Washington State Health Care Authority

Medicaid Provider Guide

Hearing Hardware for Clients 20 years of Age and Younger

[Chapter 182-547 WAC]

A Billing Instruction

Copyright Disclosure

About this publication

This publication supersedes all previous *Hearing Hardware for Clients 20 Years of Age and Younger Billing Instructions* and # Memos published by the Washington State Health Care Authority

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

Effective Date

The effective date of this publication is: **07/01/2011**.

2011 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Page Affected

How Can I Get Agency Provider Documents?

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

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

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

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Important Contacts

Note: This section contains important contact information relevant to Hearing Hardware. For more contact information, see the agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

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

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the agency's *Medical Assistance Glossary* at http://hrsa.dshs.wa.gov/download/medical_assistance_glossary.htm for a more complete list of definitions..

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

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

Deafness - Complete or partial loss of ability to hear.

Digital Hearing Aids – Hearing aids that use a digital circuit to analyze and process sound. [WAC 182-547-0200]

FM Systems – Devices used to improve and augment access to auditory information in poor acoustic conditions (helps mitigate a negative impact of noise and reverberation on the ability to understand) that are found in classrooms, auditoriums, theaters, restaurants, etc. These devices use frequency modulated (FM) radio signals to transmit the primary auditory signal from a microphone/transmitter to a receiver worn by the person. [WAC 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 Healthcare Professional – An audiologist or hearing aid fitter/dispenser licensed under Chapter 18.35 RCW, or an otorhinolaryngologist or otologist licensed under Chapter 18.71 RCW. [WAC 182-547-0200]

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

Maximum Allowable Fee - The maximum dollar amount that the agency or agency's designee 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 aids and service(s). The approval is based on medical necessity and must be received before service(s) are provided to clients as a precondition for payment. [WAC 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.*

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

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

About the Program

General Information About the Program

[Refer to WAC 182-547-0100]

The agency or agency's designee covers the hearing aid services listed in these billing instructions, according to applicable agency rules and subject to the limitations and requirements in these billing instructions.

The agency or agency's designee pays for hearing aids and services when:

- Covered.
- Within the scope of an eligible client's Benefit Service Package;
- Medically necessary;
- Authorized as required within these billing instructions and Chapters 182-501 and 182-502 WAC;
- Billed according to these billing instructions and Chapters 182-501 and 182-502 WAC; and
- Clients are 20 years of age and younger and complete a hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test performed and/or interpreted by a hearing healthcare professional.

The agency or agency's designee requires prior authorization for covered hearing aid services when the clinical criteria set forth in these billing instructions are not met. The agency or agency's designee evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 182-501-0165.

Client Eligibility

Who Is Eligible? [Refer to WAC 182-547-0700(1)]

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

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

Clients 20 years of age and younger-who are receiving services under a Benefit Services Package:

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

Clients Enrolled in an agency-Contracted Managed Care Organization [WAC 182-547-0700(2)]

Hearing aid services are not covered under the agency's managed care plans. Clients who are enrolled in an agency-contracted managed organization (MCO) are eligible under fee-for-service for covered hearing aid services that are not covered by their MCO. In those cases, bill the agency or agency's designee directly. However, clients enrolled in an agency-contracted MCO must obtain replacement parts for cochlear implants and bone anchored hearing aids (BAHA) through their MCO.

Coverage

What Is Covered? [Refer to WAC 182-547-0800]

Purchase

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

Replacement

The agency or agency's designee pays for:

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

Repair

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

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

Rental

The agency or agency's designee 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 or agency's designee pays separately for an ear mold(s).

Cochlear Implant Replacement Parts

Coverage [Refer to WAC 182-547-0800 (3)]

The agency or agency's designee pays for unilateral cochlear implant and osseointegrated hearing aids (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); and
- The part is not an external speech processor (these require written/fax authorization).

