



Florida Medicaid

Hearing Services Coverage and Limitations Handbook

Agency for Health Care Administration





JEB BUSH
GOVERNOR

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SECRETARY

November 6, 2006

Dear Medicaid Hearing Services Provider:

Enclosed please find the revised Florida Medicaid Hearing Services Coverage and Limitations Handbook, July 2006. Please use this handbook in place of the January 2004 version, which is now obsolete. The handbook revisions include Medicaid coverage for hearing aids and cochlear implants for recipients age 21 and older, the policy that Medicaid reimburses for only one cochlear implant in either ear, policy clarifications, and updated billing information.

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Florida Medicaid Provider Handbook and Resource Library CD-ROM and on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services

UPDATE LOG

HEARING SERVICES

COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the number that appears on the front of the update.

Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
August1999—Revised Handbook	August 1999
Jan2001—Revised Handbook	January 2001
Update 02-1—Replacement Pages	January 2002
Update 03-1—Replacement Pages	March 2003
Jan2004—Revised Handbook	January 2004
Jan2005—Replacement Pages	January 2005
Jul2006—Revised Handbook	July 2006

HEARING SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

Chapter/Topic	Page
Introduction	
Handbook Use and Format.....	i
Characteristics of the Handbook.....	iii
Handbook Updates	iii
Chapter 1 – Provider Qualifications and Enrollment	
Purpose and Description.....	1-1
Provider Qualifications	1-2
Provider Enrollment.....	1-3
Provider Requirements	1-4
Mobile Hearing Units.....	1-5
Chapter 2 - Covered Services, Limitations, and Exclusions	
Covered and Excluded Services.....	2-1
Newborn Hearing Screenings	2-4
Hearing Evaluation Relative to Hearing Aid Candidacy	2-7
Diagnostic Tests.....	2-10
Criteria for Hearing Aid Manufacturers	2-12
Hearing Aid Fitting and Dispensing.....	2-14
Hearing Aids.....	2-19
Binaural Hearing Aids	2-20
Hearing Aid Repairs	2-22
Cochlear Implant Services.....	2-23
Chapter 3 - Procedure Codes and Fee Schedule	
Reimbursement Information.....	3-1
How to Read the Procedure Codes and Fee Schedule.....	3-2
Modifiers and Their Descriptions	3-4
Pricing Modifiers.....	3-5

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, and who is eligible to receive them.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii

Handbook Use and Format

Purpose	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.</p>
Provider	<p>The term "provider" is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
Recipient	<p>The term "recipient" is used to describe an individual who is eligible for Medicaid.</p>
General Handbook	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources is included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
Coverage and Limitations Handbook	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
Reimbursement Handbook	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
Chapter Numbers	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
Page Numbers	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
White Space	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update No." and the "Effective Date".

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

|Paragraph with new material. |

CHAPTER 1

HEARING SERVICES

PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Medicaid Hearing Services Program and the provider qualifications.

Legal Authority

Hearing services are authorized by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Part 440. The Florida Medicaid Hearing Services Program was implemented through Chapter 409.906, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

TOPIC	PAGE
Purpose and Description	1-1
Provider Qualifications	1-2
Provider Enrollment	1-3
Provider Requirements	1-4
Mobile Hearing Units	1-5

Purpose and Description

Purpose and Description

The purpose and description of hearing services is to provide Medicaid recipients with:

- Mandatory newborn hearing screenings;
- Medically-necessary hearing evaluations, diagnostic testing, hearing aids, hearing aid fitting and dispensing, hearing aid repairs and accessories; and
- Medically-necessary cochlear implant services including provision of the device, post-operative tuning of the headset, replacement and repairs.

Purpose of This Handbook

This handbook is intended for use by physicians, audiologists and hearing aid specialists who provide hearing services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment.

Purpose and Description, continued

Purpose of This Handbook, continued

Note: The Florida Medicaid provider handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.; and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Provider Qualifications

General Qualifications

To enroll as a Medicaid hearing services provider, the practitioner must be currently licensed as:

- An audiologist as defined in Chapter 468, Part I, F.S. and Section 1861(11)(3)(13) of the Social Security Act;
- A board certified otolaryngologist or otologist as defined in Chapters 458 or 459, F.S.;
- A hearing aid specialist as defined in Chapter 484, Part II, F.S.;
- A physician (in accordance with Chapters 458 or 459, F.S.) who maintains a certificate of testing and calibration of audiometric equipment as defined in Chapter 484, Part II, F.S.; or
- A Medicaid designated cochlear device manufacturer.

Note: See Chapter 2 in this handbook for the criteria for cochlear device manufacturers.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for information on out-of-state providers and services. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Supervision of Audiology Assistants and Pre-Professional Graduate Students

Audiology assistants and pre-professional graduates who do not meet the requirements to become a Medicaid provider must be supervised by a federally-qualified licensed Medicaid audiologist in order to provide any services to a Medicaid recipient.

Note: For more details on this requirement, please refer to the May 28, 2004 Federal Register, Page 30585.

Qualified at the Time of Enrollment

Hearing services providers must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Provider Enrollment

General Enrollment Requirements

Hearing services providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, hearing services providers must follow the specific enrollment requirements that are listed in this section.

Group Providers

Two or more Medicaid-enrolled providers whose practice is incorporated under the same tax identification number must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each Medicaid member of the group must also enroll as an individual treating provider within the group. The group must have a unique location code for each location in which a group member practices as described below.

Multiple Locations

Both individual and group providers who have practices at more than one location, i.e., satellite offices, must have a separate location code for each practice location. A location code is a physical location identifier that corresponds to the last two digits of the provider's Medicaid number. Providers must use the location code assigned to the practice location when billing for services provided at that location.

