

10 Audiology/Hearing Services

Audiological function tests and hearing aids are limited to Medicaid recipients who are eligible for treatment under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. These services do not require an EPSDT referral. See chapter 39 for Patient 1st referral requirements. Hearing aids are provided through hearing aid dealers who are contracted to participate in the Alabama Medicaid Hearing Aid Program.

An eligible recipient with hearing problems may be referred to a private physician or to a Children's Specialty Clinic for medical evaluation.

The policy provisions for audiology and hearing services providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 19.

10.1 Enrollment

HPE enrolls hearing services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, *Becoming a Medicaid Provider*, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Only in-state and bordering out-of-state (within 30 miles of the Alabama state line) audiology and hearing aid providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid program.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an Audiology/hearing provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hearing-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Providers are assigned the following valid provider type and specialty:

- Audiology 20/200
- Hearing Aid Dealer 22/220

Enrollment Policy for Audiology Providers

Audiologists must hold a valid State license issued by the state in which they practice.

HPE is responsible for enrollment of audiologists. Licensed audiologists desiring to participate in the Alabama Medicaid Program must furnish the following information to HPE as part of the required enrollment application:

- Name
- Address
- Specialty provider type
- Social Security Number
- Tax ID Number
- Copy of current State license

Hearing Aid Dealers

Dealers must hold a valid license issued by the Alabama Board of Hearing Aid Dealers, as issued by the state in which the business is located.

10.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/Medically Necessary Care.

10.2.1 Cochlear Implants, Auditory Brain Stem Implants, Implantable Bone Anchored Hearing Aids and Soft Band Bone Conduction Hearing Aids

Cochlear Implants (69930)

Prior authorization for the preoperative evaluation and the implantation must be requested by a Medicaid-approved *cochlear implant team surgeon*, using the Authorization for Cochlear Implants Form (PHY-96-11). Follow this link to retrieve the form:

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_PA_Cochlear_Implant_Form96-11_1-6-06.pdf.

Specialty Code 740 is needed to enroll for Cochlear Implants.

The Criteria for the Team members is as follows;

1. Surgeon Board certified otolaryngologist
Completion of Nucleus Pediatric Cochlear Implant Surgeons' Course
or show evidence of training during residency.
Successfully performed previous Pediatric Cochlear Implantations
2. Audiologist Master's degree from an accredited institution
Certificate of Clinical competence in audiology
Alabama License in audiology
Completion of the Cochlear Implant Workshop
3. Speech/Language Pathologist
Master's degree from an accredited institution
Certificate of Clinical Competence in Speech/Language Pathology
Alabama License in Speech/Language Pathology
Experience in auditory-verbal and total communications methodologies
4. Rehabilitation Specialist-not required as part of the team, but must have available for consultation the following professionals:
Psychologists
Social Workers
Physical Therapists
Occupational Therapist

Medicaid may reimburse for cochlear implant services for recipients who meet the following criteria:

1. EPSDT referral
2. Chronological age 1 through 20 years of age
3. Severe to Profound (70 decibels or above) sensorineural hearing loss bilaterally and minimal speech perception under best aided conditions
4. Minimal or no benefit obtained from a hearing (a vibrotactile) aid as demonstrated by failure to improve on age appropriate closed-set word identification task. Appropriate amplification and rehabilitation for a minimum six-month trial period is required to assess the potential for aided benefit. Benefits may be extended to candidates with severe hearing impairment and open-set sentence discrimination that is less than or equal to 30 percent in the best aided conditions.
5. No medical or radiological contraindications, and otologically stable and free of active middle ear disease prior to cochlear implantation.
6. Families/caregivers and possible candidates well-motivated. Education must be conducted to ensure parental understanding of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the child's therapeutic program and the ability to adequately care for the external equipment.

Effective June 1, 2002, Medicaid will reimburse for a personal FM system for use by a cochlear implant recipient when prior authorized by Medicaid and not available by any other source. The replacement of lost or damaged external components (when not covered under the manufacturer's warranty) will be a covered service when prior authorized by Medicaid.

