Hearing Services
<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 Published: February 25, 2016</td>
<td>New document</td>
<td>FSSA and HPE</td>
</tr>
<tr>
<td>1.1</td>
<td>Policies and procedures as of April 1, 2016 Published: July 12, 2016</td>
<td>Scheduled update</td>
<td>FSSA and HPE</td>
</tr>
<tr>
<td>1.2</td>
<td>Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 28, 2017</td>
<td>CoreMMIS update</td>
<td>FSSA and HPE</td>
</tr>
<tr>
<td>2.0</td>
<td>Policies and procedures as of June 1, 2017 Published: December 12, 2017</td>
<td>Scheduled update</td>
<td>FSSA and DXC</td>
</tr>
</tbody>
</table>
| 3.0     | Policies and procedures as of June 1, 2018 Published: December 20, 2018 | Scheduled update:  
- Edited and reorganized text as needed for clarity  
- Incorporated text from relevant sections of the Medical Policy Manual  
- Updated links to the new IHCP website  
- Updated the note box at the beginning with new standard wording  
- Added references to the EPSDT/HealthWatch and Therapy Services modules in the Introduction section  
- Added a reference to the Provider Enrollment module in the Audiologists and Hearing Aid Dealers section  
- Updated the Audiological Assessments/Hearing Tests section, including:  
  - Added an IAC reference  
  - Added information about providers eligible to perform audiological assessments  
  - Added a reference to the new code table for audiological assessments  
- In the Medical Clearance and Audiometric Test Form section, clarified provider restrictions for Part II of the form | FSSA and DXC |
Clarified information about comprehensive audiometry versus other audiometric testing in the **Reimbursement for Hearing Tests** section

Updated the list of applicable items and added a note about hearing aid checks in the **Hearing Services That Do Not Require Prior Authorization** section

Updated the **Hearing Aids** section and its subsections, including:
- In the **Reimbursement for Hearing Aids** subsection, added references to the Fee Schedule and cost invoices and removed reference to the manually priced hearing aids code table
- Removed the EOB from the **Hearing Aid Dispensing Fee** subsection
- Added the **Coverage Criteria by Type of Hearing Aid** subsection

Clarified PA requirements in the **Cochlear Implants** section and added a reference to the **Surgical Services** module

Merged the **Cochlear Implant Maintenance and Repair** section into **Maintenance and Repair of Hearing Aids and Cochlear Implants**

Merged the **Cochlear Implant Replacement** section into **Replacement of Hearing Aids and Cochlear Implants** and clarified the information
# Table of Contents

Introduction................................................................................................................................ 1  
Audiologists and Hearing Aid Dealers..........................................................................................1  
Audiological Assessments/Hearing Tests .......................................................................................1  
  Medical Clearance and Audiometric Test Form ........................................................................2  
  Reimbursement for Hearing Tests ............................................................................................2  
  Hearing Services That Do Not Require Prior Authorization ......................................................3  
Hearing Aids....................................................................................................................................3  
  Reimbursement for Hearing Aids ...............................................................................................3  
  Hearing Aid Dispensing Fee ......................................................................................................4  
  Coverage Criteria by Type of Hearing Aid ...............................................................................4  
Cochlear Implants ..........................................................................................................................5  
Maintenance and Repair of Hearing Aids and Cochlear Implants ..............................................5  
Replacement of Hearing Aids and Cochlear Implants ................................................................6
Hearing Services

Note: For updates to coding, coverage, and benefit information, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.

The information in this module applies to services provided under the fee-for-service delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization requirements, billing procedures, and reimbursement methodologies. For services covered under the managed care delivery system, providers must contact the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member’s MCE or refer to the MCE provider manual for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.

Introduction

The Indiana Health Coverage Programs (IHCP) provides coverage of hearing services for eligible members. The following sections outline coverage parameters, prior authorization (PA) requirements, and billing procedures for hearing services, including diagnostic, preventive, and corrective services and the purchase, repair, and replacement of hearing aids and cochlear implants.

