Every effort has been made to ensure this guide’s accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.
About this guide*

This publication takes effect October 1, 2017, and supersedes earlier billing guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

<table>
<thead>
<tr>
<th>Subject</th>
<th>Change</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Integrated Managed Care (FIMC)</td>
<td>Effective January 1, 2018, the agency is implementing a second FIMC region, the North Central (NC) region, which includes Douglas, Chelan, and Grant Counties. The agency has updated and consolidated the FIMC information in this guide and provided several hyperlinks to the agency’s Managed Care web page, the agency’s Integrated physical and behavioral health care web page, and the agency’s Regional resource web page.</td>
<td>Notification of new region moving to fully integrated managed care (FIMC)</td>
</tr>
</tbody>
</table>

* This publication is a billing instruction.
How can I get agency provider documents?

To access provider alerts, go to the agency’s provider alerts web page.

To access provider documents, go to the agency’s provider billing guides and fee schedules web page.

Where can I download agency forms?

To download an agency provider form, go to HCA’s Billers and providers web page, select Forms & publications. Type the HCA form number into the Search box as shown below (Example: 13-835).

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

**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.

**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.

**Developmental Disabilities Administration (DDA)** – A division administration within the Department of Social and Health Services. DDA provides services to children and adults with developmental disabilities.

**Digital hearing aids** – Hearing aids that use a digital circuit to analyze and process sound. (WAC 182-547-0200)

**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 182-547-0200)

**Hearing health care professional** – An audiologist or hearing aid fitter/dispenser licensed under Chapter 18.35 RCW, or an otolorhinolaryngologist or otologist licensed under Chapter 18.71 RCW. (WAC 182-547-0200)

**Maximum allowable fee** - The maximum dollar amount that the agency will pay a provider for specific services, supplies, and equipment. (WAC 182-547-0200)

**Prior authorization** – A form of authorization used by the provider to obtain approval for a specific hearing aid 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 182-547-0200)

**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.

**Social Services Authorization** – A form of authorization used by the Department of Social and Health Services to preauthorize services. The approval is based on medical necessity and client eligibility for the program or service. A Social Services Authorization can be viewed in ProviderOne.
**Usual & customary fee** - The rate that may be billed to the agency for a certain service or equipment. This rate may not exceed either of the following:

1) The usual and customary charge that you bill the general public for the same services

2) If the general public is not served, the rate normally offered to other contractors for the same services
About the Program

When does the agency pay for hearing aids?

(WAC 182-547-0100)

The agency pays for hearing aids when they are:

- Covered.
- Within the scope of an eligible client's Benefit Package.
- Medically necessary.
- Authorized as required within this billing guide and Chapters 182-501 and 182-502 WAC.
- Billed according to this billing guide and Chapters 182-501 and 182-502 WAC.
- Provided to an eligible client. (See Client Eligibility.)

Note: For clients of the Developmental Disabilities Administration (DDA) age 21 and over, refer to the DDA section of this billing guide.
Client Eligibility

How can I verify a patient’s eligibility?
(WAC 182-547-0700(1))

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client’s benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient’s eligibility for Washington Apple Health.** For detailed instructions on verifying a patient’s eligibility for Washington Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in the agency’s current ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2.** If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client’s benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client’s benefit package, see the agency’s Program Benefit Packages and Scope of Services web page.

---

**Note:** Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder’s website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.
Clients age 20 and younger who are receiving services under a Benefit Package:

- Are eligible for the covered hearing aids and services listed in this billing guide and for the audiology services listed in the agency’s Physician-Related Services/Health Care Professional Services Billing Guide.

- Must have a complete hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed by a hearing healthcare professional.

- Must be referred by a licensed audiologist, otorhinolaryngologist, or otologist for a hearing aid.

**Are clients enrolled in managed care eligible?**

_WAC 182-547-0700(2)_

Hearing aids are covered under agency-contracted managed care organizations (MCO). Clients who are enrolled in an agency-contracted MCO are eligible for covered hearing aids. Bill the MCO directly for these services. Additionally, clients enrolled in an agency-contracted MCO must obtain replacement parts for cochlear implants and bone anchored hearing aids (Baha®), including batteries, through their MCO.

**Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO**

On July 1, 2017, some Apple Health clients were not enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) program. For these clients, substance use disorder (SUD) services are covered under the fee-for-service (FFS) program.

**Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care**

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency’s [Managed Care web page](#), under Providers and Billers.
Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client’s Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the agency’s Regional Resources web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder’s Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO’s requirements and be compliant with the MCO’s new policies.
Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs replaced the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Services Billing Guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client’s appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

For clients who live in a fully integrated managed care (FIMC) region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client’s agency-contracted managed care organization (MCO). The Behavioral Health Organization (BHO) will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington must choose to enroll in one of the agency-contracted MCOs available in that region; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavior health services. For more information about the services available under the FFS program, see the agency’s Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on FIMC, including which clients residing in an FIMC region are not enrolled with an MCO and information on complex behavioral health services for foster children in an FIMC region, see the agency’s Managed Care web page, the agency’s Integrated physical and behavioral health care web page, and the agency’s Regional resource web page.
FIMC Regions

North Central Region (NC) – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the NC region which includes Douglas, Chelan, and Grant Counties. Clients eligible for managed care enrollment will choose to enroll in an available MCO in their region. Specific details, including information about mental health crisis services can be found on the agency’s Managed Care web page, the agency’s Integrated physical and behavioral health care web page, and the agency’s Regional resource web page.

Southwest Washington Region (SW WA) – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the SW WA region which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region: Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW).

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be automatically enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.
Contact Information for Southwest Washington

Beginning on April 1, 2016, there is not a BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

<table>
<thead>
<tr>
<th>Molina Healthcare of Washington, Inc.</th>
<th>1-800-869-7165</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Plan of Washington</td>
<td>1-866-418-1009</td>
</tr>
<tr>
<td>Beacon Health Options</td>
<td>1-855-228-6502</td>
</tr>
</tbody>
</table>
Coverage

What is covered?
(WAC 182-547-0800)

Monaural or binaural hearing aids

The agency covers new, nonrefurbished, monaural or binaural hearing aid(s), which includes the ear mold and batteries, for eligible clients age 20 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.

See the Social Service Blanket Codes for specific procedure codes.

Replacement

The agency pays for the following replacements as long as the need for replacements is not due to the client's carelessness, negligence, recklessness, or misuse in accordance with WAC 182-501-0050(8):

- Hearing aid(s), which includes the ear mold, when all warranties are expired and the hearing aid(s) are one of the following:
  - Lost
  - Beyond repair
  - Not sufficient for the client's hearing loss

- Ear mold(s) when the client's existing ear mold is damaged or no longer fits the client's ear.

- Batteries with a valid prescription from an audiologist.

Repair

The agency 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 the following must be met:

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

The agency 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 agency pays separately for an earmold(s).

Cochlear implant – replacement parts
(WAC 182-547-0800 (3))

The agency covers:

- Cochlear implant external speech processors, including maintenance, repair, and batteries.
- Baha® speech processors, including maintenance, repair, and batteries.

See the Coverage Table for specific procedure codes.

The agency pays for cochlear implant and Baha® replacement parts when:

- The manufacturer's warranty has expired.
- The part is for immediate use, not a back-up part.
- The part needs to be replaced due to normal wear and tear and is not related to misuse or abuse of the item (see WAC 182-502-0160).

The client must pay for repairs to additional speech processors and parts.

When reimbursing for battery packs, the agency covers the least costly, equally effective product.

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

The agency 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 182-502-1101.
**Replacement parts - EPA criteria**

The following expedited prior authorization (EPA) criteria must be met:

- The cochlear implant or bone conduction (Baha®) is unilateral (bilateral requires PA).
- The manufacturer’s warranty has expired.
- The part is for immediate use (not a back-up part).

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

Use **EPA 870000001** with HCPCS codes **L8615-L8618, L8621-L8624** when billing for cochlear implant and bone conduction (Baha®) replacement parts. See [What is expedited prior authorization (EPA)](#).

**What is not covered?**

*(WAC 182-547-0900)*

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

- Tinnitus maskers
- Group screenings for hearing loss, except as provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (refer to the agency’s [Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide](#))
- FM systems, including the computer-aided hearing devices for FM systems

When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in **WAC 182-501-0165** to determine if it is medically necessary, safe, effective, and not experimental. See **WAC 182-534-0100** for EPSDT rules.

