Washington State Health Care Authority

Washington Apple Health (Medicaid)

Hearing Hardware Billing Guide

November 1, 2019

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect November 1, 2019, and supersedes earlier billing guides to this program.

The Health Care Authority (agency) is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to the agency's ProviderOne billing and resource guide for valuable information to help you conduct business with the agency.

What has changed?

Subject	Change	Reason for Change
Entire document	Housekeeping changes	To improve usability
	Changed references to "cochlear implant" to "cochlear implant device"	For consistency
	Changed references to "bone-anchored hearing aid" to "bone conduction hearing device"	To add clarity
Definitions	Changed definitions for the following terms: cochlear implant, hearing aids, and hearing health care professional	To match WAC 182-547-0200, filed under WSR 19-20-043
Behavioral Health Organization (BHO)	Removed the North Sound Region	Effective July 1, 2019, behavioral health services in the North Sound region is provided under integrated managed care

* This publication is a billing instruction.

Subject	Change	Reason for Change
Integrated Managed Care Regions	Effective July 1, 2019, a new integrated managed care region, called **North Sound**, was implemented. North Sound region includes Island, San Juan, Skagit, Snohomish, and Whatcom counties.	New integrated managed care region
Cochlear implant devices – replacement parts (for children)	Removed the paragraph regarding vendors needing a core provider agreement to be reimbursed	To remove unnecessary information
What is covered?	Added replacement batteries to list of things the agency covers	To reflect changes in WAC 182-547-0850, filed under WSR 19-20-043
Second hearing aid	Reworded section	To improve clarity
Clinical criteria for EPA #870001552	Changed trial period for monaural hearing aid from 6 months to 90 days Added new criterion: "Unable to live safely in the community with only one hearing aid"	To reflect changes in WAC 182-547-0850, filed under WSR 19-20-043
What is not covered?	Removed replacement batteries from list of things the agency does not cover	To reflect changes in WAC 182-547-0850, filed under WSR 19-20-043
Coverage table (for children) – HCPCS code L8693	Removed HCPCS code L8693 from table	Code is not appropriate for this program; it is in the OPPS fee schedule.
Coverage table (for adults) – HCPCS code V5257	Reworded last bullet in Policy/Comments column to read: "Up to three…" rather than "A minimum of three"	To reflect changes in WAC 182-547-1100, filed under WSR 19-20-043
Coverage table (for adults) – HCPCS code L8693	Removed HCPCS code L8693 from table	Code is not appropriate for this program; it is in the OPPS fee schedule.

Subject	Change	Reason for Change
Does the agency require prior authorization for hearing hardware?	Removed note box from section and added a different note box containing a reference to EPSDT	To reflect changes in WAC 182-547-1000, filed under WSR 19-20-043
What documentation is required when requesting PA or ETR?	Reworded note box in section	To reflect changes in WAC 182-547-1050, filed under WSR 19-20-043
Cochlear implant devices – replacement parts (for DDA clients)	Removed the paragraph regarding vendors needing a core provider agreement to be reimbursed	To remove unnecessary information

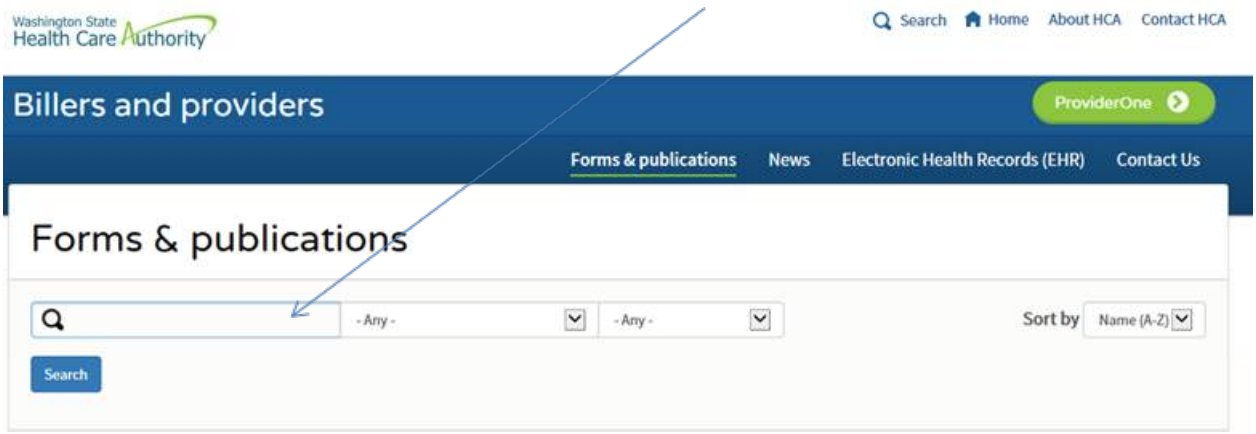
How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

Where can I download agency forms?

