

CSHCN Services Program Hearing Services Benefits (PACT Transition)

Effective for dates of service on or after September 1, 2009, the hearing services benefits for children will no longer be administered by the Department of State Health Services (DSHS) through the Program for Amplification for the Children of Texas (PACT). The hearing services for children benefit, including all claims and authorization transactions, will be administered by the Texas Medicaid & Healthcare Partnership (TMHP). Children with Special Health Care Needs (CSHCN) Services Program clients of any age will be eligible to receive medically necessary hearing aid devices and services. This article covers only the changes to CSHCN Services Program benefits. The changes to Texas Medicaid benefits are covered in a separate article.

Benefit: Hearing Services and Hearing Aid Devices

Hearing services are benefits of the CSHCN Services Program. Hearing services for CSHCN Services Program clients include, but are not limited to, the following services:

Services	Provider Type
Audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss, including, but not limited to, the following: <ul style="list-style-type: none">• Hearing screening• Audiological assessment• Otological examination• Hearing aid evaluation	Audiologists and physicians
Hearing aid devices and accessories, fitting and dispensing visits, and revisits, including, but not limited to, the following: <ul style="list-style-type: none">• Ear mold and second ear mold• Hearing aid device• Hearing aid fitting• Follow-up visits at 30 days (first follow-up) and 60 days (second follow-up)• Hearing aid repair• Refit and evaluation after repair• Hearing aid batteries and supplies	Hearing aid fitters and dispensers

Note: CSHCN Services Program clients who are 17 years of age or older who are legal residents of the state of Texas, and who are employable, may be eligible for assistance from the Department of Assistive and Rehabilitative Services (DARS). The CSHCN Services Program may request that clients who meet these requirements apply to DARS, as the CSHCN Services Program is the payor of last resort.

Reimbursement: Hearing aids and related services are reimbursed at the lower of the billed charges or the amount allowed by Texas Medicaid. Additional charges (e.g., rental fees) to the client for covered services constitute a breach of the provider's contract with the CSHCN Services Program. Beginning September 1, 2009, providers may refer to the Online Fee Lookup (OFL) available on this website for payable procedure codes and reimbursement rates. Additional procedure codes may be made benefits effective for

dates of service on or after September 1, 2009. Providers will be notified of procedure codes and set limitations in a future article.

Required forms: Required forms and required medical record documentation are indicated in the specific sections of this article. Providers must complete and maintain the information in the client's medical record and make it available upon request by the DSHS-CSHCN Services Program or by TMHP for retrospective review.

Limitations: All services provided to CSHCN Services Program clients must be medically necessary. Services may be reimbursed without prior authorization within the set limitations. Prior authorization may be requested for medically necessary services that exceed benefit limitations. Providers will be notified of procedure codes and set limitations in a future article.

Enrollment and claims filing: Audiologists who meet all required enrollment criteria may enroll in the CSHCN Services Program by choosing "Audiologist" on the CSHCN Services Program enrollment application. Hearing aid fitters and dispensers who meet all required enrollment criteria may enroll in the CSHCN Services Program by choosing "Hearing Aid" on the CSHCN Services Program enrollment application. Audiologists who meet all required enrollment criteria may also enroll as hearing aid fitters and dispensers by completing a separate application and choosing "Hearing Aid" on the second enrollment application. Providers must be enrolled appropriately to be reimbursed for audiology services and for hearing aid fitting and dispensing services.

Providers must file all claims using the appropriate electronic format or on the appropriate paper claim form after providing the services. The claims must include the following information:

- The most appropriate 3- to 5-digit *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code that represents the purpose for the service.
- The most appropriate *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code(s) that represent the service(s) provided.
- The appropriate information as indicated on the provider enrollment letter. Electronic claims must also include the most appropriate attested taxonomy code.

Refer to: *The Providers Hearing Services for Children (PACT Transition) web page on this website for information about enrolling in the CSHCN Services Program.*

Beginning June 1, 2009, PACT is no longer enrolling providers and is directing providers to enroll with TMHP as a CSHCN Services Program provider. Providers must be appropriately enrolled with the CSHCN Services Program to be reimbursed for hearing services provided to CSHCN Services Program clients.

