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1. Section Modifications

Version	Section / Column	Modification Description	Publish Date	SME
19.0	All	Published version	1/17/2017	TQD
18.1	2.2.2 Independent Therapist Qualifications	Clarified qualification information	1/17/2017	T Lombard D Baker E Garibovic
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16.2	2.15.3 Post-Payment Review	Specified MCU selects sample of claims	11/3/2016	K Eidemiller D Baker
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16.0	All	Published version	7/1/2016	J Siroky D Baker
15.20	2.16.4 Audiometric Testing	Updates to exams and testing information; removed CPT code information	7/1/2016	J Siroky D Baker
15.19	2.15.3 Post-Payment Review	Minor updates for clarity	7/1/2016	J Siroky D Baker
15.18	2.15.2 Experimental and Investigational Services	New section	7/1/2016	J Siroky D Baker
15.17	2.15.1 Excluded Services	Updated list	7/1/2016	J Siroky D Baker
15.16	2.15 Documentation	Updated daily entries information; added reference for school-based services	7/1/2016	J Siroky D Baker
15.15	2.14 Covered Services	Added reference to fee schedule	7/1/2016	J Siroky D Baker
15.14	2.13 Prior Authorization	Removed section	7/1/2016	J Siroky D Baker
15.13	2.13 Limitations	Excluded Home Health Agencies	7/1/2016	J Siroky D Baker
15.12	2.12 Plan of Care	New section	7/1/2016	J Siroky D Baker
15.11	2.11 Telehealth	New section	7/1/2016	J Siroky D Baker
15.10	2.10 Maintenance Therapy	New section	7/1/2016	J Siroky D Baker
15.9	2.8 Participants with Feeding Disorders	New section	7/1/2016	J Siroky D Baker
15.8	2.6 Reimbursement	Added reference to fee schedule; removed developmental disability agency	7/1/2016	J Siroky D Baker
15.7	2.5.1 Evaluation	Verbiage updates for clarity; added information about CPT code 92523	7/1/2016	J Siroky D Baker
15.6	2.5 Evaluation and Assessment	Minor updates	7/1/2016	J Siroky D Baker
15.5	2.4 Supervision	Added reference for school-based services	7/1/2016	J Siroky D Baker

Version	Section / Column	Modification Description	Publish Date	SME
15.4	2.3.2 Detailed Written Orders	Removed section	7/1/2016	J Siroky D Baker
15.3	2.3.1 Verbal Preliminary Order	Removed section	7/1/2016	J Siroky D Baker
15.2	2.3 Physician Orders	Updated exceptions for POC; changed “physician’s order” terminology; added information about initial orders to evaluate and treat	7/1/2016	J Siroky D Baker
15.1	2.2.2 Independent Therapist Qualifications	Updated requirements for reimbursement; removed developmental disability agency; added public or charter schools	7/1/2016	J Siroky D Baker
15.0	All	Published version	4/25/2016	TQD
14.1	2.2. Independent Speech-Language Pathologist/2.2.1. Overview	Deleted verbiage concerning Medicaid alliance with 2011 House Bill 260	4/25/2016	E Garibovic
14.0	All	Published version	1/22/2016	TQD
13.2	2.13.6 Hearing Aid Purchase	Updated content	1/22/2016	D Baker C Loveless J Siroky
13.1	2.7 Healthy Connections (HC)	Removed PCCM information	1/22/2016	D Baker C Loveless C Brock
13.0	All	Published version	10/15/15	TQD
12.1	2.13.12 PA Requests	Removed statement regarding PA denial without request from PCP	10/15/15	J Siroky D Baker
12.0	All	Published version	8/27/15	TQD
11.1	2.13.3 Participant Eligibility	Changed “ineligible aliens” to “Otherwise Ineligible Non-Citizens”	8/27/15	J Siroky D Baker
11.0	All	Published version	8/14/15	TQD
10.1	2.13.4 Audiometric Testing	Updates to CPT codes	8/14/15	A Coppinger D Baker C Taylor
10.0	All	Published version	6/26/15	TQD
9.1	2.13.12 PA Requests	Updated link to DME website and updated form name	6/26/15	J Siroky D Baker
9.0	All	Published version	2/12/15	TQD
8.3	2.6 Reimbursement	Added information about CPT code 92507	2/12/15	J Siroky D Baker C Taylor
8.2	2.3.1 Verbal Preliminary Order 2.3.2 Detailed Written Orders	New sections	2/12/15	J Siroky D Baker C Taylor
8.1	2.3 Physician Orders	Updated for clarity	2/12/15	J Siroky D Baker C Taylor
8.0	All	Published version	09/02/14	TQD
7.1	2.13.6 Hearing Aid Purchase	Added that claims should be submitted with date of service or date dispensed.	09/02/14	J Siroky C Taylor
7.0	All	Published version	07/25/14	TQD
6.1	2.13.8 Hearing Aid Follow-	Changed first bullet to reflect up to	07/25/14	J Siroky

