Washington State Health Care Authority

Washington Apple Health (Medicaid)

Hearing Services Billing Guide

July 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2025**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in Unless otherwise specified, the program(s) in this guide is governed by the rules found in chapter 182-547 WAC.

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.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Managed care enrollment	Revised section to include a second exception in the first paragraph regarding clients eligible to receive Reentry Initiative services	To clarify managed care enrollment policy for clients eligible to receive Reentry Initiative services
Integrated Apple Health Foster Care (AHFC)	Corrected acronym for Coordinated Care (CCW). Also added Unaccompanied Refugee Minors (URM) program to the list of clients under the AHFC program	Housekeeping and updating the list of clients under the AHFC program
Reentry Initiative	Added new section	**Effective for dates of service on and after July 1, 2025**, HCA covers a limited set of services for incarcerated individuals through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington state.

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to **chapter 182-500 WAC** and **WAC 182-547-0200** for a complete list of definitions for Washington Apple Health.

Bone conduction hearing device – A type of hearing aid that transmits sound vibrations through bones in the head. The inner ear translates the vibrations the same way a normal ear translates sound waves. These devices can be surgically implanted or worn on headbands.

Cochlear implant device – An electrical device that receives sound and transmits the resulting signal to electrodes implanted in the cochlea. That signal stimulates the cochlea so that hearing impaired persons can perceive sound.

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 – Wearable sound-amplifying devices that use a digital circuit to analyze and process sound.

Hearing aids - Wearable sound-amplifying devices that are intended to compensate for hearing loss. These devices use a digital circuit to analyze and process sound. Hearing aids are described by where they are worn in the ear as in-the-ear (ITE), behind-the-ear (BTE), etc.

Hearing health care professional – An audiologist or hearing aid specialist licensed under chapter 18.35 RCW, or a physician specialized in diseases and disorders of the ear licensed under chapter 18.71 RCW.

Maximum allowable fee - The maximum dollar amount that HCA will pay a provider for specific services, supplies, and equipment.

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.

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 HCA for a certain service or equipment. This rate may not exceed either of the following:

- The usual and customary charge that you bill the general public for the same services
- If the general public is not served, the rate normally offered to other contractors for the same services

About the Program

When does HCA pay for hearing services?

HCA pays for hearing services when they are:

- Covered.
- Within the scope of an eligible client's **Benefit Package**.
- Medically necessary.
- Authorized as required within this billing guide and **chapter 182-501 WAC** and **chapter 182-502 WAC**.
- Billed according to this billing guide and **chapter 182-501 WAC** and **chapter 182-502 WAC**.
- Provided to clients when all the following are true. The clients:
  - Are eligible (see **Client Eligibility**).
  - Have received a hearing evaluation, including an audiogram or developmentally appropriate diagnostic physiologic test, that is administered by, and the results interpreted by a hearing health care professional.
  - Have received a recommendation by a licensed audiologist, hearing aid specialist, otorhinolaryngologist, or otologist.
  - Meet any medical necessity guidelines found in this billing guide.

> **Note:** For clients of the Developmental Disabilities Administration (DDA), refer to the DDA section in this billing guide.

Effective January 1, 2025, hearing services information from the Physician-Related Services/Health Care Professional Services billing guide is transferred to this guide.

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-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 HCA's Apple Health managed care webpage 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 HCA will not pay for.

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 HCA'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** 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 HCA's Program benefit packages and scope of services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in **WAC 182-502-0160**.

Managed care enrollment

Most Apple Health clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exceptions:

- Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.

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 HCA's **Apply for or renew coverage webpage**.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to **Washington HealthPlanFinder website**.

- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care** webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the FFS program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CCW) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement) or in the Unaccompanied Refugee Minors program
- 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**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit Apple Health Expansion.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit **Reentry from a carceral setting**.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the **Health Care Authority's (HCA) American Indian/Alaska Native webpage**.

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Coverage – General

Audiology

HCA may pay for audiology program services for conditions that are the result of medically recognized diseases and defects.

Who is eligible to provide audiology services?

Audiologists who are appropriately licensed or registered to provide audiology services within their state of residence may provide audiology services to HCA clients.

What type of equipment must be used?

Audiologists must use annually calibrated electronic equipment, according to RCW 18.35.020.