**Exception to Rule (ETR)**

The agency evaluates a request for medical services, equipment, and/or supplies that are listed as noncovered under the provisions of **WAC 182-501-0160** 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 182-501-0160** for information about exception to rule (ETR).

To request an ETR, see [What documentation is required when requesting a PA or ETR](#)?
## Coverage Table

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>Policy Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5246</td>
<td>LT, RT, RA</td>
<td>Hearing aid, prog, mon, ite</td>
<td>Includes a prefitting evaluation, an ear mold and at least 3 follow-up appointments.</td>
</tr>
<tr>
<td>V5247</td>
<td>LT, RT, RA</td>
<td>Hearing aid, prog, mon, bte</td>
<td></td>
</tr>
<tr>
<td>V5256</td>
<td>LT, RT, RA</td>
<td>Hearing aid, digit, mon, ite</td>
<td></td>
</tr>
<tr>
<td>V5257</td>
<td>LT, RT, RA</td>
<td>Hearing aid, digit, mon, bte</td>
<td></td>
</tr>
<tr>
<td>V5050</td>
<td>LT, RT, RA, RR</td>
<td>Hearing aid monaural in ear</td>
<td>Invoice required.</td>
</tr>
<tr>
<td>V5060</td>
<td>LT, RT, RA, RR</td>
<td>Behind ear hearing aid</td>
<td></td>
</tr>
<tr>
<td>V5061</td>
<td>RA</td>
<td>Hearing aid, digit, bin, bte</td>
<td>Do not bill in conjunction with a monaural hearing aid.</td>
</tr>
<tr>
<td>V5040</td>
<td>RA</td>
<td>Body-worn hearing aid bone</td>
<td></td>
</tr>
<tr>
<td>V5260</td>
<td>RA</td>
<td>Hearing aid, digit, bin, ite</td>
<td></td>
</tr>
<tr>
<td>V5261</td>
<td>RA</td>
<td>Hearing aid, digit, bin, bte</td>
<td></td>
</tr>
<tr>
<td>V5264</td>
<td>RA</td>
<td>Ear mold/insert</td>
<td></td>
</tr>
<tr>
<td>V5014</td>
<td>RT, LT, RB (for casing)</td>
<td>Hearing aid repair/modifying</td>
<td>Used when billing for repair of a hearing aid. Maximum of 2 repairs in 1 year. (Includes parts and labor)</td>
</tr>
<tr>
<td>V5266</td>
<td></td>
<td>Battery for hearing device</td>
<td></td>
</tr>
<tr>
<td>V5298</td>
<td></td>
<td>Hearing aid noc</td>
<td>PA/invoice required.</td>
</tr>
</tbody>
</table>

**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
### Hearing Hardware

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>L7510</td>
<td>Prosthetic device repair rep</td>
<td>PA</td>
</tr>
<tr>
<td>L8615</td>
<td>Coch implant headset replace</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8616</td>
<td>Coch implant microphone repl</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8617</td>
<td>Coch implant trans coil repl</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8618</td>
<td>Coch implant tran cable repl</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8619</td>
<td>Coch imp ext proc/contr rplc</td>
<td>PA</td>
</tr>
<tr>
<td>L8621</td>
<td>Repl zinc air battery</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8622</td>
<td>Repl alkaline battery</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8623</td>
<td>Lith ion batt CID,non-earlvl</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8624</td>
<td>Lith ion batt CID, ear level</td>
<td>EPA/PA</td>
</tr>
<tr>
<td>L8627</td>
<td>CID ext speech process repl</td>
<td>PA</td>
</tr>
<tr>
<td>L8628</td>
<td>CID ext controller repl</td>
<td>PA</td>
</tr>
<tr>
<td>L8629</td>
<td>CID transmit coil and cable</td>
<td>PA</td>
</tr>
<tr>
<td>L8691</td>
<td>Osseointegrated snd proc rpl</td>
<td>PA</td>
</tr>
<tr>
<td>L8692</td>
<td>Non-osseointegrated snd proc</td>
<td>PA</td>
</tr>
<tr>
<td>L8693</td>
<td>Auditory osseointegrated device abutment, replacement only</td>
<td>PA</td>
</tr>
<tr>
<td>L9900</td>
<td>O&amp;P supply/accessory/service</td>
<td>PA</td>
</tr>
</tbody>
</table>

**Legend**

**EPA:** Expedited Prior Authorization  
**PA:** Prior Authorization required
Authorization

What is prior authorization (PA)?

