establishes the need for the service requested. ICD-9-CM is the *International Classification of Diseases - 9th Revision - Clinical Modification Coding System*.

Example:

CODE
3 8 9 • 9

SECONDARY DIAGNOSIS (Field 15)

Enter the appropriate ICD-9-CM diagnosis code that represents a secondary condition or symptom affecting treatment. Leave blank if there is no secondary diagnosis.

AIR CONDUCTION PURE TONE AVERAGE (Field 16)

The ordering provider or the audiologist completes the test and enters the average of the air conduction threshold levels in decibels of 500, 1000, and 2000 H_z for each ear. In the case of precipitous high frequency hearing loss, enter the two-frequency average that is in agreement with the speech reception threshold for each ear.

RECEPTION THRESHOLD (Field 17)

The ordering provider or the audiologist completes the test and enters the threshold level in decibels of the speech reception for each ear.

SPEECH DISCRIMINATION (Field 18)

The ordering provider or the audiologist completes the test and enters the discrimination percentage score for each ear and enters the decibel presentation level for each ear.

NOTE: The tests listed above represent the minimum tests the ordering provider or the ordering provider's authorized employee must perform, but they are not necessarily exclusive. Results from administering tests not listed in these instructions, which assist in substantiating the need for a hearing aid, may be forwarded as attachments.

REPLACEMENT / THROUGH MEDICAID (Field 19)

If the client is currently in possession of a hearing aid, check the box Replacement and indicate the manufacturer and model. If the client is not in possession of an aid, leave this field blank.

If the hearing aid was obtained through the Medicaid Program, check the box Through

Medicaid and enter the approximate date obtained and the dispenser's name and address. If the hearing aid was not obtained through Medicaid, leave this box blank and enter the approximate date obtained and the dispenser's name and address.

PURE TONE AUDIOGRAM

The ordering provider or the audiologist completes the audiogram which represents test results of air conduction and bone conduction thresholds of the right ear and left ear. Masked threshold levels shall also be recorded where appropriate. Enter on the audiogram the applicable symbols from the legend. (Field 20 and 21.)

RECEPTION THRESHOLD (Field 22)

The ordering provider or the audiologist tests and enters in decibels the threshold levels of speech reception as presented in sound field through the loudspeaker.

DISCRIMINATION AT 35dB HL; 50dB HL (Fields 23 and 24)

The ordering provider or the audiologist tests and enters, if obtainable, percentage scores at 35dB and 50dB hearing levels. When the unaided speech reception level exceeds 50dB, enter the presentation level and the percentage score.

DISC. IN NOISE (Field 25)

The ordering provider or the audiologist tests and enters the percentage score of discrimination ability within a recorded signal-to-noise ratio. This field is optional.

EAR(S) FITTED (Field 26)

The ordering provider or the audiologist indicates which ear is being fitted; right, left or both.

SPEECH RECEPTION THRESHOLD WITH RECOMMENDED AID (Field 27)

The ordering provider or the audiologist tests and enters threshold level in decibels of aided speech reception.

SPEECH DISCRIMINATION WITH RECOMMENDED AID (Fields 28 and 29)

The ordering provider or the audiologist tests and enters, if obtainable, the percentage scores at 35dB and 50dB hearing levels.

SPEECH DISC. IN NOISE WITH RECOMMENDED AID (Field 30)

The ordering provider or the audiologist tests and enters the percentage score of discrimination ability within recorded signal to noise ratio.

WHERE PERFORMED (Field 31)

Check the appropriate box.

PERFORMED BY (Field 32)

Check the appropriate box.

REPLACEMENT HEARING AID (Field 33)

Check box for yes, leave blank for no. Enter a check for a change in clinical status, lost, stolen, or damaged hearing aid, as applicable. In the case of a lost or stolen hearing aid, a written statement shall be attached by the client's caseworker or facility's social services department that includes the time, place, and reason for the loss of the device. For damaged hearing aids, a written statement from the dispenser is required regarding the extent of damage and reason for not repairing the device.

RECOMMENDATION (Field 34)

The ordering provider checks YES to indicate that while the client is in need of a hearing aid, the provider is making a general recommendation and is not prescribing a specific model. The ordering provider checks NO to indicate that a specific aid is being prescribed and a general recommendation is not being made.

POSSIBLE DISABILITY (Field 35)

Indicate whether the service was for treatment of a condition which appears to be of a disabling nature (the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months). Place an X on Y for Yes or N for No.

ACCIDENT (Field 36)

Indicate whether the service is rendered for a condition that is a result of an accident or a crime. Place an X on Y for Yes or N for No.

EAR MOLD (Field 37)

Check appropriate box for ear to be fitted or check both when applicable.

SERVICING PROVIDER NAME (Field 38)

Enter the servicing provider's name.

TELEPHONE NUMBER (Field 39)

Enter the servicing provider's telephone number.

SERVICING PROVIDER ID (Field 40)

Enter the servicing provider's ID assigned by New York State at the time of enrollment. This should be the ID number of the provider who will supply the item and bill Medicaid. Right justify the information as shown in the example below.

Example:

SERVICING PROVIDER ID									
		0	1	2	3	4	5	6	7

PROVIDER ADDRESS (Field 41)

Enter the servicing provider's address.

PROVIDER SIGNATURE (Field 42)

The signature of the ordering provider or his/her authorized agent.

LOC CODE (Field 43)

Enter the three-digit locator code assigned to the service provider.

ID/LICENSE NUMBER (Field 44)

Enter the New York State license number of the examiner (if different from the ordering provider.)

EXAMINER'S SIGNATURE AND LICENSE (Field 45)

Enter the signature of the person authorized by the ordering provider (licensed physician) to perform the audiometric tests. This may be the otolaryngologist or the audiologist.

ITEM CODE (Field 46)

This code indicates the service to be rendered to the client. Refer to the New York State Procedure Code section of this manual. Enter the appropriate 5-character code of the item ordered. For those items not listed in the MMIS Manual, call the Bureau of Medical Review and Payment at (800) 342-3005.

DESCRIPTION (Field 47)

The prescriber, when prescribing a specific hearing aid, must enter the manufacturer's name and model number of the device. The vendor must enter this information when a general recommendation has been made.

QUANTITY REQUESTED (Field 48)

Enter 1 in this field except when ordering duplicate devices for binaural fittings.

Example: Quantity of 32

Example: Quantity of 1

TOTAL AMOUNT REQUESTED (Field 49)

The dispenser enters in this field the total amount requested for the item.

PA REVIEW OFFICE CODE (Field 50)

This field is used to identify the state agency responsible for reviewing and issuing the prior approval. Enter code **A1.**

A1 – Bureau of Medical Review and Payment, Office of Medicaid Management, NYS Department of Health