Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Health and Recovery Services Administration (HRSA)

Hearing Aids & Services

Billing Instructions

[Chapter 388-547 WAC]

ProviderOne Readiness Edition

Copyright Disclosure

About this publication

This publication supersedes all previous Hearing Aids & Services Billing Instructions and # Memos published by the Washington State Department of Social & Health Services, Health and Recovery Services Administration

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Page Affected

How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

You may request a copy of the law relating to Hearing and Speech (18.35 RCW) from:

Washington State Department of Health
Board of Hearing and Speech
PO Box 47869
Olympia, WA 98504-7869

Table of Contents

Table of Contents (cont.)

Important Contacts

Note: This section contains important contact information relevant to Hearing Aids & Services. For more contact information, see the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is "Required": • A completed, TYPED ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Hearing Aid Authorization Request Form, DSHS 13-772, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Bone-Anchored Hearing Aid (BAHA) - A type of hearing aid based on bone conduction. It is primarily suited to people who have conductive hearing losses, unilateral hearing loss, and people with mixed hearing losses who cannot otherwise wear 'in the ear' or 'behind the ear' hearing aids.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Cochlear Implants - A cochlear implant is a small, complex electronic device that can help to provide a sense of sound to a person who is profoundly deaf or severely hard-of-hearing. The implant consists of an external portion that sits behind the ear and a second portion that is surgically placed under the skin.

Deafness - Complete or partial loss of ability to hear.

Digital Hearing Aids – Hearing aids that use a digital circuit to analyze and process sound. [WAC 388-547-0200]

FM Systems – Devices used to improve and augment access to auditory information in poor acoustic conditions (helps mitigate a negative impact of noise and reverberation on the ability to understand) that are found in classrooms, auditoriums, theaters, restaurants, etc. These devices use frequency modulated (FM) radio signals to transmit the primary auditory signal from a microphone/transmitter to a receiver worn by the person. [WAC 388-547-0200]

Hearing Aids - Wearable sound-amplifying devices that are intended to compensate for hearing loss. Hearing aids are described by where they are worn in the ear as In-the-Ear (ITE), Behind-the-Ear (BTE), etc. Hearing aids can also be described by how they process the amplified signal. This would include analog conventional, analog programmable, digital conventional, and digital programmable. [WAC 388-547-0200]

Hearing Healthcare Professional – An audiologist or hearing aid fitter/dispenser licensed under Chapter 18.35 RCW, or an otorhinolaryngologist or otologist licensed under Chapter 18.71 RCW. [WAC 388-547-0200]

Limitation Extension – A process for requesting reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which the Department routinely reimburses. Limitation extensions require prior authorization.

Maximum Allowable Fee - The maximum dollar amount that the Department will pay a provider for specific services, supplies, and equipment. [WAC 388-547-0200]

Medical Identification card(s) – See *Services Card*.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Prior Authorization – A form of authorization used by the provider to obtain approval for a specific hearing aids and service(s). The approval is based on medical necessity and must be received before service(s) are provided to clients as a precondition for payment.
[WAC 388-547-0200]

Programmable Hearing Aids – Hearing aids that can be "programmed" digitally by a computer. *All digital hearing aids are programmable, but not all programmable hearing aids are digital.*

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

Usual & Customary Fee - The rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

About the Program

What Is the Purpose of the Hearing Aids & Services Program? [Refer to WAC 388-547-0100]

The purpose of the Hearing Aids & Services program is to pay hearing aid providers for hearing aids and services provided to eligible Department clients.

The Department pays for hearing aids and services when:

- Covered. Refer to "Coverage-Adults" for covered hearing aids and services for clients 21 years of age and older; and refer to "Coverage-Children" for covered hearing aids and services for clients 20 years of age and younger;
- Within the scope of an eligible client's Benefit Service Package;
- Medically necessary;
- Authorized as required within these billing instructions and Chapters 388-501 and 388-502 WAC;
- Billed according to these billing instructions and Chapters 388-501 and 388-502 WAC; and
- The client:
  - ✓ Completes a hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test performed and/or interpreted by a hearing healthcare professional;
  - ✓ Is referred by a hearing healthcare professional for a hearing aid (required only for children 20 years of age and younger); and
  - ✓ For clients 21 years of age and older only, has an average decibel hearing loss (dBHL) at 45 decibels in the better ear based on a pure-tone audiometric evaluation by a licensed audiologist or licensed hearing instrument fitter/dispenser at 1000, 2000, 3000, and 4000 Hertz (Hz) with effective masking as indicated.