- For caloric vestibular testing (CPT® code 92537), bill one unit per irrigation. If necessary, providers may bill up to four units for each ear.
- For sinusoidal vertical axis rotational testing (CPT® code 92546), bill 1 unit per velocity/per direction. If necessary, providers may bill up to 3 units for each direction.

Audiology coverage

See the Physician-Related/Professional Services Fee Schedule for covered services.

Audiology billing

> **Note:** The outpatient rehabilitation benefit limits **do not apply** to therapy services provided and billed by audiologists. Audiologists (and physicians) must use the **AF modifier** when billing.

Tympanostomies

Service procedure codes

CPT® codes 69433 and 69436

Medical necessity guidelines

Based upon review of **evidence provided by HTCC (20151120B—Tympanostomy Tubes in Children)**, HCA considers tympanostomy tubes for children age 16 and

younger to be medically necessary when the child is diagnosed with one of the following:

- Acute otitis media (AOM) and the client has either of the following:
  - Complications, is immunocompromised, or is at risk for infection
  - Both of the following are true:
    - Has had 3 episodes of AOM in the last 6 months with one occurring in the last 6 months
    - Has the presence of effusion at the time of assessment for surgical candidacy
- Otitis media with effusion (OME) and the client has one of the following:
  - An effusion for 3 months or greater and there is documented hearing loss
  - A disproportionate risk
    - For persistent effusion based on anatomic abnormalities
    - From the effects of hearing loss, such as those with speech delay, underlying sensory-neuro hearing loss or cognitive disorders

HCA considers tympanostomy tubes to be medically necessary for clients age 17 and older for any of the following indications:

- Autophony due to patulous eustachian tube
- Barotitis media control
- Cholesteatoma
- Chronic retraction of tympanic membrane or pars flaccida
- Complications of otitis media such as meningitis, facial nerve paralysis, coalescent mastoiditis, or brain abscess
- Otitis media with effusion after 3 months or longer and bilateral hearing impairment (defined as 20 dB hearing threshold level or worse in both ears) (tympanostomy tube)
- Recurrent episodes of acute otitis media (more than 3 episodes in 6 months or more than 4 episodes in 12 months) (tympanostomy tube)
- Severe otalgia in acute otitis media (myringotomy)
- To obtain a culture (diagnostic tympanocentesis/myringotomy) of the middle ear fluid prior to beginning or changing antimicrobial therapy (this may be necessary in situations such as otitis media that has failed to respond to appropriate antimicrobial therapy, or for otitis media in individuals or neonates who are immunocompromised)

Fee-for-service (FFS) billing instructions

Expedited prior authorization (EPA) is required.

- For clients age 16 and younger, see EPA #870001382.
- For clients age 17 and older, see EPA #870001654.

If the client does not meet the EPA criteria, prior authorization (PA) is required (see **Prior authorization**). HCA reviews PA requests according to WAC 182-501-0165.

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Coverage – Children

What is covered?

Monaural or binaural hearing aids

The Health Care Authority (HCA) covers new, nonrefurbished, monaural or binaural hearing aid(s), which includes the ear mold and batteries, for eligible clients age 20 and younger. 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 services blanket code table for specific procedure codes.

Replacement

HCA 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(7):

- 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

HCA 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

HCA 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), HCA pays separately for an ear mold(s) when replacement is needed.

Bone conduction hearing devices

Insertion or initial placement of bone conduction hearing devices requires prior authorization (PA) (refer to Prior authorization). For billing the initial placement of soft headband bone conduction hearing devices, use the appropriate E/M procedure code and the appropriate hardware HCPCS code. See HCA's Hearing services fee schedule and Coverage Table—Children.

Note: This information relates only to those clients NOT enrolled in an HCA-contracted managed care organization (MCO). For clients enrolled in an HCA-contracted MCO, refer to the coverage guidelines in the enrollee's plan.

The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

HCA pays for replacement parts or repair for bone conduction hearing devices. HCA pays only those vendors that supply replacement parts for cochlear implants and bone conduction hearing devices who have a current Core Provider Agreement.

Cochlear implant services (clients age 20 and younger)

Service procedure codes

CPT® code 69930 (unilateral or bilateral)

Medical necessity guidelines

Based upon review of **evidence provided by HTCC (20130517A—Cochlear Implants: Bilateral vs. Unilateral),** HCA considers cochlear implant devices to be medically necessary when the following guidelines are met:

- Client has bilateral severe to profound sensorineural hearing loss
- Client has limited or no benefit from hearing aids
- Client has the cognitive ability and willingness to participate in an extensive auditory rehabilitation program
- Client has freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- Client has no other contraindications for surgery
- Device is used in accordance with the FDA-approved labeling.

