

Washington Apple Health (Medicaid)

Hearing Hardware Billing Guide

January 1, 2018

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 January 1, 2018, and supersedes earlier billing guides to this program.

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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?

Subject	Change	Reason for Change
<u>Client Eligibility</u>	<p>This section is reformatted and consolidated for clarity and hyperlinks have been updated.</p> <p>Effective January 1, 2018, the agency is implementing another FIMC region, known as the North Central region, which includes Douglas, Chelan, and Grant Counties.</p>	Housekeeping and notification of new region moving to FIMC
<u>Coverage Table</u>	Added new HCPCS codes L8625 and L8694	New HCPCS codes

* This publication is a billing instruction.

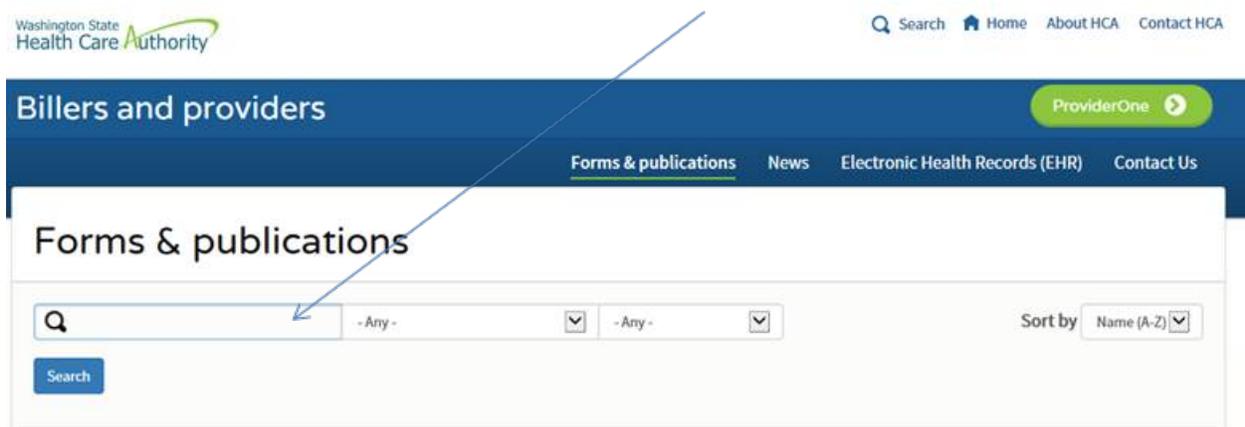
How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) webpage.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers webpage, 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 otorhinolaryngologist 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

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's [Apple Health managed care page](#) for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has 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.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Apple Health. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

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

Step 2. Verify service coverage under the Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) web page.

Note: Patients who are not 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.

Are clients enrolled in managed care eligible?

([WAC 182-547-0700](http://www.wahealthplanfinder.org)(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.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

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.

Checking eligibility

- 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 policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have [fully integrated managed care \(FIMC\)](#).

See the agency's [Mental Health Services Billing Guide](#) for details.

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The 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 may 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 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 behavioral health services. See the agency's [American Indian/Alaska Native webpage](#).

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, see the agency's [Changes to Apple Health managed care webpage](#).

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's [Apple Health managed care webpage](#).

North Central Region – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington 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.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
“Coordinated Care Healthy Options Foster Care.”

See the agency's [Apple Health managed care page](#), Apple Health Foster Care for further details.

Coverage

What is covered?

([WAC 182-547-0800](http://www.wa.gov/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\(8\)](http://www.wa.gov/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 ear mold(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

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

Hearing Hardware

HCPCS Code	Short Description	Policy
L7510	Prosthetic device repair rep	PA
L8615	Coch implant headset replace	EPA/PA
L8616	Coch implant microphone repl	EPA/PA
L8617	Coch implant trans coil repl	EPA/PA
L8618	Coch implant tran cable repl	EPA/PA
L8619	Coch imp ext proc/contr rplc	PA
L8621	Repl zinc air battery	EPA/PA
L8622	Repl alkaline battery	EPA/PA
L8623	Lith ion batt CID,non-earlvl	EPA/PA
L8624	Lith ion batt CID, ear level	EPA/PA
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	PA
L8627	CID ext speech process repl	PA
L8628	CID ext controller repl	PA
L8629	CID transmit coil and cable	PA
L8691	Osseointegrated snd proc rpl	PA
L8692	Non-osseointegrated snd proc	PA
L8693	Auditory osseointegrated device abutment, replacement only	PA
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	PA
L9900	O&P supply/accessory/service	PA

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?

([WAC 182-547-1000](#))

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](#) webpage, 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 \(EDI\)](#) webpage.

The following claim instructions relate to the Hearing Hardware program.

Name	Field Required	Entry
Reserved for Local Use	When applicable	Enter: <ul style="list-style-type: none"> • “SCI=B” (Baby on parent’s ProviderOne Client ID); or • Claim notes.
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.
Procedure Code	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.

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:

1. Select Social Services View Authorization List. The Provider Authorization List Page will appear.
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](#).

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

In addition to the documentation listed in [What is included in the administration'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 those done in 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](#) webpage, under Webinars. See [Medical provider workshop](#).

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 \(EDI\)](#) webpage.

The following claim instructions relate to the Hearing Hardware program.

Name	Field Required	Entry
Prior Authorization Number	Yes	Use the social services authorization number assigned to you.
Procedure Code	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.

Payment (DDA Clients)

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

([WAC 182-547-1100](#) (1)-(3))

The administration's payment for purchased hearing aids includes all of the following:

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

The administration denies payment for hearing aids and services when claims are submitted without the social services authorization number when required or the appropriate diagnosis or procedure code.

The administration 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?

The administration uses the Apple Health [Hearing Hardware Fee Schedule](#).