Note: *Hearing services provided before September 1, 2009, for CSHCN Services Program clients who are 20 years of age or younger must be submitted to PACT. Claims submitted to TMHP before September 1, 2009 will be denied. Additionally, claims for CSHCN Services Program clients submitted by providers who are not enrolled with the CSHCN Services Program will be denied.*

Online Provider Lookup (OPL): Providers are encouraged to complete a Provider Information Change (PIC) Form to designate themselves in the OPL as providers who are experienced with the pediatric population and who will offer auditory services to

CSHCN Services Program clients who are birth through 20 years of age. The [PIC Form](#) is available for download on this website.

Providers are not required to make this designation in order to submit claims; however, providers who choose the designation will be found when clients, parents, and guardians search the OPL. PACT providers who are already enrolled with the CSHCN Services Program and hearing services providers who are newly enrolled and who indicate they will provide hearing services to CSHCN Services Program clients who are birth through 20 years of age will automatically be assigned the designation in the OPL, so they do not need to complete the PIC form.

Note: The “hearing services for children” OPL designation should only be requested by enrolled hearing services providers who are experienced with the pediatric population and who will offer auditory services to CSHCN Services Program clients who are birth through 20 years of age.

Audiology and Audiometry Evaluation and Diagnostic Services

Hearing evaluations must be recommended by a physician based on examination of the client. Medical necessity including hearing evaluation test data must be maintained in the client’s medical record.

Note: Hearing evaluations will not be reimbursed to hearing aid fitters or dispensers unless otherwise indicated in the sections below.

Diagnostic Hearing Services

Form

- Providers must file all claims using the appropriate electronic format or on the appropriate paper claim form after providing the services.
- Documentation of medical necessity must be maintained by the provider in the client’s medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.
- No other forms are required.

Claims Filing

Providers may refer to the Online Fee Lookup for procedure codes that may be reimbursed by the CSHCN Services Program. Additional procedure codes may be made benefits effective for dates of service on or after September 1, 2009. Providers will be notified of procedure codes and set limitations in a future article.

Authorization

Authorization is not required for hearing services for the evaluation and diagnosis of hearing loss that are provided by advanced practice nurses (APNs), physicians, or audiologists.

Providers

Diagnostic hearing services may be reimbursed to physicians, APNs (as appropriate), or audiologists who provide hearing tests to clients whose hearing is found to be suspect on the routine screening, whether or not hearing is found to be impaired

Reimbursement

Reimbursed at the lower of the billed amount or the amount allowed by Texas Medicaid.

A basic comprehensive audiometry survey will be a benefit of the CSHCN Services Program and includes the following tests:

- Screening test, pure tone, air only.
- Air only or air and bone pure tone audiometry threshold.
- Speech audiometry threshold (with or without speech recognition).
- Comprehensive audiometry threshold evaluation and speech recognition.

Claims filing: The following procedure codes may be reimbursed for audiometric and diagnostic hearing services:

Audiometry Survey				
92551	92552	92553	92555	92556
92557*				
* Comprehensive procedure code 92557 must be billed when three or more audiometry surveys are performed on the same date.				
Audiometric Tests				
92563	92565	92567*	92568**	92569**
92571	92572	92575	92576	92577
92579	92582	92583	92584	92585
92586	92587	92588		
* Tympanometry (impedance testing) may be reimbursed as an objective diagnostic test of middle ear disease and is limited to four services per year by the same provider.				
** Appropriate diagnosis code required. Diagnosis limitations are indicated below.				
Hearing Diagnostic Services				
92502*	92504*	92620	92621	92625
* Examination procedure codes 1-92502 and 1-92504 may be reimbursed to physicians. Audiologists will not be reimbursed for these procedure codes.				
Hearing Aid Examination and Assessment				
92591 Hearing screening or other hearing aid examination	92592 First and second revisits for monaural fittings	92593 First and second revisits for binaural fittings		
Note: Reimbursement for these procedure codes will be published in a future article.				

