

Table of Contents

1.0 Description of the Product 1

2.0 Eligible Recipients 1

 2.1 General Provisions 1

 2.2 Limitations 1

 2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under
 21 Years of Age 1

3.0 When the Product Is Covered 2

 3.1 General Criteria 2

 3.2 Covered Hearing Aid Products and Accessories 2

 3.2.1 In-the-Ear Hearing Aids 3

 3.2.2 Analog and Digital Programmable Hearing Aids 3

 3.2.3 FM Systems 3

4.0 When the Product Is Not Covered 3

 4.1 General Criteria 4

 4.2 Non-covered Products and Services 4

5.0 Requirements for and Limitations on Coverage 4

 5.1 Prior Approval 4

 5.1.1 Requests for Digital Programmable Hearing Aids and FM Systems 5

 5.2 Examinations and Evaluations 5

 5.2.1 Evaluation 5

 5.2.2 Evaluation Form 5

 5.3 Trial Period 6

 5.4 Dispensing Fee 6

 5.5 Manufacturer Warranty 6

 5.6 Hearing Aid Accessories 6

 5.6.1 Initial Care Kit 6

 5.6.2 Dry and Store Kit 7

 5.6.3 Earmolds 7

 5.6.4 Batteries 7

 5.6.5 Miscellaneous Accessories 7

 5.7 Repairs 7

 5.8 Replacement Aids 8

 5.8.1 Prior Approval Requests for Replacement Aids 8

 5.8.2 DSS Recommendation for Replacement Aids 8

 5.8.3 Reimbursement of Replacement Aids 8

 5.9 Previous Hearing Aids 8

6.0 Providers Eligible to Bill for the Service 8

 6.1 Eligible Providers 8

 6.2 Conditions for Participation 9

7.0 Additional Requirements 9

8.0 Policy Implementation/Update Information 9

Attachment A: Claims-Related Information 10

- A. Claim Type 10
- B. Diagnosis Codes 10
- C. Procedure Code(s)..... 10
- D. Modifiers..... 10
- E. Place of Service 10
- F. Co-payments 10
- G. Reimbursement 11

1.0 Description of the Product

The N.C. Medicaid program provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.

Note: This policy does not address cochlear implant coverage. For eligible recipients with profound hearing impairment requiring cochlear implantation, refer to Clinical Coverage Policy #1A-4 (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Limitations

Hearing aids, FM systems, necessary accessories, and supplies are covered only for Medicaid recipients under the age of 21, according to Medicaid coverage policies.

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

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 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 hearing aid products when they are medically necessary and all of the following are true:

- a. the products are 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 level of service can be safely furnished and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the service is not primarily for cosmetic purposes or the convenience of the recipient, the recipient’s caretaker, or the provider.

3.2 Covered Hearing Aid Products and Accessories

Covered hearing products include the following:

- a. Hearing aids
- b. FM systems
- c. Initial care kit
- d. Batteries
- e. Repairs

- f. Cords, replacement tubes, retention straps, retention garments, harnesses, baby covers, “Huggies”
- g. Custom earmolds
- h. Dispensing fees

3.2.1 In-the-Ear Hearing Aids

Based on recommendations from the Division of Medical Assistance (DMA) audiologist consultants, in-the-ear aids are not appropriate for infants and young children as they are less adaptable to FM systems and they are more likely to pose a danger (falls, hit or struck in the ear, etc.) resulting in damage to the ear/canal. Within standard audiology practice, children 12 years old and older are considered for in-the-ear devices. Based on this standard, in-the-ear hearing aids may be approved for children 12 years old and older if the prescribing physician or audiologist documents medical necessity and verifies it with improved test results or audiograms. In-the-ear hearing aids cannot be requested or approved for cosmetic purposes only.

3.2.2 Analog and Digital Programmable Hearing Aids

Medicaid covers analog and digital programmable hearing aids based on medical necessity and the ability of the device to meet the recipient’s basic needs. The type of aid that is needed must be recorded on the general Request for Prior Approval form (372-118). Each request is reviewed on a case-by-case basis. Refer to **Section 5.1.1** for additional information on requesting prior approval.

3.2.3 FM Systems

The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three. Medicaid does not cover FM systems for children who are eligible for this service through IDEA. However, a general Request for Prior Approval form (372-118) for medically necessary FM systems that are not covered through IDEA must be submitted along with documentation of medical necessity and will be reviewed on a case-by-case basis.