Prior Authorization (PA)

The agency or agency's designee requires PA for certain replacement parts when using the following codes:

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

Expedited Prior Authorization (EPA)

The agency or agency's designee requires EPA for replacement parts for cochlear implants when using the following codes:

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

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

Payment [Refer to WAC 182-547-0800 (4) (5)]

The agency or agency's designee will pay for, maintain, and repair only one cochlear implant external speech processor and one BAHA speech processor and other necessary parts unless:

- ✓ An exception to rule has been approved; and
- ✓ The agency or agency's designee originally paid for two cochlear implants.

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

The agency or agency's designee will only purchase unilateral cochlear implantation supplies and repairs unless the agency or agency's designee authorized bilateral cochlear implantation.

When reimbursing for battery packs, the agency or agency's designee covers the least costly, equally effective product.

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

The agency or agency's designee 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 Expedited Prior Authorization?

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

To bill the agency or agency's designee for diagnoses, procedures and services that meet EPA criteria on the following pages providers must **create a 9-digit EPA number** as follows:

- The first 5 or 6 digits of the EPA number must be **87000** or **870000**; and
- The last 3 or 4 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria.

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

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

> **Note:** When billing using a paper claim form enter the EPA number in *field 23*, or when billing electronically enter the EPA number in the *Authorization* or *Comments* field.

Expedited Prior Authorization Criteria for Cochlear Implant and Bone Conduction (Baha®) Replacement Parts

Use EPA 870000001 with **HCPCS Codes L8615-L8618, L8621-L8624** for cochlear implant and bone conduction (Baha®) replacement parts when the required criteria are met as follows:

- Unilateral Cochlear Implant or bone conduction (Baha®) (bilateral requires PA);
- The manufacturer's warranty has expired;
- The part is for immediate use, not a back-up part; and
- The part is not an external speech processor (these require prior authorization.

What Is Not Covered? [Refer to WAC 182-547-0900]

The agency or agency's designee does not cover the following hearing and hearing aid-related items and services-for clients 20 years of age and younger:

- Batteries or tinnitus maskers;

- Group screenings for hearing loss, except as provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (refer to the agency's *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Instructions;* or

- Computer-aided hearing devices for FM systems used in school.

When EPSDT applies, the agency or agency's designee 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.

Exception to Rule (ETR)

The agency or agency's designee 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.

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

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

Coverage Table

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

Note: Reimbursement for all hearing instruments dispensed includes:

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

Legend

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

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

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

Legend

EPA: Expedited Prior Authorization
PA: Prior Authorization required

Prior Authorization

What Is Prior Authorization?

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

Does the agency or agency's Designee Require Prior Authorization? [WAC 182-547-1000]

NO. Except for certain services specified in the Coverage Table, PA is **not** required for clients 20 years of age and younger for hearing aids and services. Providers should send claims for clients 20 years of age and younger-directly to the agency, or Agency's designee. **Providers do not need to obtain authorization from the local Children with Special Health Care Needs (CSHCN) Coordinator.**

> **Note:** The agency or agency's designee 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 Are Limitation Extensions?

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

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

How Do I Request a Limitation Extension?

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

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

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

The request must state the following in writing:

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

Send your written request for an LE to:

Fax your written request for an LE to the agency or agency's designee at 1-866-668-1214.

Payment

What Does the agency or agency's Designee Pay for?
[WAC 182-547-1100 (1)]

The agency or agency's designee payment for purchased hearing aids includes:

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

When Does the agency or Agency's Designee Deny Payment?
[WAC 182-547-1100 (2)]

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

What Does the agency or Agency's Designee Not Pay for?
[WAC 182-547-1100 (3)]

The agency or agency's designee 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)]**

Fee Schedule

You may view the agency's **Hearing Hardware Fee Schedule** on-line at http://hrsa.dshs.wa.gov/RBRVS/Index.html

Billing and Claim Forms

What Are the General Billing Requirements?

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

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

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

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

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

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

Completing the CMS-1500 Claim Form

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

The following CMS-1500 claim form instructions relate to the **Hearing Hardware program**.

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