Commissioner Osborn and Senator Pugh,

Senator Pugh had asked a question about the Hearing Aid Specialist and billing Medicare/Medicaid, we have discovered that the Hearing Aid Specialists do not use the billing codes for their clients due to the fact that Medicare/Medicaid does not cover hearing aids (for patients over 18 years of age) or screenings and they do not authorize hearing aid specialist to do fittings for patients under 18 years of age. However, Audiologist can and do bill for these services.

We worked with OHCA to obtain the information below on the billing of those services by an audiologist:

Hearing Aids HCPCS Code range V5120-V5267 (https://coder.aapc.com/hcpcs-codes-range/450/).

Procedure V5011 (Hearing Aid Fitting/Checking) currently pays at $111.47
Procedure 92551 (Pure Tone Hearing Test Air) currently pays at $10.03

For HCPCS Code Range V5210-V5267 some are manually priced while others are priced using Fair Market Pricing. I have attached the rates for the Fair market pricing and these fall into 2 categories depending upon the hearing loss determined by the Audiologist. (See attachment V4-Fair Market Value Pricing and 2009-21 Audiology Pricing)

Hearing devices that are not on the Fair Market Pricing list are paid based off Manufacturer's Suggested Retail Price or MSRP. (These are the codes that you saw on our Fee Schedule that show the pricing as Manual and pay 0). For these codes, the provider must furnish an invoice and we price it 30% less than the MSRP or if there is no MSRP, we pay the cost plus 30%. (See attachment 2014-19 MSRP Final and FAQ – Manual Pricing)

Please let me know if you all have any further questions and if you don't mind sharing this information with the rest of the members I would greatly appreciate that!

Thank you,

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Frequently Asked Questions – Manual Pricing and Fair Market Value Pricing Methodology & Process Change

Provider Letter # 2014-19 Dated 9/2/14 – Effective 10/1/14

1. How will pricing method changes for Manually Priced Items affect Prior Authorizations in process?

PA's Processed by MAU prior to September 29, 2014 - system was set 2 days early

PA's in process at the Medical Authorization Unit and priced by MAU prior to October 1, 2014 will be processed using the current pricing methods – it will be necessary for claims associated with those PA's to match the approved amount. If the claim billed amount is different that the PA amount, the claim will be denied – a new claim with the exact amount will need to be processed.

PA's Processed by MAU September 29, 2014 and after – system was set 2 days early

For PA's in process at the Medical Authorization Unit processed October 1, 2014 and after will not be priced at the PA level. The usual & customary rate can be entered on the claim submitted related to the item. *Attachments required* will be: MSRP, Invoice Cost, and Proof of Delivery. *Optional attachments* will be the HCA-50 – Pricing Worksheet.

Claims will be processed using the lesser of MSRP -30% or Cost + 30% if not listed on the Fair Market Value Price List. Any item that is paid using a method other that MAX Fee will require proof of delivery attached to the claim prior to payment (See # 2)

2. What methods of delivery are acceptable?

Proof of Delivery and Delivery Methods

For the purpose of the delivery methods noted below, designee is defined as:

> **"A person who can sign and accept the delivery of durable medical equipment on behalf of the member"**

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a Sooner Care member (i.e. acting as a designee on behalf of the member). The relationship of the designee to the member should be noted on the delivery slip that you obtain (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier or the shipping service should note the name of the designee on the delivery slip.

There are 3 methods of delivery that are acceptable:

A. **Delivery directly to the member or an authorized designee**
B. **Delivery via shipping or delivery service – identify the member with name and ID on the shipping notice**
C. **Delivery of items to a nursing facility on behalf of the beneficiary**

3. Do items paid at MAX FEE require proof of delivery attached to claim?

MAX Fee items do not require proof of delivery attached to the claim; however, suppliers must maintain proof of delivery documents on file in case of an audit. Any item that is paid using a method other that MAX Fee will require proof of delivery attached to the claim prior to payment:

A. **Audiology Items paid at "Category" Pricing … changed to Fair Market Value Pricing**
B. **Enteral Items paid at "BY REPORT" Pricing … changed to Fair Market Value Pricing**
C. **Other Items paid as "BY REPORT" Pricing … changed to Fair Market Value Pricing**

4. **Are Waiver items affected by this change?**

Products paid exclusively by Waiver Programs are not affected by this change. Items such as PERS (Personal Emergency Response Systems) and Incontinence Supplies which are covered and paid by Waiver Programs are not subject to manual pricing or the 7.75% Budget Reduction.