To download an agency provider form, go to the agency's Forms & publications webpage. Type the agency's form number into the **Search box** as shown below (Example: 13-835).



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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Bone conduction hearing device – A type of hearing aid that transmits sound vibrations through bones in the head. The inner ear translates the vibrations the same way a normal ear translates sound waves. These devices can be surgically implanted or worn on headbands. (WAC 182-547-0200)

Cochlear implant device – An electrical device that receives sound and transmits the resulting signal to electrodes implanted in the cochlea. That signal stimulates the cochlea so that hearing impaired persons can perceive sound. (WAC 182-547-0200)

Developmental Disabilities Administration (DDA) – A division administration within the Department of Social and Health Services. DDA provides services to children and adults with developmental disabilities.

Digital hearing aids – Wearable sound-amplifying devices that use a digital circuit to analyze and process sound. (WAC 182-547-0200)

Hearing aids - Wearable sound-amplifying devices that are intended to compensate for hearing loss. These devices use a digital circuit to analyze and process sound. Hearing aids are described by where they are worn in the ear as in-the-ear (ITE), behind-the-ear (BTE), etc. (WAC 182-547-0200)

Hearing health care professional – An audiologist or hearing aid specialist licensed under Chapter 18.35 RCW, or a physician specialized in diseases and disorders of the ear licensed under Chapter 18.71 RCW. (WAC 182-547-0200)

Maximum allowable fee - The maximum dollar amount that the agency will pay a provider for specific services, supplies, and equipment. (WAC 182-547-0200)

Prior authorization – A form of authorization used by the provider to obtain approval for a specific hearing aid and service(s). The approval is based on medical necessity and must be received before service(s) are provided to clients as a precondition for payment.

Programmable hearing aids – Hearing aids that can be "programmed" digitally by a computer. *All digital hearing aids are programmable, but not all programmable hearing aids are digital.*

Social Services Authorization – A form of authorization used by the Department of Social and Health Services to preauthorize services. The approval is based on medical necessity and client eligibility for the program or service. A Social Services Authorization can be viewed in ProviderOne.

Usual & customary fee - The rate that may be billed to the agency for a certain service or equipment. This rate may not exceed either of the following:

1) The usual and customary charge that you bill the general public for the same services

2) If the general public is not served, the rate normally offered to other contractors for the same services

About the Program

When does the agency pay for hearing aids?

(WAC 182-547-0100)

The agency pays for hearing aids when they are:

- Covered.
- Within the scope of an eligible client's Benefit Package.
- Medically necessary.
- Authorized as required within this billing guide and Chapters 182-501 and 182-502 WAC.
- Billed according to this billing guide and Chapters 182-501 and 182-502 WAC.
- Provided to clients when all of the following are true. The clients:
  - ✓ Are eligible. (See Client Eligibility.)
  - ✓ Have received a hearing evaluation, including an audiogram or developmentally appropriate diagnostic physiologic test, that is administered by and the results interpreted by a hearing health care professional.
  - ✓ Have received a recommendation by a licensed audiologist, hearing aid specialist, otorhinolaryngologist, or otologist.
  - ✓ Meet the coverage criteria found in Coverage (for Children) and Coverage (for Adults).

Note: For clients of the Developmental Disabilities Administration (DDA), refer to the DDA section of this billing guide.

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne billing and resource guide.

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

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program benefit packages and scope of services webpage.

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

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

Are clients enrolled in managed care eligible?

(WAC 182-547-0700(2))

Hearing aids are covered under agency-contracted managed care organizations (MCO). Clients who are enrolled in an agency-contracted MCO are eligible for covered hearing aids. Bill the MCO directly for these services. Additionally, clients enrolled in an agency-contracted MCO must obtain replacement parts for cochlear implant devices and bone conduction hearing devices, including batteries, through their MCO.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get help enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

The Health Care Authority (agency) manages the contracts for behavioral health services (mental health and substance use disorder) for the following three Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see Changes coming to Washington Apple Health. You may also refer to the agency's Apple Health managed care webpage.

See the agency's Mental health services billing guide for details.

Apple Health – Changes for July 1, 2019

Effective July 1, 2019, the agency is continuing to shift to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and drug or alcohol treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

Agency-contracted managed care organizations (MCOs) in certain RSAs will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the Integrated managed care regions section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. The agency will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the ProviderOne client portal.
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change online through our secure Contact us – Apple Health (Medicaid) client web form. Select the topic "Enroll/Change Health Plans."
- Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

American Indian/Alaska Native (AI/AN) clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental health services billing guide and the Substance use disorder billing guide.

