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Related Clinical Coverage Policies
Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:
1A-4, *Cochlear and Auditory Brainstem Implants*

1.0 Description of the Procedure, Product, or Service

The NC Medicaid (Medicaid) and NC Health Choice (NCHC) programs provide hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.

Note: This policy does not address cochlear or auditory brainstem implant coverage. For eligible beneficiaries with profound hearing impairment requiring cochlear or auditory brainstem implantation, refer to clinical coverage policy 1A-4, *Cochlear and Auditory Brainstem Implants*.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

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

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>

Medicaid shall not cover Hearing Aid Services, according to these policy criteria, for beneficiaries 21 years of age and older.

b. <u>NCHC</u>

NCHC shall not cover Hearing Aid Services, according to these policy criteria, for beneficiaries under 6 and over 18 years of age.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. 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 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 meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health

problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid or NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Covered hearing aid products and services include:

a. Hearing aids
b. FM systems

c. Care kit
d. Batteries
e. Repairs
f. Cords, replacement tubes, retention straps, retention garments, harnesses, baby covers, "Huggies"
g. Custom ear molds
h. Dispensing fees

3.2.1.1 In-the-Ear Hearing Aids

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

3.2.1.2 Analog and Digital Programmable Hearing Aids

Analog and digital programmable hearing aids may be approved based on medical necessity and the ability of the device to meet the beneficiary's basic needs. The type of aid that is needed must be included in the prior approval request. Each request is reviewed on a case-by-case basis.

3.2.1.3 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. For consideration of FM systems not covered through IDEA, providers shall submit an electronic prior approval request at http://www.nctracks.nc.gov along with documentation of medical necessity. Each request is reviewed on a case-by-case basis.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid or NCHC shall not cover procedures, products, and services related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Non-covered hearing aid products and services include:

a. battery charger or tester
b. adapter for telephone, television, or radio
c. shipping, handling, postage, or insurance fee
d. loss and damage insurance
e. in-the-ear hearing aid that is requested for primarily cosmetic purpose
f. extended warranty policy

This list is not all inclusive.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
    1. No services for long-term care.
    2. No nonemergency medical transportation.
    3. No EPSDT.
    4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

The provider shall obtain prior approval by submitting an electronic prior approval request at http://www.nctracks.nc.gov for all hearing aids, FM systems, care kits, repairs, accessories, custom ear molds, replacement parts, batteries in excess of six claims per year with a maximum of $35 per claim, and dispensing fees.

Prior approval requests for hearing aids must include the hearing aid manufacturer's name, model name or number, style (body, BTE, etc.), type (analog or digital programmable, etc.) and the estimated invoice cost.

5.1.1 Documentation Requirements for Prior Approval Requests for New Hearing Aids

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

a. a copy of a current medical clearance signed by the physician (including otologist, otolaryngologist, and otorhinolaryngologist) for beginning the hearing aid selection process;
b. a copy of the initial hearing evaluation, including the audiogram and results of the hearing aid selection and written evaluation; and
c. a copy of the manufacturer's warranty and loss and damage policy.

Note: A current medical clearance is a medical clearance based upon a medical evaluation which has taken place within the preceding six months.

5.1.2 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.

Refer to **Attachment A, Section H,** regarding reimbursement requirements for hearing aids and related items.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

None Apply.

5.3 Limitations or Requirements

The beneficiary shall receive a medical examination from a physician (including otologist, otolaryngologist and otorhinolaryngologist) and documentation of medical clearance for the initiation of the hearing aid selection process.

5.3.1 Initial Evaluation

The beneficiary shall receive a hearing evaluation by a licensed audiologist, including an audiogram.

5.3.2 Trial Period

The beneficiary shall be given a 30 calendar-day trial period for hearing aids and hearing aid accessories prior to the post-dispensing evaluation. The beneficiary or guardian and the provider shall sign the Hearing Aid Post-Dispensing Evaluation Form after the trial period.