Note: The Department uses the following methodology to determine the dBHL: The sum of the dBHL readings are determined at each level/frequency at 1,000, 2,000, 3,000 and 4,000 Hz and divided by 4.

The Department requires prior authorization for covered hearing aid services when the clinical criteria set forth in these billing instructions are not met. The Department evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 388-501-0165.

Client Eligibility - Adults

Who Is Eligible? [Refer to WAC 388-547-0300]

Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Are Hearing Aids and Services Covered Under the Department's Managed Care Plans?

No. Hearing aid services are not covered under the Department's managed care plans. Clients who are enrolled in a Department-contracted managed care plan are eligible under fee-for-service for covered hearing aid services that are not covered by their plan. In those cases, bill the Department directly.

Coverage - Adults

To receive payment from the Department for hearing aids and services for adults, clients must meet the eligibility and criteria stated in these billing instructions.

What Is Covered? [Refer to WAC 388-547-0400 and 388-547-0100]

The Department of Social & Health Services (the Department) covers a monaural hearing aid for eligible clients 21 years of age and older, without prior authorization (PA), if the client has an average decibel loss of 45 or greater in the better ear. The Department uses the following methodology to determine the average decibel hearing loss (dBHL). The sum of the dBHL readings are determined at each level/frequency at 1,000, 2,000, 3,000, and 4,000 Hertz (Hz) and divided by 4.

> **Note:** Binaural hearing aids require PA. To receive an additional hearing aid, a client must meet expedited prior authorization (EPA) criteria.
> ***See the (EPA) section in these billing instructions.***

Purchase

The Department covers the purchase of one new nonrefurbished monaural hearing aid, including the ear mold, every five years. The hearing aid must meet the client's specific hearing needs and be covered for repairs under warranty for a minimum of one year.

Replacement

The Department covers one replacement hearing aid including the ear mold, in a five year period, when the client's hearing aid is lost or beyond repair and all warranties have expired.

The Department covers a replacement ear mold once a year when the client's existing ear mold is damaged or no longer fits the client's ear.

Repair

The Department covers a maximum of two repairs, per hearing aid, per year, when the repair is less than 50% of the cost of a new hearing aid. To receive payment, all of the following must be met:

- All warranties have expired; and
- The repair is under warranty for a minimum of 90 days.

Rental

The Department covers rental hearing aid(s) for up to two months while the client's own hearing aid is being repaired. In the case of a rental hearing aid(s), the Department pays separately for an ear mold(s).

What Is Not Covered? [Refer to WAC 388-547-0500]

The Department does not cover the following hearing and hearing aid-related items for eligible clients 21 years of age and older:

- Batteries;
- Tinnitus maskers;
- FM Systems; or
- Pocket talkers or similar devices.

Exception to Rule (ETR)

The Department evaluates a request for medical services, equipment, and/or supplies that are listed as noncovered under the provisions of WAC 388-501-0160 that relates to noncovered services. The request for a noncovered medical service, equipment, or supply is called a "request for an exception to rule." See WAC 388-501-0160 for information about exception to rule.

In order to request an ETR, ***providers must complete and fax*** the Hearing Aid Authorization Request Form, DSHS 13-772, attach all documentation listed on the form and provide justification to: 1-866-668-1214.

Download the Hearing Aid Request Form, DSHS 13-772 and the Basic Information Form, DSHS 13-756 by visiting the Department at: http://www1.dshs.wa.gov/msa/forms/eforms.html

Coverage Table - Adults

The following procedure codes are the **only procedure codes** the Department pays for under the Hearing Aids and Services program. Bill your usual and customary charge. Payment will be the lesser of the billed charge or the maximum allowable fee.