For information about augmentative and alternative communication (AAC) devices, see the Durable and Home Medical Equipment and Supplies module. For information about speech-language pathology services, see the Therapy Services module. See the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch module for more information regarding hearing screenings for newborns and children.

Audiologists and Hearing Aid Dealers

Audiologists (provider specialty 200) must be licensed and enrolled in the IHCP to receive IHCP reimbursement for services rendered. Hearing aid dealers (provider specialty 220) must be registered and enrolled in the IHCP to receive IHCP reimbursement for services. See the Provider Enrollment module for more information.

See Hearing Services Codes on the Codes Sets page at in.gov/medicaid/providers for procedure code sets that licensed audiologists and registered hearing aid dealers must use when billing the IHCP.

Audiological Assessments/Hearing Tests

IHCP coverage of audiological services is subject to the restrictions in Indiana Administrative Code 405 IAC 5-22-7, which include the following:

- A physician must certify in writing the need for audiology assessment or evaluation.
- The audiological assessment must be conducted by a licensed audiologist or otolaryngologist.
- If the member is to be fitted with a hearing amplification device, additional requirements apply, as described in the following section, Medical Clearance and Audiometric Test Form.
- IHCP reimbursement for audiological assessments is limited to one assessment every 3 years per member. For applicable codes, see Hearing Services Codes on the Codes Sets page. If more frequent audiological assessments are necessary, providers must obtain PA. PA requests are assessed on a case-by-case basis, based on documented otologic disease.
Note: All testing must be conducted in a sound-free enclosure. If a member is institutionalized and his or her physical or medical condition precludes testing in a sound-free enclosure, the ordering physician must verify medical confinement in the initial order for audiological testing.

Medical Clearance and Audiometric Test Form

When a member is to be fitted with a hearing amplification device, by either the audiologist or a registered hearing aid dealer, the Medical Clearance and Audiometric Test Form (the medical clearance form for hearing aids) must be completed in accordance with the following instructions and submitted with the request for PA:

- Any involved professionals must complete the member history (Part I of the form).
- A physician must complete Part II of the form no earlier than 6 months before the provision of the hearing aid:
  - For members 14 years of age and younger, an otolaryngologist must perform the examination.
  - For members 15 years of age and older, any licensed physician may perform the examination if an otolaryngologist is not available.
- A licensed audiologist or otolaryngologist must conduct the audiological assessment and complete Part III of the form. The IHCP does not reimburse for testing conducted by other professionals and cosigned by an audiologist or otolaryngologist.
  The member must receive further evaluation from an otolaryngologist if the audiological evaluation reveals one or more of the following conditions:
    - Speech discrimination testing indicates a score of less than 60% in either ear.
    - Pure tone testing indicates an air bone gap of 15 decibels or more for two adjacent frequencies in the same ear.
- The hearing aid evaluation (Part IV of the form) may be completed by a licensed audiologist or registered hearing aid dealer. The results must be documented on the PA request and must indicate that the member can derive significant benefit from amplification.
- A registered hearing aid dealer must sign the hearing aid contract portion of the form (Part V).

The Medical Clearance and Audiometric Test Form is available from the Forms page at in.gov/medicaid/providers. Providers must ensure that the form is complete and includes the proper signatures, where indicated. The completed form must be mailed or faxed along with the universal IHCP Prior Authorization Request Form, also available from the Forms page, or submitted as an attachment to the prior authorization request on the Provider Healthcare Portal.

Reimbursement for Hearing Tests

The IHCP considers hearing tests, such as whispered voice and tuning fork, to be part of the general otolaryngology services. Providers cannot fragment these services and bill them separately.

Basic comprehensive audiometry includes pure tone, air and bone threshold, and discrimination testing provided for both ears. The IHCP reimburses for all other audiometric testing procedures on an individual basis, only when such procedures are medically necessary.