Version	Section / Column	Modification Description	Publish Date	SME
	Up	four units rather than twice per year		D Baker
6.0	All	Published version	12/13/13	TQD
5.1	2.6 Reimbursement	Updated to include POS for ITP can be in the “natural environment” as required by federal regs. ITP recently changed enrollment from SBS to therapy group.	12/13/13	J Siroky
5.0	All	Published version	01/03/12	TQD
4.1	All	Updated entire document to make it current with policy	01/03/12	J Siroky
4.0	All	Published version	10/20/11	TQD
3.5	All	Updated links	10/20/11	TQD
3.4	2.3.6 Hearing Aid Purchase	Removed outdated information	10/20/11	K Mcneal
3.3	2.3.3.3 Excluded Services Regardless of Participant’s Age	Added information	10/20/11	K Mcneal
3.2	2.3.3.2 Excluded Adult Services	Added information	10/20/11	K Mcneal
3.1	2.3.3 Participant Eligibility	Updated participant eligibility per IR MA11-15	10/20/11	K Mcneal
3.0	All	Published version	06/27/11	TQD
2.1	2.2.9 Prior Authorization (PA)	Removed maximum amount allowed	06/01/11	J Siroky
2.0	All	Published version	08/30/10	TQD
1.3	All	Replaced member with participant	08/17/10	TQD
1.2	2.2.9	Updated PA information	08/17/10	TQD
1.1	All	Updated numbering for sections to accommodate Section Modifications	08/17/10	TQD
1.0	All	Initial document – Published version	05/07/10	TQD

2. Speech, Language, and Hearing Service Providers

2.1. Introduction

This section covers all Medicaid services rendered by Speech-Language Pathologists and Audiologists as deemed appropriate by the Department of Health and Welfare (DHW). It addresses covered and non-covered services, limitations, prior authorization (PA), and other Medicaid requirements for Speech-Language Pathologists and Audiologists.

2.2. Independent Speech-Language Pathologist

2.2.1. Overview

Medicaid covers physician-ordered speech-language pathology (SLP) services rendered by a licensed SLP, as defined in *IDAPA 24.23.01 Speech and Hearing Services Licensure Board,* and who is enrolled as a Medicaid provider.

Therapy services for speech and physical therapy combined are limited to $1,960 annually. Additional services may be covered when medically necessary.

2.2.2. Independent Therapist Qualifications

Medicaid will only reimburse for SLP services rendered by an SLP who meets all the requirements below:

- Licensed by the Board of Speech and Hearing
- Has obtained their Clinical Competency Certification (CCC) from the American Speech and Hearing Association, or who is eligible for certification within one year of employment within the maximum forty-eight (48) months span per the Bureau of Occupational Licenses
- An independent SLP who is enrolled with Medicare, and
- An SLP who is enrolled as an Idaho Medicaid provider

SLP providers whose practice is limited to the treatment of children may be allowed to enroll without Medicare Certification. However, Medicaid will not reimburse those providers for services provided to Medicare beneficiaries even if they are children. Medicare is the primary payer and must be billed prior to billing Medicaid. In accordance with Federal regulations 42 CFR-433.135-139, all payers primary to Medicaid must be billed prior to billing Medicaid.