	Code Status	Procedure Code	Modifier	Brief Description	Policy Comments
Monaural		V5246	LT, RT, RA	Digitally programmable analog, ITE	For average hearing loss 45 dBHLs or greater. When billing for a second hearing aid, EPA/PA is required. Includes a prefitting evaluation, an ear mold and at least 3 follow-up appointments.
		V5247	LT, RT, RA	Digitally programmable analog, BTE	
		V5256	LT, RT, RA	Digital, ITE	
		V5257	LT, RT, RA	Digital, BTE	
		V5050	RR	Hearing aid, ITE	Billed as a rental only
		V5060	RR	Hearing aid, BTE	Billed as a rental only

Coverage Table Continued on Next Page

Legend

Modifiers: **RA** = Replacement of DME Item **RB** = Replacement Part of DME Item

LT = Left **RT** = Right **RR** = Rental

	Code Status	Procedure Code	Modifier	Brief Description	Policy Comments
Binaural		V5260	RA	Digital ITE	PA required for adults. Do not bill in conjunction with a monaural hearing aid.
		V5261	RA	Digital BTE	
Other		V5040	RT, LT, RA	monaural, body worn, bone conduction	PA required for adults. Do not bill in conjunction with a monaural hearing aid.
		V5264	RA	Ear Molds/insert, not disposable, any type	One per year when the existing ear mold is damaged or no longer fits
		V5014	RT, LT, RB (for casing only)	Repair/modification of a hearing aid	Used when billing for repair of a **hearing aid.** Maximum of 2 repairs in 1 year (includes parts and labor). Replacement of casing allowed once every 5 years.
		V5298		Hearing Aid, NOC	PA/invoice required

Note: Reimbursement for all hearing instruments dispensed includes:

- **A prefitting evaluation;**
- **An ear mold; and**
- **A minimum of three post-fitting consultations.**

After a client has been using one hearing aid for six months, the Department may authorize only a monaural procedure code. Billing a binaural code in conjunction with a monaural code within five years is not allowed without justification and prior authorization.

Legend

Modifiers: **RA** = Replacement of DME Item **RB** = Replacement Part of DME Item

LT = Left **RT** = Right **RR** = Rental

Prior Authorization - Adults

What Is Prior Authorization?

Prior authorization (PA) is the Department of Social & Health Services (the Departments) approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider payment. Expedited prior authorization (EPA) and limitation extensions (LEs) are forms of PA.

Note: Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

What Hearing Aids and Services Does the Department Require Prior Authorization for? [WAC 388-547-0600 (1)]

The Department requires PA for binaural hearing aids for eligible clients 21 years of age and older.

Note: The Department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169. **[WAC 388-547-0600 (2)]**

How Do I Obtain Prior Authorization?

[Refer to WAC 388-547-0600 (3)]

To request PA from the Department, a provider must fax a completed Hearing Aid Authorization Request Form, DSHS 13-772, to the Department at 1-866-668-1214.

Download the Hearing Aid Authorization Request Form, DSHS 13-772, at: http://www1.dshs.wa.gov/msa/forms/eforms.html

Note: When the Department authorizes hearing aids and/or services, the PA indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for covered services at the time those services are provided. To receive payment, hearing aids and/or services must be ordered and dispensed within the authorized timeframe. **[WAC 388-547-0600 (4) and (5)**

What Are Limitation Extensions?

Limitation extensions (LEs) are cases when a provider can verify that it is medically necessary to provide more units of service than allowed in Department/HRSA Billing Instructions and Washington Administration Code (WAC).

> **Note:** Requests for LEs must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups receive all services.

How Do I Request a Limitation Extension?

There are two ways to request an LE:

1. Providers may be able to obtain authorization for an LE using an expedited prior authorization (EPA) number. These EPA numbers are subject to post payment review as in any other authorization process. (See: **What is Expedited Prior Authorization? Listed in these billing instructions**)

2. In cases where the client's situation does not meet the EPA criteria for a LE, but the provider still feels that additional services are medically necessary, the provider must request Department approval in writing. Download the Hearing Aid Authorization Request form, DSHS 13-772, at: http://www1.dshs.wa.gov/msa/forms/eforms.html

The request must state the following in writing:

1. The name and ProviderOne Client ID of the client;
2. The provider's name, National Provider Identifier (NPI), telephone number, and FAX number;
3. Additional service(s) requested;
4. Copy of current audiogram for both ears aided and unaided, and the date the last hearing aid(s) were dispensed;
5. The primary diagnosis with the HCPCS code for the requested item; and
6. Clinical justification for additional item(s).

Fax your written request for an LE to the Department at 1-866-668-1214.

What is Expedited Prior Authorization?

Expedited prior authorization (EPA) numbers are designed to eliminate the need for written authorization. The Department establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an "EPA" number using those codes.

