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SECTION 13 - BENEFITS AND LIMITATIONS

13.1 CONDITIONS OF PARTICIPATION

13.1.A PROVIDER PARTICIPATION

Participants shall have freedom of choice in selecting a provider of hearing aid services; however, payments under the Missouri Title XIX (MO HealthNet) Program are limited to audiologists and hearing instrument specialists who meet the following conditions:

- The audiologist or hearing instrument specialist must have a current permanent license to practice in accordance with the licensing provisions of the state in which he/she operates or practices. Temporary licenses are not acceptable.

- The audiologist or hearing instrument specialist must have a Title XIX Hearing Aid Participation Agreement in effect with the MO HealthNet Division before providing services for which MO HealthNet will be billed. If a provider's license is suspended or terminated by the State Licensing Agency, the MO HealthNet Division Participation Agreement will also be suspended or terminated effective the same date.

Additional information on provider conditions of participation can be found in Section 2 of the Hearing Aid Provider Manual.

13.2 ELIGIBILITY ON DATE OF SERVICE

The participant receiving Hearing Aid Program services must be eligible on the day the service is provided or the aid is dispensed, as explained in Section 1 of the Hearing Aid Provider Manual. Eligibility on the date of service is a requirement even if the service has been prior authorized. The only exception is explained in Section 13.12 of the Hearing Aid Provider Manual and regards participant loss of eligibility after a custom-made item has been ordered or fabricated. It is the responsibility of the provider to verify the bearer of the card is the person to whom the card was issued and the participant is eligible on the day that the service is provided or the hearing aid is dispensed. With the exception of procedure code 92557, Hearing Aid Program services are not covered for individuals covered under a limited benefit package as described in Section 1.5.A of the Hearing Aid Provider Manual.
13.3 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are not billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.4 BASIC PROGRAM LIMITATIONS

With certain specific exceptions discussed further in this section, benefits under the Hearing Aid Program are limited by the following:

- All hearing aids and dispensing fees require prior authorization.
- Services are to be delivered for the purpose of and in conjunction with the dispensing of a hearing aid.
- Routine testing and screening of individuals or groups is not a covered service.
- Hearing evaluation for the purpose of obtaining a hearing aid to be performed in a nursing home requires prior authorization.
- Stand alone TV or radio listening systems are not covered items.
- Participants are entitled to one (1) new hearing aid and related services (testing, fitting, dispensing and post-fitting evaluation) once every four (4) years.
- A replacement hearing aid or a binaural hearing aid may be covered. Refer to Section 13.11.A and Section 13.11.B of the Hearing Aid Provider Manual for guidelines.
- Repairs and post-fitting adjustments are limited to a combined total of three (3) per rolling calendar year.
- Replacement of an ear mold due to changes in the ear canals that affect the size or shape.
- The pure-tone average (PTA) for 500, 1000 and 2000 hertz (Hz) (measured with an earphone) must be 30 dB HL or greater in the better ear.
- Word recognition testing (with phonetically balanced 25 or 50 word lists) is required for participants seven (7) years of age and above. Ten word speech discrimination lists are not acceptable.
- All required services must be rendered before payment is made for any portion of the services.
- Hearing aids must be dispensed to the participant in person by the provider who requested authorization to fit the hearing aid. The hearing aid cannot be mailed to the participant.
- Additional benefits for children under the age of 21 are discussed in Section 13.10 of the Hearing Aid Provider Manual.
13.5 COVERED SERVICES

The following services are reimbursable subject to the basic limitations and criteria of MO HealthNet policy. Services and items must also have been provided in accordance with sound professional practice and the standards under which the provider is licensed.

13.5.A MEDICAL EAR EXAMINATION

Before being fitted with a hearing aid, all participants must have a medical ear examination for pathology or disease. It is preferable that this exam be performed after the hearing evaluation so that the physician can review the hearing evaluation results. The medical ear exam must be performed before the provider submits the Prior Authorization (PA) Request for the hearing aid. Hearing loss can result from a number of conditions and diseases for which a hearing aid may not be appropriate. The purpose of the exam is to ensure that all medically treatable conditions that may affect hearing are accurately identified and properly treated before a hearing aid is dispensed.

The medical ear examination must be performed by a physician (MD or DO) and preferably by an ear specialist. This examination must be performed within six (6) months prior to the date of the PA Request submission. This examination cannot be waived. If the medical ear examination is not performed or if the date of the examination is not within the specified period of time, the hearing aid and related services are not covered. Section B of the Report of Hearing Aid Evaluation (RHAE) form must be completed and signed by the physician before prior authorization to fit a hearing aid is granted.