The provider must notify the Medicaid fiscal agent of additional practice locations. Notification must be made in writing on an Application for a New Location Code and must include an effective date for the new location. Applications for a New Location Code can be obtained from the Medicaid fiscal agent by calling 800-377-8216 or from its website at <http://floridamedicaid.acs-inc.com>.

Any closure of a practice location must also be reported to the Medicaid fiscal agent, in writing on office letterhead stationery, along with the effective date of the closure.

Provider Requirements

General Requirements

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, hearing providers are also responsible for complying with the provisions contained in this section.

Note: The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). Medicaid providers, including their staff, contracted staff and volunteers meet the definition of a covered entity according to HIPAA and must comply with HIPAA privacy requirements effective April 14, 2003, and HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

Mobile Hearing Units

**Mobile Hearing
Unit Description**

A mobile hearing services provider unit is a fully operational vehicle, unit, or trailer that travels to different locations for the provision of hearing services and is not a stationary unit.

**Mobile Hearing
Unit Services**

Medicaid does not reimburse any providers for mobile hearing services.

CHAPTER 2 HEARING SERVICES COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Hearing Services Program, the requirements for service provision, and the service limitations and exclusions.

In This Chapter

This chapter contains:

TOPIC	PAGE
Covered and Excluded Services	2-1
Newborn Hearing Screenings	2-4
Hearing Evaluation Relative to Hearing Aid Candidacy	2-7
Diagnostic Tests	2-10
Criteria for Hearing Aid Manufacturers	2-12
Hearing Aid Fitting and Dispensing	2-14
Hearing Aids	2-19
Binaural Hearing Aids	2-20
Hearing Aid Repairs	2-22
Cochlear Implant Services	2-23

Covered and Excluded Services

Introduction

Only those services designated in this chapter and listed in the Hearing Services Fee Schedule can be reimbursed by Medicaid to a hearing services provider.

Note: The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Covered and Excluded Services, continued

**Covered Services
for all Recipients**

Medicaid reimburses the following hearing services for all recipients:

- Mandatory newborn hearing screenings,
 - Hearing evaluations to determine hearing aid candidacy,
 - Diagnostic audiological testing,
 - Hearing aids,
 - Hearing aid fitting and dispensing,
 - Hearing aid accessories,
 - Hearing aid repair, and
 - Cochlear implant services including provision of the device, postoperative computerized tuning of the headset, repairs and replacement. (Implantation of the cochlear device is reimbursed through the Medicaid physician services program.)
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**Medically
Necessary**

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Covered and Excluded Services, continued

Hearing Screenings

The Medicaid Hearing Services Program reimburses hearing screenings only for Medicaid-eligible recipients from birth through 12 months of age. Medicaid children's hearing services does not reimburse for services performed exclusively for hearing screening for any other age group under any circumstances.

Hearing Screening in Conjunction With a Child Health Check-Up

Medicaid does not reimburse for procedure codes 92555 (speech audiometry threshold) or 92557 (comprehensive audiometry threshold evaluation) when these services are performed in conjunction with or on the same day of service as any of the following Child Health Check-Up (CHCUP) procedure codes: 99381, 99382, 99383, 99384, 99385 EP, 99391, 99392, 99393, 99394, or 99395 EP.

Newborn hearing screenings can be reimbursed when performed in conjunction with or on the same day as the above listed CHCUP procedure codes.

Note: See Newborn Hearing Screenings in this chapter for additional information.

Screening Definition

A screening is the testing of individuals who do not have complaints. It is designed to detect physical and mental conditions to determine the presence of a disease or of certain risk factors known to be associated with a disease or an anomaly. A screening also includes group testing of usually asymptomatic individuals to detect the manifestation of a disease or problem.

Recipients Out of the Country

Medicaid does not reimburse services furnished to recipients when they are out of the country.

Newborn Hearing Screenings

Description

The newborn hearing screening is for the purpose of testing all Medicaid eligible newborns for hearing impairment to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. The screening is a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation.

Newborns are required to either have the screening prior to discharge from the hospital or birthing center or a referral must be made for the screening.

Who Can Perform Screenings

All newborn and infant hearing screenings must be conducted by an audiologist who is licensed under Chapter 468, F.S. and meets the requirements of Section 1861(11)(3)(13) of the Social Security Act; a physician licensed under Chapter 458 or 459, F.S.; or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or licensed audiologist.

Direct supervision means the licensed physician or licensed audiologist:

- Is on the premises when the services are rendered, and
- Reviews, signs, and dates the medical record.

Indirect supervision means the licensed physician or licensed audiologist:

- Has established a well defined protocol by which the supervised individual performs the services;
 - Is available, so as to be physically present to provide consultation or direction in a timely fashion as required for appropriate care of the patient; and
 - Reviews, signs, and dates the medical record.
-

Eligible Recipients

Medicaid reimburses newborn hearing screenings for all eligible recipients from birth through 12 months of age. Any testing services performed on recipients who are over 12 months old must be performed based on medical necessity and prescribed by and documented by the physician.

Newborn Hearing Screenings, continued

Required Service Components

The required service components for infant hearing screening include at a minimum:

- Recipient's name,
- Screening method (i.e., OAE or ABR),
- Screening outcome for each ear, and
- Any risk factors related to hearing loss.

Required Diagnosis Code

All newborn hearing screening claims must use the diagnosis V72.19 on the CMS-1500 claim form for reimbursement.

Allowable Reimbursement

Non-hospital based hearing services providers who perform screenings in a facility using their own equipment or equipment they lease may bill for a complete procedure, which includes both the technical and the professional components, and receive the maximum fee.