Audiology services provided by a nursing facility or large private or small ICF/IID s are not separately reimbursed, as audiology services are included in the facility’s established per diem rate.
**Hearing Services That Do Not Require Prior Authorization**

The following hearing services do not require PA:

- Screening tests to determine the need for additional medical examination (screenings are not reimbursed separately under the IHCP)
- Audiological assessments (one per 3 years)
- Determinations of suitability of amplification and recommendations about a hearing aid
- Determinations of functional benefit gained by use of a hearing aid
- Audiology services provided by a nursing facility or large private or small ICF/IID, which are included in the facility’s established per diem rate

**Note:** Effective November 17, 2017, hearing aid checks in one ear or both ears no longer require prior authorization.

**Hearing Aids**

In accordance with 405 IAC 5-19-13, the IHCP provides reimbursement for the purchase of hearing aids under the following conditions:

- PA is required for the purchase of hearing aids.
  - Hearing aids will be authorized only if they are medically necessary and significant, objective benefit to the member is documented. See the [Coverage Criteria by Type of Hearing Aid](#) section for specific requirements.
  - Professional services associated with dispensing a hearing aid must be performed and the Medical Clearance and Audiometric Test Form must be completed and submitted with the PA request, as described in the Medical Clearance and Audiometric Test Form section of this module.
- Hearing aids purchased by the IHCP become the property of the FSSA. All hearing aids purchased by the IHCP that are no longer needed by a member must be returned to the county Division of Family Resources (DFR).
- The IHCP does not cover hearing aids for members with a unilateral pure tone average (500, 1,000, 2,000, or 3,000 hertz) equal to or less than 30 decibels.
- The IHCP does not reimburse for canal hearing aids.

If a provider voluntarily provides a loaner hearing aid for a 30-day trial period, the loaner hearing aid for that 30-day trial period does not require PA. Purchase of a hearing aid becomes effective with the authorization of the PA request.

**Reimbursement for Hearing Aids**

Hearing aids are reimbursed at the [IHCP Fee Schedule](#) rate, if available. Manually priced hearing aid procedure codes are reimbursed at 75% of the manufacturer’s suggested retail price (MSRP). When billing these codes, providers are required to submit documentation of the MSRP (or cost invoice if no MSRP is available for the item).
**Hearing Aid Dispensing Fee**

The hearing aid dispensing fee, which is limited to once per 5 years per member, includes all services related to the initial fitting and adjustment of the hearing aid, orientation of the patient, and instructions on hearing aid use. The IHCP covers the following procedure codes for hearing aid dispensing fees:

- V5160 – Dispensing fee, binaural
- V5241 – Dispensing fee, monaural hearing aid, any type

The dispensing fee codes may be billed only in conjunction with hearing aid codes that have an established Medicaid rate. The dispensing fee codes may not be billed with hearing aid codes that are manually priced. The dispensing fee code should be billed with the date the hearing aid is delivered. Prior authorization is not required for these dispensing fee codes. Prior authorization is required if a dispensing fee is medically necessary more than once every 5 years.

**Coverage Criteria by Type of Hearing Aid**

IHCP covers conventional (air conduction), bone-anchored (bone conduction), contralateral routing of signals (CROS)/bilateral-contralateral routing of signals (BiCROS), and programmable hearing aids. Prior authorization is required for the purchase of any hearing aid.

**Bone-Anchored Hearing Aids**

Medical necessity indications for bone-anchored hearing aids (BAHAs) include the following:

- Chronic ear infection
- Congenital hearing loss
- Single-sided deafness (SSD)
- History of middle ear damage

**Programmable Hearing Aids**

The IHCP classifies programmable hearing aids as a customized item, which is defined as equipment uniquely constructed or substantially modified to meet the specific needs of an individual member.