For full details on integrated managed care, see the Medicaid agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement).
- Under the age of 21 who are receiving adoption support.
- Age 18-21 years old in extended foster care.
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni).

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care.**"

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Administrative Services Organization (BH-ASO). For details, see the agency's Mental health services billing guide, under *How do providers identify the correct payer*?

Coverage (for Children)

What is covered?

(WAC 182-547-0800)

Monaural or binaural hearing aids

The agency covers new, nonrefurbished, monaural or binaural hearing aid(s), which includes the ear mold and batteries, for eligible clients age 20 and younger. In order for the provider to receive payment, the hearing aid must meet the client's specific hearing needs and be under warranty for a minimum of one year.

See the Social services blanket code to procedure crosswalk for specific procedure codes.

Replacement

The agency pays for the following replacements as long as the need for replacements is not due to the client's carelessness, negligence, recklessness, or misuse in accordance with WAC 182-501-0050(7):

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

Repair

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

- All warranties are expired.
- The repair is under warranty for a minimum of 90 days.

Rental

The agency pays for a rental hearing aid(s) for up to two months while the client's own hearing aid is being repaired. In the case of a rental hearing aid(s), the agency pays separately for an ear mold(s).

Cochlear implant devices – replacement parts
(WAC 182-547-0800 (4))

The agency covers:

- External speech processors for cochlear implant device, including maintenance, repair, and batteries.

- Speech processors for bone conduction hearing device, including maintenance, repair, and batteries.

See the Coverage Table for specific procedure codes.

The agency pays for cochlear implant device and bone conduction hearing device replacement parts when:

- The manufacturer's warranty has expired.
- The part is for immediate use, not a back-up part.
- The part needs to be replaced due to normal wear and tear and is not related to misuse or abuse of the item (see WAC 182-501-0050(7)).

The client must pay for repairs to additional speech processors and parts.

When reimbursing for battery packs, the agency covers the least costly, equally effective product.

> **Note:** The agency does not pay providers for repairs or replacements that are covered under the manufacturer’s warranty.

See What is expedited prior authorization (EPA)? for EPA codes and clinical criteria for billing for replacement parts using the EPA process.

What is not covered?

The agency does not cover the following hearing and hearing aid-related items and services for clients age 20 and younger:

- Tinnitus maskers
- Group screenings for hearing loss, except as provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (refer to the agency's Early and periodic screening, diagnosis and treatment (EPSDT) program billing guide)
- FM systems, including the computer-aided hearing devices for FM systems

When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental. See WAC 182-534-0100 for EPSDT rules.

Exception to Rule (ETR)

The agency evaluates a request for medical services, equipment, and/or supplies that are listed as noncovered under the provisions of WAC 182-501-0160 that relates to noncovered services. The request for a noncovered medical service, equipment, or supply is called a "request for an exception to rule." See WAC 182-501-0160 for information about exception to rule (ETR).

To request an ETR, see What documentation is required when requesting a PA or ETR?

Coverage Table (for Children)

	Procedure Code	Modifier	Short Description	Policy Comments
Monaural	V5246	LT, RT, RA	Hearing aid, prog, mon, ite	Includes a prefitting evaluation, an ear mold and at least 3 follow-up appointments.
	V5247	LT, RT, RA	Hearing aid, prog, mon, bte	
	V5256	LT, RT, RA	Hearing aid, digit, mon, ite	
	V5257	LT, RT, RA	Hearing aid, digit, mon, bte	
	V5050	LT, RT, RA, RR	Hearing aid monaural in ear	Invoice required.
	V5060	LT, RT, RA, RR	Behind ear hearing aid	
Binaural	V5260	RA	Hearing aid, digit, bin, ite	Do not bill in conjunction with a monaural hearing aid.
	V5261	RA	Hearing aid, digit, bin, bte	
CROS/BiCROS	V5171		Hearing aid monaural ite	Invoice required.
	V5181		Hearing aid monaural bte	
	V5211		Hearing aid binaural ite/ite	
	V5213		Hearing aid binaural ite/bte	
	V5215		Hearing aid binaural itc/bte	
	V5221		Hearing aid binaural bte/bte	
Other	V5040		Body-worn hearing aid bone	
	V5264	RA	Ear mold/insert	Replacement only.
	V5275	RA	Ear impression, each	Replacement only.
	V5014	RT, LT, RB (for casing)	Hearing aid repair/modifying	Used when billing for repair of a **hearing aid.** Maximum of 2 repairs in 1 year. (Includes parts and labor)
	V5266		Battery for hearing device	
	V5298		Hearing aid noc	PA/invoice required.