Non-hospital based hearing services providers who perform screenings in a facility using facility-owned equipment may bill only the professional component, using a modifier on the CMS-1500 claim form.

Medicaid reimburses for newborn hearing screenings when performed in conjunction with or on the same day of service as any of the following Child Health Check-Up (CHCUP) procedure codes: 99381, 99382, 99383, 99384, 99385 EP, 99391, 99392, 99393, 99394, or 99395 EP. This applies to newborn hearing screenings done on recipients who are from birth through 12 months of age when the screening was not done prior to discharge from the hospital or birthing center.

Note: See Pricing Modifiers in Chapter 3 of this handbook for instructions on identifying the professional component.

Required Referrals

Any child who is diagnosed as having a permanent hearing impairment must be referred to the primary care physician for medical management, treatment, and follow-up services.

In addition, in accordance with the Infants and Toddlers Program and the Individuals with Disabilities Education Act (Public Law 105-17), any child from birth to 36 months of age who is identified as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services, Early Steps Program serving the geographical area in which the child resides within two calendar days of identification.

Newborn Hearing Screenings, continued

Refusal of Service If the newborn's parent or legal guardian objects to a screening, the screening must not be completed. The hearing services provider must maintain a record that the hearing screening was not performed and attach a written objection that is signed by the parent or guardian.

Prior Authorization Requirements There are no prior authorization requirements for newborn hearing screenings. Medicaid-eligible children who are enrolled in MediPass, HMOs, or Provider Service Networks do not require pre-authorization. Providers may bill Medicaid for screening services and receive the Medicaid rate of reimbursement.

Requirements for Medical Records Appropriate written documentation of service must be placed in the recipient's medical record within 24 hours after the provider completes the screening procedure or within 24 hours of the parent's or guardian's signed refusal of screening. The documentation must include:

- Referrals or reason for the screening (i.e., universal or hearing loss risk factors);
 - Screening completion including type of screen test administered, date of test, and tester's name;
 - Results;
 - Interpretation;
 - Recommendations;
 - Follow-up referrals for treatment, if applicable; and
 - Parent's or guardian's refusal of screening, if applicable.
-

Service Limitations Medicaid reimburses a maximum of two newborn hearing screenings per eligible newborn using auditory brainstem response, evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration.

If the screening procedure is interrupted because of recipient status or excessive noise, then the screening procedure must continue as soon as appropriate until a pass, fail or refer outcome is achieved. The process to obtain a pass or fail outcome will result in only one screening reimbursement regardless of the number of screenings performed to obtain the pass, fail or refer outcome.

Medicaid reimburses the second screening only if the child does not pass the initial hearing screening test in each ear.

Any additional testing required must include a signed statement from the physician and must be based solely on medical necessity. This statement must be placed in the medical record.

Hearing Evaluation Relative to Hearing Aid Candidacy

Description

The hearing evaluation relative to hearing aid candidacy is for the purpose of determining the level of hearing loss, the need for a hearing aid, and the type of aid that meets the recipient's needs. The evaluation includes a complete audiogram as appropriate for the age of the recipient and, when appropriate, will also include speech reception threshold, speech identification, most comfortable loudness (MCL) and uncomfortable loudness (UCL) values, and any other procedure necessary to select suitable amplification. Medicaid can reimburse for an evaluation even if it does not result in the dispensing of a hearing aid.

Who Can Perform Evaluations

Hearing evaluations must be performed by audiologists, hearing aid specialists, otolaryngologists or otologists.

Candidacy

A Medicaid-enrolled physician, physician assistant (PA), or nurse practitioner (ARNP) must determine the recipient's candidacy for a hearing evaluation before each evaluation. The medical determination must be made within twelve months before the hearing aid evaluation. Medicaid cannot reimburse an evaluation if the recipient's candidacy has not been established.

The candidacy statement must be written on the medical provider's letterhead stationary or prescription pad. The candidacy statement must be signed and dated by the physician, PA, or ARNP and include the statement that the recipient does not have a treatable medical problem that contraindicates the use of a hearing aid.

The hearing services provider must keep a copy of the candidacy statement in the recipient's medical record.

Hearing Evaluation Relative to Hearing Aid Candidacy, continued

Testing Environment

The provider must conduct audiometric tests in a testing room that has been certified not to exceed sound-pressure levels at specific frequencies. The frequencies are:

250 Hz-40 dB	3000 Hz-52 dB
500 Hz-40 dB	4000 Hz-57 dB
1000 Hz-40 dB	6000 Hz-62 dB
1500 Hz-42 dB	8000 Hz-67 dB
2000 Hz-47 dB	

An exception to the certified testing room requirement may be granted if the recipient requests that a test be conducted in a place other than a certified testing room. The exception request must be signed and dated by the recipient or the recipient's caregiver and retained in the recipient's medical record.

The exception is intended when difficulty is presented in transporting the recipient to a certified testing room, for example: an institutionalized recipient. The exception cannot become the provider's normal practice for the majority of services rendered. The specific reason for the exception must be documented and placed in the recipient's medical record.

Service Limitations

Medicaid reimburses only one hearing evaluation for the purpose of determining hearing aid candidacy, per recipient, every three years from the date of the last evaluation.

Authorization for additional evaluations may be granted through the prior authorization process, as described below.

When performing a hearing evaluation for the purpose of determining hearing aid candidacy or selection of a hearing aid, bill procedure code V5010.

Providers cannot bill for procedure codes 92557 and V5010 for the same recipient and same date of service.