Limitations: The procedure codes in Column A of the following table will be denied if billed with the same date of service as the procedure codes in Column B:

Column A (Denied)	Column B
92551, 92552, 92553, 92555, 92556	92557
92587	92588

Acoustic reflex testing (procedure codes 92568 and 92569) is limited to the following diagnoses:

Diagnosis Codes				
2251	3510	3511	3518	3519
38600	38601	38602	38603	38604
38610	38611	38612	38619	3862
38630	38631	38632	38633	38634
38635	38640	38641	38642	38643
38648	38650	38651	38652	38653
38654	38655	38656	38658	3868
3869	3870	3871	3872	3878
3879	3882	38830	38831	38832
38840	38841	38842	38843	38844
38845	38885	38905	38906	38913
38915	38916	38917	38920	38921
38922	7443	7804		

CSHCN Services Program Online Fee Lookup (OFL): Physician Services

The following information is available for CSHCN Services Program lookup on this website in the OFL:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
MED	92502	0-999	\$82.48	10/1/2007
MED	92504	0-999	\$21.19	10/1/2007

CSHCN Services Program OFL: Audiologist Services

The following information is available for CSHCN Services Program lookup on this website in the OFL as physician services and will be available as audiologist services on or after September 1, 2009:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
LAB	92551	0-999	\$15.75	10/1/2007
PROF	92551	0-999	\$15.00	9/1/1999
LAB	92552	0-999	\$17.18	10/1/2007
PROF	92552	0-999	\$13.09	9/1/1999
LAB	92553	0-999	\$22.05	10/1/2007
PROF	92553	0-999	\$20.19	9/1/1999
LAB	92555	0-999	\$12.03	10/1/2007

Type of Service	Procedure Code	Client Age	Fee	Effective Date
PROF	92555	0-999	\$11.19	9/1/1999
LAB	92556	0-999	\$18.33	10/1/2007
PROF	92556	0-999	\$17.46	9/1/1999
LAB	92557	0-999	\$39.52	10/1/2007
PROF	92557	0-999	\$35.73	9/1/1999
LAB	92563	0-20	\$16.04	4/1/1992
LAB	92563	21-999	\$14.89	10/1/2007
PROF	92563	0-999	\$11.19	9/1/1999
LAB	92565	0-20	\$11.73	4/1/1992
LAB	92565	21-999	\$12.32	10/1/2007
PROF	92565	0-999	\$11.73	9/1/1999
LAB	92567	0-999	\$16.91	10/1/2007
PROF	92567	0-999	\$16.10	9/1/1999
LAB	92568	0-20	\$11.18	4/1/1992
LAB	92568	21-999	\$11.74	10/1/2007
PROF	92568	0-999	\$11.19	9/1/1999
LAB	92569	0-20	\$12.27	4/1/1999
LAB	92569	21-999	\$12.88	10/1/2007
PROF	92569	0-999	\$12.27	9/1/1999
MED	92620	0-999	\$55.28	10/1/2007
MED	92621	0-999	\$13.17	10/1/2007
MED	92625	0-20	\$32.19	1/1/2005
MED	92625	21-999	\$53.84	10/1/2007
LAB	92571	0-999	\$11.46	4/1/1992
PROF	92571	0-999	\$11.46	9/1/1999
LAB	92572	0-999	\$2.45	4/1/1992
PROF	92572	0-999	\$2.46	9/1/1999
LAB	92575	0-999	\$9.00	4/1/1992
PROF	92575	0-999	\$9.00	9/1/1999
LAB	92576	0-20	\$13.37	4/1/1992
LAB	92576	21-999	\$16.90	10/1/2007
PROF	92576	0-999	\$13.37	9/1/1999
LAB	92577	0-20	\$21.82	4/1/1992
LAB	92577	21-999	\$22.91	10/1/2007
PROF	92577	0-999	\$21.82	9/1/1999