5.3.3 Post-Dispensing Evaluation

A Hearing Aid Post-Dispensing Evaluation Form is available at http://www.nctracks.nc.gov and must be completed by the provider and submitted with the claim for prior approved newly fit hearing aids.

a. If the hearing aid and related items are acceptable to both the provider and the beneficiary or guardian, the provider shall complete the Hearing Aid Post-Dispensing Evaluation Form. The form must include the signature of the beneficiary or guardian and the provider.

b. If the dispensed aid and related items are not acceptable to the provider or the beneficiary or guardian, no Hearing Aid Post-Dispensing Evaluation Form is necessary. Instead, the provider shall contact the state's fiscal agent to void the previously approved request and submit a electronic prior approval request for the more appropriate hearing aid.

c. If the beneficiary evaluation cannot be done within 30 calendar days after the aids a dispensed, the provider shall document on the Hearing Aid Post-Dispensing Evaluation Form the dates of attempts to contact the beneficiary and the reason there was no follow-up (no transportation, broken appointments, lack of cooperation by parent, etc.). The completed form must be signed by the provider.

Refer to **Attachment A**., **Section H**, **2**, **b** regarding the Hearing Aid Post-Dispensing Evaluation Forms and reimbursement.

5.3.4 Mandatory Services Included in a New Hearing Aid Dispense

The following services are included in a new hearing aid dispense:

a. The beneficiary shall receive delivery and fitting of the new hearing aid or aids, FM system, custom ear molds, other approved accessories and a one month supply of batteries.

b. The recipient shall receive instructions and counseling on the use and care of the hearing aid or aids and accessories.

c. The recipient shall receive service and regular maintenance as recommended by the manufacturer for a period of at least one year from the date of

dispensing at no extra cost to the hearing aid provider, recipient, Medicaid, or NCHC.

Refer to **Attachment A, Section H**, regarding reimbursement requirements for hearing aids and related items.

5.3.5 Hearing Aid Accessories

5.3.5.1 Care Kit

An initial care kit is covered as a separate accessory, to include a stethoscope, forced air blower, and dry aid kit. Providers shall give the recipient or guardian instructions on the use and care of the instruments. If an additional care kit, or any component of the care kit, is needed providers shall submit an electronic prior approval request that outlines the following:

a. the circumstances surrounding the loss or damage of the kit/component,
b. steps that have been taken to recover the kit/component.

Refer to **Attachment A**, **Section H**, **1 and 2**, regarding reimbursement requirements for initial care kits.

5.3.5.2 Dry and Store Kit

Dry and Store Kits may be requested for beneficiaries with moisture special needs. Providers shall submit an electronic prior approval request with documentation of medical necessity. Each request is reviewed on a case-by-case basis.

5.3.5.3 Ear Molds

Providers shall submit an electronic prior approval request for all ear molds.

Refer to **Attachment A**, **Section H**, **1, 2, and 8** regarding reimbursement requirements for ear molds.

5.3.5.4 Batteries

Up to six claims for batteries ($35.00 maximum per claim) per year do not require prior approval. If additional batteries are needed, providers shall submit an electronic prior approval request with documentation of medical necessity. Each request is reviewed on a case-by-case basis.

Refer to **Attachment A**, **Section H, 1, 2, and 10** for instructions regarding reimbursement requirements for batteries.

5.3.5.5 Miscellaneous Accessories

Cords, replacement tubes, retention straps, retention garments, baby covers, harnesses, and “Huggies” are covered accessories and the providers shall submit an electronic prior approval request for these accessories. Other accessories are evaluated on a case-by-case basis.

Refer to **Attachment A, Section H, 1, 2, and 9** regarding reimbursement requirements for hearing aid accessories.

5.3.6 Manufacturer Repairs

The following guidelines apply to hearing aid repairs:

a. Prior approval is required for all hearing aid repairs, or dispensing fees for repairs billed to Medicaid or NCHC.
b. Providers shall record an explanation of the necessary manufacturer or factory repair on the prior approval request form.
c. All manufacturer or factory repairs must be covered under warranty for six months following the repair.

Refer to **Attachment A, Section H, 1 and 4** regarding reimbursement requirements for manufacturer repairs.

5.3.7 Replacement Aids

5.3.7.1 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.

5.3.7.2 Documentation for Replacement Hearing Aids

The following documentation guidelines apply when requesting replacement hearing aids.

Medicaid beneficiaries needing replacement hearing aids because they were lost or damaged shall obtain a letter from a case manager or eligibility worker at the local DSS office. The letter should explain:

a. the circumstances surrounding the loss or damage of the aid;
b. steps that have been taken to recover the aid; and
c. the DSS recommendation for replacement.

A copy of the letter must accompany the electronic prior approval request, found at http://www.nctracks.nc.gov.