School-based providers of therapy services do not need to enroll with Medicare. School-based providers follow Medicaid handbook guidance for all therapy providers. Refer also to the handbook section Agency Professional, School-Based Services, for additional information for school-based providers.

A therapist who treats participants in a hospital (inpatient or outpatient), nursing facility, home health agency, public school, or charter school is not considered to be an independent therapist. Services provided at those locations must be billed by that enrolled Medicaid Provider.

2.3. Physician Orders

For reimbursement by Medicaid, the SLP must have an order from a physician or a midlevel practitioner (nurse practitioner, clinical nurse specialist, or a physician assistant). Services must be part of a plan of care (POC) based on that order. The participant's progress must be reviewed and the POC updated every 90 days, with the following exceptions:

- A home health agency plan of care must be reordered at least every sixty (60) days, and
- If there is supporting documentation from the participant's physician/midlevel practitioner indicating that the participant has a long-term medical condition for which therapy is necessary for more than 90 days; then an order for continued care is required at least every 365 days.

The written physician/midlevel practitioner order must stipulate:

- Type of services needed
- Frequency of treatment, and
- When applicable, the expected length of need for which the therapy will be medically necessary.

If the initial order is to evaluate and treat, but does not specify the services, frequency, and length of need, then:

1. The SLP performs a therapy evaluation based on the initial physician/midlevel practitioner order to evaluate and treat.
2. The SLP develops a plan of care based on that evaluation and sends the plan to the physician/midlevel practitioner.
3. The SLP may begin therapy.
4. The physician/midlevel practitioner must sign the plan of care specifying the service to be provided, the frequency, and the expected duration.

No claims may be billed until the completed plan of care is signed by the physician/midlevel practitioner.

2.4. Supervision

Services provided by SLP assistants or aides are considered to be unskilled services, and will be denied as not medically necessary if they are billed as SLP services.

Note: The school setting allows for SLP paraprofessional services. Refer to the *School-Based Services* section in the Agency Professional handbook.

2.5. Evaluation and Assessment

Evaluations and re-evaluations may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out.

2.5.1. Evaluation

Evaluation is a separately payable comprehensive service provided by a licensed SLP, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. These evaluative judgments are essential to development of the plan of care, including long and short-term goals and the selection of interventions. The procedure codes for evaluation are not time-based codes. They are "per visit" or "per session" codes. If components of an evaluation are divided into separate sessions or separate days, it is still one evaluation, and providers may not bill multiple evaluations for the additional sessions.

In November of 2014, Idaho Medicaid began allowing SLP providers to bill with CPT code 92523 and a UC modifier to indicate that they had provided an abbreviated service. This is

the case where the therapist only evaluated language comprehension and expression speech without evaluation of sound production. Providers who bill that combination of 92523-UC may not bill for 99523 alone nor 92522.

2.5.2. Re-evaluation

Re-evaluation provides additional objective information not included in other documentation, such as progress notes. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care.

Any evaluation or re-evaluation should include general health status and diagnosis, medical/surgical history and current conditions. The evaluation should include a standardized, norm referencing assessment. If a standardized evaluation is not appropriate for the participant, the evaluation should include therapist's observations, parental/caregiver's observations, description of the participant's deficiencies and strengths, and the medical necessity for skilled therapy services. The evaluation must be completed annually and must be signed and dated by the therapist administering the assessment.

2.5.3. Assessment

Assessment is separate from evaluation. It is ongoing, and is included in services or procedures provided. It is not separately payable. Based on the assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.