5. **IS THERE A SPECIFIC HCPCS BILLING CODE FOR SHIPPING?**

OHCA Finance staff will process the appropriate shipping charges as the related manually priced code. OHCA will not use a specific code for shipping. Identify the shipping amount on the invoice and the HCA-50 form.

6. **HOW WILL CLAIMS BE PROCESSED WITH DATES OF SERVICE AFTER 10/1/14?**

Category	PA Priced	Claim	OHCA PROCESS
Manually Priced	YES	Matches PA Price	Pay off PA amount
Manually Priced	YES	Does not match PA	Deny – claim does not match PA Amount
Manually Priced	NO	Provider bills Usual & Customary – attaches – documentation of MSRP, Invoice, Shipping, and Proof of Delivery	Claim SUSPENDS to Finance Dept. for claims adjudication
Manually Priced	NO	Provider does not include required documentation	Claims suspends to Finance Dept. and claim is denied for

			missing documentation
PROVIDER USE OF HCA-50 WILL IMPROVE THE CLAIMS PROCESSING TIMELINESS			

7. **What is the expected turnaround time for a claim with a Manual Priced item to be processed by the Finance Department?** ***Added 10/20/14***

   The OHCA Goal is to turnaround the claims associated with Manually Priced items within 3-5 days after the documents are received to support the payment – MSRP, invoice (if applicable – By Report items do not require either an MSRP or Invoice) , and proof of delivery.

   By law, OHCA has a deadline of 30 days to process a "clean claim"; however, the goal and expectation is 3-5 day turnaround. Anticipated volume of claims in unknown at this time; however, OHCA will monitor the volume and assign staff appropriately to achieve the 3-5 day turnaround.

8. **Will line items for Max Fee Items be held if there is a line item for a manually priced item entered on the same claim?** ***Added 10/20/14***

   Suspended claims will hold all line items billed on the same claim until the Manually Priced item is processed. It is in the best interest of the provider to "Split Bill" for MAX Fee items to prevent delay in payment of the MAX Fee item.

9. **How will existing PA pricing for enteral foods be affected due to the Fair Market Value pricing update for December 1, 2014?** ***Added 11/19/14***
   Any enteral food PA that has an end date after 12/1/14 that was previously priced by MAU will require an amendment to adjust the pricing to the FMV pricing effective for dates of service on or after 12/1/14. The provider must submit an amendment using the HCA-12A indicating the new price (from FMV report) – MAU will adjust the pricing and claims can be submitted using the December pricing.

If the PA does not have assigned pricing (those processed after 10/1/14), the provider may submit the claim using the FMV amount and no amendment will be required.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2009-21

June 10, 2009

Re: Audiology Pricing Effective May 15, 2009 – Correction 8/11/2009

Dear Provider:

As part of our ongoing effort to expedite claims payments for our providers, and based on further review and analysis of claims received, OHCA has established specific pricing for certain audiology items based on the type of hearing loss identified. The OHCA has determined that standard DME manual pricing as outlined in Provider Letter # 2008-53 regarding DME Manual Pricing is not appropriate for audiology products.

As a result, most items will be classified as a Cost + 20% payment method; however categories listed below for Digital hearing aids effective May 15, 2009 will have a scheduled price based on hearing loss identified. Hearing aids in the following categories for Digital Monaural and Digital Binaural will be categorized and paid at the following scheduled rates.

(Codes affected are: **V5254**, V5255, V5256, V5257, V5258, V5259, V5260, and V5261.)

Category (Schedule Pricing)	***Monaural***	***Binaural***
Flat or Gently Sloping Hearing Loss	$ 600.00	$ 1,200.00
Precipitous Loss	$ 750.00	$ 1,500.00

Each of the prior authorization requests will be reviewed and categorized by the OHCA Auditory Consultant as either Flat or Gently Sloping Hearing Loss or Precipitous Loss.

In addition, a complete listing of the auditory codes and pricing will be posted on the Provider Website at www.okhca.org/providers/dme. For questions or more information regarding this new payment methodology, please call the Provider Services unit at 1-877-823-4529, option 2.

The secure website will continue to reflect the term “Pricing Manually Determined” on the Cost + items and the scheduled price items. The new pricing will be effective with any prior authorization requests received by OHCA on or after May 15, 2009.

Thank you for your continued service to Oklahoma’s SoonerCare and Insure Oklahoma IP members.

Sincerely,

Lynn Mitchell, M.D., MPH
State Medicaid Director