Hearing Evaluation Relative to Hearing Aid Candidacy, continued

Prior Authorization for Additional Evaluations

In order to be reimbursed by Medicaid for additional hearing evaluations outside the normal program guidelines, the provider must obtain prior authorization before providing the service. Medicaid consultants will determine if the additional evaluation is medically necessary.

An additional hearing evaluation can only be authorized if the recipient meets one or more of the following criteria:

- Attends school or a training program;
 - Is gainfully employed or likely to become employed if a hearing aid is provided;
 - Is under the age of 21;
 - Is visually impaired;
 - Is physically handicapped and whose health and safety could be jeopardized without a hearing aid;
 - Lives alone and needs an evaluation for safety reasons;
 - Has a developmental disability;
 - Has a chronic mental disability; or
 - Has a chronic cognitive disability.
-

Required Documentation for Prior Authorization for Additional Evaluations

The provider must submit the following documentation with the prior authorization request:

- A physician's, physician assistant's, or nurse practitioner's (ARNP) statement indicating the medical necessity of the evaluation; and
- A copy of the last performed audiogram.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures and form. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Diagnostic Tests

Description

Medicaid reimburses audiologic diagnostic tests in addition to the hearing evaluation. The tests must be performed within accepted practice parameters. The tests must be performed by an otolaryngologist, otologist, or by an audiologist as described below.

Note: The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Required Service Components

The required service components for diagnostic testing are:

- Interpretation of study results with hard copy output, and
 - Analysis of data.
-

Tests Performed by Audiologists

An audiologist may perform the tests independent of physician supervision if a physician, advanced registered nurse practitioner, or physician assistant referred the recipient to the audiologist for the tests. The referral must include the reason for the referral and a statement of the problem. The audiologist must keep a copy of the referral in the recipient's medical record. All tests performed must also be documented in the recipient's medical record.

The name and provider number of the referring physician, advanced registered nurse practitioner, or physician assistant must be entered in items 17 and 17a of the CMS-1500 claim form or the equivalent media claims field when the test is performed and billed by an audiologist.

Audiologists must enter keyed claim type 60 in item 19 on the CMS-1500 claim form to prevent the claim from being denied if the referring number is not the MediPass primary care provider's number.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions on entering the keyed claim type on the claim. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Diagnostic Tests, continued

**Professional
Component Fee**

Non-hospital based hearing services providers who perform tests in a facility using their own equipment or equipment they lease may bill for a complete procedure, including both the technical and professional components, and receive full reimbursement.

Non-hospital based hearing services providers who perform tests in a facility using facility-owned equipment may bill only the professional component, using a modifier on the CMS-1500 claim form.

Note: See Pricing Modifiers in Chapter 3 of this handbook for instructions on identifying the professional component.

Criteria for Hearing Aid Manufacturers

Description

Medicaid hearing aid providers must provide hearing aids from manufacturers who meet the criteria described in this section.

Fixed Price

Manufacturers must agree to supply hearing aids (a complete instrument) at a single fixed price. No extra charge for postage and handling can be assessed. The price does not include a custom ear mold. Binaural contralateral routing of the signal (BICROS) and contralateral routing of the signal (CROS) adaptations are reimbursable at a separate fixed rate set by Medicaid in addition to the price of the complete hearing aid.

The manufacturer must be willing to accept payment for hearing aids from Medicaid hearing aid dispensers at the listed price for Medicaid eligible recipients, such payment constituting payment in full.

Note: See CROS and BICROS Adaptations under the Hearing Aid Fitting and Dispensing topic in this chapter for additional reimbursement instructions for these adaptations.

**Standard
Categories of
Hearing Aids**

Category I is the standard category of single linear hearing aids with one (1) or no adjustment features.

Category II is for specialized linear aids. This category includes more powerful aids, possessing unique features.

Medicaid sets a fixed price for each category.

The manufacturer must determine the category of each hearing aid sold to a provider. The provider must maintain documentation of the category type and the warranty in the recipient's medical file.

Note: See the Hearing Services Fee Schedule for global fees for Category I and Category II hearing aids reimbursable by Medicaid. The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Criteria for Hearing Aid Manufacturers, continued

Non-Linear Hearing Aids

Medicaid does not provide non-linear hearing aids when Category I or Category II hearing aids can be used unless the non-linear hearing aid meets the same criterion for price as a Category I or Category II hearing aid.

Exceptions can be requested through the prior authorization process. Providers must submit documentation indicating medical necessity, a manufacturer's invoice including manufacturer's cost, and a description of the aid with the prior authorization request. Providers must obtain prior authorization from Medicaid before providing the service. Medicaid consultants will determine if the requested non-linear hearing aid is medically necessary.

The provider must attach a statement from the Department of Health that the child does not qualify for Children's Medical Services benefits. In addition, the provider must attach a statement from the Department of Children and Families that the recipient does not qualify for Developmental Services benefits.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures and form. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Warranty

The price for each hearing aid must include a minimum 12-month warranty that covers repair, damage, and loss of the hearing aid. The provider must maintain the warranty in the recipient's medical record.

New Hearing Aids

Providers must use manufacturers that provide new hearing aids only.

Eyeglass Hearing Aids

Providers must dispense eyeglass hearing aids that have no decorative decals, engraving, advertising or other conspicuous markings on the temple portions.

Earmold Accessories

For those models that use an external, button type receiver and are normally used with a conventional type earmold, all external hearing aid receivers and adapter nubs for plastic tubing must fit the standard bushing in the conventional type earmold. Where the receiver nubs fail to meet this requirement, the vendor must provide suitable adapters, firmly attached to the receiver at the factory and at no additional cost.

