

Table of Contents

1.0	Description of the Service.....	1
2.0	Eligible Recipients.....	1
2.1	General Provisions.....	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age.....	1
3.0	When the Product or Service Is Covered.....	2
3.1	General Criteria.....	2
3.2	Specific Criteria.....	2
3.3	Speech Processor Upgrades.....	3
4.0	When the Product or Service Is Not Covered.....	3
4.1	General Criteria.....	4
4.2	Specific Criteria.....	4
5.0	Requirements for and Limitations on Coverage.....	4
5.1	Replacing or Repairing Cochlear and Auditory Brainstem Implant External Parts under Warranty.....	4
5.2	Prior Approval for Replacement Speech Processors.....	4
5.2.1	Prior Approval for Identical Replacement Speech Processors— Under Warranty.....	4
5.2.2	Prior Approval for Replacement Speech Processor—Out of Warranty.....	5
5.2.3	Prior Approval for Replacement Speech Processor—Upgrade.....	5
5.3	Documentation of Medical Necessity.....	5
5.3.1	Physician’s Prescription.....	5
5.3.2	Audiologist’s Letter.....	5
5.4	Delivery of Service.....	6
6.0	Providers Eligible to Bill for the Product or Service.....	6
7.0	Additional Requirements.....	6
7.1	Federal and State Requirements.....	6
7.2	Medical Record Documentation.....	6
7.3	Records Retention.....	6
7.4	Disclosing Ownership Information.....	7
7.5	Seeking Other Sources of Payment.....	7
7.6	Accepting Payment.....	7
8.0	Policy Implementation/Revision Information.....	7
Attachment A:	Claims-Related Information.....	8
A.	Claim Type.....	8
B.	Procedure Code(s).....	8
C.	Modifiers.....	8

D.	Billing Units.....	8	
E.	Medicare Crossover Claims.....	8	
F.	Place of Service	9	
G.	Co-Payments.....	9	
H.	Reimbursement	9	
I.	Payment Rates.....	9	
Attachment B: Cochlear Implant or Auditory Brainstem Implant External Parts Replacement and Repair Services: Instructions for Completing Claims			10
Attachment C: Lifetime Expectancy List for Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair			13
Attachment D: Instructions for Completing a Prior Approval Request Form for Replacement Speech Processors			14

1.0 Description of the Service

Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device's ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.

Refer to **Attachment A, Claims-Related Information**, for a detailed list of procedure codes and descriptions.

2.0 Eligible Recipients

2.1 General Provisions

Although there are no age limitations for cochlear and auditory brainstem implant external parts replacement and repair, Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is

medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

3.0 When the Product or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers cochlear and auditory brainstem implant external parts replacement and repair when it is medically necessary and

- a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs;
- b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

3.2 Specific Criteria

Cochlear and auditory brainstem implant external parts replacement and repair are covered when **all** of the following conditions are met:

- a. The implanted device being repaired is FDA approved and meets all Medicaid standards of coverage under Clinical Coverage Policy #1A4, *Cochlear and Auditory Brainstem Implant*.

- b. The implanted device is in continuous use and still meets the needs of the recipient.
- c. Replacement or repair is necessary to allow the implanted device to be functional.
- d. The treating, licensed audiologist has obtained a physician's prescription with complete information regarding the implant system and surgery date(s) and submitted it to the provider.

Refer to **Section 6.0, Providers Eligible to Bill for the Product or Service**, for specific criteria regarding eligible providers.

- e. The treating, licensed audiologist has established a written plan of care that substantiates the need for the replacement or repair of external part(s) and submitted it to the provider.

Refer to **Section 5.3, Documentation of Medical Necessity**, for specific criteria regarding required documentation from the treating, licensed audiologist.

- f. The component or service is furnished at a safe, efficacious, and cost-effective level.
- g. Additionally, all replacement speech processors require prior approval. Refer to Section 5.2, Prior Approval for Replacement Speech Processors, for specific information regarding additional criteria for replacement speech processors.

3.3 Speech Processor Upgrades

Upgrades of existing speech processors for next-generation speech processors are considered medically necessary only when

- a. the recipient's response to the existing speech processor is inadequate to the point of interfering with the activities of daily living; or
- b. the speech processor is no longer functional and cannot be replaced with the same model.

