

Audiologist and Hearing Aid Dispenser

Provider Manual



**Iowa Department
of Human Services**



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of Human
Services

Provider

**Audiologist and Hearing Aid
Dispenser**

Page

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

All hearing aid dispensers and audiologists licensed in Iowa are eligible to participate in the Medicaid program. Audiologist in other states must be qualified by having a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association or by having successfully completed a minimum of 350 clock-hours of supervised clinical practicum and successfully completed a nationally approved examination in audiology. Submit requests for participation to the Iowa Medicaid Enterprise (IME).

B. PROCEDURE FOR A MEMBER TO OBTAIN A HEARING AID

The steps in the process for a Medicaid member to obtain a hearing aid are:

- ◆ [Physician examination](#)
- ◆ [Audiological evaluation](#)
- ◆ [Hearing evaluation](#)
- ◆ [Hearing aid selection](#)
- ◆ [Purchase of hearing aid](#)

1. Physician Examination

Members who believe themselves to be in need of a hearing aid, or who are advised of a possible need, should begin by contacting their primary care physician for an examination to determine whether there is any condition that would contraindicate the use of a hearing aid. An examination by an otologist or otolaryngologist is preferred.

EXCEPTION: A physical examination may be waived if the member is 18 years of age or older and has signed an informed consent statement acknowledging that:

- ◆ The member has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchasing a hearing aid, and
- ◆ The member does not wish to receive a medical evaluation before the purchase.



A physician examination or waiver does not need to be repeated for replacement hearing aids, unless Medicaid payment for hearing aids was not previously made.

2. Audiologic Evaluation

A physician or an audiologist must perform pure-tone and speech audiometry to evaluate the member's hearing sensitivity.

Due to various factors, such as age and cognitive ability to understand and respond, pure-tone air conduction, bone conduction, and speech audiometry may not be applicable to all members. If alternative audiological evaluations are employed, written documentation or support reports should be included in the member's record.

3. Hearing Evaluation

The hearing aid evaluation is performed to determine whether the member may benefit from the use of amplification. The evaluation procedures should be standard and appropriate as a means of determining the type of hearing aid and amplification characteristics needed for the member's condition.

Hearing aid evaluation and selection codes 92590 and 92591 are payable only when provided by audiologists.

4. Hearing Aid Selection

A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. "Appropriate" shall mean adequate for the member's condition and a reasonable expenditure as well.

Reasonableness is determined by whether:

- ◆ The expense of the hearing aid would be clearly disproportionate to the therapeutic benefits which the member could derive from it;
- ◆ The hearing aid would be substantially more costly than an appropriate and realistically feasible alternative brand or model; or
- ◆ The hearing aid serves essentially the same purpose as an item already available to the member.



When a physician or audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform tests to determine the specific brand or model appropriate to the member's condition. Hearing aid selection, code V5010, is payable only to hearing aid dispensers.

A hearing aid selection fee is not allowed for replacement of hearing aids that are lost, broken beyond repair or stolen and the replacement aid is like for like.

5. Purchase of Hearing Aid

The member may obtain the hearing aid from the enrolled provider of the member's choice who can provide the hearing aid recommended.

C. COVERAGE OF SERVICES

1. Audiologist

Services provided by an audiologist are covered subject to the following limitations.

a. Audiological Testing

Payment will be approved for testing performed by an audiologist to establish the member's need for a hearing aid. Covered testing services are:

- ◆ Hearing evaluation, which must include bone conduction and air conduction tests
- ◆ Speech audiometry
- ◆ Hearing aid selection

The services of the audiologist also include at least one visit with the patient after the purchase of the hearing aid to determine whether the device is functioning adequately.

No payment is to be made to audiologists for services before the member's examination by a physician, except as noted under [Physician Examination](#).



A physician referral is required when comprehensive audiometry threshold evaluation and recognition, procedure code 92557 is provided to Medicare and Medicaid dual eligibles. The claim must first be submitted to Medicare for those members. A copy of the Medicare Explanation of Medicaid Benefits (EOMB) must be included with the Medicaid claim.