To bill the Department for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **form a 9-digit EPA number.** The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in *field 23* when billing or in the *Authorization* or *Comments* field when billing electronically.

The Department denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how EPA criteria was met, and make this information available to the Department on request.

Expedited Prior Authorization for Adults

Note: The Department uses the following methodology to determine the average decibel hearing loss (dBHL): the sum of the dBHL readings are determined at each level/frequency at 1,000, 2,000, 3,000, and 4,000 Hertz (Hz) and divided by 4.

Procedure Codes: V5246, V5247, V5256, or V5257

Note: For clients that have one hearing aid and need a second analog or digital hearing aid.

870000601 **Second Hearing Aid** for clients 21 years of age and older, who have tried to adapt with one hearing aid for a **period of 6 months**, whose auditory screening shows an average hearing of **45 dBHL** or greater in both ears and **one** or more of the following is documented in the client's records:

1. Inability to hear has caused difficulty with job performance;
2. Inability to hear has caused difficulty in functioning in the school environment; or
3. Client is legally blind.

Note: After waiting six months, only a monaural procedure code is authorized. Billing a binaural code in conjunction with monaural code within five years is not allowed without justification and prior approval.

Client Eligibility - Children

Who Is Eligible? [Refer to WAC 388-547-0700(1)]

Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Coverage Chart* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Clients 20 years of age and younger who are receiving services under any Benefit Services Package, **except for the Family Planning Only program and the TAKE CHARGE program**:

- Are eligible for the covered hearing aids and services listed in these billing instructions and for the audiology services listed in the Department/HRSA *Speech/Audiology Program Billing Instructions*;
- Must have a complete hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed by a hearing healthcare professional; and
- Must be referred by a licensed audiologist, otorhinolaryngologist, or otologist for a hearing aid.

Are Hearing Aids and Services Covered Under the Department's Managed Care Plans? [WAC 388-547-0700(2)]

Hearing aid services are not covered under the Department's managed care plans. Clients who are enrolled in a Department-contracted managed care plan are eligible under fee-for-service for covered hearing aid services that are not covered by their plan. In those cases, bill the Department directly.

Coverage - Children

What Is Covered? [Refer to WAC 388-547-0800]

Purchase

The Department of Social & Health Services (the Department) covers new, nonrefurbished, monaural or binaural hearing aid(s), which includes the ear mold, for eligible clients 20 years of age and younger. In order for the provider to receive payment, the hearing aid must meet the client's specific hearing needs and be under warranty for a minimum of one year.

Replacement

The Department pays for:

- Replacement hearing aid(s), which includes the ear mold, when:
  - ✓ The client's hearing aid(s) are:
    - ➢ Lost;
    - ➢ Beyond repair; or
    - ➢ Not sufficient for the client's hearing loss; and
  - ✓ All warranties are expired.
- Replacement ear mold(s) when the client's existing ear mold is damaged or no longer fits the client's ear.

Repair

The Department pays for a maximum of two repairs, per hearing aid, per year, when the repair is less than 50% of the cost of a new hearing aid. To receive payment, all of the following must be met:

- All warranties are expired; and
- The repair is under warranty for a minimum of 90 days.

Rental

The Department pays for a rental hearing aid(s) for up to two months while the client's own hearing aid is being repaired. In the case of a rental hearing aid(s), the Department pays separately for an ear mold(s).

What Is Not Covered? [Refer to WAC 388-547-0900]

The Department does not cover the following hearing and hearing aid-related items and services for clients 20 years of age and younger:

- Batteries or tinnitus maskers;
- Group screenings for hearing loss, except as provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (refer to the Department/HRSA *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Instructions;* or
- Computer-aided hearing devices for FM systems used in school.

When EPSDT applies, the Department evaluates a noncovered service, equipment, or supply according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental.

Exception to Rule (ETR)

The Department evaluates a request for medical services, equipment, and/or supplies that are listed as noncovered under the provisions of WAC 388-501-0160 that relates to noncovered services. The request for a noncovered medical service, equipment, or supply is called a "request for an exception to rule." See WAC 388-501-0160 for information about exception to rule.

In order to request an ETR, ***providers must complete and fax*** the Department the Hearing Aid Authorization Request Form, DSHS 13-772, at: 1-866-668-1214.

