MARYLAND MEDICAL ASSISTANCE PROGRAM

Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Provider Manual

Effective January 1st, 2017

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EPSDT PROVIDER MANUAL OVERVIEW

In this manual, you will find billing and reimbursement information for the following Medicaid services: Acupuncture, Chiropractic, Speech Language Pathology, Occupational Therapy, Nutrition Therapy, Physical Therapy, Audiology, and Vision Services. The information provided is related to services provider to Medicaid recipients who are 20 years of age or younger.

Audiology, occupational therapy, speech language pathology, and physical therapy services are "carved-out" from the HealthChoice Managed Care Organization (MCO) benefits package for recipients *who are 20 years of age and* younger and must be billed fee-for-service directly to the Medicaid Program.

Acupuncture, chiropractic, nutrition, and vision services are covered by the HealthChoice Managed Care Organization (MCO) benefits package for recipients *who are 20 years of age and* younger.

EPSDT refers to Early Periodic Screening Diagnosis and Treatment services for recipients under age 21.

Some services described in this manual are both EPSDT services (covered under age 21) and are also covered services for adults. Some services for adults described in this manual are only covered in certain settings. Most Medical Assistance recipients are enrolled in MCOs. Certain services for children are not part of the MCO benefit package; instead, they are carved out and must be billed to Medicaid FFS as described in this manual.

EPSDT services covered by the MCO are described in COMAR 10.09.67.20. When a recipient under age 21 is enrolled in an MCO, contact the MCO unless the service is carved out.

When a recipient age 21 and older is enrolled in an MCO, the services described in this manual that are covered for adults are the responsibility of the MCO. These services are described in COMAR 10.09.67. Providers must contact the MCO for further details.

When a recipient is not enrolled in an MCO, providers must follow the guidance in this manual.

EPSDT ACUPUNCTURE, CHIROPRACTIC, SPEECH LANGUAGE PATHOLOGY, OCCUPATIONAL & NUTRITION THERAPY SERVICES & PHYSICAL THERAPY SERVICES

EPSDT Overview

This section of the manual addresses occupational therapy, speech language pathology and physical therapy services for children when the services are not part of home health services or an inpatient hospital stay. These services are "carved-out" from the HealthChoice Managed Care Organization (MCO) benefits package for recipients *who are 20 years of age and* younger and must be billed fee-for-service directly to the Medicaid Program. Services provided by pediatricians, internists, family practitioners, general practitioners, nurse practitioners, neurologists, and/or other physicians to determine whether a child has a need for occupational therapy, physical therapy or speech language pathology services are the responsibility of the MCO and must be billed to the MCO. When therapy services are provided to recipients under age 21 as part of home health or an inpatient hospital stay they become the responsibility of the MCO. In addition, MCOs reimburse for community-based rehabilitation, including physical and occupational therapy and speech language pathology services for adult enrollees. Contact the MCO for their preauthorization and billing policy/procedures for recipients 21 years of age and older.

Acupuncture, chiropractic, and nutrition services addressed in this manual are limited to Maryland Medical Assistance's Early Periodic Screening, Diagnosis and Treatment (EPSDT) population (services for recipients who are 20 years of age and younger). These services are not generally covered for adults. When a recipient under age 21 is enrolled in HealthChoice the MCO is responsible for covering these services.

The following chart outlines the payer for these services when the recipient is enrolled in an MCO:

Service	Bill the MCO	Bill Fee for Service (FFS)
Occupational Therapy	21 + older	0-20
Physical Therapy	21 + older	0-20
Speech Language	21 + older	0-20
Acupuncture	0-20	------
Chiropractic	0-20	------
Nutrition	0-20	------
Home Health Therapy	0-99	------
Inpatient Therapy	0-99	------
DME/DMS	0-99	------

Therapy services provided by a hospital, home health agency, inpatient facility, nursing home, RTC, local lead agency, school or in accordance with an IEP/IFSP, model waiver, etc., are not specifically addressed in this manual.

Covered Services

EPSDT Acupuncture, Occupational Therapy, Speech Language Pathology & Chiropractic Services

For occupational therapy and speech language pathology services bill Fee-for-Service for recipients under 21 years of age. Contact the MCO for preauthorization for recipients 21 years of age and older. Acupuncture and chiropractic services for recipients under age 21are covered through the MCO.

Services are covered for recipients who are 20 years of age and younger when the services are:

- Necessary to correct or ameliorate defects and physical illnesses and conditions discovered in the course of an EPSDT screen;
- Provided upon the referral order of a screening provider;
- Rendered in accordance with accepted professional standards and when the condition of a participant requires the judgment, knowledge, and skills of a licensed acupuncturist, licensed occupational therapist, licensed speech pathologist or licensed chiropractor;
- Delivered in accordance with the plan of treatment
- Limited to one initial evaluation per condition; and
- Delivered by a licensed acupuncturist, licensed chiropractor, licensed occupational therapist, or a licensed speech pathologist.

In order to participate as an EPSDT-referred services provider, the provider shall:

- Gain approval by the screening provider every six (6) months or as authorized by the

Department for continued treatment of a participant. Approval must be documented by the screening provider and the therapist, acupuncturist, or chiropractor in the recipient's medical record;

- Have experience with rendering services to individuals from birth through 20 years of age;
- Submit a quarterly progress report to the recipient's primary care provider; and
- Maintain medical documentation for each visit.

PLEASE NOTE: Services provided in a facility or by a group where reimbursement is covered by another segment of the Medical Assistance Program **are not covered**.

Physical Therapy

PLEASE NOTE: Bill Fee-for-Service for recipients under 21 years of age. Contact the MCO for preauthorization for recipients 21 years of age and older.

Medically necessary physical therapy services ordered in writing by a physician, nurse practitioner, physician assistant or podiatrist are covered when:

- Provided by a licensed physical therapist or by a physical therapist assistant under direct supervision of the licensed physical therapist;
- Rendered in the provider's office, the recipient's home, or a domiciliary level facility;
- Diagnostic, rehabilitative, or therapeutic and directly related to the written treatment order;
- Of sufficient complexity and sophistication, or the condition of the patient is such, that the services of a physical therapist are required;
- Rendered pursuant to a written treatment order that is signed and dated by the prescriber;
- Treatment order is kept on file by the physical therapist as part of the recipient's permanent record;
- Not altered in type, amount, frequency, or duration by the therapist unless medically indicated. The physical therapist shall make necessary changes and sign the treatment order, advising the prescriber of the change and noting it in the patient's record;
- Limited to one initial evaluation per condition; and
- Reviewed monthly, thereafter, by the prescriber in communication with the therapist, if treatment is to exceed 30 days, and the order is either rewritten or a copy of the original order is initialed and dated by the prescriber. A quarterly progress report should be submitted to the recipient's primary care physician.

Services are to be recorded in the patient's permanent record which shall include:

- The treatment order of the prescriber;
- The initial evaluation by the therapist and significant past history;

- All pertinent diagnoses and prognoses;
- Contraindications, if any; and
- Progress notes, at least once every two weeks.

The following physical therapy services are not covered:

- Services provided in a facility or by a group where reimbursement for physical therapy is covered by another segment of the Medical Assistance Program;
- Services performed by licensed physical therapy assistants when not under the direct supervision of a licensed physical therapist;
- Services performed by physical therapy aides; and/or
- More than one initial evaluation per condition.

EPSDT Nutrition Services

(Contact the MCO for preauthorization)

- Medically necessary nutrition services provided by a licensed dietician nutritionist;
- Rendered in accordance with accepted professional standards and when the condition of a participant requires the judgment, knowledge, and skills of a licensed dietician nutritionist.

PLEASE NOTE: Nutrition services are covered through the MCO; contact the MCO for preauthorization information if serving an MCO enrollee.

Preauthorization

Contact the MCO for information regarding their billing and preauthorization procedures for acupuncture, chiropractic, nutrition, and therapy services for recipients who are under 21, or who are receiving home health and inpatient services.

Preauthorization is not required under the Fee-for-Service system; however, it is expected that a quarterly care plan be shared with the recipient's primary care provider.

Provider Enrollment

PLEASE NOTE: Under the Maryland Medical Assistance program, acupuncturists, therapists and chiropractors who are part of a physician's group are not considered physician extenders. Services rendered by these providers cannot be billed under the supervising physician's rendering number. These providers must complete an enrollment application and obtain a Maryland Medical Assistance provider number that has been specifically assigned to them under their name. The number will be used when billing directly to Maryland Medical Assistance.

Therapists, acupuncturists, nutrition dieticians, and chiropractors ***must be*** licensed to practice their specialties in the jurisdictions where they practice. (Chiropractors must be licensed and enrolled as a physical therapist in order to bill for physical therapy services.)

Once a Maryland Medical Assistance Program provider application has been approved, the Program will enroll the provider and issue a 9 digit provider identification number. This number will permit the provider to bill the Program's computerized payment processing system for services that are covered under the fee-for-service system. Applicants enrolling as a renderer in a group practice must be associated with a Maryland Medical Assistance existing or new group practice of the same provider type [i.e. a PT can enroll as a renderer in a PT group practice but not in a physician group practice].

PLEASE NOTE: At this time, renderers in a therapy group provider type practice (Provider Type 28) are not required to be assigned an individual rendering Maryland Medical Assistance provider number. A listing of therapists and license numbers of participating members of the practice must be attached to the therapy group application for in-state applicants. Out-of-state applicants must submit a copy of all licenses and/or certificates of the therapists participating in the practice.