Criteria for Hearing Aid Manufacturers, continued

Batteries	The provider must use manufacturers that use battery sizes in the hearing aids that are available from standard commercial stocks of battery manufacturers. Hearing aid models using a “special” battery are not acceptable.
Air and Bone Conduction Receivers	Air conduction receivers must include cords, when required. Bone conduction receivers must include headband, headband pads, and other items necessary for proper fitting.
Qualifications of Manufacturers	Providers must use manufacturers that have been actively engaged in the business of manufacturing hearing aids for a period of at least three (3) years, have established bona fide dealers or distributors in most major cities in Florida, and are in a position and willing to render factory or authorized dealer’s repair services. Manufacturers of foreign-made hearing aids must meet the same requirements that have been established for domestic manufacturers. The manufacturer must determine the category of each hearing aid sold to a provider.
Procedure Codes and Fees	See the Hearing Services Fee Schedule for a list and description of reimbursement rates for procedure codes. The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at http://floridamedicaid.acs-inc.com . Click on Provider Support, and then click on Fees.

Hearing Aid Fitting and Dispensing

Description	Hearing aid fitting and dispensing includes selecting, ordering, fitting, evaluating of appropriate amplification, and dispensing the hearing aid. It also includes an initial supply of batteries. Medicaid reimburses an ear mold as a separate procedure.
Who Can Dispense a Hearing Aid	Medicaid may reimburse only licensed physicians, licensed audiologists, and certified hearing aid dispensers for hearing aid fitting and dispensing.

Hearing Aid Fitting and Dispensing, continued

Hearing Loss Criteria

Medicaid may reimburse for hearing aid fitting and dispensing only for recipients who have bilateral (both ears) hearing loss. After the recipient's ears have been treated for any medical condition contributing to the hearing loss, test results of the better ear must show:

- An average hearing loss level of 40 dB or greater (current ANSI standards) for 500 Hz, 1000 Hz, and 2000 Hz by puretone air conduction; or
- The difference between level 1000 Hz and 2000 Hz is 20 dB or more, while the average of the air conduction level (current ANSI standards) at 500 Hz and 1000 Hz is 30 dB or greater.

Exceptions for recipients who do not meet the hearing loss criteria may be granted through the prior authorization process as described as follows.

Prior Authorization for Recipients Who Do Not Meet Hearing Loss Criteria

In order to be reimbursed by Medicaid for services for a recipient who does not meet hearing loss criteria, the provider must obtain prior authorization from Medicaid prior to providing the service. Medicaid consultants will determine if the hearing aid is medically necessary.

Medicaid does not grant post authorization for hearing aid fitting and dispensing for a recipient who does not meet the hearing loss criteria.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures and form. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Required Documentation for Prior Authorization

The provider must submit the following documentation with the prior authorization request:

- A physician's statement certifying the medical necessity of the evaluation; and
- A copy of the current audiogram. The audiogram cannot be more than six months old.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures and form.

Hearing Aid Fitting and Dispensing, continued

Service Components

To receive reimbursement for hearing aid fitting and dispensing, the provider must provide all of the following components:

- Evaluating the test results and selecting an appropriate hearing aid;
 - Making an ear mold impression and fitting the ear mold, if necessary;
 - Instructing the recipient (or the recipient's primary care giver, parent or guardian) on the hearing aid's operation, use, care, maintenance (including the recommended routine maintenance schedule), and the repairs that are covered under warranty;
 - Performing any other procedure that is required for proper fit and use of the hearing aid, and assurance of appropriate amplification;
 - Providing one standard package of new batteries (or the equivalent value in batteries for a body aid); and
 - Follow-up visits during the 30-day trial period, as described below.
-

Trial Period

The provider must allow the recipient to have a 30-day trial period during which time the recipient may have as many follow-up visits as necessary for counseling the recipient, adjusting the hearing aid, and ensuring proper fit of the earmold.

Body-Worn Aids

Body-worn aids come with a receiver and cord as part of their basic costs. Medicaid does not reimburse providers separately for choosing the appropriate receiver, cord, garment bag or casing color or for any extra charges associated with the garment bag or casing color.

CROS and BICROS Adaptations

In addition to the fitting and dispensing fee, an additional reimbursement is allowed for CROS and BICROS dispensing.

Note: See the Hearing Services Fee Schedule for reimbursement rates for CROS and BICROS dispensing fees. The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Ear Molds

Medicaid will reimburse for three pairs of ear molds per calendar year. No prior authorization is necessary for the first three pairs of ear molds.

Hearing Aid Fitting and Dispensing, continued

Recipient Liabilities

The provider must advise the recipient that the recipient is liable for:

- Routine maintenance;
- Replacement cords, wires and batteries;
- Repairs and replacement of the hearing aid if the recipient loses Medicaid eligibility; and
- Medicaid coinsurance on the hearing aid, unless the recipient is exempt.

Date of Service

The provider will be reimbursed for the service based on the recipient's eligibility on the date the hearing aid was ordered rather than the date that the hearing aid is dispensed. In order for the Medicaid computer system to verify the recipient's eligibility on the date the hearing aid was ordered, the provider must enter that date as the date of service on the claim form.

The provider should forward the claim to the Medicaid fiscal agent only after the fitting and dispensing is complete and the recipient has received the hearing aid.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering the date of service on the claim form. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Service Limitations

Medicaid may reimburse one fitting and dispensing service per recipient, every three years from the date the last hearing aid was ordered. Exceptions are granted for a binaural fit without prior authorization if the provider bills for two units of service.

Authorization for additional dispensing fees may be granted through the prior authorization process as described in the following sections.

Procedure code V5090 must be used for the hearing aid fitting and dispensing procedure.

