

Distribution: Hearing Aid Dealer 02-02
Hearing and Speech Center 02-02
Home Health 02-02
Hospital 02-02
Practitioner 02-02

Issued: January 2, 2002

Subject:

- Therapies in Hearing and Speech Center, Home, and Outpatient Hospital Settings
 - Occupational Therapy
 - Physical Therapy
 - Speech-Language Pathology
- Clarifications

Effective: As Indicated

Programs Affected: Medicaid, Children's Special Health Care Services

This bulletin and its attachments transmit policy for therapies provided in hearing and speech center, home, and outpatient hospital settings for the Medicaid and Children's Special Health Care Services (CSHCS) fee-for-service programs. **NOTE:** While Medicaid health plans (MHPs) (formerly referred to as qualified health plans [QHPs]) and CSHCS special health plans (SHPs) must offer the same array of services available to the fee-for-service beneficiaries, the plans may establish different prior approval requirements. Providers are responsible for contacting the applicable health plans to determine any prior approval requirements they may have.

The bulletin also clarifies MSA 00-06 bulletin, issued July 1, 2000.

Therapies in Hearing and Speech Center, Home, and Outpatient Hospital Settings

Attachments I, II, and III address occupational therapy, physical therapy, and speech-language pathology (respectively) in hearing and speech center, home, and outpatient hospital settings.

These attachments provide a centralized location for providers to review a detailed explanation of Medicaid's coverage, procedures, and processes. They contain "current operating procedures" as well as some new policy. These policies and procedures are effective for dates of service on and after February 1, 2002.

The following policy items are addressed:

- For outpatient hospital and hearing and speech center settings, prior approval is not required for the first 90 consecutive calendar days of therapy, with a maximum of 36 visits within those 90 days, IF the beneficiary remains Program eligible during the period therapy is provided and a copy of the physician's signed and dated (within 30 days prior to initiation of services) prescription for therapy is on file in the beneficiary's medical record.
- Documentation requirements are detailed.
- Occupational and physical therapy may be provided by a home health agency in the home setting for beneficiaries of all ages. However, therapy may only be provided for 60 consecutive calendar days, with a maximum of 24 visits within those 60 days, before prior approval is required.
- Speech and language rehabilitation services and speech-language therapy may be provided by a Medicaid enrolled home health agency in the home setting for CSHCS beneficiaries in exceptional cases. **NOTE:** Prior approval is required for all speech and language treatment provided in the home (i.e., even the first 60 consecutive calendar days/24 visit period requires prior approval).

Clarification of MSA 00-06 Bulletin

The CSHCS program no longer requires hearing and speech centers or hearing aid dealers to be authorized in the CSHCS eligibility system. The CSHCS program no longer sends the Provider Authorization Notice (Form MG-041) to hearing and speech centers or hearing aid dealers as an authorization of services. Since these provider types are no longer within the provider groups that must be authorized, the Client Eligibility Notice (Form MG-040) sent to the beneficiary does not include them in the list of approved providers. Because of this, the provider may wish to request that the child's family present a copy of the child's Client Eligibility Notice to verify that the child has a CSHCS qualifying diagnosis. **NOTE:** If the provider needs to verify beneficiary eligibility on the date of service, he/she must now contact MediFAX®.

These policies and procedures apply to all children not enrolled in an MHP or SHP (i.e., children covered only by Medicaid on a fee-for-service basis; children covered only by CSHCS on a fee-for-service basis; or children covered by both Medicaid and CSHCS on a fee-for-service basis) needing a hearing aid(s). Medicaid-covered children are no longer required to enroll in CSHCS to obtain a hearing aid(s). Standard hearing aids no longer require prior approval if the requirements presented in MSA 00-06 bulletin are met. Any Medicaid-enrolled hearing and speech center or hearing aid dealer may provide services to a Medicaid- and/or CSHCS-enrolled beneficiary.

1. The provision of service remains the same:

- If the beneficiary is under 18 years of age, he/she must obtain a signed statement from the otolaryngologist that a medical evaluation indicates that a hearing aid(s) is medically necessary and there are no contraindications to the use of a hearing aid(s). **NOTE:** This statement is referred to as a "medical concurrence."

- If the beneficiary is 18 years of age or older, he/she must obtain a signed statement from an otolaryngologist OR the primary care physician indicating that a hearing aid(s) is medically necessary and there are no contraindications to the use of a hearing aid(s). **NOTE:** This statement is referred to as a "medical concurrence."
2. The beneficiary takes the appropriate medical concurrence to a:
- Medicaid-enrolled hearing and speech center for beneficiaries under 18 years of age.
 - Medicaid-enrolled hearing and speech center or outpatient hospital for beneficiaries 18 years of age and older.