2.6. Reimbursement

Most speech therapy is billed using a "per visit" or "per session" code. All activities to treat a participant for communication and/or auditory processing disorders on a specific date, fall under the one "per visit" code. Idaho follows the national correct coding guidelines, which indicate that only one unit of speech therapy can be billed for a given patient on a given day. (See the Medicaid NCCI information on www.medicaid.gov.) If more than one unit of a service can be billed on a given day, the time will be specified in the code description. See the custom fee schedule on the Medicaid Fee Schedules website.

Independent SLPs are reimbursed on a fee-for-service basis for services provided in the participant's home or in the provider's office. The maximum fee paid is based upon Medicaid's fee schedule.

The office is defined as the location(s) where the practice is operated during the hours that the therapist engages in the practice at that location. Idaho Medicaid uses the Medicare definition and criteria for office. The office space must be owned, leased, or rented by the therapist/group and used for the exclusive purpose of operating the practice during those hours.

Exceptions to billing services provided outside the home or office setting include:

- "Interdisciplinary Training" as part of the children's developmental disabilities program may bill for that service (99368) in the community setting. That service is not covered except for children enrolled in the children's developmental disabilities program as part of their budget. The therapist must review the child's plan of service to see if interdisciplinary training is covered and to what extent.

- Services for children in the Infant Toddler program may be provided in the child's "natural environment" as required by federal regulation.

Therapists who treat participants in a nursing home or hospital (inpatient or outpatient), a home health agency, or in the school setting are not considered to be independent therapists. Services provided at those service locations should be billed by that entity.

Therapeutic equipment utilized by physical therapists to provide therapeutic services to Medicaid participants is included in the fee-for-service payment and may not be charged separately (*IDAPA 16.03.09.735.01*).

2.7. Healthy Connections (HC)

Effective 2/1/16, a Healthy Connections referral is no longer required for speech therapy services. See *General Provider and Participant Information, Healthy Connections (HC),* for more information.

2.8. Participants with Feeding Disorders

Feeding therapy is a service necessary for the treatment of feeding disorders including problems gathering food and getting ready to suck, chew, or swallow. A child who cannot pick up food and get it to his/her mouth, or one who cannot completely close their lips to keep food from falling out of their mouth, may have a feeding disorder.

Feeding services are covered when a physician/midlevel practitioner has diagnosed a child with a feeding disorder that has caused a clinically significant deviation from normal childhood development. Children who are below 5% on the standard growth chart and who are unable to meet their daily nutritional requirements may meet this criteria. The service must be provided by a licensed SLP (or occupational therapist) with training specific to feeding therapy.

2.9. Participants with Developmental Disabilities

Therapy services for adults with developmental disabilities must be discussed as prioritized needs through the person centered planning process, and be included on the individualized service (ISP) as part of the total cost coming out of the participant's annual budget. The person centered planning team should evaluate the therapy needs of the participant for an entire year and reflect these needs on the ISP.

When a need for additional therapy services is greater than what is indicated on the ISP, an addendum must be submitted to the regional DD care manager to evaluate budget and assessed need. Please submit this addendum to the regional DD care manager. This addendum must show goals for the remaining plan year and proposed start and end dates.

2.10. Maintenance Therapy

A maintenance program is one that is ordered by a physician and established by a therapist. To be covered by Medicaid, it must be a service that requires the skills of a therapist to perform the therapy and it cannot safely and effectively be done by unskilled personnel. It consists of therapeutic activities and mechanisms to assist a participant in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness. Maintenance therapy often includes a therapeutic home program with periodic assessments of progress.

2.11. Telehealth

Telehealth therapy services are covered according to Idaho Medicaid's Telehealth Policy found in the *Policies* section on the Medicaid Providers website.

Idaho Medicaid will cover speech therapy (92507) when provided by a licensed SLP. Covered telehealth services are real-time communication through interactive technology that enables a provider and a patient at two locations separated by distance to interact simultaneously through two-way video and audio transmission.The evaluation must provided in person and not by telehealth. The speech therapist must certify that the services can safely and effectively be done with telehealth. The physician order must specifically allow the services to be provided by telehealth, and the SLP must adhere to all requirements of the licensing board. Additional requirements will be found in the Telehealth Policy.