13.5.B HEARING EVALUATION FOR THE PURPOSE OF OBTAINING A HEARING AID

Before MO HealthNet can grant prior authorization for a hearing aid and related services, a hearing evaluation for the purpose of obtaining a hearing aid (92557 or 9255722) must be performed by an audiologist or hearing instrument specialist and the results recorded in Section C of the RHAE form. The procedure must be ordered by a qualified physician and the diagnosis must be related to disease or trauma. Supporting documentation must be retained in the patient's file. Such testing, when administered for the purpose of prescribing a hearing aid, is reimbursed by the MO HealthNet Hearing Aid Program. MO HealthNet reimbursement for each test is to cover testing of both ears. The Hearing Aid Program does not pay for testing performed in relation to a medical or surgical diagnosis or treatment by a physician when a hearing aid is not being considered. Such testing can, however, be reimbursed to a physician through the Physician's Program.

The hearing tests that are required for a hearing aid must include at a minimum, air conduction thresholds, bone conduction thresholds (with masking when necessary), speech
reception thresholds and word recognition testing. The results must be clear, internally consistent and must support the recommendation of which ear is to be fitted. If two (2) hearing aids are requested for participants under the age of 21, the test results must support a recommendation for binaural hearing aids. For infants and very young children word recognition testing is not possible and is not required. For children ages seven (7) and older, word recognition is required. If a participant’s cognitive impairment precludes word recognition testing, this must be stated on the RHAE form.

13.5.B(1) Pure-Tone Thresholds

In most cases, the pure-tone audiogram is used to select the electro-acoustic characteristics of the hearing aid. The pure-tone audiogram is also used in the otologic diagnosis. It is assumed that the participant is alert and capable of providing results that are valid and repeatable. If this is not the case, the ability to specify hearing loss has been compromised and the examiner needs to indicate the problem and how it will be dealt with in Section G of the RHAE form.

Air-conduction thresholds should be obtained at 250, 500, 1000, 2000, 3000, 4000 and 6000 Hz unless there is good reason to do otherwise. Bone-conduction thresholds should be obtained at 250, 500, 1000, 2000, 3000 and 4000 Hz unless there is good reason to do otherwise. Unless it is noted otherwise, it is assumed that bone conduction is being measured from the mastoid. It is also assumed that air- and bone-conducted signals are specified in dB HL in accordance with current ANSI standards.

Masked threshold can be noted with an asterisk or superscript m (e.g., 40* or 40m).

13.5.B(2) Speech Thresholds

Thresholds are specified in dB HL for speech. If the audiometer or acoustic appraiser indicates speech level in dB sound pressure level (SPL), subtract 20 dB to convert to dB HL for speech (e.g., 75 dB SPL for speech = 55 dB HL for speech). Speech thresholds are typically tested using CID W-1 spondaically stressed words, SRT should be in agreement with the PTA of 500 Hz, 1000 Hz, 2000 Hz, by +/- 8 dB. If the SRT is much better than the PTA, it is suspected that the participant is unwilling or unable to perform pure tone tests appropriately.

13.5.B(3) Word Recognition

Word recognition must be tested with 25 or 50 item phonetically balanced words lists. The level at which the items are presented must be in dB HL not in dB SPL or dB sensation level. Ten item lists are not acceptable. This test is used to determine
hearing aid candidacy for unilateral hearing aid fittings in adults. The ear with the best word recognition is the ear to be fitted. If the provider wishes to fit the ear with the worst word recognition, a written explanation must be in Section G of the RHAE form.

A hearing instrument specialist or audiologist must advise a MO HealthNet participant to consult promptly with a licensed physician (preferably an ear specialist) before dispensing a hearing aid if the hearing instrument specialist or audiologist determines through inquiry, actual observation or review of any other available information that the MO HealthNet participant has any of the following conditions:

1. Visible congenital or traumatic deformity of the ear.
2. History of active drainage from the ear within the previous 90 days.
3. History of sudden or rapidly progressive hearing loss within the previous 90 days.
4. Acute or chronic dizziness.
5. Unilateral hearing loss of sudden or recent onset within the previous 90 days.
6. Audiometric air-bone gap equal to or greater than 15 dB at 500 Hz, 1000 Hz and 2000 Hz.
7. Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
8. Pain or discomfort in the ear.

13.5.C BILLING FOR EVALUATION FOR THE PURPOSE OF OBTAINING A HEARING AID ONLY

The Hearing Aid Program is intended to only provide hearing aids and related services; it does not cover routine screening or testing for hearing loss. In most cases, the RHAE form submitted with the CMS-1500 claim form should document the complete process of providing a hearing aid. If the testing process is terminated, interrupted, or if after testing a hearing aid is not recommended or a hearing aid is recommended but not dispensed the provider may bill for the testing. The provider must document in Section G of the RHAE form why they are billing only for the testing.