Changes to the practice must be brought to the attention of the Program.

Provider Type	**Type of Practice**	**Specialty Codes**
AC - Acupuncture	35 (group) or 30 (individual or renderer in a group practice)	
18 - Occupational Therapist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Occupational Therapy (173)
17 - Speech Language Pathologist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Speech /Language Pathology (209)
13 - Chiropractor	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Chiropractor (106)
16 - Physical Therapist	35 (group) or 30 (individual or renderer in a group practice)	Physical Therapy (189)
28 - Therapy Group	99 (other)	Must be comprised of at least two different specialties: OT (173), PT (189), SP (209)

Provider Type	Type of Practice	Specialty Codes
85 - Nutritionist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT Nutrition Counseling (124) Healthy Start Nutrition (141)

Patient Eligibility & Eligibility Verification System (EVS)

The EVS is a telephone inquiry system that enables health care providers to verify quickly and efficiently a Medical Assistance recipient's current eligibility status. Medical Assistance eligibility should be verified on EACH DATE OF SERVICE *prior* to rendering services. Although Medical Assistance eligibility validation via the Program's EVS system is not required, it is to your advantage to do so to prevent the rejection of claims for services rendered to a canceled/non-eligible recipient. ***Before*** **rendering a Medical Assistance service, verify the recipient's eligibility *on the date of service* via the Program's Eligibility Verification System (EVS) 1-866-710-1447.**

If you need additional EVS information, please call the Provider Relations Unit at 410-767-5503 or 800-445-1159. EVS is an invaluable tool that is fast and easy to use.

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application, is now available at *www.emdhealthchoice.org*. The provider must be enrolled in eMedicaid in order to access the web EVS system. For additional information view the website or contact 410-767-5340 for provider application support.

21 years of age and older

The majority of Maryland Medical Assistance recipients are enrolled in an MCO. It is customary for the MCO to refer their enrollees to therapists in their own provider network for this age group. If a recipient is 21 or older and is enrolled in an MCO, preauthorization may be required by the MCO before treating the patient. Contact the recipient's MCO for their authorization/treatment procedures.

Under Medical Assistance's fee-for-service system, coverage for community-based therapy services for the 21 and over age population is limited to physical therapy services unless coverable under a different Maryland Medical Assistance Program that is not specifically addressed in this manual (i.e. hospital services, home health services, etc.)

Under 21 years of age – EPSDT Population

Speech language pathology, occupational therapy and physical therapy services provided to recipients who are 20 years of age or younger are part of Maryland Medical Assistance's fee-for-service system when not provided as a home health or inpatient service. Home health and inpatient care are coverable by the MCO. Therapy providers who are enrolled as a Maryland Medical Assistance provider may render the prescribed therapy services and bill the Program

directly on the CMS-1500 form under his/her Maryland Medical Assistance assigned provider identification number.

Acupuncture, nutrition, and chiropractic services continue as a covered benefit under the MCO system; these services must be billed to the MCO for MCO enrollees. Contact the MCO for preauthorization/treatment procedures for acupuncture, nutrition, and chiropractic services.

Billing Guidelines

The following billing instructions are to be used for Fee-for-Service therapy services provided by the provider types addressed in this manual. Acupuncture, occupational therapy, nutrition, speech language pathology and chiropractic services are limited to children under the age of 21 in Medical Assistance's EPSDT Program**.** Physical therapy services are covered for all age groups; however, MCO enrollees who are 21 or older are covered through the MCO and are not considered Fee-for-Service. In addition, EPSDT acupuncture, nutrition and chiropractic services are covered through the MCO for MCO enrollees.

The providers addressed in these guidelines cannot bill the Program using a ***physician's*** provider number. They are ***not*** considered physician extenders. They must enroll with the Program and be assigned a provider number. All fee-for-service claims are to be billed under the assigned Medical Assistance provider number for therapy services.

Fee for Service (FFS) Billing

Providers shall bill the Maryland Medical Assistance Program for reimbursement on the CMS-1500 and attach any requested documentation. Maryland Medical Assistance specific procedure codes are required for billing purposes. Please refer to the procedure code and fee schedule that is included in this manual.

The Program reserves the right to return to the provider, before payment, all invoices not properly signed, completed, and accompanied by properly completed forms required by the Department.

The provider shall charge the Program their usual and customary charge to the general public for similar services. The Program will pay for covered services, based upon the lower of the following:

- The provider's customary charge to the general public; or
- The Department's fee schedule.

The Provider may <u>not</u> bill the Program for:

- Services rendered by mail or telephone;
- Completion of forms and reports;
- Broken or missed appointments; or
- Services which are provided at no charge to the general public.

To ensure payment by the Maryland Medical Assistance Program, check Maryland Medical Assistance's Eligibility Verification System (EVS) for ***every Medical Assistance patient*** on the date of service to ensure payment by Maryland Medical Assistance.

Under Medical Assistance's Fee-for-Service system, services are reimbursed on a per visit basis under the procedure code that is listed on Maryland Medical Assistance's established procedure code and fee schedule. The schedule will indicate the maximum units allowed for the service and the fee amount for each unit of service. The maximum units are the total number of units that can be billed on the same day of service. Maryland Medical Assistance will reject claims that exceed the maximum units of service.

PLEASE NOTE: Providers assigned a rendering provider number must bill the Medical Assistance Program with a group provider number. At this time, only therapy group (provider type 28) providers can bill without including a rendering provider number on the claim.

MCO Billing

Claims for recipients who are 21 years of age or older and enrolled in an MCO, must be submitted to the MCO for payment. Contact the MCO for information regarding their billing and preauthorization procedures.

Acupuncture, nutrition, and chiropractic services are a covered benefit through the MCO system for recipients who are 20 years old and younger. Contact the MCO for information regarding their billing and preauthorization procedures.

Medicare

The Program will authorize payment on Medicare claims if:

- The provider accepts Medicare assignments;
- Medicare makes direct payment to the provider;
- Medicare has determined that services were medically justified;
- The services are covered by the Program; and
- Initial billing is made directly to Medicare according to Medicare guidelines.

If the recipient has insurance or other coverage, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the recipient for the services in these guidelines, the provider should seek payment from that source first. If an insurance carrier rejects the claim or pays less than the amount allowed by the Medical Assistance Program, the provider should submit a claim to the Program. A copy of the insurance carrier's notice or remittance advice should be kept on file and available upon request by the Program. In this instance, the CMS-1500 must reflect the letter K (services not covered) in box 11 of the claim form. Contact Medical Assistance's Provider Relations Office if you have questions about completing the claim form.

Medical Assistance Payments

You must accept payment from Medical Assistance as ***payment in full*** for a covered service. You ***cannot*** bill a Medical Assistance recipient under the following circumstances:

- For a covered service for which you have billed Medical Assistance;
- When you bill Medical Assistance for a covered service and Medical Assistance denies your claims because of billing errors you made, such as: wrong procedure codes, lack of preauthorization, invalid consent forms, unattached necessary documentation, incorrectly completed forms, filing after the time limitations, or other provider errors;
- When Medical Assistance denies your claim because Medicare or another third party has paid up to or exceeded what Medical Assistance would have paid;
- For the difference in your charges and the amount Medical Assistance has paid;
- For transferring the recipient's medical records to another health care provider; and/or
- When services were determined to not be medically necessary.

You ***can*** bill the recipient under the following circumstances:

- If the service provided is not covered by Medical Assistance and you have notified the recipient prior to providing the service that the service is not covered; or
- If the recipient is not eligible for Medical Assistance on the date you provided the service.

Regulations

Visit the following website to review the regulations that pertain to this manual: *http://www.dsd.state.md.us/COMAR/ComarHome.html*.

Select option #3; choose select by title number; select title number 10 - Department of Health and Mental Hygiene. Select Subtitle 09 - Medical Care Programs; Select regulations 10.09.23 EPSDT: Referred Services. To review the regulation for acupuncture, nutrition, chiropractic, occupational therapy, or speech language pathology services, select 10.09.23: Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Services. To review the regulation for physical therapy services, select 10.09.17: Physical Therapy Services.

The Health Insurance Portability & Accountability Act (HIPAA)

HIPAA of 1996 requires that standard electronic health transactions be used by health plans, including private, commercial, Medical Assistance and Medicare, health care clearinghouses, and health care providers.

More information on HIPAA may be obtained from:
http://dhmh.maryland.gov/hipaa/Pages/Home.aspx.

National Provider Identifier (NPI)

Effective July 30, 2007, all health care providers that perform medical services must have a NPI. The NPI is a unique, 10-digit, numeric identifier that does not expire or change. NPI's are assigned to improve the efficiency and effectiveness of the electronic transmission of health information. Implementation of the NPI impacts all practice, office, or institutional functions, including billing, reporting, and payment.

The NPI is administered by the Centers of Medicare and Medicaid Services (CMS) and is required by HIPAA. Providers must use the legacy MA number as well as the NPI number when billing on paper.

Apply for an NPI by using the web-based application process via the National Plan and Provider Enumeration System (NPPES) at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

Fraud and Abuse

It is illegal to submit reimbursement requests for:

- Amounts greater than your usual and customary charge for the service. If you have more than one charge for a service, the amount billed to the Maryland Medical Assistance Program should be the lowest amount billed to any person, insurer, health alliance or other payer;
- Services which are either not provided or not provided in the manner described on the request for reimbursement. In other words, you must accurately describe the service performed, correctly define the time and place where the service was provided and identify the professional status of the person providing the service;
- Any procedures other than the ones you actually provide;
- Multiple, individually described or coded procedures if there is a comprehensive procedure which could be used to describe the group of services provided;
- Unnecessary, inappropriate, non-covered or harmful services, whether or not you actually provided the service; or
- Services for which you have received full payment by another insurer or party.