After the appropriate audiologic procedures have been completed and it is determined that the beneficiary requires a hearing aid(s), a recommendation for the hearing aid must be completed and signed by the audiologist. This recommendation, as well as a copy of the physician's medical concurrence (both of which must be dated within six months prior to dispensing the hearing aid[s]), are given to the beneficiary along with a list of Medicaid-enrolled hearing aid dealers in the area. **NOTE:** You may obtain a list of Medicaid-enrolled hearing aid dealers in your county (and the surrounding counties) by contacting the Medical Services Administration's Review and Evaluation Division at 1-800-622-0276 or you may fax your request to (517) 335-0075 (please be specific as to which county[ies] you are requesting, and also include the name of a contact person and your fax number). The list does not guarantee that the hearing aid dealer is accepting Medicaid beneficiaries as patients.

3. The beneficiary takes the medical concurrence and audiologist's recommendation to any Medicaid-enrolled hearing aid dealer. If the hearing aid dealer did not provide the previous aid, the dealer may call 1-800-622-0276 to ascertain when the last Medicaid-covered hearing aid was dispensed, because the frequency of Medicaid-covered hearing aids has not changed (i.e., once every three years unless medical necessity warrants a shorter time frame). **NOTE:** If prior approval is required (e.g., the recommended hearing aid is BICROS, the beneficiary does not meet the hearing loss criteria), it is the hearing aid dealer's responsibility to obtain it from the Medical Services Administration.

Administration of a "Hearing Handicap Inventory" was mentioned in bulletin MSA 00-06 but no samples were included. Please refer to attachments IV and V of this bulletin for samples of screening inventories for adults (HHIA-S) and elderly (HHIE-S). These are samples only; providers may have others they prefer to use.

General Clarification

Effective for dates of service on and after October 1, 2000, a 4% increase was applied to procedure codes used by hearing aid dealers and hearing and speech centers. The increase applies to the dispensing fee portion as well as the maximum allowable amount for hearing aid(s), regardless of whether or not the aid(s) required prior approval. For example:

- Procedure Code 90305 has a maximum allowable amount of \$650. This allows \$221.20 for the dispensing portion and an acquisition cost of up to \$428.80.
- Procedure Code 90307 has a maximum allowable amount of \$1,248. This allows \$380.79 for the dispensing portion and an acquisition cost of up to \$867.21.

NOTE: Effective for dates of service on and after February 1, 2002, providers must use appropriate procedure codes and billing requirements presented in bulletins MSA 01-23 and MSA 02-02.

Reimbursement for a hearing aid includes the following items and services (i.e., they may not be billed in addition to the acquisition cost of the hearing aid):

- the original ear impressions and earmold, as required and specified (binaural aids include an additional earmold),
- hearing aid(s),
- hearing aid delivery and orientation,
- one standard package of appropriate batteries per aid (or charger for rechargeable models),
- one-year warranty on parts and labor repairs,
- one-time-per-one-year manufacturer's replacement guarantee (at no cost to the beneficiary, Program, or hearing aid dealer) for a lost, broken, or stolen hearing aid(s),
- a minimum 30-day trial/adjustment period, and
- all necessary components that may include cords, tubing, connectors, receiver, huggies.

Co-payment policies and procedures remain the same.

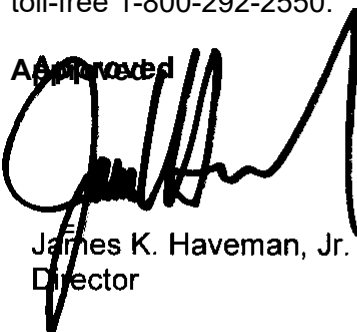
Manual Maintenance

Retain this bulletin and attachments for future reference.

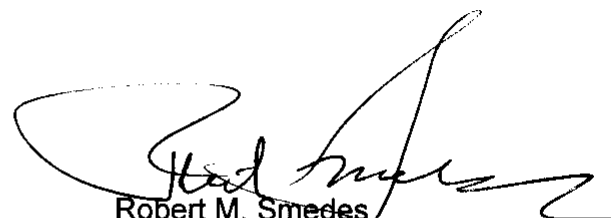
Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



James K. Haveman, Jr.
Director



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