If the hearing test was performed on a participant age 0-20, the claim for the testing does not require the RHAE form be sent with it.
13.6 HEARING AID AND RELATED SERVICES

A hearing aid is purchased for eligible participants by the MO HealthNet Program when they are provided in accordance with MO HealthNet policy as defined in this manual and are medically necessary as evidenced by information on a completed RHAE form and prior authorized. Hearing measurements and hearing aid performance are specified in accordance with ANSI standards.

Only new hearing aids are purchased by MO HealthNet. Each hearing aid will be warranted by the provider for a minimum of one (1) year from the dispensing date against premature breakdown under normal use and defects in manufacture. The warranty shall cover cost of parts, labor and postage. New hearing aids will not be purchased within six (6) months of the repair of an old hearing aid.

13.6.A EAR MOLD AND IMPRESSION

The impression for the ear mold must be billed using procedure code V5275RT or V5275LT and the ear mold must be billed using procedure code V5264RT or V5264LT. An ear mold and/or impression are covered when required for the type of device being provided. If replacement of an ear mold is required due to changes in the ear canal size or shape, providers must use procedure code V5264RT or V5264LT to bill for the replacement. If these procedure codes are the only ones billed on the claim form, the RHAE form does not need to be attached.

13.6.B HEARING AID FITTING

Hearing aid fittings are covered and must include adjustment of the ear mold, tubing and vent, adjustment/programming or electroacoustic parameters, and instruction to the participant in the use and care of the hearing aid. A user's manual that explains the use and care of the hearing aid must be given to the participant at the time of the hearing aid fitting. The reimbursement for the hearing aid fitting is included in the maximum allowable reimbursement amount for the hearing aid.

13.6.C HEARING AID DISPENSING FEE

A dispensing fee is allowed to cover the provider's cost for procuring and processing the hearing aid, handling charges, postage, etc. This may also cover selection and assessment of hearing aids to achieve maximum benefit to the participant, as long as a hearing aid is actually dispensed. The hearing aid must be delivered to the participant by the provider who requested the approval to fit the hearing aid. The hearing aid cannot be mailed to the participant.
13.6.C(1) Billing for the Dispensing Fee When the Hearing Aid is not Dispensed

All reasonable attempts to correct problems and satisfy the participant must be made. If the participant, understanding that he/she may receive only one (1) hearing aid every four (4) years, still refuses to accept or wear the hearing aid, the provider should recover the hearing aid. MO HealthNet does not pay for the hearing aid in this situation, but does reimburse for the dispensing fee when the hearing aid was previously prior authorized. When billing for the dispensing fee in this situation, an explanation should be noted on the RHAE form why the provider is billing for the dispensing fee without billing for the hearing aid. The provider must use the dispensing fee procedure code that was prior authorized when billing for this type of situation.

13.6.D POST-FITTING EVALUATION

Before a provider can be paid for a hearing aid and related services, a post-fitting evaluation must be conducted and Section F of the RHAE form completed.

The post-fitting evaluation must be performed no sooner than 14 and no later than 30 days after the hearing aid was dispensed. If providers do not perform the evaluation within the specified time period, they must show good cause why they were unable to meet this requirement or the entire claim for hearing aid services will be denied. Explanation should be made on the RHAE form and it must satisfy the state audiology consultant that a reasonable attempt was made to provide the service within the time limit. If the participant loses eligibility after the hearing aid is dispensed but before the post-fitting evaluation can be conducted, the provider should still conduct the evaluation within the specified time limits.

A post-fitting evaluation requires face-to-face contact between the provider and the participant. The purpose of the post-fitting evaluation is to determine that the patient is receiving reasonable and optimal benefit from the hearing aid, that the hearing aid is functioning properly and that the patient is actually wearing the hearing aid. Services to be provided at the time of the evaluation include some or all of the following:

- Checking if the patient's ear is sore and modifying the ear mold or custom shell;
- Adjusting frequency or gain of the hearing aid;
- Reprogramming the hearing aid;
- Checking the ear mold and tubing;
- Venting adjustment on ear mold or custom shell;
- Reinstructing the patient in the use or care of the hearing aid;
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- Electroacoustic evaluation of the hearing aid and/or real ear measurements; and
- Other adjustments or services.

If at the time of the post-fitting evaluation, it is determined that the hearing aid is unsuitable, other hearing aids should be tried for trial periods but in the end billing can be made for only one (1) mold, one (1) fitting, one (1) dispensing fee, one (1) hearing aid and one (1) post-fitting evaluation.

13.6.D(1)  Billing for Post-Fitting Evaluation When the Hearing Aid is Not Dispensed

All reasonable attempts to correct problems and satisfy the participant must be made. If the participant, understanding that he/she may receive only one (1) hearing aid every four (4) years, still refuses to accept or wear the hearing aid, the provider should recover the hearing aid. MO HealthNet does not pay for the hearing aid in this situation, but does reimburse for the post-fitting evaluation if it was performed, when the hearing aid was previously prior authorized. When billing for the post-fitting evaluation when the hearing aid was not dispensed, an explanation should be noted on the RHAE form.