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

4.0 When the Product or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Cochlear and auditory brainstem implant external parts replacement and repair are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure unnecessarily duplicates another provider's procedure; or
- d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Cochlear and auditory brainstem implant external parts replacement and repair are not covered when

- a. the component or service is for a resident of a nursing facility or
- b. the component or service is covered by another agency.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Replacing or Repairing Cochlear and Auditory Brainstem Implant External Parts under Warranty

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, pick-up or delivery of the item, or the assembly of Medicaid-reimbursed parts.

5.2 Prior Approval for Replacement Speech Processors

Prior approval is required for all replacement speech processors that are not covered under warranty. Each prior approval request for a replacement speech processor must include the reason for replacement (loss, theft, damaged beyond repair, original discontinued, inadequate performance, etc.).

5.2.1 Prior Approval for Identical Replacement Speech Processors—Under Warranty

When the requested replacement speech processor is identical to the existing speech processor and the existing speech processor is under warranty, prior approval is not required.

5.2.2 Prior Approval for Replacement Speech Processor—Out of Warranty

When the requested replacement speech processor is identical to the existing speech processor, the provider must obtain prior approval from DMA. The provider must submit a general prior approval request form (372-118), a copy of the prescribing physician's original prescription, and a letter of medical necessity from the treating, licensed audiologist. Consideration will be given to the request and a written decision will be returned to the provider. Recipients will be notified in writing if the request is denied.

5.2.3 Prior Approval for Replacement Speech Processor—Upgrade

When the requested replacement speech processor is an upgrade, the provider must obtain prior approval from DMA. Documentation must be included with the general prior approval request form (372-118) that substantiates that the recipient's response to the existing speech processor is inadequate to the point of interfering with the activities of daily living, or that the speech processor is no longer functional and cannot be replaced with the same model. A copy of the prescribing physician's original prescription, and the treating, licensed audiologist's documentation supporting the medical necessity for the upgrade, must be included with the prior approval request. Consideration will be given to the request and a written decision will be returned to the provider. Recipients will be notified in writing if the request is denied.

Refer to **Section 5.3, Documentation of Medical Necessity**, for additional information regarding specific requirements.

5.3 Documentation of Medical Necessity

For every cochlear and auditory brainstem external parts replacement and repair, the provider must have the following on file from the treating, licensed audiologist.

5.3.1 Physician's Prescription

A physician's signed prescription with complete information regarding the cochlear implant system and surgery date(s) must be kept on file with the provider.

5.3.2 Audiologist's Letter

A letter signed by the treating, licensed audiologist must be kept on file with the provider. This letter must include the following:

- a. Audiologist's name, business name, address, and telephone number
- b. Recipient's name and Medicaid identification number
- c. Copy of the recipient's current Medicaid identification card
- d. Original surgery date(s)
- e. Verification that the device is FDA approved and currently being used in a functional manner by the patient
- f. Specific information regarding the repair and/or replacement parts, and quantity of parts, that are medically necessary for the patient
- g. Plan of care and time period during which these parts will be used

5.4 Delivery of Service

Providers must dispense cochlear and auditory brainstem implant external parts replacement and repairs as quickly as possible due to the medical necessity identified for an item. However, providers who deliver an item requiring prior approval before approval has been received do so at their own risk.

Refer to **Section 5.2, Prior Approval for Replacement Speech Processors**, for specific information regarding prior authorization for payment.

6.0 Providers Eligible to Bill for the Product or Service

Cochlear and auditory brainstem implant manufacturers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for cochlear and auditory brainstem implant external parts replacement and repair.

7.0 Additional Requirements

7.1 Federal and State Requirements

Providers must comply with all applicable federal and state laws and regulations.