Type of Service	Procedure Code	Client Age	Fee	Effective Date
LAB	92579	0-20	\$20.73	2/1/1996
LAB	92579	21-999	\$25.78	10/1/2007
LAB	92582	0-20	\$21.82	4/1/1992
LAB	92582	21-999	\$32.36	10/1/2007
PROF	92582	0-999	\$21.82	4/1/1992
LAB	92583	0-999	MR	5/1/1991
LAB	92584	0-20	\$75.01	4/1/1992
LAB	92584	21-999	\$78.76	10/1/2007
PROF	92584	0-999	\$75.01	9/1/1999
LAB	92585	0-999	\$100.00	10/1/2007
PROF	92585	0-999	\$54.55	4/12/2006
TECH	92585	0-999	\$20.18	4/12/2006
LAB	92586	0-999	\$46.10	10/1/2007
LAB	92587	0-20	\$46.11	10/1/2007
LAB	92587	21-999	\$46.11	10/1/2007
PROF	92587	0-20	\$7.16	10/1/2007
LAB	92588	0-20	\$63.58	10/1/2007
LAB	92588	21-999	\$63.58	10/1/2007
PROF	92588	0-20	\$19.48	10/1/2007
PROF	92588	21-999	\$18.55	4/1/1995

(LAB) Laboratory service; (PROF) Professional interpretation component; (TECH) Technical component; (MED) Medical service; and (MR) Manually Reviewed for Pricing.

*** Effective for dates of service on or before August 31, 2009, procedure code 92591 is not reimbursed. The reimbursement for this code as noted in this table is effective for dates of service on or after September 1, 2009.**

Hearing Aid Devices and Accessories

TMHP will not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from the manufacturers of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.

The CSHCN Services Program may reimburse hearing aid fitters and dispensers for the following services:

Service	Procedure Code(s)	Limitation
Hearing aid devices	See below	1 per ear every 5 years (monaural codes = bill quantity of 1) (binaural codes = bill quantity of 1)

Service	Procedure Code(s)	Limitation
Hearing aid assessment	V5010	As medically necessary
Hearing aid accessories*	Providers will be notified of additional payable procedure codes in a future article.	Prior authorization required
Fitting and dispensing visit	Refer to the Online Fee Lookup for payable procedure codes effective September 1, 2009	1 per hearing aid procedure code
Ear impression Ear mold	V5265, V5275 V5264	1 each per hearing aid device (monaural codes = bill quantity of 1) (binaural codes = bill quantity of 2)
Revisit (as necessary)**	92592 92593	2 per calendar year when billed by any provider
Batteries (replacement only)	V5266	As medically necessary when a hearing aid device has been previously reimbursed. Note: If a hearing aid has not been reimbursed by the CSHCN Services program in the last 5 years, the replacement batteries may be reimbursed upon appeal with a statement documenting medical necessity.
Replacement or additional hearing aids within a 5-year period	The appropriate hearing aid procedure code	Prior authorization required
Hearing aid repair or modification	V5014	1 per year after the 1-year warranty period has lapsed

*** Hearing aid accessories reimbursed separately include, but are not limited to, chin straps, clips, boots, and headbands.**

Hearing Aid Devices

Form

- Providers must file all claims using the appropriate electronic format or on the appropriate paper claim form after providing the services.
- The CSHCN Services Program Authorization and Prior Authorization Request Form is required for all necessary prior authorization requests.
- No other forms are required.

Limitation

One monaural procedure code with modifier LT and one monaural procedure code with modifier RT may be reimbursed once every five years from the dispensing date of the initial services without prior authorization, *or* one binaural procedure code may be reimbursed once every five years from the dispensing date of the initial services without prior authorization. Exceptions will be considered on a case-by-case basis through the prior authorization process.

The client, client’s family, or caregiver(s) must agree to accept the responsibility for and be trained in the proper use of the hearing aid device.

Claims Filing

See below for procedure codes.

Authorization

Prior authorization will not be required for hearing aids within benefit limitations. Prior authorization will be required for additional medically necessary hearing aid devices and replacement devices required within the same five-year period. For details about submitting prior authorization requests, providers may refer to the “Prior Authorization Requirements” section of this article.