Reimbursements for manufacturer's upgrades will not be made within the first three years following initial implantation.

Prior Authorization Procedures are as follows:

1. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.
2. The prior authorization number issued for the cochlear implant must be indicated in the clinical statement section of form 342.
3. Additional medical documentation supporting medical necessity for repairs to or replacement of minor parts for cochlear external processor (L7510), replacement of the cochlear Implant Processor (L8619) or ancillary accessories, should be attached.

Auditory Brain Stem Implants (ABI) (S2235)

An ABI is covered and requires prior authorization. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

Medicaid may reimburse for ABI services for recipients who meet the following criteria:

1. Must be 12-20 years of age
2. Physician notes must indicate the diagnosis of Neurofibromatosis Type II
3. Medical assessment to ensure candidate is able to tolerate surgery
4. Documentation of anticipatory guidance to child/parents concerning expected outcomes, complications, and possible aural rehabilitation

Implantable Bone Anchored Hearing Aids (BAHA) (69714, 69715, 69717, 69718)

An Osseointegrated Implant (BAHA) is covered and requires prior authorization. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

Medicaid may reimburse for osseointegrated implant services for recipients who meet the following criteria:

1. Must be 5-20 years of age; and
2. Congenital or surgically induced malformations of the external ear canal or middle ear; or
3. Chronic external otitis or otitis media when a conventional hearing aid cannot be worn; or
4. Tumors of the external canal.

5. Must all meet audiologic criteria of: A bone conduction pure-tone average of 65 decibels or better, with no single frequency poorer than 70 decibels (at 1000 and 2000Hz) and speech discrimination score better than 60%.

For Single Sided Deafness (SSD), criteria are as follows:

1. Must be 5-20 years of age; and
2. Bone conduction of 35-40 dB or better in the contralateral ear.

Soft Band Bone Conduction Hearing Aid (L8692)

The osseointegrated device, external sound processor, used without osseointegration (soft band device without surgically implanted components) is covered for recipients less than 21 years of age whose moderate to severe bilateral, conductive or mixed hearing loss cannot be effectively restored by conventional air conduction aids or a conventional bone conduction hearing aid.

Prior approval is required for all new soft band bone conduction hearing aids. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

Medicaid may reimburse for the soft band hearing aid for recipients who meet the age requirement and the following criteria:

- Congenital or surgically induced malformations of the external ear canal or middle ear that precludes the wearing of a conventional air conduction hearing aid; or
- Chronic external otitis or otitis media with persistent discharge when a conventional hearing aid cannot be worn; or
- Tumors of the external canal and/or tympanic cavity; or
- Dermatitis of the external canal
- Must also meet audiologic criteria of: a bone conduction pure-tone average of 40-50 decibels or better, with no single frequency poorer than 50 decibels (at 1000 and 2000 Hz); *and* speech discrimination score better than 60%, except when the child is too young or developmental delays inhibit the ability to perform the speech discrimination testing
- Documentation submitted will include a copy of the medical clearance from an EENT or Otolaryngologist, a letter of medical necessity from the treating audiologist, and audiology report to include audiogram(s), evaluation, speech and sound tests (if possible to obtain), future surgery information and documentation substantiating that hearing loss cannot be effectively restored by conventional air conduction or conventional bone conduction hearing aids.
- For children deemed inappropriate for surgery, documentation in the form of a physician's statement that describes why the child would not be a candidate for surgical implantation should be submitted
- Additional documentation will be requested as needed

Upgrades to existing, functioning, replaceable sound processors to achieve aesthetic improvement are not medically necessary and will not be covered.

If the request for a sound processor, battery replacement, or repair is for spare or back-up equipment for use in emergencies it will not be covered. Replacement and repair are handled under any warranty coverage an item may have. No charge to Medicaid is allowed for replacement and repairs covered under warranty.

Children under the age of 5 yrs. that have unilateral sensorineural hearing loss (single sided deafness) will not be covered. Children with a speech discrimination score at elevated sound pressure levels (SPL) of less than 60% would not benefit from this device.