Note: See Binaural Hearing Aids in this chapter for information on the provision of binaural aids.

Hearing Aid Fitting and Dispensing, continued

Prior Authorization to Exceed the Fitting and Dispensing Limit

In order to be reimbursed by Medicaid for additional fitting and dispensing services or earmolds, the provider must obtain prior authorization before providing the service. Medicaid consultants will grant the request based on medical necessity.

An additional hearing aid fitting and dispensing service can only be authorized if the recipient meets one or more of the following criteria:

- Attends school or a training program;
 - Is gainfully employed or likely to become employed if a hearing aid is provided;
 - Is visually impaired;
 - Is physically handicapped and whose health and safety could be jeopardized without a hearing aid;
 - Is living alone and needs a replacement aid for safety reasons;
 - Has a developmental disability;
 - Has a chronic mental disability; or
 - Has a chronic cognitive disability.
-

Required Documentation for Prior Authorization

The provider must submit the following documentation with the prior authorization request:

- A physician's, physician assistant's or nurse practitioner's (ARNP) statement indicating the medical necessity of the service; and
- A copy of the current audiogram. The audiogram cannot be more than six months old.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures and form.

Hearing Aids

Description

Medicaid reimbursement for hearing aids includes the cord and receivers on the models for which they are required. All hearing aids must be new and have at least a one-year factory warranty.

Note: See the Hearing Services Fee Schedule for global fees for Category I and Category II hearing aids reimbursable by Medicaid. The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Service Limitations

Medicaid may reimburse for one hearing aid, per ear, per recipient. An aid may be replaced when the current aid cannot be repaired as determined and documented by the Medicaid provider or the recipient's hearing deficit requires a different kind of device for maximum benefit, but no more often than every three years from the date the last hearing aid was ordered.

Exceptions to the service limit may be granted through the prior authorization process as described below.

Note: See Binaural Hearing Aids in this chapter for information on the provision of binaural aids.

Prior Authorization for Replacement Hearing Aids

In order to be reimbursed by Medicaid for replacement hearing aids during the three-year time period, the provider must obtain prior authorization before providing the replacement aid. Medicaid consultants will determine if the replacement hearing aid is medically necessary.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures and form. The Medicaid handbooks are available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Documentation Required for Prior Authorization of a Replacement Hearing Aid

The provider must submit the following information with the prior authorization request:

- A physician's, physician assistant's, or nurse practitioner's (ARNP) statement indicating the specific medical necessity of the evaluation;
 - A copy of the most current audiogram (the audiogram cannot be more than six months old);
 - A statement documenting the reason the aid must be replaced; and
 - A statement indicating no current replacement or repair warranty exists on the hearing aid being replaced.
-

Hearing Aids, continued

Post Authorization A replacement aid cannot be post authorized unless the need for the hearing aid is immediate and the recipient meets one or more of the following criteria:

- Attends school or a training program;
- Is gainfully employed or likely to become employed if a hearing aid is provided;
- Is under the age of 21;
- Is visually impaired;
- Is physically handicapped and whose health and safety could be jeopardized without a hearing aid;
- Is living alone and needs a replacement aid for safety reasons;
- Has a developmental disability;
- Has a chronic mental disability; or
- Has a chronic cognitive disability.

Procedure Codes and Fees See the Hearing Services Fee Schedule for a list and description of reimbursement rates for procedure codes. The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Binaural Hearing Aids

Description Provision of a hearing aid when a recipient has a functional hearing aid (regardless of the aid's age or source) in one ear is considered to be a provision of a binaural aid.

Who Can Receive Binaural Aids Medicaid reimburses binaural aids only for recipients who meet one or more of the following criteria:

- Attend school or a training program;
- Are gainfully employed or likely to become employed if a hearing aid is provided;
- Have a physical handicap and whose health and safety could be jeopardized without a hearing aid;
- Live alone and need an additional aid for safety reason;
- Are visually impaired;
- Have a developmental disability;
- Have a chronic mental disability; or
- Have a chronic cognitive disability.

Binaural Hearing Aids, continued

Prior Authorization for Binaural Aids

Medicaid does not require prior authorization for binaural hearing aids for recipients who meet the hearing loss criteria and need Category I or Category II hearing aids. Providers must obtain prior authorization for recipients who do not meet the hearing loss criteria or who require specialized aids.

Medicaid will reimburse for two earmolds, two hearing aids, one evaluation and up to two fitting and dispensing fees.

Medicaid does not grant post authorizations for binaural aids.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures and form. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Documentation Required for Prior Authorization for Binaural Aids

The provider must submit the following information with the prior authorization request:

- A physician's, physician assistant's, or nurse practitioner's (ARNP) statement indicating the medical necessity of the binaural aids;
- A copy of the current audiogram (the audiogram cannot be more than six months old);
- An explanation of any extenuating circumstances, such as other physical handicaps or difficult living conditions, as listed under Who Can Receive Binaural Aids; and
- The services for which the provider is requesting reimbursement; for example, hearing aid type, ear mold, fitting and dispensing.

Procedure Codes and Fees

See the Hearing Services Fee Schedule for a list and description of reimbursement rates for procedure codes. The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Hearing Aid Repairs

Description

Medicaid reimburses for hearing aid repairs. Medicaid can reimburse for repairs on hearing aids that were not purchased by Medicaid.

Service Limitations

Medicaid cannot reimburse for repairs on hearing aids that are still under warranty or an insurance protection plan.

Medicaid does not reimburse for hearing aid repairs for one full year from the date the hearing aid was dispensed.

Medicaid reimbursement for hearing aid repairs is limited to three repairs per 366 days per hearing aid.