13.6.D(2)  Billing for Post-Fitting Evaluation When Patient No Longer Eligible For MO HealthNet

If the patient becomes ineligible for MO HealthNet prior to performing the post-fitting evaluation, MO HealthNet pays for the post-fitting evaluation if it was performed according to the guidelines stated in Section 13.6.D of the Hearing Aid Provider Manual. When billing for this service, the date of service entered on the claim form must be no later than the last date of MO HealthNet eligibility. On the RHAE form, the actual date of service must be shown for the post-fitting evaluation along with the explanation as to why the dates on the claim and the RHAE form are different.

13.6.E  POST-FITTING ADJUSTMENTS

Post-fitting adjustments are covered for dates of service after the post-fitting evaluation. The evaluation should cover any adjustment necessary on that day. A post-fitting adjustment requires face-to-face contact between provider and participant and must be at the request of the participant. Examples of services covered under the code for post-fitting adjustment are:
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- Checking if the patient's ear is sore and modifying the ear mold or custom shell;
- Adjusting frequency or gain of the hearing aid;
- Reprogramming the hearing aid;
- Checking the ear mold and tubing;
- Venting adjustment on ear mold or custom shell;
- Reinstructing the patient in the use and care of the hearing aid;
- Minor hearing aid repairs if aid hearing is not under warranty such as changing microphone screens, replacing tubing, replacing domes;
- Hearing re-tests;
- Electroacoustic evaluation of the hearing aid and/or real ear measurements;
- Removal of cerumen from the ear mold and tubing; and
- Other adjustments and services.

Post-fitting adjustments do not include replacing batteries or deodorizing the hearing aid.

A claim for a post-fitting adjustment only does not require a RHAE form. A maximum of three (3) post-fitting adjustments or three (3) hearing aid repairs or any combinations totaling three (3) are covered in a 12-month period. Complete explanation of actions taken during post-fitting adjustments, for each date the participant is seen must be kept in the clinic record.

13.7 REPAIR OF HEARING AID OR HEARING ASSISTIVE WIRELESS TECHNOLOGY

Repairs within the scope of the warranty for the hearing aid or hearing assistive wireless technology such as FM/Bluetooth personal listening systems and repairs for premature breakdown under normal use are not covered for one (1) year following the dispensing date. Repairs resulting from participant abuse or neglect are not covered. All repairs for hearing aids or hearing assistive wireless technology must include a six (6)-month warranty. Repairs to a hearing aid or hearing assistive wireless technology that is five (5) years of age or older are noncovered. New hearing aids will not be purchased within six (6) months of the repair of an old hearing aid. During a hearing aid's warranty period, repairs that cannot be covered by the warranty are considered on a prior authorization basis. The PA Request must give the procedure code, date of purchase, describe the nature of the repairs and explain why the repairs are beyond the scope of the warranty.

MO HealthNet covers necessary repairs to the participant’s hearing aid that is no longer under warranty. The methods of reimbursement for repairs are as follows.
13.7.A OUT-OF-SHOP REPAIRS

Necessary repairs made out of shop, when the aid must be sent out to the manufacturer or repair lab are reimbursed at twenty dollars ($20.00) plus the invoiced cost of the repair. The $20.00 covers the provider's cost for postage for returning the aid to the provider or any insurance fee charged. A copy of the repair invoice must be attached to the claim. The RHAE form is not required.

13.8 SPECIAL TESTS

The following special tests are covered when requested by the examining physician to rule out retrocochlear involvement or middle ear disease before recommending a hearing aid.

Procedure codes used to rule out retrocochlear involvement or middle ear disease:

- 92550 Tympanometry and reflex threshold
- 92567 Tympanometry (impedance testing)
- 92570 Acoustic Immittance; includes tympanometry, acoustic reflex threshold and reflex decay

13.9 SERVICES PROVIDED IN A NURSING HOME OR INSTITUTION

Requests for hearing evaluation for the purpose of obtaining a hearing aid and hearing aids must originate with the participant and must proceed with the participant’s full knowledge and consent. It is not the intent of the MO HealthNet Program for large groups of participants residing in nursing homes to be screened to determine the need for hearing aids.

Except for post-fitting evaluations, post-fitting adjustments and repairs to hearing aids no longer under warranty, all hearing evaluations, hearing aids and dispensing fees performed or provided in a nursing home or institution require prior authorization.

The following procedure code must be used for requesting hearing evaluation which is to be provided in a nursing home or institution:

- 9255722 Comprehensive audiometry threshold evaluation and speech recognition, Nursing Home

Hearing evaluations performed in a residential care center or an adult boarding home do not require prior authorization.
13.9.A HEARING EVALUATION, NURSING HOME

- If hearing evaluation is to be performed in a nursing home or institution, the provider must first request prior authorization to perform the evaluation.