Legend

Modifiers: **RA** = Replacement of DME Item
RB = Replacement Part of DME Item
LT = Left
RT = Right
RR = Rental

Note: Reimbursement for all hearing instruments dispensed includes all of the following:

- A prefitting evaluation
- An ear mold
- A minimum of three post-fitting consultations

HCPCS Code	Short Description	PA?	Policy
L7510	Prosthetic device repair rep	PA	
L8615	Coch implant headset replace	Use EPA #870000001. If client does not meet EPA clinical criteria, PA is required.	
L8616	Coch implant microphone repl		
L8617	Coch implant trans coil repl		
L8618	Coch implant tran cable repl		
L8619	Coch imp ext proc/contr rplc	PA	PA
L8621	Repl zinc air battery	Use EPA #870000001. If client does not meet EPA clinical criteria, PA is required.	
L8622	Repl alkaline battery		
L8623	Lith ion batt CID,non-earlvl		
L8624	Lith ion batt CID, ear level		
L8625	Charger coch impl/aoi battry	PA	Replacement only, each
L8627	CID ext speech process repl	PA	
L8628	CID ext controller repl	PA	
L8629	CID transmit coil and cable	PA	
L8691	Osseointegrated snd proc rpl	PA	
L8692	Non-osseointegrated snd proc	PA	
L8694	Aoi transducer/actuator repl	PA	Replacement only, each
L9900	O&P supply/accessory/service	PA	

Legend

EPA: Expedited Prior Authorization
PA: Prior Authorization required

Coverage (for Adults)

To receive payment from the Health Care Authority (agency) for providing hearing hardware to clients age 21 and older, clients must meet the eligibility and criteria stated in this billing guide.

What is covered?

(WAC 182-547-0850)

For clients age 21 and older, the agency covers the following:

- **Nonrefurbished, monaural hearing aids.** The agency covers one new nonrefurbished monaural hearing aid, which includes the ear mold, every 5 years. The client must have an average decibel loss of 45 or greater in the better ear, based on a pure-tone audiometric evaluation by a licensed audiologist or a licensed hearing aid specialist at 1000, 2000, 3000, and 4000 Hertz (Hz) with effective masking as indicated. The hearing aid must meet the client's specific hearing needs and carry a manufacturer's warranty for a minimum of one year.

- **Binaural hearing aids.** The agency covers binaural hearing aids. Prior authorization (PA) is required. See Prior Authorization - Adults for more details.

Replacement

The agency covers the following replacements only if the need for the replacement is not due to the client's carelessness, negligence, recklessness, deliberate intent, or misuse under WAC 182-501-0050:

- One replacement hearing aid, including the ear mold, in a 5-year period when the client's hearing aid(s) is lost or broken and cannot be repaired, and the warranty is expired

- One replacement ear mold, per year when the client's existing ear mold is damaged or no longer fits the client's ear

- Batteries, with a valid prescription from an audiologist

Repair of hearing aids

The agency covers two repairs, per hearing aid, per year, when the cost of the repair is less than 50% of the cost of a new hearing aid. To receive payment, all warranties must have expired and the repair is under warranty for a minimum of 90 days.

Repair or replacement of external parts of cochlear implant devices and bone conduction hearing devices

The agency covers the following:

- Repair or replacement of external parts of cochlear implant devices. If the client has bilateral cochlear implant devices, both devices are eligible for repair and replacement of external parts.

- Repair or replacement of external parts of bone conduction hearing aids, whether implanted or worn with a headband. If the client has bilateral bone conduction hearing aids, both devices are eligible for repair and replacement of external parts.

PA is required. See the Coverage Table for specific procedure codes.

Rental of hearing aids

The agency covers the rental of hearing aid(s) for up to 2 months while the client's own hearing aid(s) is being repaired. For rental hearing aid(s) only, the agency pays separately for an ear mold(s).

Second hearing aid

The agency pays for a second hearing aid when the client either meets the clinical criteria or a limitation extension is requested and approved.

> **Note:** Auditory rehabilitation may be covered under other programs. Clients may be referred to an audiologist or speech language pathologist to determine the medical necessity of auditory rehabilitation. See the Physician-related services billing guide and the Outpatient rehabilitation billing guide for details.

What is not covered?

(WAC 182-547-0900)

The agency does not cover the following items for clients age 21 and older:

- Tinnitus maskers

- Frequency Modulation (FM) systems, including the computer-aided hearing devices for FM systems

- Nonprescription hearing aids or similar devices including, but not limited to, the following:

  - ✓ Personal sound amplification products (PSAPs)
  - ✓ Hearables
  - ✓ Pocket talkers or similar devices

Exception to Rule (ETR)

The agency evaluates a request for medical services, equipment, and supplies that are listed as noncovered under the provisions of WAC 182-501-0160 that relates to noncovered services. The request for a noncovered medical service, equipment, or supply is called a "request for an exception to rule." See WAC 182-501-0160 for information about exception to rule.

