



Florida Medicaid

Hearing Services Coverage Policy

Agency for Health Care Administration

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1.0 Introduction

1.1 Description

Hearing services are designed to provide screening, assessment and testing services, and appropriate hearing devices to recipients in order to detect and mitigate the impact of hearing loss.

1.1.1 Medicaid Policies

This policy is intended for use by hearing services providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of hearing services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Hearing services are authorized by the following:

- Title XIX, section 1905 of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 440.110
- Section 409.906, Florida Statutes (F.S.)
- Rule 59G-4.110, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Bone Anchored Hearing Aid

Hearing aids used to treat severe conductive hearing loss through the use of a titanium screw that is placed in the skull behind the ear (also referred to as BAHA).

1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Hearing Screening

An objective physiological test conducted for the purpose of determining the likelihood of hearing loss.

1.3.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.7 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary hearing services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

2.3 Coinsurance, Copayment, or Deductible

There is no coinsurance, copayment, or deductible for this service.

3.0 Eligible Provider

3.1 General Criteria

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Practitioners licensed within their scope of practice to perform this service
- County health departments administered by the Florida Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for the following services in accordance with the American Medical Association (AMA) Current Procedural Terminology, the AMA Healthcare Common

Procedural Coding System, the applicable Florida Medicaid fee schedule(s), or as specified in this policy.

4.2.1 Diagnostic Audiological Tests

When medically necessary by a physician's examination or to document treatment outcome.

4.2.2 Bone Anchored Hearing Aids (BAHA)

For recipients who have documented profound, severe hearing loss in one or both ears as follows:

- Implanted device for recipients age five years and older
- Non-implantation (softband) device for recipients under the age of five years

4.2.3 Cochlear Implants

For recipients age 12 months and older who have documented profound to severe, bilateral sensorineural hearing loss.

4.2.4 Hearing Aids

For recipients who have moderate hearing loss or greater, including the following services:

- One new, complete, (not refurbished) hearing aid device per ear, every three years, per recipient
- Up to three pairs of ear molds per year, per recipient
- One fitting and dispensing service per ear, every three years, per recipient

4.2.5 Hearing Assessment and Reassessment

One hearing assessment every three years for the purpose of determining hearing aid candidacy and the most appropriate hearing aid.

4.2.6 Newborn and Infant Hearing Screening

Up to two newborn hearing screenings for recipients under the age of 12 months. A second screening may be performed only if the recipient does not pass the initial hearing screening test in one or both ears.

4.2.7 Repairs and Replacements of Hearing Devices

- Repairs and replacement of both Medicaid and non-Medicaid provided hearing aids.
- Up to two hearing aid repairs every 366 days, after the one year warranty period has expired.
- Bone anchored hearing aid external components and cochlear implant components, including batteries, after the manufacturer's warranty period or insurance protection plan coverage period has expired.

The BAHA or cochlear device manufacturer must provide a loaner sound or speech processor in coordination with the recipient's hearing services practitioner, regardless of the warranty status.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Freight, shipping, and tax expenses associated with the provision of a BAHA or cochlear implant device
- Hearing aid repairs:
 - For the purpose of cleaning, cord and wire replacements, and routine maintenance of the device
 - For damage as a result of tampering, misuse, abuse, or neglect
 - Within one full year from the date the hearing aid was dispensed
- Initial hearing aid assessments on the same date of service as a replacement hearing aid service
- Hearing screenings (excluding newborn and infant hearing screenings) on the same date of service as a Child Health Check-Up, in accordance with Rule 59G-4.087, F.A.C.
- Insurance protection plans or extended warranty coverage for BAHA, cochlear implant and hearing aid devices
- New hearing aid devices within six months from the date of a hearing aid repair
- Non-standard hearing aid batteries
- Spare sound processors for BAHA and cochlear implant devices
- Zinc air battery replacements for BAHA devices

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

There is no coverage-specific documentation requirement for this service.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

7.2 Specific Criteria

7.2.1 Bone Anchored Hearing Aid and Cochlear Implant Services

Ordering providers must obtain authorization from the quality improvement organization (QIO) for the implantation service and provide proof of the authorization to the device manufacturer. The authorization request must include the following:

- Status of previous device system(s), if applicable
- Manufacturer and model number of device

Device manufacturers must request authorization from the QIO for the device, external component replacements, and repairs. The authorization request must include the following:

- Documentation supporting medical necessity for the service dated no more than six months prior to the request
- The type, model, and serial number of the device
- The status of the manufacturer warranty or insurance protection coverage

Providers may obtain post-authorization for repairs after the warranty period has expired.

7.2.2 Exceptions to Hearing Aid and Assessment Services Coverage

Providers must obtain authorization from the QIO to exceed the coverage limits specified in sections 4.2.4 and 4.2.5 of this policy, and for hearing aid services for recipients who do not meet the hearing loss criteria.

The authorization request must include the following, as applicable:

- Copy of current audiogram or auditory brainstem response
- Documentation regarding the recipient's current or most recent hearing aid device (i.e., make, model, purchase date, and current condition and status)
- Statement indicating no current replacement or repair warranty exists on the hearing aid being replaced, if applicable

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Specific Criteria

Florida Medicaid reimburses for newborn and infant hearing screenings fee-for-service irrespective of whether the recipient is enrolled in a Florida Medicaid managed care plan.

Providers may not submit claims for reimbursement before hearing aid fitting and dispensing is complete, and the recipient has received the hearing aid.

Providers must include the date the hearing aid was dispensed as the date of service on the claim form; however, providers may use the order date as the date of service if the recipient loses Florida Medicaid eligibility prior to the completion of the service.

8.3 Claim Type

Professional (837P/CMS-1500)

8.4 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4.1 Modifier

26 Professional component performed by a different provider than the technical component

8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

Providers must include the current diagnosis code that describes "other examination of ears and hearing" on the claim form for screening services rendered to recipients under the age of 13 months.

8.6 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

8.6.1 Contralateral Routing of Signal (CROS) and Binaural Contralateral Routing of Signal Dispensing (BiCROS)

Florida Medicaid reimburses an additional fee for CROS and BiCROS services in addition to the fitting and dispensing fee, as applicable.