4.0 When the Product 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

Hearing aid services are not covered when any one or more of the following are true:

- 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 service duplicates another provider's procedure and the request for service does not include documentation of medical necessity for the duplication; or
- d. the service is experimental, investigational, or part of a clinical trial.

4.2 Non-covered Products and Services

Hearing aid products and services that Medicaid does not cover include the following:

- a. battery chargers or testers
- b. adapters for telephones, television, or radios
- c. shipping/handling fees, postage, or insurance
- d. loss and damage insurance
- e. in-the-ear hearing aids that are requested for primarily cosmetic purposes
- f. extended warranty policies

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 Prior Approval

The general Request for Prior Approval form (372-118) must be submitted for all hearing aids, FM systems, earmolds, accessories, repairs, replacement parts, and for batteries in excess of six claims per year with a maximum of \$35 per claim (refer to **Section 5.6.4**). Prior approval requests for hearing aids must include the manufacturer's name, model name and/or number, style (body, BTE, etc.), type (analog programmable, digital programmable, etc.) and the approximate invoice cost.

The following items must be submitted with each prior approval request for new hearing aids:

- a. the physician or otologist (including otolaryngologist or otorhinolaryngologist) certification (medical clearance) of the need for beginning the hearing aid selection process;
- b. a copy of the hearing evaluation (including the audiogram) and the results of the hearing aid selection and evaluation; and
- c. a copy of the manufacturer's warranty and loss and damage policy.

5.1.1 Requests for Digital Programmable Hearing Aids and FM Systems

Prior approval requests for digital programmable hearing aids and FM systems require documentation of medical necessity and the estimated invoice cost.

5.2 Examinations and Evaluations

Each Medicaid recipient must receive a medical examination from a physician or otologist (including otolaryngologist or otorhinolaryngologist) and documentation of certification (medical clearance) of the need for the initiation of the hearing aid selection process.

5.2.1 Evaluation

The recipient must receive a hearing evaluation, including an audiogram, and a hearing aid selection/evaluation by a licensed audiologist.

5.2.2 Evaluation Form

An evaluation form will be sent to the provider with the approved prior approval request.

- a. If the dispensed aid and related items are not acceptable to the otologist, audiologist or recipient, the hearing aid/aids claim will not be honored. A new general Request for Prior Approval form (372-118) must be submitted to Medicaid's fiscal agent for the more appropriate replacement hearing aid. The prior approval request form must include documentation regarding the insufficiency of the original aid and an audiogram that supports the documentation.
- b. If the recipient evaluation cannot be done within 30 days after the aids are dispensed (no transportation, broken appointments, lack of cooperation by parent, etc.), the provider can submit the claim for payment. The claim must be accompanied by documentation supporting efforts to contact or evaluate the recipient, and all appropriate invoices. Medicaid's fiscal agent will advise DMA of the problem and DMA will enlist the help of the local department of social services (DSS) case worker.
- c. If invoices and the evaluation form or the documentation explaining the inability to evaluate the recipient do not accompany the claim, the claim will deny. The provider will be required to resubmit the claim, copies of the required invoices and the evaluation form documenting acceptance of the aid/aids or an explanation of why the recipient was not evaluated.

5.3 Trial Period

The recipient must be given a 30-day trial period for hearing aids and hearing aid accessories indicating satisfaction with the hearing aids and the fitting.

The recipient (or responsible person), otologist or audiologist, and the dispensing provider must sign the evaluation statement after the trial wearing period.

When the otologist, audiologist, or recipient finds the amplification or performance of the dispensed aid and accessories unacceptable, Medicaid does not honor the claim for the hearing aid.

5.4 Dispensing Fee

A dispensing fee for a new hearing aid includes the following mandatory services:

- a. The recipient must receive delivery and fitting of the new hearing aid or aids, FM system, custom earmolds, other approved accessories and a one month supply of batteries. A separate dispensing fee cannot be billed for these accessories, which are considered components of the new aid. The initial month's supply of batteries can not be billed separately.
- b. The recipient must receive instructions and counseling on the use and care of the hearing aid or aids and accessories.
- c. The recipient must receive services and regular maintenance as recommended by the manufacturer for a period of one year from the date of delivery.
- d. The recipient must receive the manufacturer's warranty services for the materials and workmanship for at least one year from the delivery date. This includes any applicable loss and damage policy issued by the manufacturer at no extra cost to the hearing aid provider, recipient, or the Medicaid program.
- e. Upon expiration of the manufacturer's warranty and/or loss and damage policy, the provider may advise the recipient of available extended coverage policies. The recipient should further be advised that Medicaid will not pay for insurance policies, but the recipient has the option to purchase a policy at his or her own expense.