Medicaid beneficiaries receiving Social Security Income (SSI) or who are legally adopted are not required to obtain a letter from a DSS case manager or eligibility worker. Instead, providers shall note on the electronic prior approval request that the recipient receives SSI or is legally adopted.

NCHC beneficiaries requesting replacement hearing aids shall communicate to the provider the circumstances surrounding the loss or damage. Providers shall include this information on the electronic prior approval request.

Refer to **Attachment A, Section H, 1 and 3** regarding reimbursement requirements for replacement hearing aids.

5.3.8 Previous Hearing Aids

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

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Providers shall be licensed by the state of North Carolina as a hearing aid dealer and fitter (facility providers shall also enroll as hearing aid dealer and fitter providers).

6.1.1 Conditions for Participation

Enrolled providers shall 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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: February 1, 1976

Revision Information:

Date	Section Revised	Change
09/22/1999	Subsection 3.2.3	Services were revised to include coverage of FM systems and programmable hearing aids
12/01/2006	Subsection 2.3	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
04/01/2007	Attachment A	The Place of Service table was removed and a list of allowed places of service was added.
04/01/2007	Sections 2.3, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age
05/01/2007	Subsection 5.1	Deleted "not covered by the manufacturer's warranty and loss and damage policy" from "replacement parts." A dispensing fee is paid for all replacement parts, so all replacement parts require prior approval.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age.
07/01/2010	All sections and attachment(s)	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/12/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 7 under Session Law 2011-145, § 10.41.(b)
06/15/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
05/01/2013	Subsection 2.1	Added ",birth through 20 years of age," so first sentence is: NC Medicaid (Medicaid) beneficiaries, birth through 20 years of age, shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.
05/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
07/01/2013	All sections and attachment(s)	Changed "HP" to "CSC." Updated websites and contact information. Updated Prior Approval instructions to match CSC technology.

07/01/2013	Attachment A, F	Updated place of service numerical values.
07/01/2013	Attachment D	Added contractor contact information.
08/15/2014	Subsection 2.1.2	Statement for NCHC corrected **from**, "NCHC shall not cover Hearing Aid Services, according to these policy criteria, for beneficiaries under 6 and over 8 years of age" **to** " NCHC shall not cover Hearing Aid Services, according to these policy criteria, for beneficiaries under 6 and over 18 years of age."
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
10/01/2015	Attachment A, A and H.11.	Updated to reflect legislative changes to G.S. 97D-14(b) and DMA Provider Enrollment criteria revisions as they relate to G.S. 97D-14(b) by adding doctor of audiology to providers eligible for credentialing to render services outlined in this policy.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Hearing aid dealer and fitter or doctor of audiology provider bills services on the CMS-1500 claim form or the 837 professional transaction.

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
The relevant HCPCS codes are as follows:

HCPCS Code	Use When Billing For The Following Service(s)
V5014	Repair or modify hearing aid
V5050	Any newly fit monaural hearing aid
V5060	Any replacement hearing aid
V5090	Dispensing new monaural hearing aid
V5110	Dispensing new binaural hearing aids
V5130	All newly fit binaural hearing aids
V5160	Dispensing assistive listening/FM system
V5240	Dispensing hearing aid repair
V5241	Dispensing hearing aid replacement
V5264	Ear molds
V5266	Battery (bill one unit per claim)
V5267	Supplies and accessories
V5274	FM system only
V5299	Dispensing accessories and ear molds

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Provider(s) shall **not** bill modifiers for services covered under the Hearing Aid Policy.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient hospital (21), outpatient hospital (22), comprehensive outpatient rehabilitation facility (62), office (11), state or local public health clinics (71), rural health clinics (72), and home (12).

Place of service coding information is found in the North Carolina Medicaid Bulletin, December 2005, under All Providers, Place of Service Codes. The Web address is http://www.ncdhhs.gov/dma/bulletin/1205bulletin.htm.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://www.ncdhhs.gov/dma/plan/sp.pdf.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

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

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, see: http://www.ncdhhs.gov/dma/fee/

1. Reimbursement for Hearing Aids and Related Items

Reimbursement for all hearing aids and related items except batteries is at 100% of the manufacturer's invoice cost to the provider, less the applicable discounts, shipping, handling, taxes and non-covered items and services. All discounts must be *documented. The amount billed cannot exceed the cost that the provider paid to the* manufacturer or supplier.

a. Invoices must include the beneficiary's name and hearing aid model and serial number.
b. Invoices for a bulk purchase must be billed for the appropriate percentage of the total invoice and denote which hearing aid or related item belongs to the named recipient.