- A RHAE form with Sections A and D completed must accompany the PA Request form.

- The provider receives a MO HealthNet Authorization Determination advising whether the request has been approved or denied.

- In the event that a PA Request is denied for the hearing aid, the provider may submit a claim for the prior authorized 9255722.

13.9.B HEARING AIDS AND RELATED SERVICES, NURSING HOME

- If the hearing evaluation results indicate a hearing aid would be beneficial to the participant, the provider must submit a second PA Request form for the hearing aid and related services.

- The second PA Request form must be accompanied by the original RHAE form with Sections B and C completed in addition to Sections A and D.

- The provider receives a MO HealthNet Authorization Determination advising whether the request has been approved or denied.

13.9.C CLAIM SUBMISSION—NURSING HOME

- Nursing facility level of care must be indicated on the MO HealthNet eligibility file.

- Upon receipt of an approved PA Request form for the hearing aid, the provider may proceed with the fitting and dispensing of the hearing aid.

- After the post-fitting and evaluation has been performed, the claim may be submitted to the fiscal agent.

- The post-fitting evaluation—V5011RT22 or V5011LT22 must be billed on the same claim with the appropriate hearing aid, dispensing fee, ear mold and ear mold impression procedure codes.

- In the event that a PA Request form for a hearing aid is returned to the provider marked denied, the provider may submit a claim for the prior approved hearing evaluation.
13.10 HEALTHY CHILDREN AND YOUTH (HCY) EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

A medically necessary item or service that is normally noncovered that is identified as a result of a physician, hearing instrument specialist, audiologist or other health care professional visit or exam (interperiodic screen) may be covered for persons under 21 years of age on a prior authorization basis by the MO HealthNet Division. Additional benefits through the HCY Program include:

- Hearing assistive wireless technology such as FM/Bluetooth personal listening systems (hearing assistive wireless technology such as FM/Bluetooth personal listening systems are not covered for participants 21 years of age or older), prior authorization is required.

- Two (2) new hearing aids (binaural hearing aid fitting) and related services (testing, fitting, dispensing, and post-fitting evaluation) every four (4) years (for binaural hearing aid users only), and one (1) hearing assistive wireless technology, such as FM/Bluetooth personal listening systems every four (4) years.

- For participants under 21 years of age, the following audiometric threshold criteria (measured by earphone, sound field, or auditory brainstem response testing or auditory steady-state response testing) must be met:
  - Pure-tone threshold average for the frequencies 500, 1000, and 2000 Hz of 20 dB HL or greater;
  - Pure-tone threshold of 25 dB HL at two (2) consecutive high frequencies for 2000, 3000, 4000 Hz; and
  - Pure-tone threshold of 25 dB HL at three (3) consecutive high frequencies for 3000, 4000, and 6000 Hz.

It is important to note that every MO HealthNet eligible child should have a complete HCY (EPSDT) screen. If the child has not had a full screen, the provider should refer the child for a full screen to be done at a later date. Refer to Section 9 of the Hearing Aid Provider Manual for information about screening providers.

The following guidelines must be used to request prior authorization:

- PA Requests for coverage of non-covered items/services, non-covered testing, etc., must be sent to Wipro Infocrossing, P.O. Box 5700, Jefferson City, MO 65102.

- The PA Request form should be clearly marked as an HCY request. The procedure code to use is V5299 if there is not a specific code. Please refer to Section 19.2 of the Hearing Aid Provider Manual for a list of HCY codes and their billing requirements.

- The following documentation must be included on, or submitted with, the PA Request form for procedure code V5299:
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- The nature of the item or service to be provided, the duration of time the item is needed and the projected outcome; and
- An invoice showing the provider's cost if the request is for a special type of hearing aid or some type of instrument.

Upon receipt of the request, a decision is made regarding medical necessity and approval of each service. A MO HealthNet Authorization Determination is sent to the provider after a decision to approve or deny has been made. Prior authorization must be obtained before the services are provided in order for MO HealthNet payment to be made.

Prior authorization approves the medical necessity of the item or service requested. Prior authorization does not establish MO HealthNet eligibility. The participant must be MO HealthNet eligible on the date of service.

13.10.A HEARING AID BATTERIES

Hearing aid batteries are covered for participants under age 21 only. A manufacturer's invoice of the provider's cost for the batteries must be attached to each claim submitted for batteries. The invoice must indicate the number of batteries in a package. Field #24g of the CMS-1500 claim form must indicate the specific number of batteries being dispensed, not the number of packages. The participant must be eligible on the date the batteries are dispensed.

13.10.B HEARING ASSISTIVE WIRELESS TECHNOLOGY

Hearing assistive wireless technology such as FM/Bluetooth personal listening systems are covered for participants under age 21 for coupling to hearing aids, bone anchored hearing aids (BAHA) and cochlear implant speech processors. Covered items include any necessary hearing aid boots/shoes, cords, microphones, rechargeable batteries and battery chargers.