Implantation may be performed unilaterally or bilaterally.

Fee-for-service (FFS) billing instructions

For clients 20 years of age and younger: If the medical necessity guidelines are met, use EPA# **870000423** for unilateral and EPA# **870001365** for bilateral.

If the medical necessity guidelines are not met, providers may request prior authorization (PA). HCA reviews requests for PA according to WAC 182-501-0165.

Cochlear implant devices and replacement parts

HCA covers:

- Speech processors for cochlear implant device, including maintenance, repair, and batteries.
- Speech processors for bone conduction hearing device, including maintenance, repair, and batteries.

See the **Coverage Table** for specific procedure codes.

HCA pays for cochlear implant device and bone conduction hearing device 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.

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

For battery packs, HCA pays for the least costly, equally effective product.

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

See What is expedited prior authorization (EPA) for EPA codes and clinical criteria for billing for replacement parts using the EPA process.

What is not covered?

HCA 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 HCA's **EPSDT Well-Child Program Billing Guide**)
- FM systems, including the computer-aided hearing devices for FM systems

When EPSDT applies, HCA 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)
HCA 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 – Children

Type	Procedure Code	Short Description	Modifier	Policy Comments
Monaural	V5256	Hearing aid, digit, mon, ite	RA, LT, RT	Includes a prefitting evaluation, an ear mold and at least 3 follow-up appointments
Monaural	V5257	Hearing aid, digit, mon, bte	RA, LT, RT	Same as V5246
Monaural	V5050	Hearing aid monaural in ear	RR, LT, RT,	See fee schedule
Monaural	V5060	Behind ear hearing aid	RR, LT, RT,	See fee schedule
Binaural	V5260	Hearing aid, digit, bin, ite	RA	Do not bill in conjunction with a monaural hearing aid.
Binaural	V5261	Hearing aid, digit, bin, ite	RA	Do not bill in conjunction with a monaural hearing aid
CROS/ BiCROS	V5171	Hearing aid monaural ite		Invoice required
CROS/ BiCROS	V5181	Hearing aid monaural bte		Invoice required
CROS/ BiCROS	V5211	Hearing aid binaural ite/ite		Invoice required
CROS/ BiCROS	V5213	Hearing aid binaural ite/bte		Invoice required
CROS/ BiCROS	V5215	Hearing aid binaural itc/bte		Invoice required
CROS/ BiCROS	V5221	Hearing aid binaural bte/bte		Invoice required
Other	V5040	Body-worn hearing aid bone		
Other	V5264	Ear mold/insert	RA	Replacement only

Type	Procedure Code	Short Description	Modifier	Policy Comments
Other	V5275	Ear impression, each	RA	Replacement only
Other	V5014	Hearing aid repair/ modifying	RB, RT, LT (for casing)	Used when billing for repair of a hearing aid. Maximum of 2 repairs in 1 year. (Includes parts and labor)
Other	V5266	Battery for hearing device		
Other	V5298	Hearing aid noc		PA/invoice required
	69710	Implant/replace hearing aid		Replacement procedure includes removal of old device
	69711	Remove/repair hearing aid		
	69714	Implant temple bone w/stimul		
	69717	Temple bone implant revision		

Legend - Modifier Descriptions:

RA = Replacement of DME Item
RB = Replacement part of DME item
LT = Left
RT = Right

Note: HCA's payment for hearing instruments dispensed includes the following:

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

HCPCS Code	Short Description	Authorization?	Policy
L7510	Prosthetic device repair rep	Yes. PA required	
L8614	Cochlear device	Yes. PA required	
L8615	Coch implant headset replace	Yes. Use EPA #870000001. If client does not meet EPA clinical criteria, PA is required	
L8616	Coch implant microphone repl	Same as L8615	
L8617	Coch implant trans coil repl	Same as L8615	
L8618	Coch implant tran cable repl	Same as L8615	
L8619	Coch imp ext proc/contr rplc	Yes. PA required	
L8621	Repl zinc air battery	Same as L8615	
L8622	Repl alkaline battery	Same as L8615	
L8623	Lith ion batt CID non-earlyl	Same as L8615	
L8624	Lith ion batt CID, earl level	Same as L8615	
L8625	Charger coch impl/aoi battry	Yes. PA required	Replacement only, each
L8627	CID ext speech process repl	Yes. PA required	
L8628	CID ext controller repl	Yes. PA required	
L8629	CID transmit coil and cable	Yes. PA required	
L8691	Osseointegrated snd proc rpl	Yes. PA required	
L8692	Non-osseointegrated snd proc	Yes. PA required	
L8693	Auditory osseointegrated device	Yes. PA required	Replacement only
L8694	Aoi transducer/actuator repl	Yes. PA required	Replacement only, each