See What documentation is required when requesting PA or ETR? for details on submitting requests for ETR.

(See Where can I download agency forms?)

Coverage Table (for Adults)

The following procedure codes are the **only procedure codes** the agency pays for under the Hearing Hardware program. Bill your usual and customary charge. Payment will be the lesser of the billed charge or the maximum allowable fee.

Monaural

Code Status	HCPCS Code	Modifier	Short Description	PA?	Policy Comments
	V5050	RR	Hearing aid monaural in ear	No	Billed as a rental only
	V5060	RR	Behind ear hearing aid	No	Billed as a rental only
	V5246	LT, RT, RA	Hearing aid, prog, mon, ite	No	For average hearing loss 45 dBHLs or greater. Bundled rate includes all of the following: • An audiometric evaluation • An impression for an ear mold • An ear mold • The fitting fee, which includes up to three follow-up visits for the fitting, orientation, and checking of the hearing aid • The dispensing fee • A conformity evaluation, if done • Three batteries When billing for a second hearing aid, use EPA #870001552. If client does not meet EPA clinical criteria, PA is required.
	V5247	LT, RT, RA	Hearing aid, prog, mon, bte	No	
	V5256	LT, RT, RA	Hearing aid, digit, mon, ite	No	
	V5257	LT, RT, RA	Hearing aid, digit, mon, bte		

Legend

Modifiers:
RA = Replacement of DME Item
RB = Replacement Part of DME Item
LT = Left
RT = Right
RR = Rental

Note: If a client has been using one hearing aid for 90 days and the agency authorizes a second hearing aid, bill for the second hearing aid using a monaural procedure code. Billing a binaural code in conjunction with a monaural code within 5 years is not allowed without prior authorization.

Binaural

Code Status	HCPCS Code	Modifier	Short Description	PA?	Policy Comments
	V5260	RA	Hearing aid, digit, bin, ite	Yes	Do not bill in conjunction with a monaural hearing aid.
	V5261	RA	Hearing aid, digit, bin, bte	Yes	Do not bill in conjunction with a monaural hearing aid.

CROS/BiCROS

Code Status	HCPCS Code	Modifier	Short Description	PA?	Policy Comments
	V5171		Hearing aid monaural ite	Yes	Invoice required
	V5181		Hearing aid monaural bte	Yes	Invoice required
	V5211		Hearing aid binaural ite/ite	Yes	Invoice required
	V5213		Hearing aid binaural ite/bte	Yes	Invoice required
	V5215		Hearing aid binaural itc/bte	Yes	Invoice required
	V5221		Hearing aid binaural bte/bte	Yes	Invoice required

Legend

Modifiers:
RA = Replacement of DME Item
RB = Replacement Part of DME Item
LT = Left
RT = Right
RR = Rental

Other

Code Status	HCPCS Code	Modifier	Short Description	PA?	Policy Comments
	V5011		Hearing aid fitting/checking	Use EPA #870001600. If client does not meet EPA clinical criteria, PA is required.	Allowed up to three times per year for additional follow-up visits only after the initial three visits bundled with each new hearing aid are used
	V5040		Body-worn hearing aid bone		
	V5264	RA	Ear mold/insert		
	V5275		Ear impression	Use EPA #870001599. If client does not meet EPA clinical criteria, PA is required.	For annual ear impression, per hearing aid if needed.
	V5014	RT, LT, RB (for casing only)	Hearing aid repair/modifying		
	V5298		Hearing aid noc		

Legend

Modifiers:
RA = Replacement of DME Item
RB = Replacement Part of DME Item
LT = Left
RT = Right
RR = Rental

HCPCS Code	Short Description	PA?	Policy
L7510	Prosthetic device repair rep	PA	
L8615	Coch implant headset replace	Use EPA #870000001. If client does not meet EPA clinical criteria, PA is required.	
L8616	Coch implant microphone repl		
L8617	Coch implant trans coil repl		
L8618	Coch implant tran cable repl		
L8619	Coch imp ext proc/contr rplc	PA	PA
L8621	Repl zinc air battery	Use EPA #870000001. If client does not meet EPA clinical criteria, PA is required.	
L8622	Repl alkaline battery		
L8623	Lith ion batt CID,non-earlvl		
L8624	Lith ion batt CID, ear level		
L8625	Charger coch impl/aoi battry	PA	Replacement only, each
L8627	CID ext speech process repl	PA	
L8628	CID ext controller repl	PA	
L8629	CID transmit coil and cable	PA	
L8691	Osseointegrated snd proc rpl	PA	
L8692	Non-osseointegrated snd proc	PA	
L8694	Aoi transducer/actuator repl	PA	Replacement only, each
L9900	O&P supply/accessory/service	PA	

Legend

EPA: Expedited Prior Authorization
PA: Prior Authorization required

Where can I find the fee schedule?