Download the Hearing Aid Request Form, DSHS 13-772, and the Basic Information Form, DSHS 13-756, by visiting the Department at: http://www1.dshs.wa.gov/msa/forms/eforms.html

Coverage Table - Children

	Code Status	Procedure Code	Modifier	Brief Description	Policy Comments
Monaural		V5246	LT, RT, RA	Digitally programmable analog, ITE	Includes a prefitting evaluation, an ear mold and at least 3 follow-up appointments.
		V5247	LT, RT, RA	Digitally programmable analog, BTE	
		V5256	LT, RT, RA	Digital, ITE	
		V5257	LT, RT, RA	Digital, BTE	
		V5050	LT, RT, RA, RR	Hearing aid, ITE	Invoice required.
		V5060	LT, RT, RA, RR	Hearing aid, BTE	
Binaural		V5260	RA	Digital ITE	Requires PA for adults 20 years of age and older. Do not bill in conjunction with a monaural hearing aid.
		V5261	RA	Digital BTE	
Other		V5040		Monaural, body worn, bone conduction	
		V5264	RA	Ear molds/insert, not disposable, any type	
		V5014	RT, LT, RB (for casing)	Repair/modification of a hearing aid	Used when billing for repair of a **hearing aid.** Maximum of 2 repairs in 1 year. (Includes parts and labor)
		V5274		FM Systems	Children Only – requires PA.
		V5298		Hearing Aid, NOC	PA/invoice required.

Note: Reimbursement for all hearing instruments dispensed includes:

- **A prefitting evaluation;**
- **An ear mold; and**
- **A minimum of three post-fitting consultations.**

Legend

Modifiers: **RA** = Replacement of DME Item **RB** = Replacement Part of DME Item

LT = Left **RT** = Right **RR** = Rental

Prior Authorization - Children

What Is Prior Authorization?

Prior authorization (PA) is Department of Social & Health Services' (the Department's) approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider payment. **Expedited prior authorization (EPA) and limitation extensions are forms of PA.**

Does the Department Require Prior Authorization for Children? [WAC 388-547-1000]

NO. PA is **not** required for clients 20 years of age and younger for hearing aids and services. Providers should send claims for clients 20 years of age and younger directly to the Department. **Providers do not need to obtain authorization from the local Children with Special Health Care Needs (CSHCN) Coordinator.**

> **Note:** The Department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169. **[WAC 388-547-1000 (2)]**

What Are Limitation Extensions?

Limitation extensions (LEs) are cases when a provider can verify that it is medically necessary to provide more units of service than allowed in Department/HRSA Billing Instructions and Washington Administration Code (WAC).

> **Note:** Requests for LEs must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups receive all services.

How Do I Request a Limitation Extension?

There are two ways to request a limitation extension (LE):

1. Providers may be able to obtain authorization for these LEs using an expedited prior authorization number. These EPA numbers are subject to post payment review as in any other authorization process. (See "**What is Expedited Prior Authorization?" in these billing instructions.**)

2. In cases where the client's situation does not meet the EPA criteria for an LE, but the provider still feels that additional services are medically necessary, the provider must request Department approval in writing. Download the Hearing Aid Authorization Request form, DSHS 13-772, at: http://www1.dshs.wa.gov/msa/forms/eforms.html

The request must state the following in writing:

1. The name and ProviderOne Client ID of the client;
2. The provider's name, National Provider Identifier (NPI), telephone number, and FAX number;
3. Additional service(s) requested;
4. Copy of current audiogram for both ears aided and unaided, and the date the last hearing aid(s) were dispensed;
5. The primary diagnosis with the HCPCS code for the requested item; and
6. Clinical justification for additional item(s).

Send your written request for an LE to:

Fax your written request for an LE to the Department at 1-866-668-1214.

Cochlear Implant Replacement Parts

What Cochlear Implant Replacement Parts are Covered?

The Department covers certain replacement parts for cochlear implant devices and bone anchored hearing aids (BAHA) when all of the following are true:

- The manufacturer's warranty has expired;
- The part is for immediate use, not a back-up part; and
- The part is not an external speech processor (these require written/fax authorization).

What Services Require Prior Authorization (PA)?

The Department requires PA for certain replacement parts when using the following codes:

- HCPCS code L9900 when billing for other replacement parts (e.g., the controller or ear hook). L9900 requires PA.
- Replacement of a speech processor (upgrade) (HCPCS code L8619).
- Repair of a speech processor, HCPCS code L7510.
- Replacement of a speech processor, HCPCS code L8691 (BAHA).