Reimbursement for telehealth therapy is according to the fee schedule. There is no additional fee for either the originating or the distant site.

2.12. Plan of Care

All therapy is provided under a plan of care that is established prior to beginning treatment. The plan must be signed by the therapist who established the plan and the physician. It must be consistent with the therapy evaluation, and must contain at a minimum:

- The diagnoses
- Measurable treatment goals that pertain to the functional impairment identified in the evaluation
- Type, frequency, and duration of the therapy services

2.13. Limitations

Once Medicaid has reimbursed the cap amount for SLP and PT services combined, providers should assess the participant to determine if the services continue to be medically necessary and that the skills of a therapist are required. If the services continue to be necessary, the provider may continue to bill for services by appending a **KX** modifier to subsequent claims. The KX modifier is the provider's attestation that the services are medically necessary.

Beginning November 1, 2016, the utilization review process for therapy services will be primarily targeting claims which indicate high utilization, high dollars, adults transitioning to maintenance, feeding therapies, and other claims with unusual circumstances. In order to ensure an effective and efficient review process, we are requesting for therapy providers to only submit supporting documents once requested by the Department. Please do not submit supporting documentation unless requested by the Department. Providers must submit the required documentation within two days of the receipt of the Department's request. Failure to provide the supporting documentation within this timeframe will result in denial of the claim.

The required documentation includes:

- Therapy Service Documentation Coversheet
- Physician order (signed and dated)
- Evaluation
- Current plan of care signed and dated by the physician or mid-level. (Reordered every 90 days for acute conditions and at least every 365 days for chronic conditions.) It must specify:

  - Diagnosis
  - Modalities
  - Anticipated short and long-term goals that are outcome-based with measurable objectives
  - Frequency of treatment
  - Expected duration of treatment
  - Home follow-through program
  - Discharge plan
- Current progress notes

The Department may deny the claim if, at the time of the review, the documentation requested is outdated or missing.

Fax or mail supporting documentation to:

Fax: 1 (877) 314-8779
Mail to:
Medical Care Unit
PO Box 83720
Boise, ID 83720-0009

The Department will select a number of claims billed with the KX modifier to review. All other claims will continue through the claims process. If, after the review, it is determined that a service does not meet criteria for coverage, the claim will be denied and all future SLP claims submitted in that calendar year for that participant will be denied. If the participant has a setback, has a new condition, or if there is new information available, the provider can submit a prior authorization request to the Department.

2.14. Covered Services

Idaho Medicaid covers SLP evaluation and treatment of speech, language, voice, communication, dysphagia, oral motor/oral sensory feeding disorder, and/or auditory processing as described in the Current Procedural Terminology (CPT) Manual. The services must:

- Be medically necessary as defined in *IDAPA 13.03.09.011.14*
- Require the skills of an SLP
- Be within the therapist's scope of practice and according to the recognized standards of practice
- Be performed by a therapist who has received adequate training
- Be in accordance with all other Medicaid requirements

See the Independent Therapy fee schedule on the Medicaid Fee Schedules website for information about covered procedure codes.

2.15. Documentation

According to *IDAPA 16.05.07* Section 101, "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five years from the date the item or service was provided."

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries must include at least the following:

- Date and time of service
- Duration of the session (time in and time out – this is the only way to accurately support the amount of time billed)
- Specific treatment provided and the corresponding procedure codes
- Problem(s) treated
- Objective measurement of the participant's response to the services provided during the treatment session
- Signatures and credentials of the performing provider

If a scheduled session does not occur as scheduled, the provider must indicate the reason the plan of care was not followed. Missed visits are not a covered service and cannot be billed to Medicaid.

Note: The school setting allows for SLP paraprofessional services. Refer to the *School-Based Services* section in the *Agency Professional* handbook.