See the agency's Hearing hardware fee schedule webpage.

Authorization (for Children)

What is prior authorization (PA)?

PA is agency approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider payment.

Does the agency require prior authorization for hearing hardware?

(WAC 182-547-1000)

No. Except for certain services specified in the Coverage table, PA is **not** required for clients age 20 and younger for hearing aids and services.

> **Note:** The agency pays for services according to the early and periodic screening, diagnostic, and treatment (EPSDT) provisions, as described in Chapter 182-534 WAC. The standard for coverage for EPSDT is that services, treatment, or other measures are medically necessary, safe and effective, and not experimental.

Providers must send claims for clients age 20 and younger directly to the agency. **Providers do not need to obtain authorization from the local Children with Special Health Care Needs (CSHCN) Coordinator.**

What is expedited prior authorization (EPA)?

The EPA process is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an EPA number using those codes.

The agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number. The billing provider must document in the client's file how the EPA criteria were met and make this information available to the agency upon request.

> **Note:** When billing electronically, enter the EPA number in the *Prior Authorization* section.

Replacement parts - EPA criteria

The following EPA criteria must be met:

- The cochlear implant device or bone conduction hearing device is unilateral (bilateral requires PA).
- The manufacturer's warranty has expired.
- The part is for immediate use (not a back-up part).

> **Note:** If the client does not meet the EPA criteria, then PA is required.

Use **EPA 870000001** with **HCPCS codes L8615-L8618, L8621-L8624** when billing for cochlear implant device or bone conduction hearing device replacement parts.

What documentation is required when requesting PA or ETR?

Providers may submit requests for prior authorization online through direct entry into ProviderOne (see the agency's prior authorization webpage for details), or by faxing the following to 1-866-668-1214:

- ✓ A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form MUST be the initial page when you submit your request.
- ✓ A completed *Hearing Aid Authorization Request* form, HCA 13-772, and all the documentation listed on this form and any other medical justification.

To access forms, see Where can I download agency forms?

Prior Authorization (for Adults)

What is prior authorization (PA)?

PA is agency approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider payment.

What hearing hardware does the agency require prior authorization for?

(WAC 182-547-0850 (1))

The agency requires PA for binaural hearing aids for eligible clients age 21 and older.

> **Note:** The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501-0169.
> (WAC 182-547-1050 (3))

What is expedited prior authorization (EPA)?

The EPA process is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an EPA number using those codes.

The agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number. The billing provider must document in the client's file how the EPA criteria were met and make this information available to the agency upon request.

> **Note:** When billing electronically, enter the EPA number in the *Prior Authorization* section.

What documentation is required when requesting PA or ETR?

Providers may submit requests for PA online through direct entry into ProviderOne (see the agency's prior authorization webpage for details). Providers must complete the *Hearing Aid Authorization Request* form, HCA 13-772, attach all documentation listed on the form, and provide medical justification.

Providers may also submit their requests for PA by faxing the following to 1-866-668-1214:

- ✓ A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form MUST be the initial page when you submit your request.
- ✓ A completed *Hearing Aid Authorization Request* form, HCA 13-772, and all the documentation listed on this form and any other medical justification.

To access forms, see Where can I download agency forms?

Note: When the agency authorizes hearing aids or hearing aid-related services, the PA indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for covered services at the time those services are provided.

EPA criteria table

EPA code	HCPCS code	Short description	Clinical criteria
870000001	L8615	Coch implant headset replace	The following must be met: 1. The cochlear implant device or bone conduction hearing device is unilateral (bilateral requires PA). 2. The manufacturer's warranty has expired. 3. The part is for immediate use (not a back-up part).
	L8616	Coch implant microphone repl	
	L8617	Coch implant trans coil repl	
	L8618	Coch implant tran cable repl	
	L8621	Repl zinc air battery	
	L8622	Repl alkaline battery	
	L8623	Lith ion batt CID,non-earlvl	
	L8624	Lith ion batt CID, ear level	
870001552	V5246	Hearing aid, prog, mon, ite	**Second Hearing Aid** for clients 21 years of age and older, who have tried to adapt with one hearing aid for a **period of 90 days**, whose auditory screening shows an average hearing of **45 dBHL** or greater in both ears and **one** or more of the following is documented in the client's record. The client is: 1. Unable to or has difficulty with conducting job duties with only one hearing aid. 2. Unable to or has difficulty with functioning in the school environment with only one hearing aid. 3. Unable to live safely in the community with only one hearing aid. 4. Legally blind. If a client has been using one hearing aid for 90 days, and the agency authorizes a second hearing aid, bill for the second hearing aid using a monaural
	V5247	Hearing aid, prog, mon, bte	
	V5256	Hearing aid, digit, mon, ite	
	V5257	Hearing aid, digit, mon, bte	