PA is agency approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider payment.

Does the agency require prior authorization for hearing hardware?

No. Except for certain services specified in the Coverage table, PA is not required for clients age 20 and younger for hearing aids and services. Providers must send claims for clients age 20 and younger-directly to the agency. Providers do not need to obtain authorization from the local Children with Special Health Care Needs (CShCN) Coordinator.

Note: The agency 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 182-501-0169. (WAC 182-547-1000 (2))

What is expedited prior authorization (EPA)?

The EPA process is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an EPA number using those codes.

The agency 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 the EPA criteria were met and make this information available to the agency upon request.

Note: When billing electronically, enter the EPA number in the Prior Authorization section.
What documentation is required when requesting PA or ETR?

For all requests for prior authorization, the following documentation is required:

- A completed, TYPED General Information for Authorization form, HCA 13-835. This request form MUST be the initial page when you submit your request. See Where can I download agency forms?

- A completed Hearing Aid Authorization Request form, HCA 13-772, and all the documentation listed on this form and any other medical justification.

Fax your request to: (866) 668-1214.
Billing

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency’s Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the agency’s ProviderOne Billing and Resource Guide. These billing requirements include:

- The time limits for submitting and resubmitting claims and adjustments.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

Note: For guidance on when a provider may bill a client, see the agency’s “Billing a Client” webinar presentation.

What records must be kept in the client’s file?

In addition to the documentation listed in What is included in the agency’s payment for hearing aids, 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)
- Electronystagmogram (ENG) (not a hearing test but a special test of inner ear balance)

A valid prescription from an audiologist for replacement batteries must be kept in the client’s chart.
How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency’s Billers and Providers web page, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) web page.

The following claim instructions relate to the Hearing Hardware program.

<table>
<thead>
<tr>
<th>Name</th>
<th>Field Required</th>
<th>Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserved for Local Use</td>
<td>When applicable</td>
<td>Enter:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “SCI=B” (Baby on parent’s ProviderOne Client ID); or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Claim notes.</td>
</tr>
<tr>
<td>Prior Authorization Number</td>
<td>When applicable</td>
<td>Use the prior authorization number assigned to you if/when services have been denied and you are requesting an exception to rule.</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Yes</td>
<td>Enter the appropriate Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS) procedure code for the services being billed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modifier: When appropriate enter a modifier.</td>
</tr>
</tbody>
</table>
Payment

What is included in the agency’s payment for hearing aids?
(WAC 182-547-1100 (1)-(3))

The agency’s payment for purchased hearing aids includes all the following:

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

The agency 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).

The agency 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 182-547-1100 (4))

Where can I view the fee schedule?

View the agency’s fee schedule online: [Hearing Hardware Fee Schedule](#).
About the Program
(Developmental Disabilities Administration [DDA] Clients)

When does DDA pay for hearing aids?

The administration pays for hearing aids when they are:

- Medically necessary.
- Authorized as required within this billing guide and Chapters 182-501, 182-502, and 388-845 WAC.
- Billed according to this billing guide and Chapters 182-501 and 182-502 WAC.
- Provided to an eligible client. (See How can I verify a patient’s eligibility?)
- Of direct medical or remedial benefit to the client and necessary as a result of the client's disability.
- Identified in the waiver participant’s DDA assessment and documented in the person-centered plan.
- Requested for prior approval by the DDA client’s case manager and approved by the DDA regional administrator or designee.
Client Eligibility (DDA Clients)

How can I verify a client’s eligibility?

Providers must verify that a patient has a valid social services authorization for the date of service and that the client’s benefit package covers the applicable service. This helps prevent delivering a service the administration will not pay for.