HCPCS Code	Short Description	Authorization?	Policy
L9900	O&P supply/accessory/service	Yes. PA required	

Legend – Authorization Descriptions

EPA = Expedited prior authorization PA = Prior authorization

Coverage – Adults

For the provider to receive payment for providing hearing services to clients age 21 and older, the client must meet the eligibility and criteria stated in this billing guide.

What is covered?

Nonrefurbished, monaural hearing aids

HCA covers one new nonrefurbished monaural hearing aid, which includes the ear mold, every 5 years.

The client must have an average decibel loss of 45 or greater in the better ear, based on a pure-tone audiometric evaluation by a licensed audiologist or a licensed hearing aid specialist at 1000, 2000, 3000, and 4000 Hertz (Hz) with effective masking as indicated.

The hearing aid must meet the client's specific hearing needs and carry a manufacturer's warranty for a minimum of one year.

Binaural hearing aids

HCA covers binaural hearing aids. Prior authorization (PA) is required. See Prior Authorization - Adults for more details.

Second hearing aid

HCA pays for a second hearing aid when the client meets the following clinical criteria:

- Client has tried to adapt with one hearing aid for a period of 90 days
- Client has an auditory screening showing an average hearing of 45 dBHL or greater in both ears
- One or more of the following is documented in the client's record. The client is:
    - Unable to or has difficulty with conducting job duties with only one hearing aid.
    - Unable to or has difficulty with functioning in the school environment with only one hearing aid.
    - Unable to live safely in the community with only one hearing aid. Include a brief explanation of why the client's safety is a concern.
    - Legally blind.

> **Note:** If a client has been using one hearing aid for 90 days, and HCA authorizes a second hearing aid, bill for the second hearing aid using a monaural procedure code. Billing a binaural code in conjunction with a monaural code within 5 years is not allowed without prior authorization.

If clinical criteria are met, use EPA# 870001552. If the client does not meet the clinical criteria, prior authorization (PA) is required. HCA reviews PA requests according to WAC 182-501-0165.

To exceed these limitations, a limitation extension (LE) may be requested.

Replacements

HCA covers the following replacements only if the need for the replacement is not due to the client's carelessness, negligence, recklessness, deliberate intent, or misuse under **WAC 182-501-0050**:

- One replacement hearing aid, including the ear mold, in a 5-year period when the client's hearing aid(s) is lost or broken and cannot be repaired, and the warranty is expired
- One replacement ear mold, per year when the client's existing ear mold is damaged or no longer fits the client's ear
- Batteries

Repair of hearing aids

HCA covers two repairs, per hearing aid, per year, when the cost of the repair is less than 50% of the cost of a new hearing aid. To receive payment, all warranties must have expired, and the repair is under warranty for a minimum of 90 days.

Rental of hearing aids

HCA covers the rental of hearing aid(s) for up to 2 months while the client's own hearing aid(s) is being repaired. For rental hearing aid(s) only, HCA pays separately for an ear mold(s).

Cochlear implant services (clients age 21 and older)

Service procedure codes

CPT® code 69930 (unilateral or bilateral)

Medical necessity guidelines

Based upon review of **evidence provided by HTCC (20130517A—Cochlear Implants: Bilateral vs. Unilateral),** HCA considers cochlear implant devices to be medically necessary when the following guidelines are met:

- Client has bilateral severe to profound sensorineural hearing loss

- Client has limited or no benefit from hearing aids
- Client has the cognitive ability and willingness to participate in an extensive auditory rehabilitation program
- Client has freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- Client has no other contraindications for surgery
- Device is used in accordance with the FDA-approved labeling.

Implantation may be performed unilaterally or bilaterally.

Fee-for-service (FFS) billing instructions

For clients 21 years of age and older: Prior authorization (PA) is required. HCA reviews PA requests according to WAC 182-501-0165.