Hearing assistive wireless technology such as FM/Bluetooth personal listening systems may be covered for participants under age 21 with normal hearing sensitivity, who have auditory processing disorder or auditory dyssynchrony confirmed by appropriate testing. Neurologic conditions that may cause compromise to the auditory neural system include, but are not limited to, auditory neuropathy, traumatic brain injury, kernicterus and certain developmental disorders. MO HealthNet does not automatically cover wireless personal listening systems for children with autism, language impairment, dyslexia, ADHD, developmental delay or listening difficulties.

Tests for auditory processing disorder must include at least one (1) measure for each of the following auditory skill areas, and test materials must be commercially pre-recorded and calibrated:
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1. Temporal processing, such as Gaps in Noise or Frequency Pattern test.

2. Dichotic listening, such as Staggered Spondaic Word Test, Dichotic Digits, competing words.

3. Speech understanding in noise, such as Auditory Figure Ground subtest, or Katz’s W22’s in Noise, Masking Level Difference testing.

4. Understanding of distorted speech, such as words that are filtered, compressed, and/or in reverberation.

Auditory processing testing must be performed by a licensed audiologist with expertise in the area of auditory processing evaluation. A comprehensive written report regarding auditory processing test results and interpretation must be attached to the PA Request for review by the state audiology consultant. Hearing assistive wireless technology, such as FM/Bluetooth personal listening systems, for the purposes of treating auditory processing disorders are not covered for children under seven (7) years of age, since there are very limited valid test materials for younger children. It is suggested instead that children under seven (7) years of age, suspected of auditory processing disorder, undergo a comprehensive receptive/expressive language evaluation. Hearing assistive wireless technology such as FM/Bluetooth personal listening systems must be prior authorized. The procedure code to use is V5299.

13.11 EXCEPTIONS TO THE BASIC LIMITATIONS

Exceptions to the basic limitations as set forth earlier in this section may be prior authorized by the state audiology consultant. Detailed justification must be provided for overriding the limitations.

The items and services that are to be provided and the charge for each must be listed in the III. SERVICE INFORMATION field on the PA Request form. The explanation for the exception to the basic limitation must be written in Field #24 on the PA Request form. If authorization is granted, the provider must bill the procedure codes that have been prior authorized, along with the procedure codes for the hearing evaluation, ear molds and ear mold impressions. The date of service entered on the claim form for the hearing aid, dispensing fee, ear mold and ear impression must be the date the hearing aid is dispensed.

Prior authorization must be requested for the following exceptions to the basic limitations.

13.11 EXCEPTIONS TO THE BASIC LIMITATIONS

Exceptions to the basic limitations as set forth earlier in this section may be prior authorized by the state audiology consultant. Detailed justification must be provided for overriding the limitations.

The items and services that are to be provided and the charge for each must be listed in the III. SERVICE INFORMATION field on the PA Request form. The explanation for the exception to the basic limitation must be written in Field #24 on the PA Request form. If authorization is granted, the provider must bill the procedure codes that have been prior authorized, along with the procedure codes for the hearing evaluation, ear molds and ear mold impressions. The date of service entered on the claim form for the hearing aid, dispensing fee, ear mold and ear impression must be the date the hearing aid is dispensed.

Prior authorization must be requested for the following exceptions to the basic limitations.
13.11.A  SECOND HEARING AID IN FOUR (4) YEARS: REPLACEMENT

For replacement of a hearing aid within four (4) years of its purchase, the provider must request prior authorization. The request must contain, in Field #24 of the PA Request form, the date the original hearing aid was purchased and detailed information of the circumstances under which it was lost, destroyed or ceased to function effectively. The information needs to make clear why the original hearing aid cannot be repaired. If authorization is granted, a medical ear examination and audiometric testing must be performed, if none has been done within the previous six (6) months. Replacement resulting from participant abuse or neglect is not covered. When requesting prior authorization, use the appropriate hearing aid procedure code and dispensing fee procedure code found in Section 19 of the Hearing Aid Provider Manual.

13.11.B  SECOND HEARING AID IN FOUR (4) YEARS: BINAURAL FITTING

Any hearing aid for the purpose of binaural amplification must be prescribed by an Otolaryngologist, Otologist or Otorhinolaryngologist; however, backup or spare hearing aids are noncovered. It is not the intent of the MO HealthNet Program to routinely pay for two (2) hearing aids for eligible participants 21 years of age and older. MO HealthNet pays for a second hearing aid only when special justification is documented for binaural aids, such as: educational purposes, learning of language for children and legally blind. Any hearing aid for the purpose of binaural amplification for participants 21 years of age and older is a covered service only in cases of blindness. Physicians must enter their specialty, the prescription and a detailed description of the medical necessity for fitting binaural aids in Part B, Field #11 of the RHAE form.