Service Requirements

All factory and laboratory repairs must be performed by an authorized dealer, factory or laboratory. Repairs must have a six-month warranty on all work done on or on the entire aid.

Date of Service

The provider will be reimbursed for the repair based on the recipient's eligibility on the date the hearing aid repair was ordered rather than the date that the repaired hearing aid is dispensed. In order for the Medicaid computer system to verify the recipient's eligibility on the date that hearing aid repair was ordered, the provider must enter that date as the date of service on the claim form.

The provider should forward the claim to Medicaid only after the recipient has received the repaired hearing aid.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering the date of service on the claim form. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Hearing Aid Repairs, continued

Factory Repairs	Medicaid reimburses the actual cost of factory repairs up to a maximum of \$67.50. A copy of the factory invoice summarizing all repair costs, the six-month warranty on the repair or entire aid, and a statement that no warranty existed at the time of the repair must be placed in the recipient's medical file.
Service Exclusions	<p>Medicaid does not reimburse routine maintenance, cleaning, cord or wire replacements, and batteries.</p> <p>Medicaid does not reimburse repairs if the hearing aid was damaged by tampering or misuse.</p>

Cochlear Implant Services

Description	Cochlear implant services provide restoration of auditory capacity to Medicaid eligible recipients with hearing loss that is not improved through the use of a hearing aid.
Service Components	<p>Components of the cochlear implant service include the implantable electrode array, the wearable speech processor and related components provided by the physician, postoperative computerized tuning of the headset, repairs and replacement.</p> <p>Implantation (surgery) of the cochlear implant electrode array is reimbursed through the Medicaid Physician Services Program.</p> <p>The cochlear implant device is reimbursed directly to the device manufacturer through the Hearing Services Program.</p> <p>Cochlear implant device claims should be mailed to the Medicaid Hearing Services Analyst at:</p> <p style="text-align: center;">Agency for Health Care Administration Bureau of Medicaid Services 2727 Mahan Drive, Mail Stop #20 Tallahassee, FL 32308</p> <p>The prior authorization number for the recipient's cochlear implant surgery must be included on the claim form.</p>

Cochlear Implant Services, continued

Eligible Recipients

Medicaid will reimburse for cochlear implant services for all eligible recipients. For recipients ages 1-17, the onset of hearing impairment must have occurred during the pre or postlinguistic period. For recipients ages 18 and older, the onset of hearing impairment must have occurred during the prelinguistic, perilinguistic or postlinguistic period.

Postlinguistic recipients ages 18 and older must demonstrate test scores of 30 percent or less on sentence recognition scores from tape-recorded tests in the recipient's best listening condition.

In addition, the recipient must meet the following criteria:

- Have profound, bilateral sensorineural hearing loss;
- Have no improvement with hearing aid trial;
- Have no medical or radiological contraindications such as complete ossification; and
- Be well motivated and have a well-motivated family.

Prior Authorization

The physician who performs the cochlear implant procedure must obtain prior authorization from Medicaid before providing the implantation.

Requests for authorization must include documentation of the criteria listed above in Eligible Recipients.

Before submitting a prior authorization request for a cochlear implant procedure, the provider must verify whether or not the recipient has third party liability (TPL) insurance coverage. If the recipient has TPL insurance, the provider must first seek coverage for the cochlear implant procedure through the TPL source. If the TPL source denies coverage of the cochlear implant procedure, the provider must obtain written documentation of the denial and submit a copy of the denial with the prior authorization request to Medicaid.

If a recipient loses his cochlear speech processor, the provider must obtain prior authorization before replacing the processor and requesting reimbursement.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the prior authorization procedures. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Cochlear Implant Services, continued

Post-Implant Program and Rehab Services	<p>Postoperative services for tuning the cochlear device are reimbursed using the following procedure codes:</p> <ul style="list-style-type: none"> • For programming services, use 92601, 92602, 92603, and 92604; • For rehabilitation services, use 92626, 92627, 92630, and 92633. <p>The service may be provided by a physician, by an audiologist working under the supervision of a physician, or by an audiologist enrolled in the hearing program.</p>
Service Limitations	<p>Medicaid reimburses for one cochlear implant in either ear. Medicaid does not reimburse for bilateral cochlear implantation.</p> <p>Medicaid reimburses for only one wearable speech processor at the time the cochlear implant is purchased.</p>
Repair of the Device	<p>If repair or replacement of the implant external parts is warranted outside the manufacturer's warranty, then it may be post authorized. Medicaid will reimburse \$395.00 for implant external device repairs billed under procedure code L7510. The treating provider must submit with the claim the manufacturer's invoice that reflects the actual cost of the service, the manufacturer and type of cochlear implant system (body processor or ear-level processor), and the reason for repair or replacement. The treating provider must document that no manufacturer warranty exists.</p> <p>The manufacturer must provide a refurbished speech processor to the recipient while the recipient's speech processor is either being repaired under warranty or being repaired outside the manufacturer's warranty. In order to have the speech processor repaired, the treating provider must send the processor in for repair and make the appropriate arrangements with the manufacturer to have a refurbished processor for loan while the recipient's processor is being repaired.</p>
Batteries	<p>Medicaid limits payment to rechargeable batteries for implant devices specially designed for speech processors. Medicaid does not reimburse for hearing aid batteries.</p>
Procedure Codes and Fees	<p>See the Hearing Services Fee Schedule for a list and description of reimbursement rates for procedure codes. The Hearing Services Fee Schedule is available on the Medicaid fiscal agent website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then click on Fees.</p>

CHAPTER 3 HEARING SERVICES PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction

This chapter describes the procedure codes and maximum fees for services covered by the Medicaid Hearing Services Program.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1
How to Read the Procedure Codes and Fee Schedule	3-2
Modifiers and Their Descriptions	3-4
Pricing Modifiers	3-5

Reimbursement Information

Procedure Codes

The procedure codes listed on the Hearing Services Fee Schedule are Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in the *Physician's Current Procedural Terminology* (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes are descriptions and copyright 2006 by the American Medical Association. All rights reserved.