Cochlear implant devices and bone conduction hearing devices

(Repair or replacement of external parts)

HCA covers the following:

- Repair or replacement of external parts of cochlear implant devices. If the client has bilateral cochlear implant devices, both devices are eligible for repair and replacement of external parts.
- Repair or replacement of external parts of bone conduction hearing aids, whether implanted or worn with a headband. If the client has bilateral bone conduction hearing aids, both devices are eligible for repair and replacement of external parts.

Prior authorization is required. See the **Coverage Table - Adults** for specific procedure codes.

> **Note**: For clients age 21 and older, HCA considers requests for removal, repair, or replacement of previously implanted cochlear or bone conduction hearing devices when medically necessary. Prior authorization is required. HCA does not pay for initial bone conduction hearing devices for clients age 21 and older.

Note: Auditory rehabilitation may be covered under other programs. Clients may be referred to an audiologist or speech language pathologist to determine the medical necessity of auditory rehabilitation. See the Physician-related services billing guide and the Outpatient rehabilitation billing guide for details.

What is not covered?

HCA does not cover the following items for clients age 21 and older:

- Tinnitus maskers
- Frequency modulation (FM) systems, including the computer-aided hearing devices for FM systems
- Nonprescription hearing aids or similar devices including, but not limited to, the following:
  - Personal sound amplification products (PSAPs)
  - Hearables
  - Pocket talkers or similar devices

Exception to Rule (ETR)

HCA evaluates a request for medical services, equipment, and 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.

See What documentation is required when requesting PA or ETR? for details on submitting requests for ETR.

See Where can I download HCA forms?

Coverage Table – Adults

The following procedure codes are the **only procedure codes** HCA pays for under the Hearing Services program. Bill your usual and customary charge. HCA's payment is the lesser of the billed charge or the maximum allowable fee.

Type	Procedure Code	Short Description	Modifier	PA?	Policy Comments
Monaural	V5050	Hearing aid monaural in ear	RR, LT, RT	No	Billed as a rental only
Monaural	V5060	Behind ear hearing aid	RR, LT, RT	No	Billed as a rental only
Monaural	V5256	Hearing aid, digit, mon, ite	RA, LT, RT	No	For average hearing loss 45 dBHLs or greater. Bundled rate includes all the following: • An audiometric evaluation • An impression for an ear mold • An ear mold • The fitting fee, which includes up to three follow-up visits for the fitting, orientation, and checking of the hearing aid • The dispensing fee • A conformity evaluation, if done • Three batteries When billing for a **second hearing aid,** use EPA #870001552. If client does not meet EPA clinical criteria, PA is required.

Type	Procedure Code	Short Description	Modifier	PA?	Policy Comments
Monaural	V5257	Hearing aid, digit, mon, bte	RA, LT, RT	No	Same as V5256
Binaural	V5260	Hearing aid, digit, bin, ite	RA	Yes	Do not bill in conjunction with a monaural hearing aid
Binaural	V5261	Hearing aid, digit, bin, bte	RA	Yes	Do not bill in conjunction with a monaural hearing aid
CROS/ BiCros	V5171	Hearing aid monaural bte		Yes	Invoice required
CROS/ BiCROS	V5181	Hearing aid monaural bte		Yes	Invoice required
CROS/ BiCROS	V5211	Hearing aid binaural ite/ite		Yes	Invoice required
CROS/ BiCROS	V5213	Hearing aid binaural ite/bte		Yes	Invoice required
CROS/ BiCROS	V5215	Hearing aid binaural itc/bte		Yes	Invoice required
CROS/ BiCROS	V5221	Hearing aid binaural bte/bte		Yes	Invoice required
Other	V5011	Hearing aid fitting/checking		Use EPA #870001600. If the client does not meet EPA clinical criteria, PA is required	Allowed up to 3 times per year for additional follow-up visits only after the initial 3 visits bundled with each new hearing aid are used
Other	V5040	Body-worn hearing aid bone			

Type	Procedure Code	Short Description	Modifier	PA?	Policy Comments
Other	V5264	Ear mold/insert	RA, RT, LT		Limit one per calendar year, replacement only
Other	V5266	Battery for hearing device			
Other	V5275	Ear impression	RA, RT, LT	Use EPA #870001599. If the client does not meet clinical criteria, PA is required	**Clinical criteria:** Limit one per calendar year replacement only, per hearing aid if needed.
Other	V5014	Hearing aid repair/modifying	RB, RT, LT, (for casing only)		
Other	V5298	Hearing aid noc			

Legend Modifier Descriptions

RA = Replacement of DME Item
RB = Replacement part of DME item
LT = Left
RT = Right
RR = Rental

Note: If a client has been using one hearing aid for 90 days and HCA authorizes a second hearing aid, bill for the second hearing aid using a monaural procedure code. Billing a binaural code in conjunction with a monaural code within 5 years is not allowed without prior authorization.