2.15.1. Excluded Services

The following services are excluded from payment by Idaho Medicaid.

- Acupuncture (with or without electrical stimulation)
- Biofeedback services
- Services that address developmentally acceptable error patterns
- Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not require the skills of a therapist to maintain their progress
- Services for participants who have achieved stated goals
- Services that do not require the skills of a therapist or therapy assistant
- Services provided by aides or technicians
- Massage, work hardening, and conditioning
- Services not medically necessary as defined in *IDAPA 16.03.09.011*
- Duplicate services
- Services that are considered to be experimental or investigational
- Skilled therapy for the primary goal of weight management
- Group therapy in settings other than School-Based Services or Infant Toddler Program
- Vocational programs
- Vision therapy/eye exercise therapy

2.15.2. Experimental and Investigational Services

Services that are considered to be experimental or investigational are not covered. Certain types of therapy services such as hippotherapy or any animal-assisted therapy, music therapy, or sensory integration and auditory integration are considered to be investigational, and must not be billed to Medicaid as therapy services.

2.15.3. Post-Payment Review

All orders, evaluations, plans of care, and any other documentation supporting the billed services must be maintained by the provider. The Medical Care Unit may select a random sample of claims for post-payment review.

When a claim is selected for review, the provider will be notified in person or in writing by the Department of Health and Welfare or its representative. The therapist must provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity

of the billed service including time in and time out. Medicaid may recoup the payment if proper documentation cannot be produced by the provider.

To ensure the integrity of Idaho's Medicaid program, there are a number of federal and state program integrity agencies that may conduct Medicaid payment review. Providers must provide requested documentation to the Department, to the Centers for Medicare and Medicaid Services (CMS), and to any Department or CMS contractor immediately upon request.

2.16. Audiology Services Policy

2.16.1. Introduction

This section covers all Medicaid services provided by hearing aid and audiology service providers as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Payment
- Participant Eligibility
- Prior authorization (PA)

2.16.2. Payment

Medicaid reimburses hearing aid and audiology services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

2.16.3. Participant Eligibility

Participants under the age of 21 are eligible for audiological function testing unless they are participating in a restricted program.

Adults age 21 and over are eligible for testing only when the physician writes an order for testing to obtain a differential diagnosis.

Participants enrolled in the following restricted programs are not eligible for audiology services:

- Pregnant women (PW)
- Presumptive eligibility (PE)
- Otherwise Ineligible Non-Citizens (OINC)
- Qualified Medicare beneficiary (QMB)

2.16.3.1. Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, there are guidelines that must be followed to ensure reimbursement for providing Medicaid covered services. See *General Provider and Participant Information, Healthy Connections (HC),* for more information.

2.16.4. Audiometric Testing

All audiometric testing must be physician ordered. Testing for adults is only covered when the physician determines that the testing is necessary to obtain a differential diagnosis. Testing payment is limited to one set of tests each calendar year (January to December). Audiometric testing by a licensed audiologist and/or licensed physician do not require PA. The comprehensive audiometric exam must be ordered in writing by a physician prior to

performing the testing. Comprehensive exams include air, bone, and speech audiometry, which are all necessary for differential diagnosis.

Audiometric tests, including audiologic function tests, evaluation of central auditory function, and evaluation/programming of cochlear implants, are reimbursable for audiology services.

The audiometric test implies the use of calibrated electronic equipment. Other hearing tests, such as whispered voice or tuning fork, are considered part of the general otorhinolaryngologic services and are not reported separately. All services include testing of both ears. See *CMS 1500 Instructions* for covered services.

2.16.5. Hearing Aid Visits

Hearing aid visits include one visit for the exam and selection of the hearing aid and up to two visits for hearing aid checks. The exam and select code should only be billed one time for one date of service. Two hearing aid checks are allowed following the exam and selection visit. A hearing check is not allowed on the same day as an exam and selection visit.