You are required to refund all overpayments received from the Medical Assistance Program within 30 days. Providers must not rely on Department requests for any repayment of such overpayments. Retention of any overpayments is also illegal.

A provider who is suspended or removed from the Medical Assistance Program or who voluntarily withdraws from the Program must inform recipients ***before*** rendering services that he/she is no longer a Medical Assistance provider and the recipient is therefore financially responsible for the services.

Appeal Procedure

Appeals related to Medical Assistance are conducted under the authorization of COMAR 10.09.36.09 and in accordance with COMAR 10.01.03 and 28.02.01. To initiate an appeal, the appeal must be filed within 30 days of receipt of a notice of administrative decisions in accordance with COMAR 10.01.03.06.

Procedure Codes and Fee Schedules January 2017

EPSDT Acupuncture Services

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15-minutes of personal one-on-one contact with the patient	N	1	$28.37
97811	Acupuncture without electrical stimulation, each additional 15-minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	N	1	$21.11
97813	Acupuncture with electrical stimulation, initial 15-minutes of personal one-on-one contact with the patient	N	1	$30.27
97814	Acupuncture with electrical stimulation, initial 15-minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	N	1	$23.86

EPSDT Chiropractic Services

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
98940	Chiropractic Manipulative Treatment Spinal, 1 to 2 regions	N	1	$22.00
98941	Chiropractic Manipulative Treatment Spinal, 3 to 4 regions	N	1	$31.51
98942	Chiropractic Manipulative Treatment Spinal, 5 regions	N	1	$41.04

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
98943	Chiropractic Manipulative Treatment Extra spinal, 1 or more regions	N	1	$21.18

Physical Therapy

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97161	Physical Therapy Evaluation, Low complexity, 20 minutes	N	1	$69.20
97162	Physical Therapy Evaluation, Moderate complexity, 30 minutes	N	1	$69.20
97163	Physical Therapy Evaluation, High complexity, 45 minutes	N	1	$69.20
97164	Physical Therapy Re-Evaluation, Established plan of care	N	1	$47.19
97010	Application of modality to 1 or more Areas; hot or cold packs (supervised)	N	10	$4.77
97012	Mechanical Traction (supervised)	N	10	$12.67
97014	Electrical Stimulation (unattended)	N	1	$12.52
97016	Vasopneumatic Device	N	2	$15.37
97018	Paraffin Bath	N	10	$8.76
97022	Whirlpool	N	10	$18.81
97024	Diathermy (e.g. microwave)	N	10	$5.34
97026	Infrared	N	10	$4.77
97028	Ultraviolet Light	N	10	$5.87
97032	Attended Electrical Stimulation, each 15 minutes	N	4	$14.96
97033	Iontophoresis, each 15 minutes	N	4	$17.48
97034	Contrast Bath, each 15-minutes	N	4	$14.17
97035	Ultrasound, each 15-minutes	N	4	$9.90
97036	Hubbard Tanks, each 15-minutes	N	4	$26.01

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97110	Therapeutic Procedure, each 15-minutes	N	4	$29.03
97112	Neuromuscular Reeducation	N	4	$26.58
97113	Aquatic Therapy	N	4	$33.98
97116	Gait Training	N	4	$22.08
97124	Therapeutic Massage	N	4	$20.46
97140	Manual Therapy Techniques, each 15 minutes	N	4	$23.45
97597	Selective Debridement (for wounds ≤ 20 sq. cm.)	N	1	$59.82
97598	Selective Debridement (for each additional 20 sq. cm wound)	N	1	$25.68
97605	Negative pressure wound therapy	N	1	$32.38
97606	Total wound surface area ≥ 50 sq.cm.	N	1	$38.27
92607	Evaluation for speech generating device, first hour			$121.74
92608	Evaluation for speech generating device, each additional 30 minutes			$41.74
92609	Programming and modification of speech generating device			$86.26
97750	Physical performance test or measurement, each 15 minutes	N	3	$25.72
97755	Assistive Technology Assessment each 15 minutes	N	2	$27.68

EPSDT Occupational Therapy

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97165	Occupational Therapy Evaluation, Low complexity, 30 minutes	N	1	$ 67.01
97166	Occupational Therapy Evaluation, Moderate complexity, 45 minutes	No	1	$67.01
97167	Occupational Therapy Evaluation, High Complexity, 60 minutes	No	1	$67.01
97168	Occupational Therapy Re-Evaluation, Established plan of care	N	1	$ 44.34
97530	Therapeutic Activities, each 15 minutes	N	4	$ 30.56

EPSDT Speech Language Pathology

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
92507	Individual	N	1	$ 63.99
92508	Group	N	1	$ 30.47
92521	Evaluation of speech fluency	N	1	$ 91.35
92522	Evaluation of speech sound production	N	1	$74.00
92523	Evaluation of speech sound production with evaluation of language comprehension and expression	N	1	$153.97
92524	Behavioral and qualitative analysis of voice and	N	1	$77.40
92526	Treatment of swallowing dysfunction and/or oral function for feeding	N	1	$80.85
92610	Evaluation of oral and pharyngeal swallowing function	N	1	$81.43
92626	Evaluation of auditory rehabilitation status	N	1	$70.21
92627	Evaluation of auditory rehabilitation	N	3	$17.37

EPSDT Nutrition Services

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97802	Nutrition Assessment and intervention	N	4	$30.03
97803	Nutrition Re-assessment and intervention	N	4	$26.35
97804	Group Nutrition Service	N	1	$13.55

PLEASE NOTE: Services are reimbursed up to the maximum units as indicated on this schedule. Providers enrolled as a Therapy Group (Provider Type 28) may bill the per visit charge for each ***enrolled*** discipline participating in the group. Please refer to the fee schedule for maximum reimbursement.

Claims must reflect the above referenced procedure codes for proper reimbursement. These codes are specific to services outlined in the Provider Manual for EPSDT acupuncture, nutrition, chiropractic, speech language pathology, and occupational therapies, as well as physical therapy services, and they are specific to the Maryland Medical Assistance Fee-for-Service system of payment.

AUDIOLOGY SERVICES

Overview

Audiologist and hearing aid service coverage is limited to Maryland Medical Assistance's EPSDT Program population (20 years of age or younger) who are at risk for hearing impairment. To be at risk for hearing impairment means the condition of a recipient with a suspect or positive hearing screening.

As of November 1999, audiologist and hearing aid dispenser services for the EPSDT population were "carved out" from the managed care organization (MCO) payment system. These services were placed back into Maryland Medical Assistance's Fee-for-Service (FFS) system of payment. The recipient *does not* have to receive a preauthorization or referral from the MCO before visiting an audiologist for evaluation and/or treatment. Maryland Medical Assistance FFS requires preauthorization on certain services. In order to determine which service requires preauthorization, review the attached fee schedule for audiology services.

Covered Services

All services for which reimbursement is sought must be provided in accordance with the regulations for Maryland Medical Assistance EPSDT Audiology Services (COMAR 10.09.51).

A. The Program covers the following medically necessary audiological services for EPSDT recipients who are at risk for hearing impairment:

1. Audiological assessments;

2. Electrophysiological measures such as auditory brainstem response (ABR), otoacoustic emissions, and brainstem auditory evoked response for recipients, when one of the following criteria is met:

a. Failure of the recipient to provide consistent behavioral responses to auditory signals, using procedures appropriate for the recipient's developmental age;

b. Presence of neuromotor involvement or behavioral disorder, or both, which precludes observation of consistent behavioral responses;

c. Failure to respond to test signal intensities appropriate for the recipient's developmental age, using developmentally appropriate test procedures;

d. Presence of inconsistencies in the results of tests administered during the audiological assessment which suggest, but do not define, a hearing impairment;

e. The Infant High Risk Questionnaire delineates a need; or

f. A physician refers the infant for the service;

3. Hearing aid evaluations; and

4. All services as listed on the Audiology Procedure Code and Fee Schedule, Revision 2010, contained in the EPSDT Provider Manual, dated January 1, 2017.

B. Medically necessary hearing aid services, as follows:

1. Hearing aids which are:

a. Not used or rebuilt, and which meet the current standards set forth in 21 CFR §§801.420 and 801.421, which are incorporated by reference;

b. Recommended and fitted by an audiologist in conjunction with written medical clearance from a physician who has performed a medical examination within 6 months;

c. Sold on a 30-day trial basis;

d. Fully covered by a repair warranty for a period of 2 years, at least 1 year of which is provided by the manufacturer at no cost to the Program; and

e. Insured for loss or theft for a period of 2 years per hearing aid; and

2. Hearing aid accessories and services, as listed below:

a. Ear molds;

b. Batteries;

c. Chest harnesses or belts;

d. Replacement receivers and cords;

e. Tone hooks;

f. Huggie aids;

g. Protective coverings for hearing aids;

h. Battery testers;

i. Dehumidification kits;

j. Hearing aid stethoscopes;

k. Other amplification-related items recommended by an audiologist;

l. Routine follow-ups and adjustments;

m. Repairs after all warranties have expired;

n. Insurance policies as required by §B(1)(c) and (d) of this regulation; and

o. Extended repair warranties.