- If two (2) hearing aids are to be fitted simultaneously, the provider must request authorization for both hearing aid procedure codes and both dispensing fee procedure codes on the same PA Request form. The RHAE form must accompany the PA Request form. If authorization is granted, both hearing aid procedure codes and dispensing fee procedure codes must be billed on the same claim form with one (1) unit of each along with the hearing evaluation and post-fitting evaluation. Additional reimbursement for the testing and post-fitting evaluation is not allowed. The completed RHAE form is required for claim submission. The date of service for both codes must be the day the hearing aids were dispensed.

- If the second hearing aid is not to be fitted at the same time as the first, the provider should wait at least until the first hearing aid has been evaluated and found satisfactory before requesting authorization for the second hearing aid.

A copy of the RHAE form for the first hearing aid must accompany the PA Request form for the second hearing aid.
If more than six (6) months has elapsed between the original medical examination and the fitting of the second hearing aid, another medical examination is required and *must* be recorded on a second RHAE form. In addition, hearing evaluation for the purpose of obtaining a hearing aid *must* be performed if more than six (6) months elapses from the original date of testing. The hearing evaluation for the purpose of obtaining a hearing aid results *must* be entered on a second RHAE form and submitted with the PA Request form. Testing (when applicable), the hearing aid, ear mold, ear impression, dispensing fee and a post-fitting evaluation are covered for the second hearing aid if the second hearing aid is *not* fitted simultaneously with the first hearing aid.

Use the binaural hearing aid procedure codes found in Section 19 of the Hearing Aid Provider Manual on the PA Request.

**13.12 EXCEPTION FOR COVERAGE DUE TO PARTICIPANT LOSS OF ELIGIBILITY**

The participant *must* be eligible on the date a service is provided or the aid is dispensed. This is a requirement even if the service has been prior authorized. It is the responsibility of the provider to verify the participant’s eligibility on the date that the hearing aid is dispensed to ascertain that the participant is eligible on that date.

However, MO HealthNet payment may be made for the hearing aid when the participant becomes ineligible for the service or dies *after* the aid is ordered and before the aid can be fitted or the post-fitting evaluation can be conducted.

The following prerequisites apply to all such payments:

- There *must* have been a commitment by the provider to provide the service and to accept the MO HealthNet payment based upon verified MO HealthNet eligibility at the initiation of the service;
- There *must* have been reason to believe that the participant’s MO HealthNet eligibility would continue;
- The participant *must* have been eligible when the service was first initiated and following receipt of an approved PA Request, if required. The participant *must* also have been eligible when the ear mold impression was made and the hearing aid was ordered;
- The medical examination and hearing evaluation *must* have been conducted and results *must* have met the policy requirements set forth in this section;
- The hearing aid or ear mold *must* have been ordered and fabricated to the specific medical needs of the participant; and
Section 13 - Benefit and Limitations

- The hearing aid *must* have been fitted and dispensed and a post-fitting evaluation conducted within the time period specified by policy if the participant is living.

Payments under this exception are made as follows:

- If the hearing aid is dispensed to the participant following loss of eligibility and *all* the prerequisites listed above have been met, payment may be made for those services rendered during the participant’s eligibility and also for the hearing aid, the fitting, the dispensing fee and the post-fitting evaluation. Likewise, if the participant loses eligibility after the hearing aid is dispensed but before the post-fitting evaluation is conducted, payment may be made for the post fitting evaluation. Payments under this exception are subject to applicable copay requirements.

- If the hearing aid cannot be dispensed due to the death of the participant, payment is made *not* only for those services actually rendered during the participant’s eligibility but also for any restocking fee (less applicable copay) charged by the manufacturer to return the hearing aid. If the aid is *not* returnable, MO HealthNet pays the provider's cost. Such payments as provided under the conditions of this paragraph will *not* exceed the MO HealthNet maximum allowable fee for a hearing aid less applicable copay amounts.

This policy does *not* apply to a situation in which:

- The hearing aid *cannot* be dispensed because the participant refuses to accept it or it is determined that a hearing aid will *not* benefit the participant.

Procedures for submitting a claim under this exception are as follows:

- All dates of service entered on the CMS-1500 claim form *must* be no later than the last date on which service was provided to the eligible participant. Entering a date of service for which the participant is ineligible causes that line of the claim to be denied.

- The amount billed for the hearing aid *must* not exceed the fee charged by the manufacturer to restock or remake it. Alternately, the amount billed *must* not exceed the invoice cost of the aid less its salvage value.

- The provider *must* enter the phrase "loss of eligibility exception," in Field #10d of the CMS-1500 claim form.