7.2 Medical Record Documentation

Providers must keep the following documentation of their services:

- a. A copy of the physician's signed prescription with complete information regarding the cochlear or auditory brainstem implant system and surgery date(s)
- b. The signed letter documenting medical necessity from the treating, licensed audiologist (refer to **Section 5.3, Documentation of Medical Necessity**, for specific requirements)
- c. A full description of all item(s) supplied to a recipient
- d. The dates the items were supplied and to whom they were shipped
- e. A full description of any services or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair

Note: All recipient information, including the recipient's Medicaid status, must be kept confidential and may be shared only with those who are authorized to receive it.

7.3 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Records and documentation relating to the delivery of cochlear and auditory brainstem implant external parts replacement and repair must be maintained through the life of the implant, and not less than 5 years.

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

7.4 Disclosing Ownership Information

Providers must disclose ownership and control information, and information about the owners or employees who have been convicted of criminal offenses against Medicare, Medicaid, and the Title XX services program (10A NCAC 22N.0202).

7.5 Seeking Other Sources of Payment

The provider must take all reasonable measures to determine the legal liabilities of third parties, including Medicare and private insurance, to pay for services. If third-party liability is established, providers must bill the third party before billing Medicaid (10A NCAC 22J.0106).

Refer to **Attachment A: Claims-Related Information, E. Medicare Crossover Claims** for specific information regarding Medicare crossover claims.

Refer to the *Basic Medicaid Billing Guide* on DMA’s Web site at <http://www.ncdhhs.gov/dma/medbillcaguide.htm> for additional information regarding third-party insurance.

7.6 Accepting Payment

Providers must accept Medicaid payment according to the rules and regulations for reimbursement promulgated by the Secretary of the Department of Health and Human Services and the State of North Carolina, and established under the N.C. Medicaid program. This includes accepting Medicaid payment as payment in full (10A NCAC 22J.0106).

8.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 2008

Revision Information:

Date	Section Revised	Change
7/1/08	Throughout	Initial promulgation of current coverage

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Procedure Code(s)

HCPCS Code	Description
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, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8622	Alkaline battery for use with cochlear implant device, any size, 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, each
L7510	Repair of prosthetic device, repair or replace minor parts

Refer to **Attachment C, Lifetime Expectancy List for Cochlear and Auditory Brainstem Implant External Parts**, for specific information regarding lifetime expectancies.

C. Modifiers

Providers are required to follow applicable modifier guidelines.

D. Billing Units

Medicaid pays for services in specific units that measure the amount of service provided to the recipient.

For cochlear and auditory brainstem implant external parts replacement and repair, the units of service are as follows:

1. Purchased Equipment: The unit of service is **1** for each item provided.
2. Service and Repair: The unit of service is **1** for each service or repair.

E. Medicare Crossover Claims

Effective with **date of service September 6, 2004**, claims filed to **Medicare cross over automatically** to Medicaid for payment if a Medicare Crossover Request form is on file with Medicaid for that provider and Medicare and Medicaid have matching data for the recipient. It is the provider's responsibility to check the Medicaid Remittance and Status Report to verify that the claim crosses over from Medicare. Providers may verify that their Medicare provider number is cross-referenced to their Medicaid provider number by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888. If the Medicare provider number is not cross-referenced to the Medicaid provider number, the provider must complete the

Medicare Crossover Request form (available from DMA's Web site at <http://www.ncdhhs.gov/dma/forms.html>) and submit it by fax or mail to the fax number or address listed on the form. Claims will be paid to the Medicaid provider number indicated on the claim filed to Medicare. If no Medicaid provider number is on the claim filed to Medicare, claims will be paid to the Medicaid provider number indicated on the Medicare Crossover Request form.

Note: When a provider has more than one Medicaid provider number, the provider number that is to receive payment must be indicated on the Medicare claim form. Refer to the August 2004 Special Bulletin V, *Medicare Part B Billing*, for details regarding crossover claims for recipients with both Medicaid and Medicare eligibility.

F. Place of Service

Recipient's home

G. Co-Payments

Medicaid-eligible recipients are exempt from co-payments.

H. Reimbursement

Providers must bill their usual and customary charges.

I. Payment Rates

Payment is calculated based on the lower of the provider's billed charge or the maximum amount allowed by Medicaid.