What Services Require Expedited Prior Authorization (EPA)?

The Department requires EPA for replacement parts for cochlear implants when using the following codes:

- HCPCS codes L8615-L8618 and L8621-L8624 that are given directly to a client;
- Unilateral cochlear implantation (CPT code 69930).

Note: If the client does not meet the EPA criteria, then PA is required.

The Department will pay for, maintain, and repair only one cochlear speech processor and other necessary parts unless:

- ✓ An exception to rule has been approved; and
- ✓ The Department originally paid for two cochlear implants.

The client must pay for repairs to additional speech processors and parts.
When reimbursing for battery packs, the Department covers the **least costly, equally effective** product.

> **Note:** The Department does not pay providers for repairs or replacements that are covered under the manufacturer's warranty.

The Department will reimburse only those vendors with a current core provider agreement. If the cochlear implant device is provided by a vendor without a current core provider agreement, replacement parts, accessories, and repairs for these devices may or may not be covered. See WAC 388-502-1101 and 388-502-1101.

HCPCS Code	Description	Policy
L7510	Repair of prosthetic device, repair or replace minor parts for cochlear devices includes Ear hook; direct connect; charges, case; power cell charger; care adapter	PA
L8615	Headset or headpiece replacement	EPA/PA
L8616	microphone replacement	EPA/PA
L8617	Transmitting coil	EPA/PA
L8618	Transmitting cable	EPA/PA
L8619	Replace cochlear processor	PA
L8621	Zinc air batter, each	EPA/PA
L8622	Alkaline battery, any size, each	EPA/PA
L8623	Lithium ion battery for use with speech processor	EPA/PA
L8624	Lithium ion battery for use with speech processor; ear	EPA/PA
L8627	Cochlear implant, external speech processor, component replacement	PA
L8628	Cochlear implant, external controller component replacement	PA
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device	PA
L8691	BAHA-speech processor	PA
L8692	Auditory osseointegrated device, external sound processor, used without (BAHA)	PA
L9900	Accessory and/or other replacement parts for other L HCPCS codes	PA

EPA: Expedited Prior Authorization
PA: Prior Authorization required

Payment

What Does the Department Pay for? [WAC 388-547-1100 (1)]

The Department payment for purchased hearing aids includes:

- A prefitting evaluation;
- An ear mold; and
- A minimum of three post-fitting consultations.

When Does the Department Deny Payment? [WAC 388-547-1100 (2)]

The Department denies payment for hearing aids and/or services when claims are submitted without the prior authorization number, when required, or the appropriate diagnosis or procedure code(s).

What Does the Department Not Pay for? [WAC 388-547-1100 (3)]

The Department does not pay for hearing aid charges paid by insurance or other payer source.

> **Note:** To receive payment, the provider must keep documentation in the client's medical file to support the medical necessity for the specific make and model of the hearing aid ordered for the client. This documentation must include the record of the audiology testing providing evidence that the client's hearing loss meets the eligibility criteria for a hearing aid. **[WAC 388-547-1100 (4)]**

Fee Schedule

You may view the Department/HRSA **Hearing Aids & Services Fee Schedule** on-line at http://hrsa.dshs.wa.gov/RBRVS/Index.html

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

What Records Specific to Hearing Aids Providers Must Be Kept in the Client's File?

Providers must keep documentation of all hearing tests and results in the complete client's chart and record.

This includes, but is not limited to, the following tests:

- Audiogram results/graphs/tracings (including air conduction and bone conduction comparisons);
- Basic or simple hearing tests or screening, such as is done in many schools;
- Tympanogram;
- Auditory Brainstem Response (ABR); and
- Electronystagmogram (ENG) (not a hearing test but a special test of inner ear balance).

Completing the CMS-1500 Claim Form

Note: Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 claim form instructions relate to the **Hearing Aids & Services program**.

Field No.	Name	Field Required	Entry
19.	**Reserved for Local Use**	When applicable	Enter: • "SCI=B" (Baby on parent's ProviderOne Client ID); or • Claim notes.
23.	**Prior Authorization Number**	When applicable	Use the prior authorization number assigned to you if/when services have been denied and you are requesting an exception to rule.
24D.	**Procedures, Services or Supplies CPT/HCPCS**	Yes	Enter the appropriate Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS) procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.