EPA code	HCPCS code	Short description	Clinical criteria
			procedure code. Billing a binaural code in conjunction with a monaural code within 5 years is not allowed without prior authorization.
870001599	V5275	Ear impression	For annual ear impression, per hearing aid if needed.
870001600	V5011	Hearing aid fitting/checking	Allowed up to three times per year for additional follow-up visits only after the initial three visits bundled with each new hearing aid are used

What are limitation extensions?

Limitation extensions (LEs) are requests to authorize covered services beyond the limit regarding scope, amount, duration, or frequency of a covered service. The agency does not approve LEs when prohibited by program rules. When an LE is permissible, the client's provider must establish that it satisfies criteria in WAC 182-501-0169, including being medically necessary.

Note: Requests for LEs must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups receive all services.

How do I request a limitation extension?

You may request an LE two ways:

- Providers may be able to obtain authorization for an LE using an EPA number. These EPA numbers are subject to post payment review as in any other authorization process. (See: **What is Expedited prior authorization (EPA)**

- In cases where the client's situation does not meet the EPA criteria for an LE, but additional services appear medically necessary, providers may submit LE requests online through direct entry into ProviderOne (see the agency's prior authorization webpage for details), or by faxing the following to 866-668-1214:

  ✓ A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form MUST be the initial page when you submit your request.

  ✓ A completed *Hearing Aid Authorization Request* form, HCA 13-772, and all the documentation listed on this form and any other medical justification.

To access forms, see Where can I download agency forms?

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the agency's ProviderOne billing and resource guide. These billing requirements include the following:

- Time limits for submitting and resubmitting claims and adjustments
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

Note: For guidance on when a provider may bill a client, see the agency's "Billing a Client" webinar presentation.

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

Providers must keep documentation of all hearing tests and results in the complete client's chart and record.

This includes, but is not limited to, the following tests:

- Audiogram results/graphs/tracings (including air conduction and bone conduction comparisons)
- Basic or simple hearing tests or screening, such as is done in many schools
- Tympanogram

A valid prescription from an audiologist for replacement batteries must be kept in the client's chart.

Note: To receive payment, the provider must keep documentation in the client's medical file to support the medical necessity for the specific make and model of the hearing aid ordered for the client. This documentation must include the record of the audiology testing providing evidence that the client's hearing loss meets the eligibility criteria for a hearing aid. (WAC 182-547-1100 (4))

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers, providers, and partners webpage.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA electronic data interchange (EDI) webpage.

The following claim instructions relate to the Hearing Hardware program.

Name	Field Required	Entry
Reserved for Local Use	When applicable	Enter either of the following: • "SCI=B" (Baby on parent's ProviderOne Client ID). • Claim notes.
Prior Authorization Number	When applicable	Use the prior authorization number assigned to you if/when services have been denied and you are requesting an exception to rule.
Procedure Code	Yes	Enter the appropriate Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS) procedure code for the services being billed. Modifier: When appropriate, enter a modifier.

About the Program (for DDA Clients)

When does the Division of Developmental Disabilities (DDA) pay for hearing aids?

DDA pays for hearing aids when they are:

- Medically necessary.
- Authorized as required within this billing guide and Chapters 182-501, 182-502, and 388-845 WAC.
- Billed according to this billing guide and Chapters 182-501 and 182-502 WAC.
- Provided to an eligible client. (See How can I verify a patient's eligibility?).
- Of direct medical or remedial benefit to the client and necessary as a result of the client's disability.
- Identified in the waiver participant's DDA assessment and documented in the person-centered plan.
- Requested for prior approval by the DDA client's case manager and approved by the DDA regional administrator or designee.

Client Eligibility (for DDA Clients)

How can I verify a client's eligibility?

Providers must verify that a patient has a valid social services authorization for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the administration will not pay for.

Providers can verify that a client has a valid social services authorization in ProviderOne. (See How do I view a social services authorization?)

Coverage (for DDA Clients)

What is covered?

(WAC 388-845-1810)

Monaural or binaural hearing aids

The administration covers new, non-refurbished, monaural or binaural hearing aids, which includes the ear mold and batteries, for clients eligible for the service. In order for the provider to receive payment, the hearing aid must meet the client's specific hearing needs necessary as a result of the individual's disability and be under warranty for a minimum of one year.