Service Limitations

A. Covered audiology and postoperative cochlear implant services are limited to:

1. Recipients under 21 years old who are referred for the service or have had cochlear implant surgery;

2. One audiological assessment per year, unless the time limitations are waived by the Program;

3. One monaural or binaural hearing aid every 3 years unless the Program approves more frequent replacement;

4. Replacement of hearing aids that have been lost, stolen, or damaged beyond repair, after all warranties and insurance policies have expired;

5. Repairs and replacements that take place after all warranties and insurance policies have expired;

6. A maximum of 48 batteries per recipient per year for a monaural hearing aid, or 96 batteries per recipient per year for a binaural hearing aid, purchased from the Department not more frequently than every 6 months, and in quantities of 24 or fewer for a monaural hearing aid, or 48 or fewer for a binaural hearing aid;

7. A maximum of 476 disposable batteries for a cochlear implant per calendar year, purchased every 6 months in quantities of 238 or fewer;

8. Two replacement cochlear implant component rechargeable batteries per 12-month period;

9. Two cochlear implant replacement transmitter cables per 12-month period;

10. Two cochlear implant replacement headset cables per 12-month period; and

11. Charges for routine follow-ups and adjustments which occur more than 60 days after the dispensing of a new hearing aid.

B. Services which are not covered are:

1. Services not medically necessary;

2. Hearing aids and accessories not medically necessary;

3. Cochlear implant services and external components not medically necessary;

4. Cochlear implant audiological services and external components provided less than 90 days after the surgery or covered through initial reimbursement for the implant and the surgery;

5. Spare or backup cochlear implant speech processors;

6. Upgrades to new generation hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;

7. Replacement of hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;

8. Spare or backup hearing aids, equipment, or supplies;

9. Repairs to spare or backup hearing aids, equipment, or supplies;

10. Investigational, experimental, or ineffective services or devices, or both;

11. Educationally or socially needed services or equipment;

12. Replacement of improperly fitted ear mold or ear molds unless:

a. Replacement service is administered by someone other than the original provider; and

b. Replacement service has not been claimed before;

13. Additional professional fees and overhead charges for a new hearing aid when a dispensing fee claim has been made to the Program; and

14. Loaner hearing aids.

Eligibility Verification System – (EVS)

EVS is a telephone inquiry system that enables health care providers to verify quickly and efficiently a Medical Assistance recipient's current eligibility status. Medical Assistance eligibility should be verified on EACH DATE OF SERVICE prior to rendering services. Although Medical Assistance eligibility validation via the Program's EVS system is not

required, it is to your advantage to do so to prevent the rejection of claims for services rendered to a canceled/non-eligible recipient. Before rendering a Medical Assistance service, verify the recipient's eligibility on the date of service via the EVS at **1-866-710-1447.**

If you need additional EVS information, please call the Provider Relations Unit at **410- 767-5503** or **800-445-1159**. EVS is an invaluable tool that is fast and easy to use.

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application, is now available at *www.emdhealthchoice.org*. The provider must be enrolled in eMedicaid in order to access the web EVS system. For additional information view the website or contact **410-767-5340** for provider application support.

Preauthorization Requirements

A. The Department shall issue preauthorization for EPSDT Audiology Services when the provider:

1. Meets Program procedures and limitations; and

2. Submits to the Department adequate documentation demonstrating that the services to be preauthorized are necessary, as stated in COMAR 10.09.23.07.

B. The Program requires preauthorization for the following audiology services:

1. Certain hearing aids;

2. Unlisted hearing aid accessories; and

3. Unlisted post-cochlear implant external components.

C. Preauthorization for audiology services expires 6 months from the authorized span of time that is issued by the Department and is valid if the recipient is eligible at the time the service is rendered to the recipient.

D. The following written documentation shall be submitted by the provider with each new hearing aid that requires preauthorization:

1. Audiology report;

2. Audiogram; and

3. Written medical approval by a physician.

A preauthorization request for EPSDT an audiologist or hearing aid dispenser service is submitted on form DHMH 4525. The provider must complete, sign (original signature from the

audiologist or hearing aid dispenser is required) and mail to the address listed on the form *prior* to rendering the service to the recipient to ensure coverage. It is imperative that correct procedure codes be placed on the request form. Incorrect or omitted information will result in a rejected request.

Determination of authorization is issued via a letter after the receipt and review of the request (form DMHM-4525) has taken place. A copy of the notification letter is sent to the provider as well as to the recipient.

Billing Information

Services such as developmental screens or pure tone audiologic screening tests provided by a physician or nurse practitioner for the purpose of identifying children who need a referral for further evaluation are not billable to the Medical Assistance Program. These screening tests remain the responsibility of the child's MCO and need to be provided within the MCO'S guidelines. Newborn hearing screens, in or out of the hospital, also remains under the MCO payment system.

Payment Procedures

Providers shall submit requests for payment for audiology services as stated in COMAR 10.09.36.

A. Providers shall submit requests for payment for audiology services as stated in COMAR 10.09.36.04.

B. Audiologists, audiological centers, and hearing aid dispensers shall charge the Program usual and customary charges, not exceeding those charged to the general public for similar professional services.

C. The provider shall charge the Program the acquisition cost for certain hearing aids, accessories, external cochlear implant accessories, and supplies.

D. The provider shall itemize all hearing aid and external cochlear implant charges including accessories, supplies, shipping or handling, or both, insurance, and warranties.

E. The provider shall submit the request for payment on the form designated by the Department.

F. The provider may not bill the Department for:

   1. Completion of forms and reports;

   2. Broken or missed appointments;

3. Professional services rendered by mail or telephone; and

4. Services provided at no charge to the general public.

G. Audiological centers licensed as a part of a hospital may charge for and be reimbursed according to rates approved by the Health Services Cost Review Commission (HSCRC), set forth in COMAR 10.37.03.

H. The provider shall refund to the Program payment for hearing aids, supplies, or both, that have been returned to the manufacturer.

I. The provider shall give the Program the full advantage of any and all manufacturer's warranty and trade-ins offered on hearing aids, equipment, or both.

J. The Program shall reimburse for covered services at the lower of:

1. The provider's usual and customary charge to the general public;

2. The Program's fee schedule; or

3. The provider's acquisition cost.

Health Insurance Portability & Accountability Act (HIPAA)

The HIPAA requires that standard electronic health transactions be used by health plans, including private, commercial, Medical Assistance and Medicare, health care clearinghouses and health care providers. The intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes. More information on HIPAA can be found at: *http://dhmh.maryland.gov/hipaa/Pages/Home.aspx*.

National Provider Number (NPI)

The NPI is a 10-digit, numeric identifier that does not expire or change. It is administered by CMS and is required by HIPAA. The NPI will replace all of your existing provider numbers that you use to bill Medical Assistance, Medicare and other health care payers.

If you have not applied for your NPI, please do so at once and report it to us. You should be using the NPI as the primary identifier and your Medical Assistance Provider number as the secondary identifier on all paper and electronic claims.

Audiology Procedure Codes & Fee Schedule January 1, 2017

Audiology Services

Procedure Code	Description	Maximum Fee
92550	Tympanometry and reflex threshold measurements (do not report 92567 or 92568 in addition to 92550)	$35.00
92551	Screening test, pure tone, air only	$9.72
92552	Pure tone audiometry (threshold); air only	$25.40
92557	Comprehensive audiometry-pure tone, air and bone, and speech threshold and discrimination - annual audiological assessment (annual limitation may be waived if medically necessary and appropriate)	$46.80
92567	Typanometry (impedance testing) (do not report 92550 or 92568 in addition to 92567)	$20.00
92568	Acoustic reflex testing; threshold (do not report 92550 or 92567 in addition to 92568)	$16.22
92570	Acoustic immittance testing (includes tympanometry Acoustic reflex threshold and acoustic reflex decay testing)	$50.00
92585	Auditory evoked potentials for evoked response audiometry (ABR) comprehensive	$140.00
92586	Auditory evoked potentials for evoked response audiometry (ABR) - limited	$70.00
92587	Distortion product evoked otoacoustic emissions; limited evaluation (single stimulus level, either transient or distortion products)	$50.00
92588	Evoked otoacoustic emissions; comprehensive (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	$75.00
92601	Diagnostic analysis of cochlear implant, patient Under 7 years of age; with programming	$140.40
92602	Subsequent reprogramming (do not report 92602 in addition to 92601)	$ 96.30
92603	Diagnostic analysis of cochlear implant, age 7 yrs or older, with programming	$118.62
92604	Subsequent reprogramming (do not report 92604 in addition to 92603)	$70.49
92620	Evaluation of central auditory function, with report; initial 60 minutes	$73.76

Procedure Code	Description	Maximum Fee
V5299	Hearing service, miscellaneous (procedure not listed; service not typically covered, request for consideration. Documentation demonstrating medical necessity required – to be submitted with preauthorization request.)	I/C*