Attachment B: Cochlear Implant or Auditory Brainstem Implant External Parts Replacement and Repair Services: Instructions for Completing Claims

Refer to the following information for completing a CMS-1500 claim form for DME/cochlear and auditory brainstem implant external parts replacement and repair.

Field No.	Field Name	Instruction
1		Place an X in the MEDICAID block.
1a	Insured's ID Number	Enter the recipient's Medicaid ID number (nine digits and the alpha suffix) from the recipient's Medicaid ID card.
2	Patient's Name	Enter the recipient's last name, first name, and middle initial from the Medicaid ID card.
3	Patient's Birth Date/Sex	Enter eight numbers to show the recipient's date of birth in MMDDYYYY format. The birth date is on the Medicaid ID card. <i>EXAMPLE: November 14, 1949, is 11141949.</i> Place an X in the appropriate block to show the recipient's sex.
4	Insured's Name	Leave blank.
5	Patient's Address	Enter the recipient's street address, including the city, state, and zip code. The information is on the Medicaid ID card. Entering the telephone number is optional.
6-8		Leave blank.
9	Other Insurer's Name	Enter applicable private insurer's name or the appropriate Medicare override statement if you know that Medicare will not cover the billed item, using the EXACT wording shown below: <i>This is a Medicare non-covered service.</i> <i>Service does not meet Medicare criteria.</i> <i>Medicare benefits are exhausted.</i> REMEMBER: You must have documentation to support the use of any of these statements.
9a-d		Enter applicable insurance information.
10	Is Patient's Condition...?	Place an X in the appropriate block for each question.
11-14		Optional.
15-16		Leave blank.
17, 17a		Optional.
17b	NPI	Enter requesting clinician's National Provider Identifier.
18	Hospitalization Dates...	Optional.
19	Reserved for Local Use	If the claim is for a Carolina ACCESS participant, enter the primary care provider's referring number—otherwise leave blank.
20	Outside Lab...	Leave blank.
21	Diagnosis or Nature of Illness	Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22	Medicaid Resubmission Code	Leave blank.
23	Prior Authorization Number	Leave blank.

Note: Blocks 24A–K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a “detail.” When completing these blocks, observe the following conventions:

- ◆ Use one line for each HCPCS code that you bill on a given date.
- ◆ If you provide more than one unit of the same item on one day, include all the items on the same line. For example, if you provide 60 batteries on May 1, include 60 on one line. Enter 60 units in 24G for that date of service.
- ◆ If you provide multiple miscellaneous items on the same day, enter L7510 on one line, enter one unit, and enter the total invoice cost of all the items. Do not bill each miscellaneous item separately.
- ◆ Invoices for billing L7510 must include the manufacturer’s item number for each miscellaneous item being billed.
- ◆ Include only those dates of service on which the recipient is eligible for Medicaid.

Field No.	Field Name	Instructions
24a	Date(s) of Service, From/To	Enter the date of shipment to the recipient’s home as the date of service. Place the date in the FROM block. Enter the same date in the TO block.
24b	Place of Service	Enter 12 to show the items are provided at the recipient’s residence.
24c	EMG	Leave blank.
24d	Procedures, Services...	Enter the appropriate HCPCS code and modifier: NU for new purchase. Indicate RT for right side or LT for left side, if appropriate to the HCPCS code.
24e	Diagnosis Code	Leave blank.
24f	Charges	Enter the total charge for the items on the line.
24g	Days or Units	Enter the number of units provided on the date of service.
24h, i		Leave blank.
24j, k		Optional.
25	Federal Tax ID Number	Optional.
26	Patient’s Account No.	Optional. You may enter your agency’s record or account number for the recipient. The entry may be any combination of numbers and letters up to a total of nine characters. If you enter a number, it will appear on your RA. This will assist in reconciling your accounts.
27	Accept Assignment	Leave blank.
28	Total Charge	Enter the sum of the charges listed in Item 24F .
29	Amount Paid	Enter the total amount received from third-party payment sources.
30	Balance Due	Subtract the amount in Item 29 from the amount in Item 28 and enter the result here.
31	Signature of Physician or Supplier...	Leave blank if there is a signature on file with Medicaid. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.
32, a, b	Service Facility...	Optional.
33	Billing Provider Info...	Enter your agency’s name, address, including zip code, and phone number. The name and address must be EXACTLY as shown on your Medicaid DME/Cochlear Implant Manufacturer participation agreement.
a.	NPI	Enter National Provider Identifier.
b.		Enter your seven-digit Medicaid DME/Cochlear Implant Manufacturer provider number.