HCPCS Code	Short Description	Authorization?	Policy
L7510	Prosthetic device repair rep	PA	
L8614	Cochlear device	Yes. PA required	
L8615	Coch implant headset replace	Use EPA #870000001. If clients do not meet EPA clinical criteria, PA is required	
L8616	Coch implant microphone repl	Same as L8615	
L8617	Coch implant trans coil repl	Same as L8615	
L8618	Coch implant tran cable repl	Same as L8615	
L8619	Coch imp ext proc/contr rplc	PA	PA
L8621	Repl zinc air battery	Same as L8615	
L8622	Repl alkaline battery	Same as L8615	
L8623	Lith ion batt CID non-earlyl	Same as L8615	
L8624	Lith ion batt CID, earl level	Same as L8615	
L8625	Charger coch impl/aoi battry	PA	Replacement only, each
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	PA	Replacement only, each
L8694	Aoi transducer/actuator repl	PA	Replacement only, each

HCPCS Code	Short Description	Authorization?	Policy
L9900	O&P supply/accessory/ service	PA	

Legend – Authorization Descriptions

EPA = Expedited prior authorization
PA = Prior authorization

Where can I find the fee schedule?

See HCA's Hearing Services Fee Schedule webpage.

Washington State Health Care Authority

Authorization – Children

What is prior authorization (PA)?

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

Does HCA require prior authorization for hearing services?

No. Except for certain services specified in the Coverage Table - Children, PA is not required for clients age 20 and younger for hearing aids and services.

> **Note:** HCA pays for services according to the early and periodic screening, diagnostic, and treatment (EPSDT) provisions, as described in chapter 182-534 WAC. The standard for coverage for EPSDT is that services, treatment, or other measures are medically necessary, safe and effective, and not experimental.

Providers must send claims for clients age 20 and younger directly to HCA. Providers do not need to obtain authorization from the local Children with Special Health Care Needs (CSHCN) Coordinator.

What is expedited prior authorization (EPA)?

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

HCA 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 HCA upon request.

> **Note:** When billing electronically, enter the EPA number in the *Prior Authorization* section.

Replacement parts - EPA criteria

The following EPA criteria must be met:

- The cochlear implant device or bone conduction hearing device 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 device or bone conduction hearing device replacement parts.

What documentation is required when requesting PA or ETR?

Providers may submit requests for prior authorization online through direct entry into ProviderOne (see HCA's **prior authorization webpage** for details), or by faxing the following toll-free to 1-866-668-1214:

- A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form MUST be the initial page when you submit your request.
- A completed *Hearing Aid Authorization Request* form, HCA 13-772, and all the documentation listed on this form and any other medical justification.

To access forms, see **Where can I download HCA forms?**

Washington State Health Care Authority

Authorization - Adults

What is prior authorization (PA)?

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

What requires prior authorization?

HCA requires prior authorization (PA) for binaural hearing aids for eligible clients age 21 and older.

> **Note:** HCA 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.

What is expedited prior authorization (EPA)?

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

HCA 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 HCA upon request.

> **Note:** When billing electronically, enter the EPA number in the Prior Authorization section.

Replacement parts - EPA criteria

The following EPA criteria must be met:

- The cochlear implant device or bone conduction hearing device 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. HCA reviews PA requests according to WAC 182-501-0165.

Use EPA 870000001 with HCPCS codes L8615-L8618, L8621-L8624 when billing for cochlear implant device or bone conduction hearing device replacement parts.

What documentation is required when requesting PA or ETR?

Providers may submit requests for PA online through direct entry into ProviderOne (see HCA's **prior authorization webpage** for details). Providers must complete the *Hearing Aid Authorization Request* form, HCA 13-772, attach all documentation listed on the form, and provide medical justification.

Providers may also submit their requests for PA by faxing the following toll free to: 1-866-668-1214:

- A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form MUST be the initial page when you submit your request.
- A completed *Hearing Aid Authorization Request* form, HCA 13-772, and all the documentation listed on this form and any other medical justification.