2. Additional Reimbursement Requirements for New Hearing Aids

The following billing guidelines apply to new hearing aid claims:

a. Providers shall bill V5050 (hearing aid) and V5090 (dispensing) for one new hearing aid and V5130 (hearing aids) and V5110 (dispensing) for two new hearing aids.

b. All electronic and paper claims for new hearing aids must be accompanied by a manufacturer invoice and a Hearing Aid Post-Dispensing Evaluation Form.

c. A separate dispensing fee cannot be billed for ear molds, initial care kits, or accessories which are considered components of the new hearing aids.

d. The initial month supply of batteries cannot be billed separately.

e. The dispensing claim can only be billed after the recipient has received a post-dispensing evaluation, which should generally occur within thirty days after dispensing. Refer to **Subsection 5.3.3, c** for exception to the thirty day post-dispensing evaluation requirement.

3. Reimbursement for Replacement Hearing Aids

The following billing guidelines apply to replacement hearing aid claims:

a. Providers shall bill V5060 (hearing aid) and V5241 (dispensing) for a replacement hearing aid.

b. If the hearing aid being replaced is covered under the manufacturer's warranty and loss and damage policy, reimbursement is limited to the manufacturer's loss and damage replacement fee, if applicable, and the invoice cost of the related, prior approved accessories not covered by the policy, and a dispensing fee.

c. If the hearing aid being replaced is no longer covered under the manufacturer's warranty and loss and damage policy, reimbursement is limited to the invoice cost, less the applicable discounts, shipping, handling, or taxes, of the approved replacement aid, accessories, and a dispensing fee.

d. Electronic and paper claims must be accompanied by invoices which include the beneficiary's name and the hearing aid model and serial number.

e. Providers 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.

4. Reimbursement for Manufacturer Repairs for Hearing Aids

The following billing guidelines apply to manufacturer repair for hearing aid claims:

a. Providers shall bill V5014 (repair) and V5240 (dispensing) for hearing aid repairs.

b. Reimbursement for the repair of a hearing aid covered under the manufacturer's warranty and loss and damage policy is limited to a service fee, if applicable, and a hearing aid dispensing fee.

c. Reimbursement for the repair of a hearing aid not covered by the manufacturer's warranty and loss and damage policy is limited to the factory invoice cost of the repair and a hearing aid dispensing fee.

d. Electronic and paper claims must be accompanied by invoices which include the beneficiary's name and the hearing aid model and serial number.

5. Reimbursement for New FM System

The following guidelines apply to new FM system claims:

a. Providers shall bill V5274 (FM system) and V5160 (dispensing fee).
b. Electronic and paper claims must be accompanied by an invoice.

6. Reimbursement for Replacement FM System

The following guidelines apply to replacement of FM system claims:

a. Providers shall bill V5274 (FM system) and V5241 (dispensing) for a replacement FM system.
b. If the FM system being replaced is covered under the manufacturer's warranty and loss and damage policy, reimbursement is limited to the manufacturer's loss and damage replacement fee, if applicable, and a dispensing fee.
c. If the FM system being replaced is no longer covered under the manufacturer's warranty and loss and damage policy, reimbursement is limited to the invoice cost, less the applicable discounts, shipping, handling, or taxes, and a dispensing fee.
d. Electronic and paper claims must be accompanied by invoices which include the beneficiary's name and FM system information.

7. Reimbursement for Repair of FM System

The following billing guidelines apply to manufacturer repair for FM system claims:

a. Providers shall bill V5014 (repair) and V5240 (dispensing).
b. Reimbursement for the repair of a FM system covered under the manufacturer's warranty and loss and damage policy is limited to a service fee, if applicable, and a dispensing fee.
c. Reimbursement for the repair of a FM system not covered by the manufacturer's warranty and loss and damage policy is limited to the factory invoice cost of the repair and a dispensing fee.
d. Electronic and paper claims must be accompanied by invoices which include the beneficiary's name and the FM system information.

8. Reimbursement for Ear Molds

The following guidelines apply to ear mold claims:

a. Providers shall bill V5264 (ear mold) and V5299 (dispensing).
b. Providers shall not bill an ear mold dispensing fee on a new hearing aid claim.
c. Electronic and paper claims for ear molds must be accompanied by an invoice.