Hearing Aid & Cochlear Implant Codes & Supplies

Procedure code	Description	Maximum fee
92590	Hearing aid examination and selection; monaural	$78.00
92591	Hearing aid examination and selection; binaural	$78.00
92592	Hearing aid check; monaural	$42.00
92593	Hearing aid check, binaural	$42.00
L8614	Cochlear device/system (limited external replacement components)	B/R*
L8615	Cochlear implant headset/headpiece, replacement	$450.00
L8616	Cochlear implant microphone, replacement	$300.00
L8617	Cochlear implant transmitting coil, replacement	$250.00
L8618	Cochlear implant transmitter cable, replacement	$95.00
L8619	Cochlear implant external speech processor (limited to non-repairable out of warranty cases)	A/C*
L8621	Cochlear implant, battery, zinc air, replacement	$1.56
L8622	Cochlear implant, battery, alkaline, replacement	$1.56
L8623	Cochlear implant speech processor lithium ion battery, (replacement)	$150.00
L8624	Cochlear implant speech processor lithium ion battery, ear (replacement)	$165.00
V5030	Body worn, air conduction hearing aid	B/R
V5040	Body worn, bone conduction hearing aid	$2,500.00
V5050	Monaural, in the ear	$350.00
V5060	Monaural behind the ear aids (specify)	$350.00
V5080	Glasses, bone conduction	A/C*
V5100	Body worn, bilateral	B/R
V5120	Body, binaural	B/R

Procedure code	Description	Maximum fee
V5130	In the ear, binaural	$700.00
V5140	Behind the ear, binaural (specify)	$700.00
V5150	Glasses, binaural	A/C*
V5160	Dispensing fee, binaural	$175.00
V5170	Cros, in the ear	$1,600.00
V5180	Cros, BTE (behind the ear)	$1,190.00
V5190	Cros, glasses	A/C*
V5200	Dispensing fee, cros	$106.00
V5210	Bicros, ITE (in the ear)	$1,190.00
V5220	Bicros, BTE (behind the ear)	$1,190.00
V5230	Bicros, glasses	A/C*
V5240	Dispensing fee, bicros	$106.00
V5242	Analog, monaural, CIC (completely in the ear canal)	A/C*
V5243	Analog, monaural, ITC (in the canal)	A/C*
V5244	Digitally programmable analog, monaural, CIC	A/C*
V5245	Digitally programmable analog monaural, ITC	A/C*
V5246	Digitally programmable analog, monaural, ITE (in the ear)	A/C*
V5247	Digitally programmable analog, monaural, BTE (behind the ear)	$900.00
V5248	Analog, binaural, CIC	A/C*
V5249	Analog, binaural, ITC	A/C*
V5250	Digitally programmable analog, binaural, CIC	A/C*
V5251	Digitally programmable analog, binaural, ITC	A/C*
V5252	Digitally programmable, binaural, ITE	$1,900.00
V5253	Digitally programmable, binaural, BTE	$1,900.00
V5254	Digital, monaural, CIC	A/C*
V5255	Digital, monaural, ITC	A/C*
V5256	Digital, monaural, ITE	$950.00
V5257	Digital, monaural, BTE	$950.00
V5258	Digital, binaural, CIC	A/C*
V5259	Digital, binaural, ITC	A/C*
V5260	Digital, binaural, ITE	$1,900.00
V5261	Digital, binaural, BTE	$1,900.00
V5160	Dispensing fee +, binaural	$175.00
V5200	Dispensing fee +, cros	$106.00

Procedure code	Description	Maximum fee
V5240	Dispensing fee +, bicros	$106.00
V5241	Dispensing fee +, monaural	$106.00
V5264	Ear mold, not disposable, (limitation = up to 2 per monaural/4 per binaural per year)	$27.00
V5266	Replacement battery for use in hearing device maximum 48 per year for monaural maximum 96 per year for binaural	$1.56
V5267	Hearing aid supplies /accessories (medically necessary and effective services. Note: prophylactic ear protection - a copy of the signed prescription from the primary care doctor, and a documented history of tympanostomy tube must be on file.)	A/C*
V5014	Repair/Modification of a hearing aid (Extended warranty period for aid has expired. Note: regulations stipulate that new aids be fully covered by a repair warranty and insured for loss or theft for a period of 2 years per hearing aid.)	$250.00
X0103	Hearing aid insurance/warranty	$150.00
99002	Handling/conveyance service for devices	$15.00

KEY:

***** Requires preauthorization for all recipients

A/C Acquisition cost

B/R By report-attach audiology report, audiogram, medical clearance & invoice to claim

I/C Individual Consideration

VISION CARE SERVICES

Overview

Vision screening and treatment services are included in the comprehensive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children and adolescents under 21 years of age. At a minimum, EPSDT must include age-appropriate vision assessment and services to correct or ameliorate vision problems, including eyeglasses.

Covered Services

All services for which reimbursement is sought must be provided in accordance with the Maryland Medical Assistance Vision Care Services (COMAR 10.09.14).

The Medical Assistance Program covers the following vision care services:

1. A maximum of one optometric examination to determine the extent of visual impairment or the correction required to improve visual acuity, every two years for recipients 21 years and older, and a maximum of one optometric examination a year for recipients younger than 21 years old, unless the time limitations are waived by the Program, based upon medical necessity.

2. A maximum of one pair of eyeglasses a year for recipients younger than 21 years old (unless the time limitations are waived by the Program, based on medical necessity) which have first quality, impact resistant lenses (except in cases where prescription requirements cannot be met with impact resistant lenses) and frames which are made of fire-resistant, first quality material, when at least one of the following conditions are met:

a. The recipient requires a diopter change of at least 0.50;

b. The recipient requires a diopter correction of less than 0.50 based on medical necessity and preauthorization has been obtained from the Program;

c. The recipient's present eyeglasses have been damaged to the extent that they affect visual performance and cannot be repaired to effective performance standards, or are no longer usable due to a change in head size or anatomy; or

d. The recipient's present eyeglasses have been lost or stolen.

3. Examination and eyeglasses for a recipient with a medical condition, other than normal physiological change necessitating a change in eyeglasses (before the normal time limits have been met) when a preauthorization has been obtained from the program.

4. Visually necessary optometric care rendered by an optometrist when these services are:

a. Provided by the optometrist or his licensed employee;

b. Related to the patient's health needs as diagnostic, preventative, curative, palliative, or rehabilitative services; and

c. Adequately described in the patient's record.

5. Optician services when they are:

a. Provided by the optician or optometrist, or by an employee under their supervision and control;

b. Adequately described in the patient's record; and

c. Ordered or prescribed by an ophthalmologist or optometrist.

Service Limitations

A. The Vision Care Program does not cover the following services:

1. Services not medically necessary;

2. Investigational or experimental drugs or procedures;

3. Services prohibited by the State Board of Examiners in Optometry;

4. Services denied by Medicare as not medically justified;

5. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients 21 years or older;

6. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients younger than 21 years old which were not ordered as a result of a full or partial EPSDT screen;

7. Repairs, except when repairs to eyeglasses are cost effective compared to the cost of replacing with new glasses;

8. Repairs for recipients 21 or older;

9. Combination or metal frames except when required for proper fit;

10. Cost of travel by the provider;

11. A general screening of the Medical Assistance population;

12. Visual training sessions which do not include orthoptic treatment; and

13. Routine adjustment.

B. The optometrist may not bill the Program nor the recipient for:

1. Completion of forms and reports;

2. Broken or missed appointments;

3. Professional services rendered by mail or telephone;

4. Services which are provided at no charge to the general public; and

5. Providing a copy of a recipient's patient record when requested by another licensed provider on behalf of the recipient.

C. An optometrist certified by the Board as qualified to administer diagnostic pharmaceutical agents may use the following agents in strengths not greater than the strengths indicated:

1. Agents directly or indirectly affecting the pupil of the eye including the mydriatics and cycloplegics listed below:

a. Phenylephrine hydrochloride (2.5%);

b. Hydroxyamphetamine hydrobromide (1.0%);

c. Cyclopentolate hydrochloride (0.5 - 2.0%);

d. Tropicamide (0.5 and 1.0%);

e. Cyclopentolate hydrochloride (0.2%) with Phenylephrine hydrochloride (1.0%);

f. Dapiprazole hydrochloride (0.5%);

g. Hydroxyamphetamine hydrobromide (1.0%) and Tropicamide (0.25%).

2. Agents directly or indirectly affecting the sensitivity of the cornea including the topical anesthetics listed below:

a. Proparacaine hydrochloride (0.5%); and

b. Tetracaine hydrochloride (0.5%).

3. Diagnostic topical anesthetic and dye combinations listed below:

a. Benoxinate hydrochloride (0.4%) - Fluorescein sodium (0.25%); and

b. Proparacaine hydrochloride (0.5%) - Fluorescein sodium (0.25%).

D. An optometrist certified by the Board as qualified to administer and prescribe topical

therapeutic pharmaceutical agents is limited to:

1. Ocular antihistamines, decongestants, and combinations thereof, excluding steroids;

2. Ocular antiallergy pharmaceutical agents;

3. Ocular antibiotics and combinations of ocular antibiotics, excluding specially formulated or fortified antibiotics;

4. Anti-inflammatory agents, excluding steroids;

5. Ocular lubricants and artificial tears;

6. Tropicamide;

7. Homatropine;

8. Nonprescription drugs that are commercially available; and

9. Primary open-angle glaucoma medications, in accordance with a written treatment plan developed jointly between the optometrist and an ophthalmologist.

E. The Program will only pay for lenses to be used in frames purchased by the Program or to replace lenses in the recipient's existing frames, which are defined as those which have been fitted with lenses and previously worn by the recipient for the purpose of correcting that patient's vision.

F. Providers may not sell a frame to a recipient as a private patient and bill the Program for the lenses only.

G. Providers may not bill the Program for lenses when the recipient presents new, unfitted frames which were purchased from another source.

H. Providers may not bill the Program for the maximum allowed fee for frames and collect supplemental payment from the recipient to enable that recipient to purchase a desired frame that exceeds Program limits.

