INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Hearing Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 12, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: March 28, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of June 1, 2017 Published: Dec. 12, 2017	Scheduled update	FSSA and DXC
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4.0	Policies and procedures as of Aug. 1, 2019 Published: Oct. 3, 2019	Scheduled update	FSSA and DXC
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6.0	Policies and procedures as of Oct. 1, 2021 Published: Dec. 21, 2021	Scheduled update	FSSA and Gainwell
7.0	Policies and procedures as of June 1, 2023 Published: Aug. 29, 2023	Scheduled update: • Edited as needed for clarity • Updated where to send prior authorization information in the *Medical Clearance and Audiometric Test Form* section • Added a note clarifying unilateral pure-tone average in the *Hearing Aids* section • Updated the *Coverage Criteria by Type of Hearing Aid* section, removed the *Bone-Anchored Hearing Aids* subsection and updated the *Programmable Hearing Aids* subsection	FSSA and Gainwell

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> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Bulletins 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.

See the following modules for specific information not included in this module:

- For augmentative and alternative communication (AAC) devices, see the *Durable and Home Medical Equipment and Supplies* module.
- For speech-language pathology services, see the *Therapy Services* module.
- For hearing screenings for newborns and children, see the *Early and Periodic Screening, Diagnostic and Treatment (EPSDT)* module.

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.

For procedure codes that licensed audiologists and registered hearing aid dealers must use when billing the IHCP, see *Hearing Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

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 *Medical Clearance and Audiometric Test Form* section.
- IHCP reimbursement for audiological assessments is limited to one assessment every three years per member. For applicable codes, see *Hearing Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. If more frequent audiological assessments are necessary, providers must obtain PA. PA requests are assessed on a case-by-case basis, based on documented otological disease.

> *Note: All testing must be conducted in a sound-free enclosure. If members are institutionalized and their 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* (available from the *Forms* page at in.gov/medicaid/providers) 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 perform an examination and complete Part II of the form no earlier than six 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 licensed audiologist or registered hearing aid dealer must sign the hearing aid contract portion of the form (Part V).

Providers must ensure that the *Medical Clearance and Audiometric Test Form* is complete and includes the proper signatures, where indicated. The completed form must be submitted to the appropriate PA contractor for the member's plan (see the *IHCP Quick Reference Guide* for contact information). For FFS members, the form may uploaded as an attachment to the PA request using the FFS PA-UM contractor's provider portal, or it may be sent to the FFS PA-UM contractor by fax or mail, along with the universal *IHCP Prior Authorization Request Form* (also available from the *Forms* page).

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 unbundle 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 intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) 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 three 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, because these services are included in the facility's established per diem rate

> *Note: Hearing aid checks in one ear or both ears do not 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 a significant and 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 become the property of the state and may be required to be returned to the county Division of Family Resources (DFR).
- The IHCP does not reimburse for canal hearing aids.
- The IHCP does not cover hearing aids for members with a unilateral pure-tone average (for frequencies of 500, 1,000, 2,000 or 3,000 hertz) equal to or less than 30 decibels.

> *Note: "Unilateral pure-tone average" in this context is referring to the coverage of a hearing aid for a **single** ear. If an individual has one ear that has a pure-tone average (PTA) equal to or less than 30 decibels, they are denied a hearing aid only within that single ear. Meanwhile, if the other ear hears at a PTA greater than 30 decibels, the same individual is still entitled to a monaural hearing aid or a contralateral routing of signals (CROS) device to assist them with their hearing. Therefore, an individual who is hearing impaired in only one ear is entitled to hearing aid coverage under the IHCP, given that the PTA in the hearing-impaired ear is greater than 30 decibels.*
>
> *Additionally, providers are expected to use all four hertz levels (500, 1,000, 2,000 and 3,000 hertz) when calculating PTA for a member to satisfy prior authorization requirements. PTAs calculated with only three hertz levels (500, 1,000 and 2,000) do not satisfy PA requirements for 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 Professional Fee Schedule rate, if available for the code billed. The Professional Fee Schedule can be accessed from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Manually priced hearing aid procedure codes are reimbursed at 75% of the manufacturer's suggested retail price (MSRP) or 120% of cost invoice. 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 five 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 five years.

Coverage Criteria by Type of Hearing Aid

The 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. The IHCP follows national clinical guidelines when determining medical necessity.

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 necessary. Coverage may be considered when indicated according to national clinical guidelines.

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 three 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

The IHCP reimburses the cost of Healthcare Common Procedure Coding System (HCPCS) code L8614 – *Cochlear device, includes all internal and external components* separately from the cochlear implantation procedure when the implantation is performed in the outpatient surgical setting.

Facility providers may submit claims for separate reimbursement for L8614 on a professional claim (*CMS-1500* claim form, IHCP Provider Healthcare Portal professional claim or 837P electronic transaction). Prior authorization is not required for the cochlear implant (L8614); however, PA continues to be required for the *implantation procedure*. All prerequisite testing to document medical necessity also requires PA.

This module provides information about maintenance, repair and replacement of the cochlear implant. For information about the cochlear implantation procedure, including PA requirements, see the *Surgical Services* module.

Auditory Brainstem Implants

The IHCP covers HCPCS code S2235 – *Implantation of auditory brainstem implant*. Prior authorization is required.

HCPCS code S2235 encompasses both the implantation procedure and the device itself.

This module provides information about maintenance, repair and replacement of the auditory brainstem implant. For information about implantation of the device, including PA requirements, see the *Surgical Services* module.

Maintenance and Repair of Hearing Aids, Cochlear Implants and Auditory Brainstem Implants

The IHCP reimburses for the maintenance and repair of hearing aids, cochlear implants and auditory brainstem implants in accordance with *405 IAC 5-19-14*. 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 allows for repairs to hearing aids, ear molds, cochlear implants or auditory brainstem implants up to once every 12 months without PA. 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 pay for the following:

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

Accessories

The IHCP does not require PA for the following accessories:

- For hearing aids – Batteries, sound hooks, tubing or cords
- For cochlear implants and auditory brainstem implants – Batteries, headset/headpiece, microphone or 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.*

Replacement of Hearing Aids, Cochlear Implants and Auditory Brainstem Implants

The IHCP reimburses for the replacement of hearing aids, cochlear implants and auditory brainstem implants in accordance with *405 IAC 5-19-15*. Prior authorization is required for all replacements of hearing aids, cochlear implants and auditory brainstem implants. The following requirements apply:

- Requests for a replacement hearing aid, cochlear implant or auditory brainstem 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 or an auditory brainstem 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 four years.
- Replacement hearing aids, cochlear implants and auditory brainstem implants are limited to once every five 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, cochlear implants or auditory brainstem implants that is necessitated by member misuse or abuse, whether intentional or unintentional.