9. Reimbursement for Accessories

The following guidelines apply to accessory claims:

a. Providers shall bill V5267 (accessory) and V5299 (dispensing) accessories for accessory reimbursement.
b. Electronic and paper claims for accessories must be accompanied by an invoice or invoices.
c. For claims with multiple invoices, providers shall bill one unit with the combined invoice total and one dispensing fee.

10. Reimbursement for Batteries

The following guidelines apply to battery claims:

a. Providers shall bill V5266 (battery) as one unit for each battery claim up to $35.
b. Providers shall not bill a dispensing fee for batteries.
c. Claims for batteries do not require an invoice.
d. The initial month supply of batteries for a new hearing aid cannot be billed separately, as it is considered a component of the new hearing aid.

11. Hearing Aid Taxonomy Code

All hearing aid and accessory claims must include the hearing aid taxonomy code, 237700000X which maps to the hearing aid dealer and fitter or 23760000X which maps to doctor of audiology, who received the initial prior approval for the hearing aid service(s).

Attachment B: Instructions for Submitting Attachments for Electronic Prior Approval Requests and Claims

A. Electronic Prior Approval Attachment

Providers shall submit required prior approval request attachments through either:

1. The web, at http://www.nctracks.nc.gov
2. Fax to, (855) 710-1964

B. Electronic Claim Attachment

Providers shall submit required claim attachments through either:

1. The web, at http://www.nctracks.nc.gov
2. Fax to, (919) 859-9703

Attachment C: Required Documentation Examples for Prior Approval Requests for Newly Fit Hearing Aid(s)

The provider shall include, with all prior approval requests for newly fit hearing aids, written evaluation, medical clearance, audiogram, , and manufacturer warranty information. Below are examples of each of the required documents:

October 2, 2009

Medicaid
MEDICAL REVIEW/EVALUATION

Re: Joe B. Patient
Medicaid ID #: 999-99-9999-Q
DOB: 4/1/1999
Tax ID: 01-2345678
NPI: 1234567890

To Whom It May Concern:

Joe B. Patient was seen on 9-29-2009 in the Department of Speech Pathology and Audiology. Auditory Brainstem Response (ABR) testing revealed a mild sensorineural hearing loss for his left ear. Please see attached report. Without appropriate amplification, this hearing loss can be educationally and communicatively handicapping. We are requesting prior authorization for monaural hearing aid, earmold, initial care kit, and the dispensing fee for the new hearing aid.

Appropriate hearing aid for Joe would be the Phonak Nios micro V behind-the-ear hearing aid. Alternative hearing aids were considered but it was decided that the requested hearing aid would be most appropriate.

If there are any questions, Ms. Smith or myself can be contacted at (999) 555-5555.

Sincerely,

A Great Provider

A Great Provider, M.A. CCC-A
Clinical Audiologist

A GREAT PROVIDER
Department of Speech and Audiology

Hearing Aid Dispensary

Name: Joe B. Patient

Office MRN: 0918273

DOB: 4/1/1999

MEDICAL CLEARANCE FOR HEARING AID USE

I have evaluated this patient and determined that there are no medical contraindications to hearing aid use.

Special considerations:

X. Y. White MD
Physician's Signature

X. Y. White MD
Physician's Name (Please Print)

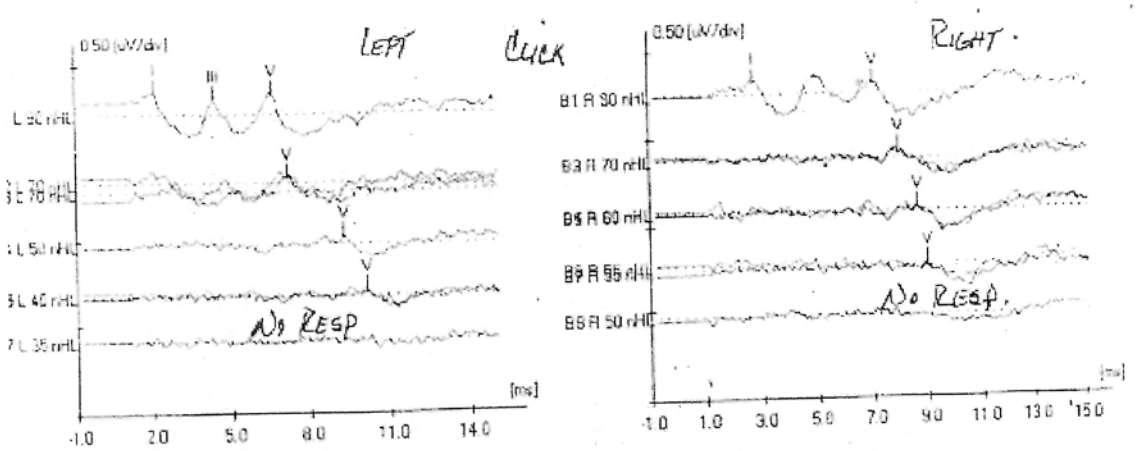
9/29/2009
Date

EVOKED POTENTIAL REPORT

A Great Provider
Audiology Department
123 Any Street
Anytown, NC 12345
(999) 555-5555

Patient:	Joe B. Patient	*Birth date:*	4/1/99	*Physician:*	Dr. X. Y.White
ID#:	ABC123	*Test date:*	10/2/09	*Tested by:*	A. Smith/B. Jones
Gender	Male			TIME IN: 1:45	
Results	Auto# 50A/14			TIME OUT: 4:30	

BACKGROUND: Joe is an 1 month old with a diagnosis of Costello Syndrome and complicated medical history including atrial tachycardia, cardiac arrest, J-tube, and trach. She has a history of referring in one ear or the other on AABR and OAE tests. Due to her significant developmental delay she is not behaviorally testable. Diagnostic ABR testing in conjunction with tube placement was recommended. RESULTS: Repeatable ABR responses were observed to click stimuli down to 40 dBnHL in the left ear and down to 55 dBnHL in the right ear. Responses to 500 Hz tone burst stimuli were observed down to 40 dBnHL (corrected to 20 dB) in the left ear and down to 60 dBnHL (corrected to 40dB) in the right ear. Responses to masked bone conduction clicks were obtained down to 35-40 dBnHL in the left ear and down to 20-25 dBnHL in the right ear. No significant evidence of auditory neuropathy/dyssynchrony was seen with reversal of click polarity IMPRESSIONS: Results of ABR testing are interpreted to indicate the presence of a mild peripheral hearing loss in the left ear and a mild to moderate peripheral hearing loss in the right ear. Bone conduction testing suggests the left ear loss to be of sensorineural origin while the right appears to be predominantly conductive in etiology. It is unknown whether the right ear conductive loss is temporary in nature. It should be noted that a small right pre-auricular tag is present. RECOMMENDATIONS: 1)Earmold impressions were taken today for acquisition of a hearing aid(s). 2)Otologic clearance for hearing aid use in the left ear will be sought from Dr. White . If the right ear conductive loss appears to be permanent on f/u, a hearing aid will be acquired for that ear also. 3)Repeat OAE testing at time of F/U to assist in determining need for hearing aid in right ear. Anne Audiologist MSA CCC/A



Collection Parameters

Trace	Transducer	Ear	Intensity	Type	Frequency
A1	Insert Earphones	Left	90dB nHL	Click	N/A
A2	Insert Earphones	Left	70dB nHL	Click	N/A
A3	Insert Earphones	Left	70dB nHL	Click	N/A
A4	Insert Earphones	Left	50dB nHL	Click	N/A

Latencies (ms)

I	II	III	IV	V
2.08		4.39		6.64
				7.20
				9.26

Interlatencies (ms)

I-III	III-V	I-V
2.31	2.25	4.56

PRICE & POLICY - 04.01.10

Warranty Policy

- All new Exélia Art, Versáta Art, Naida IX & V, Audéo MINI/SMART/YES/ZIP IX & V & Nios micro V digital hearing instruments are covered by a 2-year warranty.
- All other new Phonak hearing instruments are covered by a 12-month warranty.
- inspiro, ML9i, ML10i, ML11i, ML12i, MLxi, MLxi BAHA, iSense, SmartLink+, ZoomLink+, EasyLink+, MyLink+ & DynaMic are covered by a 2-year warranty.
- All other new Phonak FM transmitters and receivers are covered by a 12-month warranty.
- Warranties for BTE and FM instruments begin at the date of invoice and include a 60-day grace period to account for the stocking time.
- Warranties for ITE instruments begin at date of invoice and incluoe a 30-day grace period.
- Most accessories are covered for 90 days for defects in materials and workmanship. The following accessories carry a 12-month warranty: accessory microphones, boom microphones, auxiliary input cords, myPilot and iCom.