No payment is made for duplicate testing procedures.

b. Cerumen Removal

Removal of impacted cerumen (69210) is considered included with reimbursement for hearing testing and should not be separately billed. It is covered when otherwise medically necessary. The "SC" modifier should be used when billing for members who are eligible for both Medicare and Medicaid.

c. Newborn and Infant Hearing Screening

All newborns and infants born in Iowa, except those born with a condition that is incompatible with life, must be screened for hearing loss. (Iowa Code 135.131)

Click [here](#) to obtain information regarding Iowa's Early Hearing Detection and Intervention (EHDI) program.

The primary goals for the EHDI program are:

- 1 month** All infants will be **screened** for hearing loss before **1 month** of age, preferably before hospital discharge.
- 3 months** All infants who do not pass the screening will have **diagnostic audiologic evaluation** before **3 months** of age.
- 6 months** All infants identified with hearing loss receive appropriate **early intervention services** before **6 months** of age.



d. Travel

Travel by the audiologist to perform testing services may be approved when the member is unable to travel due to medical reasons. Travel will be approved only from the provider's local base of operation to the member's home or care facility.

e. Vestibular Testing

Payment will be approved for vestibular function tests when prescribed by a physician to evaluate problems with vertigo and balance.

2. FM Systems

FM systems require prior authorization and may be allowed for children who use hearing aids but need additional amplification in settings such as a classroom. The device should be billed using V5274 for the FM system and V5299 for the dispensing fee.

3. Hearing Aids

The hearing aid should be adequate for the member's condition and a reasonable expenditure as well.

An invoice must be submitted with claims for monaural hearing aids with a submitted charge of \$401 or more and binaural hearing aids with a submitted charge of \$802 or more.

If a hearing aid is returned to the provider within the allowable period of time, the provider should return the aid to the manufacturer. Notify the IME Provider Services Unit of the situation. Include copies of claims and invoices, remittance statements, and any peer review documentation. An adjustment to the payment for the hearing aid will be made.



a. Binaural Amplification

Binaural amplification is covered when suitable for bilateral hearing loss. Examples include:

- ◆ The aid is for a blind person
- ◆ The aid is needed for educational or vocational purposes
- ◆ Lack of binaural amplification poses a hazard to a member's safety
- ◆ The member's hearing loss has caused marked restriction of daily activities and constriction of interests, resulting in seriously impaired ability to relate to other people

The member record must document the reason for binaural hearing aids.

b. Dispensing Service

A dispensing service is covered to allow for the fitting and adjustment of the hearing aid when one is provided. It is considered to include follow up services for the first six months after the aid is provided.

When the member is unable to travel to the provider's business due to medical reasons, the U-3 modifier should be used. Dispensing fees should be billed as follows:

<u>Procedure Code</u>	<u>Description</u>
V5241	Monaural hearing aid
V5241-U3	Monaural hearing aid, nursing home
V5160	Binaural hearing aids
V5160-U3	Binaural hearing aids, nursing home

When binaural hearing aids are appropriate but the member prefers to receive only one hearing aid initially and later returns for the second aid for binaural hearing, the monaural dispensing code should be billed for each hearing aid.



c. Ear Molds, Replacement

Payment for a service charge in addition to the cost of material for ear molds is allowed if it is the provider's practice to make such a service charge to the general public.

When a service charge is made, it is considered to include all functions performed in connection with fitting of the ear mold, including travel, if necessary. Therefore, no additional charge may be made to the member or others for the service.

d. Maintenance Items

Maintenance items, such as batteries, cords, and dry storage devices are payable when obtained from a participating provider. An invoice must be included with claims with a submitted charge of \$51 or more.