Remember: When submitting a claim for manually priced items (L7510), you must attach an **invoice** to the claim.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999-99-9999-B																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Joe A.						3. PATIENT'S BIRTH DATE MM DD YY 12 18 93		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																	
5. PATIENT'S ADDRESS (No., Street) 100 Someplace Dr.						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																																															
CITY Any Town			STATE NC			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY			STATE																																												
ZIP CODE 12345			TELEPHONE (Include Area Code) (919)555-5555			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE			TELEPHONE (Include Area Code) ()																																												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME																																															
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																															
SIGNED _____ DATE _____												SIGNED _____																																															
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. NPI 17b. NPI Clinician's NPI (requested)						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																															
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)												23. PRIOR AUTHORIZATION NUMBER																																															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE						C. EMG						D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER						E. DIAGNOSIS POINTER						F. \$ CHARGES						G. DAYS OR UNITS						H. ICD-9-CM QUAL.						I. RENDERING PROVIDER ID #					
1 07:01:08 07:01:08 12 L8615 NU 15:01 1 NPI																																																											
2 07:01:08 07:01:08 12 L8621 27:00 60 NPI																																																											
3																																																											
4																																																											
5																																																											
6																																																											
25. FEDERAL TAX I.D. NUMBER						SSN EIN						26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 42,611						29. AMOUNT PAID \$						30. BALANCE DUE \$ 42,611																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) SIGNED A. Provider DATE 7-15-08												32. SERVICE FACILITY LOCATION INFORMATION												33. BILLING PROVIDER INFO & P# (800) 555-5555 CI Provider, Inc. 123 Any Street Any Town, NC 12345 NPI # Medicaid Provider #																																			

Attachment C: Lifetime Expectancy List for Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair

HCPCS Code	Code Description	Lifetime Expectancy
L8615	Headset/headpiece for use with cochlear implant device, replacement	Once every 3 years
L8616	Microphone for use with cochlear implant device, replacement	Once annually
L8617	Transmitting coil for use with cochlear implant device, replacement	Once annually
L8618	Transmitter cable for use with cochlear implant device, replacement	8 times each year
L8619	Cochlear implant external speech processor, replacement	Once every 5 years
L8621	Zinc air battery for use with cochlear implant device, replacement, each	N/A
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each	N/A
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	1 set of 3 each year
L8624	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each	1 set of 4 each year
L7510	Repair of prosthetic device, repair or replace minor parts	As necessary; requires invoice

Providers are reminded to bill their usual and customary rates. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of the billed usual and customary rate or the maximum reimbursement rate.

Attachment D: Instructions for Completing a Prior Approval Request Form for Replacement Speech Processors

Fax prior approval requests and attachments to EDS at (919) 233-6834, ATTN: CI Parts.

The following fields of the General Request for Prior Approval, North Carolina Medicaid Program, form (372-118) must be completed as described below to allow proper processing of prior approval requests for replacement speech processors.

Field No.	Field Name	Instruction
1	Prior Authorization Number	Leave blank.
2	Patient Name	Enter the recipient's full name (Last, First, Middle) as it appears on the Medicaid card.
3	Medicaid Identification Number	Enter the recipient's Medicaid Identification Number as it appears on the Medicaid card.
4	Date of Birth	Enter the recipient's date of birth (mm/dd/yy).
5	Diagnosis	Enter the description of the principal diagnosis.
6	ICD 9 th Edition	Enter the ICD-9-CM code. Check 'other' and enter CI Parts/SP or ABS Parts/SP
7	Brief Summary of Clinical Findings	Enter "See Attached" and attach audiologist's documentation.
8 & 9	Retroactive Date(s) Requested	Leave blank (retroactive prior approval is not applicable).
10	Procedure to be Performed	Enter "Replacement speech processor for cochlear implant" or "Replacement speech processor for auditory brainstem implant."
11	Procedure Code	Enter the appropriate HCPCS code for the device.
12	Reason Procedure is Necessary to Patient's Health	Enter the reason for replacement (loss, theft, damaged beyond repair, original discontinued, inadequate performance, upgrade, etc.).
13 a, b	Has Patient Been Previously Provided With This Service?	Complete all applicable spaces.
14	Physician or Dentist, Hearing Aid Dealer, Optometrist	Enter the manufacturer's representative's signature on the line and print the representative's name below the line.
15	Provider's Number	Enter the Medicaid provider billing number.
16	Date	Enter the date the prior approval request form (372-118) is signed.
17	Place of Service	Enter 12.
18	Type, Print, or Stamp	Enter the Medicaid provider's (manufacturer's) name, mailing address, and phone number.