Level 1 procedure codes are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five-digit numeric code.

Level II procedure codes are national codes usually used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits.

In compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

Reimbursement Information, continued

Diagnosis Codes

Diagnosis codes are found in the *International Classification of Diseases, Clinical Modifications*, (ICD-9-CM). A diagnosis code is required on the CMS-1500 claim form. The most specific code, including the fourth and fifth digits, when available, must be used.

How to Read the Procedure Codes and Fee Schedule

Introduction

The Hearing Services Fee Schedule is a table listing the procedure codes, their descriptions, and other information pertinent to each code associated with Medicaid reimbursable hearing services.

The information that follows identifies and describes the individual column headings, reading from left to right.

Note: The Hearing Services Fee Schedule available on the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Fees.

Procedures Without Specific Fee

Procedure codes with an “R” in the Spec column are designated as too unusual or variable to be assigned a maximum fee. Pertinent information concerning the nature, extent, and need for the procedure and service along with the time, skill, and equipment must be furnished in a report submitted with the claim. An ICD-9 diagnosis code is also required in the report.

Code

This column identifies the five-digit procedure codes associated with the covered services. The codes are listed in ascending order on the fee schedule.

Code Description

The information in this column describes the service or procedure associated with the procedure code. Medicaid providers are instructed to refer to the current CPT or HCPCS Level II books for a complete description for billing purposes. The CPT book and HCPCS Level II books include identifying codes and descriptions for reporting medical services and procedures.

How to Read the Procedure Codes and Fee Schedule, continued

Max Fee

The amount that appears in this column is the maximum amount Medicaid will pay for the complete procedure.

PC Fee

The fee in this column designates the amount payable for the professional component of the service only.

Age

The letters in this column indicate the maximum age for which Medicaid will reimburse the procedure:

- “All” indicates that Medicaid will reimburse the procedure for all recipients.
 - “CO” indicates that Medicaid will reimburse the procedure only for recipients under 21 years of age.
-

Max Units

The number in this column indicates the number of units that can be billed on one claim line.

Spec

An alphabetic code in this column indicates special requirements for submission of a claim for that procedure. Any of the alphabetic codes described below may appear in this column.

PA

Identifies a procedure code for which written prior authorization from the Medicaid office for services is required before performing the service. Prior authorization forms are available from the Medicaid fiscal agent by calling 800-289-7799 (in state) or 800-955-7799 (out of state) or from the fiscal agent’s website at <http://floridamedicaid.acs-inc.com>.

Note: See Prior Authorization in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for additional information on the prior authorization process. The Reimbursement Handbook, CMS 1500 is available on the Medicaid Handbook and Resource Library CD-Rom and the Medicaid fiscal agent’s website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

R

An R in the Spec column identifies a “by report” procedure code for which either documentation of medical necessity for the procedure performed is required or information is needed in order to review and price the procedure correctly. This requires a written report be submitted with the claim.

Modifiers and Their Descriptions

Definition of Modifier

A modifier is a two-digit code that is used with a procedure code to more fully describe the procedure performed so that accurate payment may be determined.

There are two different types of modifiers that hearing services providers use: pricing modifiers and local-code modifiers. The two types of modifiers are described below.

Pricing Modifiers

Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review. The provider is required to use pricing modifiers under certain circumstances described in Chapter 2 of this handbook or in the pricing modifiers' definitions in this section.

Note: See Pricing Modifiers in this chapter for the definitions of the pricing modifiers used when billing for Medicaid hearing services.

Local-Code Modifiers

The second type of modifiers are "local-code" modifiers. The Health Insurance Portability and Accountability Act (HIPAA) required Florida Medicaid to convert its locally-assigned procedure codes to national HCPCS codes effective October 16, 2003. Some of the procedures that Florida Medicaid covers are not adequately defined by HCPCS procedure codes, so Florida Medicaid added modifiers to the HCPCS procedure code to better define the procedure.

The procedure codes with local-code modifiers are listed on the fee schedule. Local-code modifiers can only be used with the procedure codes listed. Use of local-code modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: Please refer to Chapter 5 in the Florida Medicaid Provider General Handbook for Medicaid policy regarding provider abuse.

Entering Modifiers on the Claim Form

The modifier is entered in the field next to the procedure code field in item 24D, Modifier, on the CMS-1500 claim form.

Entering pricing modifiers: Enter the pricing modifier in the first Modifier field on the claim form. If more than one pricing modifier is applicable, enter the multiple pricing modifier 99. See Modifier 99 in this chapter for the full requirements.

Entering a pricing modifier and local-code modifier: If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first Modifier field on the claim form, and enter the local-code modifier in the second Modifier field.

Pricing Modifiers

Introduction

The modifiers listed in this section are the valid pricing modifiers, which are used with the procedures listed in the fee schedule to affect the procedure code's payment or cause the claim to pend for review.

**26
Professional
Component**

When a diagnostic test is performed in an inpatient or outpatient hospital setting, use this modifier to report the professional component.

Acceptable procedure codes billable for professional component are identified in the PC column in the fee schedule.

**52
Reduced Services**

Under certain circumstances a service or procedure is partially reduced or eliminated at the provider's election. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service. This modifier reimburses 90 percent of the maximum fee of the procedure code.



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