Programmable hearing aids are usually considered a comfort/convenience and not medically reasonable or necessary. Coverage may be considered for any of the following indications:

- Fluctuating hearing loss resulting from a condition such as the following:
  - Meniere’s disease
  - Autoimmune sensorineural hearing loss
  - Otogenic syphilis
  - Large vestibular aqueduct syndrome
- Progressive hearing loss resulting from a condition such as the following (retrocochlear hearing loss must be excluded, particularly when the loss is asymmetrical):
  - Meniere’s disease
  - Alport syndrome
- Severe recruitment or very narrow dynamic range
- Very young children who are hard to test or hard to fit
- Hearing loss with unusual audiometric configurations
The PA requests for programmable hearing aids must be accompanied by the following documentation:

- A completed *Medical Clearance and Audiometric Test Form* (required with all PA requests for hearing aids, as described in the *Medical Clearance and Audiometric Test Form* section), with medical necessity for programmable hearing aids clearly documented in either the *Recommendation Information* section (Part III) or the *Special Conditions* section (Part IV)

- A record of the audiogram obtained not more than 3 months before the date of the request

- An otological examination report, signed by the physician, that includes the medical etiology and diagnosis for the hearing loss

- A diagnosis supporting the medical necessity (must be included on the PA request and on the claim)

- A documented case history that includes at least the following information regarding the member’s needs and lifestyle:
  - The member’s past history of hearing aid use
  - The reason programmable hearing aids, rather than conventional hearing aids, would be medically necessary
    - Documentation must be provided that supports the medical necessity of the programmable hearing aids outside vocational needs.
  - A description of the hearing environments in which the member has trouble hearing and to which the member is subjected
    - The frequency and duration of exposure to these environments should also be included.
  - Other relevant factors, such as lack of normal dexterity
    - Documentation of these factors should be included.

Documentation should support the number of preprogrammed settings requested. Only the least costly alternative medically necessary to meet the member’s hearing aid needs will be approved.

**Cochlear Implants**

Prior authorization is required for both the cochlear implant device and the implantation procedure. All prerequisite testing to document medical necessity also requires PA. For more information about cochlear implants, see the *Surgical Services* module.

**Maintenance and Repair of Hearing Aids and Cochlear Implants**

In accordance with *405 IAC 5-19-14*, the IHCP reimburses for the maintenance and repair of hearing aids and cochlear implants. The device must be in continuous use and must still meet the medical necessity needs of the member. All charges for parts and repairs are to reflect no more than the usual and customary (U&C) charge to the public.

The IHCP does not require PA for repairs to hearing aids and ear molds or cochlear implants, except when repairs are more frequent than once every 12 months.

Providers can obtain PA for more frequent repairs for members under 21 years of age if the provider documents circumstances justifying the need.
The IHCP does not require PA for the following accessories:

- For hearing aids – Batteries, sound hooks, tubing, or cords
- For cochlear implants – Batteries, headset/headpiece, microphone, and transmitting coil/cable

Providers must use the appropriate HCPCS code and indicate the number of packages in the units field of the CMS-1500 claim form or the electronic equivalent.

**Note:** The IHCP designates one unit of code V5266 to represent four batteries. Therefore, when submitting claims to the IHCP for reimbursement for hearing aid batteries, providers are to report one unit of V5266 for each package of four batteries supplied.

The IHCP does not pay for the following:

- Repair of hearing aids or cochlear implants still under warranty
- Routine servicing of functional hearing aids or cochlear implants
- Repair or replacement of hearing aids or cochlear implants that is necessitated by member misuse or abuse, whether intentional or unintentional

### Replacement of Hearing Aids and Cochlear Implants

In accordance with 405 IAC 5-19-15, the IHCP reimburses for the replacement of hearing aids and cochlear implants. Prior authorization is required for all replacements of hearing aids and cochlear implants.

The following requirements apply:

- Requests for a replacement hearing aid or cochlear implant must do both of the following:
  - Document a change in the member’s hearing status.
  - State the purchase date and condition of the current device.
- For replacement of a cochlear implant with an upgraded model, the following requirements must be met:
  - Documentation substantiates that the newer generation technology provides additional capacity.
  - The current implant has been worn for at least 4 years.
- Replacement hearing aids and cochlear implants are limited to once every 5 years; providers can obtain PA for more frequent replacements for members under 21 years of age if the provider documents circumstances justifying the need.
- The IHCP makes no payment for repair or replacement of hearing aids or cochlear implants that is necessitated by member misuse or abuse, whether intentional or unintentional.