I. If after the provider has fully explained the extent of Program coverage, the recipient knowingly elects to purchase the desired frames and lenses, the provider may sell a complete pair of eyeglasses (frames and lenses) to a recipient as a private patient without billing the Program.

Preauthorization Requirements

A. The following services require written preauthorization:

1. Optometric examinations to determine the extent of visual impairment or the correction

required to improve visual acuity before expiration of the normal time limitations;

2. Replacement of eyeglasses due to medical necessity or because they were lost, stolen or damaged before expiration of the normal time limitations;

3. Contact lenses;

4. Subnormal vision aid examination and fitting;

5. Orthoptic treatment sessions;

6. Plastic lenses costing more than equivalent glass lenses unless there are six or more diopters of spherical correction or three or more diopters of astigmatic correction;

7. Absorptive lenses, except cataract; and

8. Ophthalmic lenses or optical aids when the diopter correction is less than:

a. 0.50 D. sphere for myopia in the weakest meridian;

b. + 0.75 D. sphere for hyperopia in the weakest meridian;

c. + 0.75 additional for presbyopia;

d. ± 0.75 D. cylinder for astigmatism;

e. A change in axis of 5 degrees for cylinders of 1.00 diopter or more; and

f. A total of 4 prism diopters lateral or a total of 1 prism diopter vertical.

B. Preauthorization is issued when the provider submits to the Program adequate documentation demonstrating that the service to be preauthorized is medically necessary. "Medically necessary means that the service or benefit is directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability, or health condition; consistent with current accepted standards of good medical practice; the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and not primarily for the convenience of the consumer, their family or the provider.

C. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued.

D. Preauthorization must be requested in writing. A Preauthorization Request Form for Vision Care Services (DHMH 4526) must be completed and submitted to:

Medical Care Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, MD 21203

E. Documentation substantiating medical necessity must be attached to the preauthorization request. A copy of the patient record report and/or notes describing the service must be included with the request. If available, include a copy of the laboratory invoice at this time. Otherwise, a copy of the invoice must be attached to the claim for proper pricing of the item after the service has been authorized by the Program.

F. Procedure codes followed by a "**P"** in this manual require written preauthorization.

G. The Program will cover medically justified contact lenses for recipients younger than 21 years old. The following criteria are used when reviewing written preauthorization requests for contact lenses:

1. Monocular Aphakia:

a. When visual acuity of the two eyes is equalized within two lines (standard Snellen designation);

b. When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage; and

c. When tests conclude that disrupted binocular function will be restored and enhanced when compared to alternative treatment.

2. Anisometropia:

a. When the prescriptive difference between the two eyes exceeds 4.00 diopters (S.E.) and visual acuity of the two eyes is equalized within two lines;

b. When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage; and

c. When tests conclude that disrupted binocular function will be restored and enhanced when compared to alternative treatment.

3. Keratoconus/Corneal Dyscrasies:

a. When contact lenses are accepted as the treatment of choice relative to the phase of a particular condition;

b. When the best spectacle correction in the best eye is worse than 20/60 and when the contact lens is capable of improving visual acuity to better than 20/40 or four lines better than the best spectacle acuity; and

c. When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage.

Provider Enrollment

PLEASE NOTE: Under the Maryland Medical Assistance program, optometrists and optical centers that are part of a physician's group cannot bill under the physician's provider number. Services rendered by the optometrist or optical center cannot be billed under the physician's provider number. These providers must complete an enrollment application and be assigned a Medical Assistance provider number that has been specifically assigned to them. The number will be used when billing directly to Maryland Medical Assistance for optometric or optical center services**.**

Contact the Provider Master File office at **410-767-5340** for an enrollment packet for vision services (Provider Type 12). Ophthalmologists are enrolled under Medical Assistance's physician program (Provider Type 20), and should follow the regulations and manual specific to that particular provider type.

Provider Requirements

The provider must meet requirements as set forth in COMAR 10.09.36, General Medical Assistance Provider Participation Criteria, including:

1. Be licensed and legally authorized to practice optometry in the state in which the service is provided;

2. Verify a Medical Assistance recipient's eligibility prior to rendering services;

3. Maintain adequate records for a minimum of 6 years and make them available, upon request, to the Department or its designee;

4. Provide service without regard to race, creed, color, age, sex, national origin, marital status, or physical or mental handicap;

5. Not knowingly employ an optometrist or optician to provide services to Medical Assistance patients after that optometrist or optician has been disqualified from the Program, unless prior approval has been received from the Department;

6. Accept payment by the Department as payment in full for services rendered and make no
   additional charge to any person for covered services;

7. Use first quality materials that meet the criteria established by the Department;

8. Place no restrictions on recipients' right to select providers of their choice;

9. Agree that if the Program denies payment or requests repayment on the basis that an

otherwise covered service was not medically necessary, the provider may not seek payment for that service from the recipient or family members; and

10. Agree that if the Program denies payment due to late billing, the provider may seek payment from the recipient.

Payment Procedures

The provider shall submit requests for payment for vision services as stated in COMAR 10.09.36.

The request for payment must include any required documentation, such as, preauthorization number, need for combination or metal frame, patient record notes, and laboratory invoices, when applicable.

The Medical Assistance Program has established a fee schedule for covered vision care services provided by optometrists and optical centers (MD MA Provider Type 12). The fee schedule lists all covered services by CPT and national HCPCS codes and the maximum fee.

The provider shall submit a request for payment on the billing form CMS-1500. The request for payment must include any required documentation, such as preauthorization number, need for combination or metal frame, patient record notes, and laboratory invoices, when applicable. Maryland Medical Assistance Billing Instructions for the CMS-1500 can be obtained from Provider Relations at **(410) 767-5503** or **(800) 445-1159**.

The Medical Assistance Program has established a fee schedule for covered vision care services provided by optometrists and optical centers (MD MA Provider Type 12). The fee schedule lists all covered services by CPT and national HCPCS codes and the maximum fee allowed for each service. Vision care providers must bill their usual and customary charge to the general public for similar professional services.

The Program will pay professional fees for covered services the lower of the provider's usual and customary charge or the Program's fee schedule. For professional services, providers must bill their usual and customary charges. The Program will pay for materials at acquisition costs not to exceed the maximum established by the Program. For materials, providers must bill their acquisition costs.

Where a **"By Report"** (**B/R)** status is indicated on the schedule, attach a copy of the lab invoice to the claim for pricing purposes as well as the records to substantiate medical necessity (record report/notes describing the service).

When the fee for a vision care procedure is listed as "**Acquisition Cost"** (**A/C**) in this manual, the value of the procedure is based on acquisition cost. Bill the Program the acquisition cost for the item. The lab invoice substantiating the charge as well as other records must remain on file for a 6 year period and made available upon request by the Program.

Procedures with a preauthorization requirement **(P)** must be authorized prior to treating the patient. If the procedure is authorized, the preauthorization number must appear on the claim.

The provider must select the procedure code that most accurately identifies the service performed. Any service rendered must be adequately documented in the patient record. The records must be retained for 6 years. Lack of acceptable documentation may cause the Program to deny payment or if payment has already been made, to request repayment, or to impose sanctions, which may include withholding of payment or suspension or removal from the Program. Payment for services is based upon the procedure(s) selected by the provider. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is subject to audit.

The **NFAC** (Non-Facility) fee is paid for place of service 11, 12, and 62.

The **FAC** (facility) fee is paid for all other places of service.

Payments for lenses, frames, and the fitting and dispensing of spectacles include any routine follow-up and adjustments for 60 days. No additional fees will be paid. Providers must bill and will be paid for the supply of materials at acquisition costs not to exceed the maximum established by the Program. If a maximum has not been established, the provider must attach laboratory documentation to the invoice.

Fitting includes facial measurements, frame selection, prescription evaluation and verification and subsequent adjustments. The maximum fee for lenses includes the cost for FDA hardening, testing, edging, assembling and surfacing. The maximum fee for frames includes the cost of a case.

1. Use the following procedure codes for the billing of frames:

a. **V2020** for a child/adult ZYL frame;

b. **V2025** for a metal or combination frame when required for a proper fit; and

c. **V2799** (preauthorization required) for a special or custom frame when necessary and appropriate.

2. Use procedure codes **92340 - 92342** for the fitting of spectacles.

3. Use procedure code **92370** and attach a copy of the lab invoice to the claim when billing for a repair. **PLEASE NOTE**: Repair charges not traditionally billed to the general public cannot be billed to Maryland Medical Assistance. (Review the regulations for coverage of eyeglass repairs.)

Contact lens services require preauthorization and include the prescription of contact lenses (specification of optical and physical characteristics), the proper fitting of contact lenses (including the instruction and training of the wearer, incidental revision of the lens and

adaptation), the supply of contact lenses, and the follow-up of successfully fitted extended wear lenses. Use the following procedure codes for the billing of these services:

1. **92310-26** for the professional services of prescription, fitting, training, and adaptation;
2. **V2500 - V2599, S0500** for contact lenses;
3. **V2784** for polycarbonate lenses; and
4. **92012** for follow-up subsequent to a proper fitting.

Vision care claims must be received within **12** months of the date that services were rendered. If a claim is received within the 12 month limit but rejected due to erroneous or missing data, re-submittal will be accepted within 60 days of rejection or within 12 months of the date that the service was rendered, whichever is later. If a claim is rejected because of late receipt, the recipient may not be billed for that claim.

Medicare/Medical Assistance Crossover claims must be received within **120** days of the date that payment was made by Medicare. This is the date of Medicare's Explanation of Benefits form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing.