Providers can verify that a client has a valid social services authorization in ProviderOne. (See How do I view a Social Services Authorization?)
Coverage (DDA Clients)

What is covered?
(WAC 388-845-1810)

Monaural or binaural hearing aids

The administration covers new, non-refurbished, monaural or binaural hearing aids, which includes the ear mold and batteries, for clients eligible for the service. In order for the provider to receive payment, the hearing aid must meet the client's specific hearing needs necessary as a result of the individual’s disability and be under warranty for a minimum of one year.

See the Social Services Blanket Codes for specific procedure codes.

Replacement

The administration pays for the following replacements when approved with a social services authorization:

- Hearing aids, which includes the ear mold, when all warranties are expired and the hearing aids are one of the following:
  - Lost
  - Beyond repair
  - Not sufficient for the client's hearing loss

- Ear molds when the client's existing ear mold is damaged or no longer fits the client's ear.

- Batteries with a valid prescription from an audiologist.

Repair

The administration pays for repair when approved with a social services authorization. To receive payment, all the following must be met:

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

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

Cochlear implant – replacement parts

(WAC 182-547-0800 (3))

The administration covers:

- Cochlear implant external speech processors, including maintenance, repair, and batteries.
- Baha® speech processors, including maintenance, repair, and batteries.

See the Social Service Blanket Codes for specific procedure codes.

The administration pays for cochlear implant and Baha® replacement parts when:

- The manufacturer's warranty has expired.
- The part is for immediate use, not a back-up part.
- The part needs to be replaced due to normal wear and tear and is not related to misuse or abuse of the item (see WAC 182-502-0160).

When reimbursing for battery packs, the administration covers the least costly, equally effective product.

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

The administration 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 182-502-1101.
**What is not covered?**

*(WAC 182-547-0900)*

The administration does not cover the following hearing and hearing aid-related items and services for clients age 21 and older:

- Tinnitus maskers
- Group screenings for hearing loss

**Coverage Table (DDA)**

See [Social Service Blanket Codes](#) for list of covered services.
Authorization (DDA Clients)

What is a social services authorization?

A social services authorization is administration approval for certain services, equipment, or supplies before the services are provided to clients as a precondition for provider payment.

How do I request a social services authorization?

The client or the client’s representative initiates the request for a social services authorization by requesting a prior approval for hearing hardware through ProviderOne. The provider can assist the client or representative in requesting a social services authorization by providing the following information:

- What equipment is necessary, using the names and procedure codes of the equipment.
- An exact amount of the total cost of all equipment requested, using the Apple Health Hearing Hardware Fee Schedule.
- How the hearing hardware will assist the client to perceive, control, or communicate with the environment in which they live or to increase their abilities to perform activities of daily living.
- How the items are of direct medical or remedial benefit to the client and necessary because of the client’s disability.
- How the ancillary supplies or equipment will support proper functioning and continued use of the equipment, if the needed equipment supports the continued functioning of equipment the client already uses.

How do I view a social services authorization?

The social services authorization can be viewed in ProviderOne. If you have questions about the social services authorization, contact the case manager listed on the authorization.

Providers will receive an alert message when a social services authorization has been created or changed. To view the social services authorization from the provider portal:

2. Enter the authorization number from the alert or search by the Client ID.
What happens after the social services authorization is approved?

When the prior approval is reviewed and approved, the case manager will enter a social service authorization for SA893 for one unit and a dollar amount based on the information used to request a prior approval.

The provider will bill using the appropriate HCPCS codes for the equipment and will be paid no more than the amount listed in the Hearing Hardware Fee Schedule.
Billing (DDA Clients)

What are the general billing requirements?

Providers must follow the Apple Health ProviderOne Billing and Resource Guide. These billing requirements include:

- The time limits for submitting and resubmitting claims and adjustments.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

Note: For information on when a provider may bill a client, see HCA’s “Billing a Client” webinar presentation.

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<td>Yes</td>
<td>Use the social services authorization number assigned to you.</td>
</tr>
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<td>Procedure Code</td>
<td>Yes</td>
<td>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.</td>
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Payment (DDA Clients)

What is included in the administration’s payment for hearing aids?

(WAC 182-547-1100 (1)-(3))

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Where can I view the fee schedule?

The administration uses the Apple Health Hearing Hardware Fee Schedule.