The provider *must* complete:

- The RHAE as usual, entering the actual dates of service in the required fields. In the Comments section of the RHAE, however, the provider *must* explain the circumstances, including the date of the participant’s death if the hearing aid was *not* dispensed due to that reason. The provider *must* also justify the amount billed for the hearing aid, showing both invoice cost and salvage value, or declaring the amount of the restocking fee. This
statement **must** be signed and dated. Further documentation may be required if needed for review by the state audiology consultant.

### 13.13 NON-COVERED ITEMS/SERVICES

- Hearing aid batteries for participants 21 years old and over;
- Hearing aids for participants with medical contraindications;
- Eyeglass hearing aid models;
- Hearing aids provided on a rental or loan basis;
- Postage for mailing a hearing aid to a participant;
- Hearing aids determined to be ineffective or unsatisfactory by the provider or participant during or before the post-fitting evaluation;
- Back-up or spare hearing aids;
- Routine testing and screening of individuals or groups; and
- Custom in-the-ear hearing aids for participants age 12 or younger.

### 13.14 PARTICIPANT COPAY

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. This amount is referred to as copay. The copay amount is paid by the participant at the time services are rendered. Services of the Hearing Aid Program described in this manual are subject to a copay amount. The provider **must** accept in full the amounts paid by the state agency plus any copay amount required of the participant.

#### 13.14.A PROVIDER RESPONSIBILITY TO COLLECT COPAY AMOUNTS

Providers of service **must** charge and collect the copay amount. *Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the participant’s inability to pay the fee when charged.* A participant’s inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant’s liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant’s statement of inability to pay at the time the charge is imposed.
The provider of service must keep a record of copay amounts collected and of the copay amount due but uncollected because the participant did not make payment when the service was rendered.

The copay amount is not to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the copay amount is deducted from the MO HealthNet maximum allowable amount, as applicable, before reimbursement is made.

**13.14.B PARTICIPANT RESPONSIBILITY TO PAY COPAY AMOUNTS**

Unless otherwise exempted (refer to Section 13.14.B(2)), it is the responsibility of the participant to pay the required copay amount due. Whether or not the participant has the ability to pay the required copay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service.


Unless an exemption applies, the following copay amounts are applied to all Hearing Aid Program services:

<table>
<thead>
<tr>
<th>MO HEALTHNET MAXIMUM ALLOWABLE</th>
<th>COPAY AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.99 or less</td>
<td>$0.50</td>
</tr>
<tr>
<td>$11.00 to $25.99</td>
<td>$1.00</td>
</tr>
<tr>
<td>$26.00 to $50.99</td>
<td>$2.00</td>
</tr>
<tr>
<td>$51.00 or more</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

**13.14.B(2) Exemptions to the Copay Amount**

The following participants or conditions are exemptions to the participant’s responsibility to the copay amount as they apply to the Hearing Aid Program:

Participants ages 17 and under are exempt from copay amounts. Participants age 18 and over must pay the copay amount unless the individual is a foster care child or meets another exemption:

- Foster care children up to 21 years of age *(ME codes 07 and 08)*;
- Hospice participants;
- Institutionalized participants who are residing in a skilled nursing facility, a psychiatric hospital, a residential care facility or an adult boarding home;
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• MO HealthNet Managed Care health plan enrollees are exempt from copay amounts for services provided by the health plan, except MO HealthNet Managed Care enrollees must pay the shared pharmacy dispensing fee. MO HealthNet Managed Care enrollees whose services are outside of the plan benefit must pay the copay amount when applicable.

The exemption to the copay amount is identified by MO HealthNet when processing the claim. Services related to an EPSDT are exempt from a copay amount. (EPS diagnosis or EPSDT condition code must appear on the claim form).

NOTE: The EPSDT exemption only applies to those participants under age 18. Participants age 18 and over must pay the copay amount for EPSDT-related services unless another exemption applies.

13.15 MO HEALTHNET MANAGED CARE HEARING AID PROGRAM BENEFITS

Health plans are required to provide all hearing testing, auditory evoked potentials testing, cochlear implant testing, BAHA testing and hearing aid services for all MO HealthNet Managed Care enrolled individuals under 21 years of age. This includes binaural hearing aids for participants under age 21. This includes all medically necessary hearing aid services including HCY screens, treatment, personal wireless listening systems such as FM and Bluetooth, aural habilitation, post cochlear implant training, special hearing aid accessories needed for coupling to listening systems, accessories needed for cleaning and care, battery chargers and hearing aid batteries, etc. For participants age 21 and over who are eligible for hearing aids and related services, these services are covered by the health plans.

Hearing aids that have been prior approved by MO HealthNet for enrollees prior to enrollment in a health plan are reimbursed fee-for-service by the state agency.

Hearing aids that have been prior approved by the MO HealthNet Managed Care health plans prior to the participant becoming fee-for-service are reimbursed by the MO HealthNet Managed Care health plan.