Reimbursement

The reimbursement for the monaural and binaural procedure codes will include the required hearing aid package as follows:
 Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted).
 Manufacturer’s postage and handling charges.
 All necessary hearing aid accessories or supplies.
 Instructions for care and use.
 A one-month supply of batteries or batteries as appropriate according to the manufacturer’s warrant.y

Claims filing: The CSHCN Services Program may reimburse hearing aid providers for the following hearing aid procedure codes:

Monaural Hearing Aids*				
V5030	V5040	V5170	V5180	V5244
V5245	V5246	V5247	V5254	V5255
V5256	V5257			

* Modifier LT or RT required to indicate the ear for which the hearing aid was fitted.

Medical necessity: Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following medical necessity documentation must be maintained in the client's medical record:

Hearing loss in the better ear of 35 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz.

A spondee threshold in the better ear of 35 dBHL or greater when pure tone thresholds cannot be established.

Hearing loss in each ear is less than 35 dBHL at the frequencies below 2,000 Hz and thresholds in each ear are greater than 40 dBHL at 2,000 Hz and higher.

Documentation stating medical necessity and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance.

Binaural hearing Aids*

V5100	V5210	V5220	V5249	V5250
V5252	V5253	V5258	V5259	V5260
V5261				

* Binaural procedure codes must be billed with a quantity of 1. The reimbursement for one binaural procedure code will include the set of hearing aid devices (one set of two devices).

Medical necessity: To meet the criteria for binaural hearing aids, clients must meet the conditions for a monaural hearing aid and have at least a 35-dB hearing loss in both ears.

Limitations: The client, client's family, or caregiver(s) must agree to accept the responsibility for and be trained in the proper use of the hearing aid device.

Hearing aids that are medically necessary but are not currently benefits of the CSHCN Services Program may be reimbursed with prior authorization.

Replacement of a hearing aid device will be considered for prior authorization when loss or irreparable damage has occurred. Replacement will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.

Providers may refer to the 2009 *CSHCN Services Program Provider Manual* section 5.6.2.7, "Place of Service (POS) Coding," on page 5-20, for more information about coding place of service for "other locations".

Supplies and Accessories

Form

- Providers must file all claims using the appropriate electronic format or on the appropriate paper claim form after providing the services.
- The CSHCN Services Program Authorization and Prior Authorization Request Form is required for all necessary prior authorization requests.
- No other forms are required.

Limitation

Providers must dispense each hearing aid with all necessary hearing aid accessories and supplies, including the one-month supply of batteries.

Batteries may be replaced as medically necessary without prior authorization.

Claims Filing

Supplies and accessories included in the hearing aid package will be included in the reimbursement of the hearing aid procedure code and are not reimbursed separately.

V5266	Replacement hearing aid batteries
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Replacement hearing aid batteries: Replacement hearing aid batteries may be reimbursed as medically necessary without prior authorization for clients with a previously billed hearing aid.

Hearing aid batteries for clients who did not receive the hearing aid device through the CSHCN Services Program may be reimbursed on appeal with a statement documenting medical necessity.

Replacement hearing aid batteries provided as part of the manufacturer's warranty will not be reimbursed separately.

Accessories: Medically necessary hearing aid accessories that are not part of the hearing aid package including, but not limited to, chin straps, clips, boots, and headbands may be reimbursed with prior authorization. Providers may purchase the accessories from a vendor of their choice.

The prior authorization number must be included on the claim.

Note: Providers will be notified of additional payable procedure codes in a future article.

Authorization

Documentation for the medical necessity of the item requiring prior authorization must indicate that the requested supply is medically necessary for the appropriate use or functioning of the hearing aid device.

For details about submitting prior authorization requests, providers may refer to the "Prior Authorization Requirements" section of this article.

Hearing Aid Warranty: Repairs

Form

- Providers must file all claims using the appropriate electronic format or on the appropriate paper claim form after providing the services.
- The CSHCN Services Program Authorization and Prior Authorization Request Form is required for all necessary prior authorization requests.
- No other forms are required.

Limitation

After the warranty period has lapsed, repair or modification of a hearing aid may be considered once a year without prior authorization if repair is a better alternative than a new purchase.