Dispensing of hearing aid batteries is considered a service and must be documented in the member's chart with the date of service and number of batteries dispensed. Up to 30 hearing aid batteries are covered within a 90-day period for a member with a monaural hearing aid. Up to 60 hearing aid batteries are covered within a 90-day period for a member with binaural hearing aids.

e. Prior Authorization

Prior authorization is required for the following:

- ◆ A monaural hearing aid costing more than \$650
- ◆ Binaural hearing aids costing more than \$1,300
- ◆ Replacement of a hearing aid in less than four years for members 21 years of age and older
- ◆ FM systems



The [Request for Prior Authorization, form 470-0829](#), should be submitted with:

- ◆ [Examiner Report of Need for a Hearing Aid, form 470-4767](#)
- ◆ Results of hearing tests
- ◆ Member history and diagnosis
- ◆ Date of purchase of the current hearing aid, if known, or the approximate age of the hearing aid
- ◆ Whether the aid is covered under warranty, if less than one year old
- ◆ Reason for replacement

Payment will be approved for a monaural aid costing more than \$650 and for binaural aids costing more than \$1,300 for either of the following:

- ◆ Educational purposes when the member is participating in primary or secondary education or an academic program leading to a degree, and either:
 - An in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise
 - An in-office comparison of two aids, one of which is single-channel, shows significantly improved audibility
- ◆ Vocational purposes when documentation submitted indicates the necessity such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and either:
 - An in-office comparison of an analog aid and a digital aid matched (+- 5 dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise
 - An in-office comparison of two aids, one of which is single-channel, shows significantly improved audibility

The following hearing aid services are covered when provided by audiologists or hearing aid dispensers.



f. Repair

Repair of hearing aids resulting from conditions not covered under the manufacturer's warranty are covered.

(1) Parts and Labor

- ◆ **In-house repairs** are reimbursed at the current fee schedule amount. The U5 modifier must be billed with V5014 for in-house repairs.
- ◆ **Out-of-house repairs** are reimbursed at the amount shown on the manufacturer's invoice plus a service charge, when applicable.

(2) Service Charge

Payment is allowed for a service charge in addition to the charge for parts and labor for out-of-house repairs if it is the provider's practice to make such a charge to the general public. Bill the usual, customary, and reasonable service charge. Procedure code V5014 should be billed.

When a service charge is billed, it is considered to include all service functions performed in connection with repair of the hearing aid, including necessary travel, "loaners," or any other service or supplies. Therefore, no additional charge may be made to the member or to others.

g. Replacement of Hearing Aids

Prior authorization is required for replacement of a hearing aid less than four years old, except when the member is a child under 21 years of age.

Adults requiring replacement of a hearing aid should have audiological tests reviewed by the physician or audiologist if the last evaluation is more than two years old. Children under 18 years of age should have an audiological test reviewed by the physician or audiologist before replacement of a hearing aid if the last evaluation is more than six months old.



h. Routine Maintenance

Routine maintenance is payable once every twelve months after the initial six month-service period.

<u>Procedure Code</u>	<u>Description</u>
92592	Monaural aid
92593	Binaural aids

4. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- ◆ Provided by interpreters who provide only interpretive services
- ◆ Interpreters may be employed or contracted by the billing provider
- ◆ The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- ◆ Interpreter's name or company,
- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ Cost of providing the service.



b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code 361. Oral interpreters should be guided by the standards developed by the [National Council on Interpreting in Health Care](#).

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- ◆ Bill code T1013
 - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
 - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- ◆ Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

5. Vibrotactile Aids (V5999)

A vibrotactile aid is covered when the member has a diagnosis of bilateral profound sensory-neural hearing loss and little or no benefit from amplification. Reimbursement is invoice priced.

The member records must document:

- ◆ The member's hearing condition
- ◆ Waiver of a medical evaluation for members 21 years of age and over
- ◆ Results of the hearing testing
- ◆ Results of the hearing aid evaluation and selection



D. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Click [here](#) to access the fee schedule for Audiologists and Hearing Aid Dispensers.

Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from the IME.

It is the provider's responsibility to select the procedure code that best describes the item dispensed. A claim submitted without a procedure code and a corresponding diagnosis code will be denied.

Modifiers **Description**

52	Test applied to one ear instead of two ears
EP	Services performed as the result of an EPSDT (early periodic screening, diagnosis and treatment) exam
LT	Left
RT	Right
SC	Sometimes covered by Medicare
U3	Nursing home dispensing fee
U5	In-house repairs
UC	Telephone translation

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Audiologists and Hearing Aid Dispensers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click [here](#).

To view billing instructions for the CMS-1500, click [here](#).

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:

http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.