Note: Prior approval requests for replacement speech processors must be accompanied by a letter of medical necessity from the treating, licensed audiologist. The provider must have a copy of the prescribing physician's original prescription and a copy of the recipient's current Medicaid identification card on file.

Refer to **Section 5.2, Prior Approval for Replacement Speech Processors**, for specific information regarding required documentation.

REQUEST FOR PRIOR APPROVAL NORTH CAROLINA MEDICAID PROGRAM						P.O. BOX 311 RALEIGH, N.C. 27602	
						1. PRIOR AUTHORIZATION NUMBER	
						3. MEDICAID IDENTIFICATION NUMBER	
2. PATIENT NAME (LAST) Recipient		(FIRST) Joe		(M.I.) A.		999999999B	
4. DATE OF BIRTH MO. 11 DAY 18 YEAR 93			5. DIAGNOSIS: Sensorineural Hearing Loss			ICD 9TH EDITION 389.1	
7. BRIEF SUMMARY OF CLINICAL FINDINGS: See attached						8. (✓) TYPE OF REQUEST	
						<input type="checkbox"/> 01 SURGICAL TRANSPLANT <input type="checkbox"/> 02 HOSPITALIZATION FOR: DENTAL EXTRACTION <input type="checkbox"/> 03 COSMETIC SURGERY <input type="checkbox"/> 04 HEARING AID <input checked="" type="checkbox"/> 05 Speech Processor	
						RETROACTIVE DATE(S) REQUESTED	
						FROM: MO. DA. YR. TO: MO. DA. YR.	
10. PROCEDURE TO BE PERFORMED Replacement speech processor for cochlear implant						11. PROCEDURE CODE L8619	
12. REASON PROCEDURE IS NECESSARY TO PATIENT'S HEALTH: Original damaged beyond repair							
13. HAS PATIENT BEEN PREVIOUSLY PROVIDED WITH THIS SERVICE? No YES NO							
(a) IF YES, GIVE DATE PREVIOUS SERVICE RENDERED AND _____							
(b) GIVE DATES OF ANY PREVIOUS PRIOR APPROVAL(S) GRANTED _____							
14. PHYSICIAN OR DENTIST HEARING AID DEALER OPTOMETRIST						16. DATE 7-15-08	
SIGNATURE A. Provider							
15. PROVIDER'S NUMBER 1234567						17. PLACE OF SERVICE 12 (SEE OTHER SIDE FOR CODE)	
EDS USE ONLY							
<input checked="" type="checkbox"/> 01 APPROVAL <input checked="" type="checkbox"/> 02 DENIED							
REVIEWED BY _____ DATE _____							
COMMENTS							
APPROVAL CONSTITUTES MEDICAL APPROVAL FOR SERVICES ONLY. ELIGIBILITY FOR CARE ON THE DATE(S) THE SERVICES ARE PROVIDED SHOULD BE VERIFIED FROM THE PATIENT'S MEDICAID CARD.							
18. TYPE, PRINT OR STAMP							
NAME CI Provider, Inc. (800) 555-5555							
STREET 123 Any Street							
CITY Any Town NC 12345 (STATE) (ZIP CODE)							
← INDICATE: PROVIDER'S NAME AND MAILING ADDRESS TO ENSURE RETURN OF THIS FORM.							