10.2.2 Procedure Codes and Modifiers

Audiological function tests must be referred by the attending physician before testing begins. The (837) Professional electronic claim has been modified to accept up to four Procedure Code Modifiers.

Audiology Tests

The following CPT codes represent comprehensive audiological tests that may be performed each calendar year. Additional exams may be performed as needed when medically necessary to diagnose and test hearing defects.

Procedure Code	Description
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
92534	Optokinetic nystagmus
92537	Assessment and recording of balance system during hot and cold irrigation of both ears
92538	Assessment and recording of balance system during irrigation of both ears
92540	Basic Vestibular Evaluation
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions with recording
92544	Optokinetic nystagmus test, bi-directional, foreal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Torsion swing test, with recording
92547	Use of vertical electrodes in any or all of above vestibular function tests counts as one additional test
92557	Basic comprehensive audiometry (92553 & 92556 combined)
92582	Conditioning play audiometry (for children up to 5 years old)
92585	Brainstem evoked response recording (evoked response (EEG) audiometry)

Added: 92537 and 2538

Deleted: 92543

NOTE:

Procedure codes 92531-92547 are normally performed on adults; however, children are occasionally tested.

The following procedure codes are not included in the annual limitations.

Procedure Code	Description
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	Pure tone audiometry (threshold); air and bone
92555	Speech audiometry; threshold only
92556	Speech audiometry; threshold and discrimination
92557	Comprehensive audiometry threshold
92558	Evoked otoacoustic emissions; screening, automated analysis.
92560	Bekesy audiometry; screening
92561	Bekesy audiometry; diagnostic
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92570	Acoustic immittance testing
92571	Filtered speech test
92572	Staggered spondaic word test
92573	Lombard test
92575	Sensorineural activity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92583	Select picture audiometry
92584	Electrocochleography
92585	Brainstem evoked response recording
92586	Auditory evoked potentials for
92587	Evoked otoacoustic emissions
92588	Comprehensive/diagnostic evaluation
92590	Hearing aid examination and selection; monaural
92591	Hearing aid examination and selection; binaural
92592	Hearing aid check; monaural
92593	Hearing aid check; binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630	Auditory Rehabilitation; pre-lingual hearing loss
92633	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour

Cochlear & Auditory Brain Stem Implants (ABI) and BAHA System

Procedure Code	Description
69930**	Cochlear Device Implantation (See NOTE below)
69714**	Implantation, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715**	Implantation, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech

Procedure Code	Description
	processor/cochlear stimulator; with mastoidectomy
69717**	Replacement, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718**	Replacement, osseointegrated implant, temporal bone, with percutaneous or transcutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
92601	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; with programming.
92602	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; subsequent reprogramming.
92603	Diagnostic analysis of Cochlear Implant, age 7 years or older, with programming.
92604	Diagnostic analysis of Cochlear Implant, age 7 years of age or older; subsequent reprogramming.
92507*	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Group, two or more individuals
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630*	Auditory Rehabilitation; pre-lingual hearing loss
92633*	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour
L7368-RB**	Lithium ion battery charger
L7510-RB**	Repair of prosthetic device, repair or replace minor parts. Will reimburse at invoice price.
L8615**	Headset/headpiece for use with cochlear implant device, replacement
L8616**	Microphone for use with cochlear implant device, replacement
L8617**	Transmitting coil for use with cochlear implant device, replacement
L8618**	Transmitter cable for use with cochlear implant device, replacement
L8619**	Cochlear implant, external speech processor and controller, integrated system replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8623**	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each
L8624**	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement
L8627**	Cochlear Implant, external speech processor, component, replacement
L8628**	Cochlear Implant, external controller component, replacement
L8691**	Auditory osseointegrated device, external sound processor, replacement
L8692**	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code. Use to bill for BAHA soft band headband replacement.
S2235**	Implantation of Auditory Brain Stem Implant

*Cannot bill 92507 on the same day as 92630 or 92633

**Requires Prior Authorization

Effective January 1, 2014 and thereafter, procedure codes L7510 and L7368 must be filed with modifier RB

NOTE:

The Cochlear, ABI and BAHA Implantable Device is purchased at contract price established by hospital and supplier and covered through the hospital per diem.