The Medical Assistance Program is always the payer of last resort. Whenever a Medical Assistance recipient is known to be enrolled in Medicare, Medicare must be billed first. Claims for Medicare/Medical Assistance recipients must be submitted on the CMS-1500 directly to the Medicare Intermediary.

For additional information about the MD Medical Assistance Program, go to the following link: *https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx*.

A copy of the regulations can be viewed at:
http://www.dsd.state.md.us/COMAR/subtitle_chapters/Titles.aspx (title 10) (subtitle 09) 10.09.14.

The Health Insurance Portability & Accountability Act (HIPAA)

HIPPA requires that standard electronic health transactions be used by health plans, including private, commercial, Medical Assistance and Medicare, health care clearinghouses and health care providers. The intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes. More information on HIPPA can be found at: *http://dhmh.maryland.gov/hipaa/Pages/Home.aspx*.

National Provider Identifier (NPI)

Since July 30, 2007, all health care providers that perform medical services have been required to have an NPI. It is a unique 10-digit, numerical identifier that does not expire or change. It is administered by CMS and is required by HIPAA.

Apply for an NPI by using the web-based application process via the National Plan and Provider Enumeration System (NPPES) at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*. You should use the NPI as the primary identifier and your Medical Assistance Provider number as the secondary identifier on all paper and electronic claims.

Preauthorization Required Prior To Treatment

When the fee for a vision care procedure is listed as "**By Report"** (**B/R**) on this schedule a copy of the optometrist's patient record report and/or notes which describe the services rendered and the lab invoice must be submitted with the claim.

When the fee for a vision care procedure is listed as "**Acquisition Cost"** (**A/C**) on this schedule, the value of the procedure is to be determined from a copy of a current laboratory or other invoice which clearly specifies the unit cost of the item.

When the fee for a vision care procedure is listed with a "P", a request for preauthorization must be submitted on form DHMH 4526. A copy of the patient record report and/or notes describing the services must be submitted to the Program prior to rendering the service.

The maximum fee for lenses includes the cost for FDA hardening, testing, edging, assembling and surfacing. The maximum fee for frames includes the cost of a case Services provided must be medically necessary.

Professional Services/Materials Reimbursements - Provider Type 12 (Non-facility & Facility Included) January 1, 2017

Procedure Code	Description	Requires Pre-Auth	Maximum Payment NFAC	Maximum Payment FAC
65205	Removal of foreign body from eye		$ 44.11	$ 34.43
65210	Removal of foreign body embedded in eye		$ 53.88	$ 41.63
65220	Removal of foreign body w/o lamp		$ 45.98	$ 33.43
65222	Removal of foreign body w/ lamp		$ 52.46	$ 40.77
92002	Eye exam w/new patient		$ 63.71	$ 37.20
92004	Eye exam w/new patient comprehensive		$ 116.51	$ 77.46
92012	Eye exam and treatment of established patients		$ 67.09	$41.15
92014	Eye Exam and treatment of establish patients, comprehensive		$ 96.99	$62.22
92015	Determination of Refractive state		$ 19.02	$15.03
92020	Special Eye Evaluation - Gonioscopy		$ 21.00	$16.43
92025	Computerized Corneal Topography		$ 29.90	$ 29.90
92060	Sensorimotor exam with multiply measure Ocular deviation		$ 51.21	$ 51.21
92065	Orthoptic/pleoptic training	P	$ 42.98	$ 42.98
92071	Fitting contact lens for treatment of ocular surface disease		$ 31.59	$28.03
92072	Fitting contact lens for management of keratoconus initial fitting		$ 104.54	$80.01
92081	Visual field exam(s) limited		$ 33.37	$ 33.37
92082	Visual field exam(s) Intermediate		$ 49.38	$ 49.38
92083	Visual field exam(s) extended		$ 56.74	$ 56.74
92100	Serial Tonometry exam(s)		$ 63.33	$34.29
92132	Scanning Computerized ophthalmic diagnostic imaging anterior segment, with interpretation and report		$ 30.41	$ 30.41
92133	Scanning Computerized ophthalmic diagnostic imaging posterior segment, with interpretation and report unilateral or bilateral; optic nerve		$ 37.09	$ 37.09

Procedure Code	Description	Requires Pre-Auth	Maximum Payment NFAC	Maximum Payment FAC
92134	Scanning Computerized ophthalmic diagnostic imaging posterior segment, with interpretation and report unilateral or bilateral; retina		$ 37.09	$ 37.09
92140	Glaucoma provaction tests w/o tonography		$ 40.68	$18.79
92225	Ophthamoscopy, initial		$ 20.98	$16.70
92226	Ophthamoscopy, subsequent		$ 19.36	$14.80
92250	Fundus photography w/ interpretation and report		$ 53.55	$ 53.55
92260	Ophthalmodynamoetry		$ 14.48	$8.49
92283	Color vision examination extended, e.g., anomaloscope or equivalent		$ 44.78	$ 44.78
92284	Dark adaptation examination w/ interpretation and report		$ 51.16	$ 51.16
92285	External ocular photography w/ interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)		$ 30.13	$ 30.13
92286	Special anterior segment photography w/interpretation and report; with specular endothelial microscopy and cell count.		$ 93.71	$ 93.71
92310	Contact lenses fitting	P	$ 75.28	$ 46.21
92311	Contact lens fitting - 1/aphakia	P	$ 79.33	$ 43.13
92312	Contact lens fitting - 1/aphakia	P	$ 92.38	$ 49.91
92313	Contact lens fitting - 1/aphakia	P	$ 75.89	$ 36.56
92314	Fitting Special Contact lens		$ 62.97	$ 27.34
92325	Modification of contact lens	P	$ 33.95	$ 33.95
92326	Replacement of contact lens	P	$ 36.82	$ 36.82
92340	Fitting of spectacles, monofocal		$ 27.88	$ 14.48
92341	Fitting of spectacles, bifocal		$ 31.71	$ 18.60
92342	Fitting of spectacles, multifocal		$ 34.16	$ 20.77

Procedure Code	Description	Requires Pre-Auth	Maximum Payment NFAC	Maximum Payment FAC
92354	Fitting of spectacles mounted low vision aid; single element system	P	$ 61.53	$ 61.53
92355	Fitting of spectacles mounted low vision aid; telescopic or other compound lens system	P	$ 43.11	$ 43.11
92370	Repair & refitting spectacles		$ 24.26	$12.58

Professional Services/Materials Reimbursements - Provider Type 12 – (Facility Only) January 1, 2017

Procedure Code	Description	Requires Pre-Auth	Maximum Payment FAC
92499	Unlisted eye service or procedure		B.R.
S0500	Disposable contact lens, per lens	P	A.C.
V2020	Adult/child ZYL frames w /case		$ 20.00
V2025	Metal or combination frame		$ 25.00
V2100	Lens sphere single plano 4.00, per lens		$ 12.00
V2101	Single vision sphere 4.12 - 7.00, per lens		$ 7.20
V2102	Single vision sphere 7.12 - 20.00, per lens		$ 22.15
V2103	Spherocylinder, SV, 4.00d/.12-2.00, per lens		$ 15.00
V2104	Spherocylinder, SV, 4.00d/2.12-4d, per lens		$ 15.00
V2105	Spherocylinder, SV,4.00d/4.25-6d, per lens		$ 7.30
V2106	Spherocylinder, SV,4.00d/over6.00d, per lens		A.C.
V2107	Spherocylinder, SV,+-4.25d/.12-2d, per lens		$ 15.00
V2108	Spherocylinder, SV,+-4.25d/2.12-4d, per lens		$ 15.00
V2109	Spherocylinder, SV,+-4.25d/4.25-6d, per lens		$ 9.20
V2110	Spherocylinder, SV,+-4.25d/over 6d, per lens		B.R.
V2111	Spherocylinder, SV,+-7.25d/.25-2.25d, per lens		$ 22.15
V2112	Spherocylinder, SV,+-7.25d/2.25-4d, per lens		$ 19.00
V2113	Spherocylinder, SV,+-7.25d/4.25-6d, per lens		A.C.
V2114	Spherocylinder, SV, over +-12.00d, per lens		$ 36.00
V2115	Lenticular (myodisc), SV, per lens		B.R.
V2118	Aniseikonic lens, SV	P	A.C.
V2121	Lenticular lens, Per Lens, Single, per lens		A.C.
V2199	Not otherwise classified, SV lens	P	A.C.
V2200	Sphere, bifcl, plano +-4.00d, per lens		$ 21.00
V2201	Sphere, bifcl,+-4.12/+-7.00d, per lens		$ 13.00
V2202	Sphere ,bifcl,+-7.12/+-20d, per lens		A.C.
V2203	Spherocylinder, BF, 4.00d/.12-2.00d, per lens		$ 21.00
V2204	Spherocylinder, BF, 4.00d/2.12-4, per lens		$ 14.50
V2205	Spherocylinder, BF, 4.00d/4.25-6, per lens		$ 16.50
V2206	Spherocylinder, BF, 4.00d/over 6, per lens		B.R.
V2207	Spherocylinder, BF, 4.25-7/.12 to 2, per lens		$ 14.50
V2208	Spherocylinder, BF, 4.25+-7/2.12 to 4, per lens		$ 15.50
V2209	Spherocylinder, BF, 4.25+-7/4.25-6, per lens		$ 17.50
V2210	Spherocylinder, BF, 4.25+-7/over 6, per lens		A.C.
V2211	Spherocylinder, BF, 7.25+-12/.25-2.25, per lens		A.C.
V2212	Spherocylinder, BF, 7.25+-12/2.25-4, per lens		A.C.
V2213	Spherocylinder, BF, 7.25+-12/4.25-6, per lens		A.C.
V2214	Spherocylinder, BF, sphere over +-12.00d, per lens		A.C.
V2215	Lenticular (myodisc) bifocal, per lens		B.R.
V2218	Aniseikonic, bifocal, per lens	P	A.C.
V2219	Bifocal seg width over 28 mm	P	A.C.

