



Hearing Hardware for Clients 20 Years of Age and Younger Provider Guide

September 1, 2014

Washington State
Health Care Authority

About this guide*

This publication takes effect September 1, 2014, and supersedes earlier guides to this program.

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
Definitions	Changed bone-anchored hearing aid to BAHA. Also updated the definition.	Discontinued spelling out BAHA. Not all BAHAs are bone anchored and it is confusing billers.
Are clients enrolled in managed care eligible?	Revised to clarify which services are covered under the MCO and which services are covered under fee-for-service	Clarify for billing purposes
What documentation must be kept in the client's file?	Added "all services rendered, whether a test, evaluation, office visit, or repair" – also added "all invoices for parts and labor"	Clarify documentation keeping requirements

Additional resources

To download and print agency provider guides, see the agency's [Provider Publications website](#). For additional resources, see the agency's online list of [Resources Available](#).

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

* This publication is a billing instruction.


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Alert! The page numbers in this table of contents are now “clickable”—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks  on the left side of the document. (If you don’t immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Definitions

This section defines terms and abbreviations, including acronyms, used in this guide. Please refer to the agency's online [Washington Apple Health Glossary](#) for a more complete list of definitions.

BAHA – Auditory sound processors that allow wearers to hear by vibrating sound to the cochlea, or inner ear, by bone conduction. These sound processors are attached to a post implanted in the skull or held against the skull with a soft headband. Regardless of how these devices are held in position, they are considered BAHAs.

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.

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.*

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 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](#).
- Provided to an eligible client. (See [Who is eligible?](#))

Client Eligibility

How can I verify a patient's eligibility?

([WAC 182-547-0700\(1\)](#))

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

Verifying eligibility is a two-step process:

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

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

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

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

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

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Hearing Hardware for Clients 20 Years of Age and Younger

Clients 20 years of age and younger who are receiving services under a Benefit 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 [Physician-Related Services/Health Care Professional Services](#) Provider Guide.
- Must have a complete hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed by a hearing health care professional.
- Must be referred by a licensed audiologist, otorhinolaryngologist, or otologist for a hearing aid.

Are clients enrolled in an agency-contracted managed care organization eligible?

[\(WAC 182-547-0700\(2\)\)](#)

- **Hearing aids, including fitting, follow-up care, batteries, and repair, are not covered under agency-contracted managed care organizations (MCO).** These services are covered under fee-for-service. Providers must bill the agency directly using V-series HCPCS procedure codes.
- **Cochlear implants and BAHAs are covered by the agency-contracted MCOs.** This includes BAHA devices (both surgically implanted and soft band headbands), replacement parts, and batteries.

Coverage

What is covered?

([WAC 182-547-0800](#))

Monaural or binaural hearing aids

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

See the [Coverage Table](#) for specific procedure codes.

Replacement

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

- Hearing aid(s), which includes the ear mold, when all warranties are expired and the hearing aid(s) are one of the following:
 - ✓ Lost
 - ✓ Beyond repair
 - ✓ Not sufficient for the client's hearing loss
- Ear mold(s) when the client's existing ear mold is damaged or no longer fits the client's ear.
- Batteries with a valid prescription from an audiologist.

Repair

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

- One cochlear implant external speech processor, including maintenance, repair, and batteries.
- One BAHA speech processor, including maintenance, repair, and batteries.

See the [Coverage Table](#) for specific procedure codes.

The agency pays for unilateral cochlear implant and BAHA replacement parts when all of the following are met:

- 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.

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

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 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 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 20 years of age 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 Instructions](#))
- 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.

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 for
Clients 20 Years of Age and Younger**

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
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
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 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. **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 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.

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.
- A completed Hearing Aid Authorization Request form, [13-772](#), and all the documentation listed on this form and any other medical justification.

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

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 of 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](#).

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include the following:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- 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

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

All services rendered, whether a test, evaluation, office visit, or repair must be clearly documented in the client's medical record. All invoices for parts and labor must also be kept.

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 complete the CMS-1500 claim form?

Note: Refer to the agency's [ProviderOne Billing and Resource Guide](#) at for general instructions on completing the CMS-1500 claim form.

The table below indicates which fields on the CMS-1500 form have specific requirements regarding the Hearing Hardware program.

Field No.	Name	Field Required	Entry
19.	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.
23.	Prior Authorization Number	When applicable	Use the prior authorization number assigned to you if/when services are 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