Hearing Aid Monaural

<i>Procedure Code</i>	<i>Description</i>
V5030	Hearing aid, monaural, body worn, air conduction
V5040	Hearing aid, monaural, body worn, bone conduction
V5050	Hearing aid, monaural, in the ear
V5060	Hearing aid, monaural, behind the ear
V5070	Glasses, air conduction
V5080	Glasses, bone conduction
V5244	Hearing aid, digitally programmable analog, monaural, completely in the ear canal
V5245	Hearing aid, digitally programmable analog, monaural, in the canal
V5246	Hearing aid, digitally programmable analog, monaural, in the ear
V5247	Hearing aid, digitally programmable analog, monaural, behind the ear
V5254	Hearing aid, digital, monaural, completely in the ear canal
V5255	Hearing aid, digital, monaural, in the canal
V5256	Hearing aid, digital, monaural, in the ear
V5257	Hearing aid, digital, monaural, behind the ear

Hearing Aid Binaural

Binaural aids should be billed with one unit.

<i>Procedure Code</i>	<i>Description</i>
V5100	Hearing Aid, bilateral, body worn
V5120	Binaural, body
V5130	Binaural, in the Ear
V5140	Binaural, behind the Ear
V5150	Binaural, glasses
V5210	Hearing aid, bicros, in the Ear
V5220	Hearing aid, bicros, behind the Ear
V5250	Hearing aid, digitally programmable analog, binaural, completely in the ear canal
V5251	Hearing aid, digitally programmable analog, binaural, in the canal
V5252	Hearing aid, digitally programmable analog, binaural, in the ear
V5253	Hearing aid, digitally programmable analog, binaural, behind the ear
V5258	Hearing aid, digital, binaural, completely in the ear canal
V5259	Hearing aid, digital, binaural, in the canal
V5260	Hearing aid, digital, binaural, in the ear
V5261	Hearing aid, digital, binaural, behind the ear

(Extra ear mold is a billable expense in connection with binaural aids.)

Hearing Aid Accessories

<i>Procedure Code</i>	<i>Description</i>
V5298	Hearing aid, not otherwise classified
V5266	Battery for use in hearing device (1 package for monaural aid and 2 packages for binaural aid every 2 months)
V5264	Ear Mold (1 package for monaural aid and 2 packages for binaural aid every 4 months)
V5014	Factory Repair of hearing aid, out of warranty (1 every 6 months for use with monaural aid and 2 every 4 months with binaural aid)
V5267	Hearing aid supplies/accessories include, but not limited to chin strap, clips, boot, and headband

When billing for hearing services, replacement items and supplies, providers should bill the actual acquisition cost.

10.3 Prior Authorization and Referral Requirements

Hearing services procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP). When an EPSDT referral is required for treatment of medically necessary services, the Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

10.4 Cost Sharing (Copayment)

Copayment does not apply to hearing services.

10.5 Completing the Claim Form

NOTE:

An audiologist employed by a physician cannot file a claim for the same services billed by that physician for the same patient, on the same date of service.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hearing services providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical/Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

10.5.1 Time Limit for Filing Claims

Medicaid requires all claims for hearing services to be filed within one year of the date of service. Refer to Chapter 5 Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

10.5.2 Diagnosis Codes

Hearing aid dealers must bill with one of the following diagnosis codes:

V72.11, V72.12 and V72.19 for ICD-9 and Z01.10, Z01.110, Z01.118, and Z01.12 for ICD-10.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

Audiologists are required to use a valid ICD-10 diagnosis code. The International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885 or 1-800-621-8335.

10.5.3 Place of Service Codes

The following place of service codes apply when filing claims for hearing services:

<i>POS Code</i>	<i>Description</i>
11	Office

10.5.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Chapter 5 for more information on required attachments.

10.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N