See the Social services blanket code to procedure crosswalk for specific procedure codes.

Replacement

The administration pays for the following replacements when approved with a social services authorization:

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

Repair

The administration pays for repair when approved with a social services authorization. To receive payment, all the following must be met:

- All warranties are expired.
- The repair is under warranty for a minimum of 90 days.

Rental

The administration pays for a rental hearing aid for up to two months while the client's own hearing aid is being repaired. In the case of a rental hearing aid, the agency pays separately for an ear mold.

Cochlear implant device – replacement parts

(WAC 182-547-0800 (4))

The administration covers:

- Cochlear implant device external speech processors, including maintenance, repair, and batteries.

- Bone conduction hearing device speech processors, including maintenance, repair, and batteries.

See the Social services blanket code to procedure crosswalk for specific procedure codes.

The administration pays for cochlear implant device or bone conduction hearing device replacement parts when:

- The manufacturer's warranty has expired.
- The part is for immediate use, not a back-up part.
- The part needs to be replaced due to normal wear and tear and is not related to misuse or abuse of the item (see WAC 182-501-0050).

When reimbursing for battery packs, the administration covers the least costly, equally effective product.

> **Note:** The administration does not pay providers for repairs or replacements that are covered under the manufacturer’s warranty.

What is not covered?

The administration does not cover the following hearing and hearing aid-related items and services for clients age 21 and older:

- Tinnitus maskers
- Group screenings for hearing loss

Coverage Table (for DDA clients)

See the Social services blanket code to procedure crosswalk for a list of covered services.

Where can I find the fee schedule?

See the agency's Hearing hardware fee schedule webpage.

Authorization (for DDA Clients)

What is a social services authorization?

A social services authorization is administration approval for certain services, equipment, or supplies before the services are provided to clients as a precondition for provider payment.

How do I request a social services authorization?

The client or the client's representative may request authorization of hearing hardware through the Washington State Developmental Disabilities Administration (DDA) Home and Community Based waiver benefit by contacting the client's case manager. The provider can assist the client or representative in requesting a social services authorization by providing the following information to the DDA case manager:

- Reason for denial through the client's Apple Health benefit
- What equipment is necessary, using the names and procedure codes of the equipment
- An exact amount of the total cost of all equipment requested, using the Apple Health Hearing Hardware Fee Schedule
- How the hearing hardware will assist the client to perceive, control, or communicate with the environment in which they live or to increase their abilities to perform activities of daily living
- How the items are of direct medical or remedial benefit to the client and necessary because of the client's disability
- How the ancillary supplies or equipment will support proper functioning and continued use of the equipment, if the needed equipment supports the continued functioning of equipment the client already uses

How do I view a social services authorization?

The social services authorization can be viewed in ProviderOne. If you have questions about the social services authorization, contact the case manager listed on the authorization.

Providers will receive an alert message when a social services authorization has been created or changed. To view the social services authorization from the provider portal:

1. Select Social Services View Authorization List. The Provider Authorization List Page will appear.

2. Enter the authorization number from the alert or search by the Client ID.

What happens after the social services authorization is approved?

When the prior approval is reviewed and approved, the case manager will enter a social service authorization for SA893 for one unit and a dollar amount based on the information used to request a prior approval.

The provider will bill using the appropriate HCPCS codes for the equipment and will be paid no more than the amount listed in the Hearing hardware fee schedule.

Billing (for DDA Clients)

What are the general billing requirements?

Providers must follow the Apple Health ProviderOne billing and resource guide. These billing requirements include the following:

- Time limits for submitting and resubmitting claims and adjustments
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

> **Note:** For information on when a provider may bill a client, see the agency's "Billing a Client" webinar presentation.

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

Providers must keep documentation of all hearing tests and results in the complete client's chart and record.

This includes, but is not limited to, the following tests:

- Audiogram results/graphs/tracings (including air conduction and bone conduction comparisons)
- Basic or simple hearing tests or screening, such as those done in schools
- Tympanogram

A valid prescription from an audiologist for replacement batteries must be kept in the client's chart.

> **Note:** To receive payment, the provider must keep documentation in the client's medical file to support the medical necessity for the specific make and model of the hearing aid ordered for the client. This documentation must include the record of the audiology testing providing evidence that the client's hearing loss meets the eligibility criteria for a hearing aid. (WAC 182-547-1100 (4))

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers, providers, and partners webpage.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA electronic data interchange (EDI) webpage.

The following claim instructions relate to the Hearing Hardware program.

Name	Field Required	Entry
Prior Authorization Number	Yes	Use the social services authorization number assigned to you.
Procedure Code	Yes	Enter the appropriate Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS) procedure code for the services being billed. Modifier: When appropriate, enter a modifier.