Procedure Code	Description	Requires Pre-Auth	Maximum Payment FAC
V2220	Bifocal add over 3.25d	P	A.C.
V2221	Lenticular lens, bifocal, per lens		$ 24.00
V2299	Specialty bifocal	P	A.C.
V2300	Sphere, trifcl, pl+-4.00d, per lens		$ 16.50
V2301	Sphere, trifcl +-4.12/-7.00d, per lens		$ 19.00
V2302	Sphere, trifcl +-7.12/+-20.00, per lens		A.C.
V2303	Spherocylinder, trifcl, pl+-4/.12-2, per lens		$ 18.00
V2304	Spherocylinder, trifcl, p+-4/2.25-4, per lens		$ 20.50
V2305	Spherocylinder, trifcl, p+-4/4.25-6, per lens		$ 24.00
V2306	Spherocylinder, trifcl, p+-4/over 6, per lens		A.C.
V2307	Spherocylinder, trifcl, +-4.25/…2d, per lens		$ 20.50
V2308	Spherocylinder, trifcl, +-4.25/…4d, per lens		$ 22.00
V2309	Spherocylinder, trifcl, +-4.25/…6d, per lens		$ 25.00
V2310	Spherocylinder, trifcl, +-4.25/over 6d, per lens		A.C.
V2311	Spherocylinder, trifcl, +-7.25/…2.25d, per lens		A.C.
V2312	Spherocylinder, trifcl ,+-7.25/…4.00d, per lens		A.C.
V2313	Spherocylinder, trifcl, +-7.25/…6.00d, per lens		A.C.
V2314	Spherocylinder, trifcl, over p-12.00d, per lens		A.C.
V2315	Lenticular (myodisc), trifocal, per lens		A.C.
V2318	Aniseikonic lens, trifocal	P	A.C.
V2319	Trifocal seg width over 28 mm	P	A.C.
V2320	Trifocal add over 3.25d	P	A.C.
V2321	Lenticular lens, trifocal, per lens		A.C.
V2399	Specialty trifocal (by report)	P	A.C.
V2410	Variable asph, SV, full fld,gl/pl	P	A.C.
V2430	Variable asph, bifcl, full fld,gl/pl	P	A.C.
V2499	Variable sphericity, other type	P	A.C.
V2500	Contact lens, PMMA spherical	P	A.C.
V2501	Contact lens PMMA toric/prism	P	A.C.
V2502	Contact lens PMMA bifocal	P	A.C.
V2503	Contact lens PMMA color vision def	P	A.C.
V2510	Contact lens, gas permeable, spherical, per lens	P	A.C.
V2511	Contact lens, gas permeable, toric, prism ballast, per lens	P	A.C.
V2512	Contact lens, gas permeable, bifocal, per lens	P	A.C.
V2513	Contact lens, gas permeable, extended wear, per lens	P	A.C.
V2520	Contact lens, hydrophilic, spherical, per lens	P	A.C.
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	P	A.C.
V2522	Contact lens, hydrophilic, bifocal, per lens	P	A.C.
V2523	Contact lens, hydrophilic, extended wear, per lens	P	A.C.
V2530	Contact lens, scleral, gas imperm, per lens	P	A.C.
V2599	Contact lens, other type	P	A.C.
V2600	Hand held low vision aids	P	A.C.

Procedure Code	Description	Requires Pre-Auth	Maximum Payment FAC
V2610	Single lens spectacle mount low vision aids	P	A.C.
V2615	Telescopic & other compound lens	P	A.C.
V2700	Balance lens		A.C.
V2715	Prism lens	P	A.C.
V2718	Press-on lens, Fresnel prism	P	A.C.
V2745	Add. tint, any color/solid/grad		B.R.
V2784	Polycarbonate lens, any index (Greater than 6 Diopters or other medically necessary condition)		$6.50
V2799	Vision service, miscellaneous	P	A.C.

ATTACHMENT A: MARYLAND MEDICAL ASSISTANCE PROGRAM FREQUENTLY REQUESTED TELEPHONE NUMBERS

Audiology Policy/Coverage Issues	**(410) 767-1903**
Vision Policy/Coverage Issues	**(410) 767-1903**
Healthy Start/Family Planning Coverage	**(800) 456-8900**
Maryland Medical Assistance Children's Services	**(410) 767-1903**
Rare and Expensive Case Management Program (REM)	**(800) 565-8190**
Eligibility Verification System (EVS)	**(866) 710-1447**
Board of Audiologists/Hearing Aid Dispensers/Speech Language Pathologists	**(410) 764-4725**
Maryland State Board of Examiners in Optometry	**(410) 764-4710**
Provider Enrollment **P.O. Box 17030** **Baltimore, MD 21203**	**(410) 767-5340**
Provider Relations **P.O. Box 22811** **Baltimore, MD 21203**	**(410) 767-5503** **(800) 445-1159**
Missing Payment Voucher/Lost or Stolen Check	**(410) 767-5503**
Third Party Liability/Other Insurance	**(410) 767-1771**
Recoveries	**(410) 767-1783**

ATTACHMENT B: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PREAUTHORIZATION REQUEST FORM - AUDIOLOGY SERVICES

SECTION I - Patient Information

Medicaid Number | | | | | | | | | | | |

Last Name _____ **First Name** _____ **MI**__

DOB _____ **Sex** _____ **Telephone** _____

Address_____

SECTION II - Preauthorization General Information

Pay to Provider | | | | | | | | | | **Number**

Name _____ **Request Date** _____

Address_____

Contact_____

Provider's Signature_____ **Telephone** (___)_____

SECTION III – Additional Preauthorization Information

Prescribing Provider | | | | | | | | | |

Name _____ **Telephone** (___)_____

Address_____

_____

SECTION IV – Preauthorization Line Item Information

DESCRPTION OF SERVICE	PROCEDURE CODE	MOD	REQUESTED UNITS	AMOUNT	DATES OF SERVICE FROM	THRU	AUTHOR. UNITS	AUTHOR. AMOUNT
				$	/ / /	/ / /		$
				$	/ / /	/ / /		$
				$	/ / /	/ / /		$
				$	/ / /	/ / /		$
				$	/ / /	/ / /		$

PREAUTHORIZATION NUMBER

DOCUMENT CONTROL NUMBER (STAMP HERE)

SUBMIT TO: **Program Systems and Operations Administration**
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

SECTION V – Specific Preauthorization Information

Patient Location: Home __Nursing Home_ Hospital In-Patient__ Discharge Date_____

Address where equipment will be used (if different from above): **Period of time requested:**

_____ _____
_____
_____

MFGR	MODEL/PRODUCT NUMBER	SINGLE UNIT PRICE	AMT. PKG
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____

Diagnosis and Present Physical Condition_____
_____
_____

Prognosis_____
_____
_____

Treatment Plan_____
_____
_____

Expected Therapeutic Effect_____
_____
_____

ATTACMENT C: HEALTH INSURANCE CLAIM FORM

(SEE NEXT PAGE)

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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 ☐

PLEASE PRINT OR TYPE

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

APPROVED OMB-0938-1197

FORM 1500 (02-12)

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.

SIGNED DATE

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

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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	

PHYSICIAN OR SUPPLIER INFORMATION

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

ATTACHMENT D: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PREAUTHORIZATION REQUEST FORM - VISION CARE SERVICES

SECTION I - Patient Information

Medicaid Number | | | | | | | | | | | |

Last Name _____ **First Name** _____ **MI**__

DOB _____ **Sex** _____ **Telephone** _____

Address_____

SECTION II - Preauthorization General Information

Pay to Provider | | | | | | | | | | **Number**

Name _____ **Date Service**

Address_____ **Requested by**

Contact_____ **Provider** _____

Provider's Signature_____ **Telephone** (__)_____

SECTION III – Additional Preauthorization Information

Give Reason(s) for Requested Service_____

_____

_____

SECTION IV – Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE CODE	REQUESTED UNITS	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT
_____	_____	_____	$_____	_____	$_____
_____	_____	_____	$_____	_____	$_____
_____	_____	_____	$_____	_____	$_____
_____	_____	_____	$_____	_____	$_____
_____	_____	_____	$_____	_____	$_____

PREAUTHORIZATION NUMBER

DOCUMENT CONTROL NUMBER (STAMP HERE)

SUBMIT TO: **Program Systems and Operations Administration**
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

SECTION V – Specific Preauthorization Information

New Prescription: **O.D.**_____ **Best Visual Activity** _____

_____

O.D._____ **Best Visual Activity** _____

CONTACT LENS REQUESTS:

Health Condition of each eye: **O.D.**_____ **O.S.**_____

Date of Surgery: **O.D.**_____ **O.S.**_____

Best visual acuity with contact lenses: **O.D.**_____ **O.S.**_____

Advantage of contact lenses over glasses:_____

_____

SECTION VI (DHMH Only)

_____**Approved** _____**Denied** _____**Returned**

Reason(s)_____

Medical Consultant's Signature_____**Date**_____