Claims Filing

V5014

May be reimbursed for the repair or modification of a hearing aid device.

Authorization

Additional repairs or modifications per year may be reimbursed with prior authorization if medical necessity can be demonstrated. Requests for prior authorization must include documentation that supports the need for the requested repair or modification. For details about submitting prior authorization requests, providers may refer to the "Prior Authorization Requirements" section of this article.

A hearing aid dispensed through the CSHCN Services Program must meet the following criteria:

- Be a new and current model.
- Meet the performance specifications indicated by the manufacturer.
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.
- Meet the needs of the individual client receiving the device.

During the 12-month manufacturer's warranty period, the CSHCN Services Program will not reimburse providers for the following:

- Replacement hearing aid batteries that are provided as part of the manufacturer's warranty.
- Hearing aid repair or modification.

Providers must follow the manufacturer's repair process as outlined in the manufacturer's warranty contract.

CSHCN Services Program OFL: Hearing Aid Services

The following information will be available for CSHCN Services Program lookup on this website in the OFL as hearing aid services on or after September 1, 2009:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
MED	92592	0-999	\$31.50	12/2/2008
MED	92593	0-999	\$101.10	12/2/2008
HA	V5010	0-999	\$44.35	8/24/2005
HA	V5014	0-999	\$300.02	12/2/2008
HA	V5030	0-999	\$1,650.34	7/1/2008
HA	V5040	0-999	\$1,300.00	7/1/2008
HA	V5100	0-999	\$2,392.77	7/1/2008
HA	V5170	0-999	\$2,500.00	7/1/2008
HA	V5180	0-999	\$900.00	7/1/2008
HA	V5210	0-999	\$1,000.00	7/1/2008

Type of Service	Procedure Code	Client Age	Fee	Effective Date
HA	V5220	0-999	\$2,500.00	7/1/2008
HA	V5244	0-999	\$2,253.75	7/1/2008
HA	V5245	0-999	\$1,800.00	7/1/2008
HA	V5246	0-999	\$2,042.50	7/1/2008
HA	V5247	0-999	\$1,957.25	7/1/2008
HA	V5249	0-999	\$1,850.00	7/1/2008
HA	V5250	0-999	\$2,557.50	7/1/2008
HA	V5252	0-999	\$2,495.00	7/1/2008
HA	V5253	0-999	\$3,380.00	7/1/2008
HA	V5254	0-999	\$2,650.00	7/1/2008
HA	V5255	0-999	\$2,200.00	7/1/2008
HA	V5256	0-999	\$2,100.00	7/1/2008
HA	V5257	0-999	\$2,450.00	7/1/2008
HA	V5258	0-999	\$4,306.00	7/1/2008
HA	V5259	0-999	\$3,575.00	7/1/2008
HA	V5260	0-999	\$3,412.00	7/1/2008
HA	V5261	0-999	\$3,981.00	7/1/2008
HA	V5264	0-999	\$67.50	7/1/2008
HA	V5265	0-999	\$60.00	7/1/2008
HA	V5266	0-999	\$1.30	12/2/2008
HA	V5275	0-999	\$45.00	7/1/2008

(MED) Medical service. (HA) Hearing aid device/service. (MP) Manually priced.

Noncovered Services

The following hearing aid procedure codes will not be reimbursed by the CSHCN Services Program:

Procedure Codes				
V5050	V5060	V5070	V5080	V5120
V5130	V5140	V5150	V5190	V5230
V5242	V5243	V5248	V5262	V5263

Fitting and Dispensing Visits and Revisits

Forms

Providers must file all claims using the appropriate electronic format or on the appropriate paper claim form after providing the services.