Hearing Instrument Extended Warranty Coverage

Extended new product warranties can be ordered at any time during the instrument's coverage under Phonak's Original Manufacturing Warranty.

2nd, 3rd & 4th Year Extended "Protection Plus" Warranty	Per Year
Classic/Analog/Wireless CROS/BiCROS	$ 109.00
Digital/Programmable	$ 119.00
FM Transmitter/Receiver	$ 109.00
FM Charger	$ 25.00
DHC/SoundPilot/WatchPilot2/myPilot	$ 59.00
FM Auxiliary Products	$ 59.00

Right-of-Return Policy

All hearing instruments may be returned up to 60 days from date of invoice unless otherwise stated on the invoice. A restocking fee of $100 will apply to all products returned after 60 days from invoice date. Certain promotional activities may restrict the right-of-return. Reconditioned hearing instruments cannot be returned for credit.

Service & Repair Plan

Devices less than 5 years post invoice date:

Description	6 - Month	12 - Month
Classic/Analog/Wireless CROS/ BiCROS	$ 119.00	$ 139.00
Digital/Programmable	$ 129.00	$ 149.00
FM	$ 119.00	$ 139.00
Remotes & DWA *(myPilot, iCom & iCube)*	$ 60.00	$ 70.00
Transmitter Mic	$40.00	N/A
FM Auxiliary Products	$60.00	$70.00
Remote Battery Change ($25)	N/A	N/A

Service & Repair Plan Continued

Devices more than 5 years post invoice date:

Description	6 - Month	12 - Month
Classic/Analog/Wireless CROS/ BiCROS	$ 169.00	N/A
Digital/Programmable	$ 179.00	N/A
FM	$ 139.00	N/A
Remotes & DWA *(myPilot, iCom & iCube)*	$ 70.00	N/A

Repair Disclosure: Instruments more than 5 years post invoice date will be repaired if parts are available.

Remake & Recase Service Options

Remake and recase charges are in addition to a service plan.

Options	Recase	Remake*
ITE	N/A	$ 169.00
BTE	$ 39.00	N/A

*All remakes are for the same model, same ear and same patient.

Service Options	Price
24-Hour Rush Service Fee*	$ 49.95
Shipping Directly to Residential Address	$ 19.95
Shipping and Handling	$ 16.99
Packaging for Pick-up Orders	$ 4.95

*24-hour service can be provided at an additional charge.
Rush service refers to the "in-house" time required. Please add an additional 2-3 days for shipping when estimating delivery time.

Shipping & Handling Charges

A charge of $16.99 per order will be assessed to cover shipping and administrative costs. These charges are non-refundable and will not be credited on hearing instruments returned for credit. A packaging fee of $4.95 will be assessed on all pick-up orders.

Payment Terms

All payment terms are net 30 days from invoice date. Phonak will assess a 1.5% interest charge per month on all past due balances.

Special Handling Charge for Shipping to Residential Addresses

An additional charge of $19.95 will be assessed when shipping orders directly to a residential address. Please be aware that this is necessary due to higher incidents of loss, theft and incorrect addressing that occurs when sending directly to residential addresses. To do so, please provide a complete address (FedEx does not accept P.O. boxes), a contact name and telephone number for delivery questions.

As a service to you, Phonak's standard mode of shipment is FedEx.

Attachment D: Contractor Contact Information

This contact information is for providers only and should not be given to Medicaid or NCHC recipients. Recipients may call the phone number on the back of their Medicaid or NCHC card.

A. State's Fiscal Agent Contractor

CSC is the fiscal agent contracted by DMA to process Medicaid and NCHC prior approval requests and claims for Medicaid enrolled providers according to DMA's policies and guidelines.

Fiscal Agent Prior Approval Unit	CSC P. O. Box 31188 Raleigh, North Carolina 27622 Fax (855) 710-1964
Fiscal Agent Claims Unit	CSC Enterprises P. O. Box 30968 Raleigh, North Carolina 27622 Fax (919) 859-9703
CSC Call Center	Phone: (800) 688-6696

B. Provider Enrollment and Support Contractor

CSC is the agent contracted by DMA to perform Medicaid provider enrollment, verification, credentialing provider file update and maintenance.

EVC Call Center	866-844-1113