To access forms, see **Where can I download HCA forms**?

> **Note:** When HCA authorizes hearing aids or hearing aid-related 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.

What are limitation extensions?

Limitation extensions (LEs) are requests to authorize covered services beyond the limit regarding scope, amount, duration, or frequency of a covered service. HCA does not approve LEs when prohibited by program rules. When an LE is permissible, the client's provider must establish that it satisfies criteria in **WAC 182-501-0169**, including being medically necessary.

> **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?

You may request an LE two ways:

- Providers may be able to obtain authorization for an LE using an EPA number. These EPA numbers are subject to post payment review as in any other authorization process. (See: **What is Expedited prior authorization (EPA))**
- In cases where the client's situation does not meet the EPA criteria for an LE, but additional services appear medically necessary, providers may submit LE requests online through direct entry into ProviderOne (see HCA's **prior authorization webpage** for details), or by faxing the following toll-free to 1-866-668-1214:

- A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form MUST be the initial page when you submit your request.
- A completed *Hearing Aid Authorization Request* form, HCA 13-772, and all the documentation listed on this form and any other medical justification.

To access forms, see **Where can I download HCA forms?**

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information, see the agency's **ProviderOne Billing and Resource Guide webpage** and scroll down to *Paperless billing at HCA*.

For providers approved to bill paper claims, visit the same webpage and scroll down to *Paper Claim Billing Resource*.

What are the general billing requirements?

Providers must follow HCA's **ProviderOne billing and resource guide**. These billing requirements include the following:

- 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 HCA's **Billing a Client" webinar presentation**.

What records 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

A valid prescription from an audiologist for replacement batteries must be kept in the client's chart.

> **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.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**.

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**.

Note: The agency processes hardware claims using one of the following billing taxonomies:

- 237600000X
- 237700000X
- 332S00000X

The following claim instructions relate to the Hearing Services program.

Name	Field Required	Entry
Reserved for local use	When applicable	Enter either of the following: **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 CPT or HCPCS procedure code for the services being billed Modifier: When appropriate, enter a modifier

About the program – DDA Clients

When does the Division of Developmental Disabilities (DDA) pay for hearing aids?

DDA 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.

Washington State Health Care Authority

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?

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. 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 code list 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

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 services (clients age 21 and older)

Service procedure codes

CPT® code 69930 (unilateral or bilateral)

Medical necessity guidelines

Based upon review of **evidence provided by HTCC (20130517A—Cochlear Implants: Bilateral vs. Unilateral),** HCA considers cochlear implant devices to be medically necessary when the following guidelines are met:

- Client has bilateral severe to profound sensorineural hearing loss
- Client has limited or no benefit from hearing aids
- Client has the cognitive ability and willingness to participate in an extensive auditory rehabilitation program
- Client has freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- Client has no other contraindications for surgery
- Device is used in accordance with the FDA-approved labeling.

Implantation may be performed unilaterally or bilaterally.

Fee-for-service (FFS) billing instructions

For clients 20 years of age and younger: If the medical necessity guidelines are met, use EPA# **870000423** for unilateral and EPA# **870001365** for bilateral.

If the medical necessity guidelines are not met, providers may request prior authorization (PA). HCA reviews requests for PA according to WAC 182-501-0165.

Cochlear implant device – replacement parts

The administration covers:

- Cochlear implant device external speech processors, including maintenance, repair, and batteries.
- Bone conduction hearing device speech processors, including maintenance, repair, and batteries.

See the **social services blanket code list** for specific procedure codes.

The administration pays for cochlear implant device or bone conduction hearing device 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 182-501-0050).

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.

What is not covered?

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

See the social services blanket code list for covered procedure codes.

What can I find the fee schedule?

See HCA's Hearing Services Fee Schedule webpage.

Authorization

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 may request authorization of hearing services through the Washington State Developmental Disabilities Administration (DDA) Home and Community Based waiver benefit by contacting the client's case manager. The provider can assist the client or representative in requesting a social services authorization by providing the following information to the DDA case manager:

- Reason for denial through the client's Apple Health benefit
- 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 Services Fee Schedule
- How the hearing services 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 Services Fee Schedule**.

Billing

What are the general billing requirements?

Providers must follow the Apple Health ProviderOne billing and resource guide. These billing requirements include the following:

- 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?

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

A valid prescription from an audiologist for replacement batteries must be kept in the client's chart.

> **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.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**.

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 Services 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.