The hearing aid checks are intended as a mechanism for the provider to check the hearing aid after the initial issuance. It is understood the hearing aid will be checked and be in proper functioning order when it is issued.

2.16.6. Hearing Aid Purchase

Hearing aids are not a covered benefit for adult participants age 21 and older.

Medicaid will reimburse for medically necessary monaural or binaural hearing aids for participants under the age of 21. Binaural hearing aids will be covered in cases where it is documented that, without a binaural hearing aid, the child's ability to learn would be severely restricted. The documentation should be kept in the child's record, but prior authorization of the binaural hearing aid is not required.

Claims should be submitted with the date of the service or the date dispensed. The claim must be submitted by the hearing aid vendor as a professional claim, and may not be billed as a hospital claim. The following components are separately billable from the hearing aid.

- Ear molds
- Exam and selection
- Batteries

2.16.7. Hearing Aid Warranty and Insurance

Medicaid requires a two year warranty or two years of insurance be provided; the cost of the warranty or insurance is included in the reimbursement rate of the hearing aid.

2.16.8. Hearing Aid Follow-Up

In addition to hearing aid purchase, the following services are covered for participants under the age of 21.

- Ear molds that are purchased after the initial six months to one year period may be billed for participants age 21 and under, if medically necessary, and up to four units per year thereafter without prior authorization.
- 20 batteries per month. (1 unit = 1 battery.)

- Follow-up hearing aid testing and repairs resulting from normal use are allowed after the second year.
- Hearing aid testing and repairs during the first two years after purchase are included as part of the initial hearing aid purchase.

Refitting of hearing aids or additional ear molds are not covered for adults over the age of 21.

2.16.9. Payment Procedures

Payment amount for hearing aids is determined by Medicaid.

2.16.10. Physician Orders

The vendor must keep the following documentation in its files for a period of five years. Physician's signed and dated order that includes:

- The participant's diagnosis.
- The results of the basis comprehensive audiometry exam.
- Brand name, model, and type needed, including any options or accessories.

2.16.11. Program Abuse

Medical equipment items, including hearing aids, used by or provided to an individual other than the participant for whom the items were billed are prohibited. Violators are subject to strict enforced penalties for program fraud and abuse.

Medicaid has no obligation to repair or replace any item or supply that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the item.

2.16.12. Prior Authorization (PA) Requests

Approved PAs are valid only for the period between the start and stop dates. PA numbers must be included on the claim or the authorized service will be denied.

Requests for replacement hearing aids for participants under the age of 21 must be sent to the Durable Medical Equipment (DME) Unit for PA, and must include the following information:

- A completed Idaho Medicaid DME/Supplies Request form
- A copy of the audiometric test results
- Make/model of the hearing aid, including any option or accessories
- Justification for the options or accessories
- Physician prescription

Attach the invoice or quote to the PA request form for consideration. The authorized reimbursement will be entered on the PA approval letter See the *General Billing Instructions*, *Medicaid Prior Authorization (PA)*, for more information.

The DME Request Form is available online on the Durable Medical Equipment website or as a paper copy by request from Provider Services. Use it to make copies as needed.

Send completed PA request form to:

Medical Care Unit
Attn: DME
PO Box 83720
Boise, ID 83720-0009

1 (866) 205-7403
Fax: 1 (877) 314-8779

2.16.13. Post-Payment Review

All orders, evaluations, plans of care, and any other documentation supporting the billed services must be maintained by the provider. A random sample of claims will be selected for post-payment review.

When a claim is selected for review, the provider will be notified in person or in writing by the Department of Health and Welfare or its representative. The therapist must provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity of the billed service including time in and time out. Medicaid may recoup the payment if proper documentation cannot be produced by the provider.

To ensure the integrity of Idaho's Medicaid program, there are a number of federal and state program integrity agencies that may conduct Medicaid payment review. Providers must provide requested documentation to the Department, to the Centers for Medicare and Medicaid Services (CMS), and to any of the Department or CMS contractors immediately upon request.