The dispensing claim can only be billed to the Medicaid program after the recipient has received an evaluation. The recipient is normally re-evaluated within 30 days after dispensing. Refer to **Section 5.2.2**.

5.5 Manufacturer Warranty

Both the manufacturer's warranty and loss, stolen, or damage policies must be submitted with the provider's prior approval form. Providers must submit invoices for each aid, FM system, accessories, and factory repairs with the provider's claim form. These policies and invoices must document the hearing aid model and serial number in addition to the recipient's name and Medicaid identification number.

5.6 Hearing Aid Accessories

5.6.1 Initial Care Kit

Medicaid covers an initial care kit as a separate accessory, to include a stethoscope, forced air blower, and dry aid kit. The provider should give the recipient or the recipient's guardian instructions on the use and care of the instruments. A dispensing fee for the care kit is not allowed at the initial hearing

aid dispensing for a first-time hearing aid wearer. Previous hearing aid wearers, who have never received a care kit, are eligible for this accessory and a dispensing fee is then applicable. If an additional care kit, or any component of the care kit, is needed the provider must submit a general Request for Prior Approval form (372-118) with a letter from a case manager or eligibility worker at the local DSS, that outlines the following:

- a. the circumstances surrounding the loss, theft, or damage of the kit/component,
- b. steps that have been taken to recover the kit/component, and
- c. the department of social services' recommendation of replacement.

5.6.2 Dry and Store Kit

Dry and Store Kits may be requested for recipients with moisture special needs. Providers must submit a general Request for Prior Approval form (372-118) with documentation of medical necessity. Each request is reviewed on a case-by-case basis.

5.6.3 Earmolds

Reimbursement for initial earmolds is limited to the invoice cost of the molds. Replacement earmolds also require prior approval. Their reimbursement is limited to the invoice cost of the mold and a dispensing fee.

5.6.4 Batteries

Up to six claims for batteries (\$35.00 maximum per claim) per year do not require prior approval and can be billed at retail cost with no dispensing fee. If additional batteries are needed, the provider must submit a general Request for Prior Approval form (372-118) with documentation of medical necessity. Each request is reviewed on a case-by-case basis.

5.6.5 Miscellaneous Accessories

Cords, replacement tubes, retention straps, retention garments, baby covers, harnesses, and "Huggies" are covered accessories. Other accessories are evaluated on a case-by-case basis.

5.7 Repairs

Repair of a hearing aid is as follows:

- a. Reimbursement for the repair of a hearing aid covered under the manufacturer's warranty or loss and damage policy is limited to a service fee.
- b. Reimbursement for the repair of a hearing aid not covered by the manufacturer's warranty or loss and damage policy is limited to the factory invoice cost of the repair and a hearing aid dispenser's fee.
- c. All factory or manufacturer's repairs must be covered under warranty for six months following the repair.

5.8 Replacement Aids

5.8.1 Prior Approval Requests for Replacement Aids

Prior approval specialists carefully review all requests and approval is granted or denied based on the responsibility in the loss or damage, extenuating circumstances, frequency of other replacements, medical necessity, etc. Improper care or negligence does not constitute extenuating circumstances.

5.8.2 DSS Recommendation for Replacement Aids

Recipients who are requesting replacement hearing aids because they were lost, stolen, broken or damaged must each obtain a letter from a case manager or eligibility worker at the local DSS. The letter should explain:

- a. the circumstances surrounding the loss, theft, or damage of the aid;
- b. steps that have been taken to recover the aid; and
- c. the department of social services' recommendation of replacement.

The letter, or a copy, must accompany the general Request for Prior Approval form (372-118) from the hearing aid provider.

5.8.3 Reimbursement of Replacement Aids

Reimbursement for an exact-replacement hearing aid and its related accessories within a year is as follows:

- a. If it is covered under the manufacturer's warranty or loss and damage policy, reimbursement is limited to the manufacturer's loss and damage replacement fee, if applicable, plus invoice cost of the related, prior approved accessories not covered by the policy, and a dispensing fee.
- b. If it is no longer covered under the manufacturer's warranty or loss and damage policy, reimbursement is limited to the invoice cost of the approved replacement aid, accessories, and a dispensing fee.
- c. A provider cannot bill a dispensing fee for a replacement aid if the manufacturer pays a dispensing fee to the provider for replacing an aid that is under warranty.

5.9 Previous Hearing Aids

Hearing aids are the property of the State of North Carolina. The provider should collect the previous Medicaid hearing aids when dispensing the new hearing aids for a Medicaid recipient. The previous hearing aids may be used in the provider's office as loaner hearing aids.

6.0 Providers Eligible to Bill for the Service

6.1 Eligible Providers

Hearing aid dealers enrolled in the N.C. Medicaid program who provide this service may bill for these services. Facility providers must enroll in the N.C. Medicaid program as hearing aid fitters/providers.

Refer to Clinical Coverage Policy #10C, *Independent Practitioners*, for additional information.

6.2 Conditions for Participation

Enrolled providers can provide hearing aids, related accessories, and supplies in accordance with the rules and regulations set forth in the following publications.

- a. Federal Register Vol. 42, No. 31, 801.420 and 801.421, 1977
- b. Federal Register Vol. 44, No. 103, 441.31, 1979
- c. N.C. General Statutes 93D and 93D-14
- d. N.C. State Hearing Aid Dealer and Fitters Board Laws
- e. N.C. Administrative Code
- f. North Carolina has adopted the Food and Drug Administration (FDA) rule by reference, in addition to the state rules and laws.
- g. Title 21, Chapter 22, Hearing Aid Dealer and Fitters Board Laws

7.0 Additional Requirements

There are no additional requirements.

8.0 Policy Implementation/Update Information

Original Effective Date: February 1, 1976

Revision Information:

Date	Section Revised	Change
9/22/1999	Section 3.2.3	Services were revised to include coverage of FM systems and programmable hearing aids
12/1/06	Section 2.3	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
4/1/07	Attachment A	The Place of Service table was removed and a list of allowed places of service was added.
4/1/07	Sections 2.3, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
5/1/07	Section 5.1	Deleted "not covered by the manufacturer's warranty or a loss and damage policy" from "replacement parts." A dispensing fee is paid for all replacement parts, so all replacement parts require prior approval.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.

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

Physicians, audiologists, otologists, facility providers, and hearing aid dealers (type 084) bill services on the CMS-1500 claim form or the 837 professional transaction.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

The relevant HCPCS codes are as follows:

HCPCS Code	Description
V5014	Repair/modification of hearing aid
V5050	Hearing aid, monaural, in the ear (for newly fit monaural hearing aids)
V5060	Hearing aid, monaural, behind the ear (for all replacement hearing aids)
V5090	Dispensing fee, unspecified hearing aid (for dispensing new monaural hearing aids)
V5110	Dispensing fee, binaural (for dispensing new binaural hearing aids)
V5130	Binaural, in the ear (for newly fit binaural hearing aids)
V5160	Dispensing fee, binaural (for dispensing assistive listening/FM system)
V5240	Dispensing fee, BICROS (for dispensing hearing aid repair)
V5241	Dispensing fee, monaural hearing aid, any type (for dispensing hearing aid replacement)
V5264	Earmold/insert, not disposable, any type
V5266	Battery for use in hearing device
V5267	Hearing aid supplies/accessories
V5274	Assistive listening device, not otherwise specified
V5299	Hearing services, miscellaneous (for dispensing accessories and earmolds)

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Inpatient hospital, outpatient hospital, comprehensive outpatient rehabilitation facility, office, state or local public health clinics, rural health clinics, home, long-term-care facilities

F. Co-payments

Co-payments may not be charged for hearing aid services.

G. Reimbursement

Providers must bill usual and customary charges.

1. Hearing Aids and Related Items

Reimbursement for a new hearing aid and related items is based on the manufacturer's invoice cost of materials billed to the provider. The amount billed to the Medicaid program cannot exceed the cost that the provider paid to the supplier.

2. Batteries

Reimbursement for batteries is limited to six claims (\$35.00 maximum for each claim) per year for each recipient, unless prior approval is obtained for additional batteries. The initial month's supply of batteries cannot be independently billed to Medicaid. See **Section 5.6.4**.

3. Materials

Medicaid reimburses materials at 100% of the manufacturer's invoice cost to the provider, less the applicable discounts, shipping, handling, taxes and noncovered items and services. All discounts must be documented. Each invoice should identify the recipient's name. When providers purchase hearing aids in bulk, each hearing aid must be billed at the appropriate percentage of the total invoice cost. Providers should attach copies of the manufacturer's invoices to each claim for an aid, which documents the model and serial number. Providers should circle the aid/serial numbers of the aids. When ordering one or two hearing aids for a single recipient, the provider should attach the invoice with the serial number, model number, and the recipient's name identified on the invoice.

4. Dispensing Fees

Dispensing fees are reimbursed at 100% of the Medicaid allowed fee schedule.