<p>Additional forms: The following additional forms are required for the fitting and dispensing visits as follows:</p> <ul style="list-style-type: none"> • Client acknowledgement statement. • 30-day trial period certification statement. • Medical record documentation maintained in the client's medical record.
<p>Limitation</p>
<p>See below</p>
<p>Claims Filing</p>
<p>See below</p>
<p>Authorization</p>
<p>Not required</p>

Hearing aid visits include the fitting and dispensing visit, the first revisit, and the second revisit (as needed):

Visit		Limitations
Hearing aid examination	92591	May be used for a hearing screen or other hearing aid examination.
Fitting and dispensing visit	V5011 <i>Note: Refer to the OFL for payable procedure codes effective September 1, 2009.</i>	Includes the fitting, dispensing, and post-fitting check of the hearing aid. The post-fitting check of the hearing aid must be performed within five weeks of the initial fitting. The post-fitting check is part of the dispensing procedure and will not be reimbursed separately.
First revisit	92592** 92593**	If additional visits are required after the post fitting check, two additional revisits may be reimbursed as medically necessary. The first revisit must include a hearing aid check. The second revisit must include either a real ear measurement or aided sound field testing according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry readings from the first evaluation.
Second revisit*	92592** 92593**	

*** The second revisit is available as needed after the post-fitting check and first revisit.**

**** Procedure code 92592 may be used for the first and second revisit for a monaural fitting. Procedure code 92593 may be used for the first and second revisit for a binaural fitting.**

Client acknowledgement statement: To confirm that the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need, the client must

sign an acknowledgement statement (created by the provider) before the provider dispenses the hearing aid device and supplies. The statement must be maintained in the client's medical record. Retrospective review may be performed to ensure the documentation supports the medical necessity of the device, service, or supply.

30-day trial period certification statement: After the hearing aid has been dispensed, the client must be allowed a 30-consecutive-day trial period that begins with the dispensing date to determine satisfaction with a purchased hearing aid. The hearing aid fitter/dispenser must provide the client in a written agreement that includes the beginning and ending dates of the 30-day trial period. The contract agreement must include all charges and fees associated with the trial period as well as the name, address, and telephone number of the State Board of Examiners for Speech-Language Pathology and Audiology. The client must receive a copy of this agreement, and a copy must also be maintained in the client's medical record.

During the trial 30-day trial period, if the client is not satisfied with the purchased hearing aid or if hearing is not improved with use of the purchased hearing aid, the client may return it to the provider. Providers may dispense additional hearing aids as medically necessary until the client is satisfied with the results of a hearing aid or until the provider determines that the client cannot benefit from the dispensing of an additional hearing aid. A new trial period begins with the dispensing date of each hearing aid.

The fitter/dispenser must allow 30 days to elapse from the hearing aid dispensing date before completing a 30-day trial period certification statement, which indicates that the client has completed the trial period and has accepted the dispensed hearing aid. The certification statement must be maintained by the provider in the client's medical record.

The hearing aid provider must use the appropriate fitting and dispensing procedure code for services rendered during the trial period. No additional fees may be charged to the client or to the CSHCN Services Program during this period.

CSHCN Services Program OFL: Hearing Aid Services

The following information will be available for CSHCN Services Program lookup on this website in the OFL as hearing aid services on or after September 1, 2009:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
MED	92591	0-20	\$38.05	9/1/2009
MED	92591	21-999	\$38.96	9/1/2009
HA	V5011	0-999	\$50.00	9/1/2009
HA	V5090	0-999	\$200.00	9/1/2009
HA	V5110	0-999	\$250.00	9/1/2009
HA	V5160	0-999	\$270.00	9/1/2009
HA	V5200	0-999	\$270.00	9/1/2009
HA	V5240	0-999	\$270.00	9/1/2009
HA	V5241	0-999	\$215.00	9/1/2009

(HA) Hearing aid device/service.

Prior Authorization Requirements

Forms

CSHCN Services Program Authorization and Prior Authorization Request Form

Note: *The CSHCN Services Program will not require prior authorization for hearing aid devices and services that are medically necessary and that are provided within the limitations outlined in this article unless otherwise indicated.*

Limitation

For services that require prior authorization, prior authorization must be obtained before the services are provided. Prior authorization may also be requested for medically necessary services required beyond benefit limitations.

Claims Filing

The prior authorization number must be included on the claim form when submitted to TMHP.

Authorization

Requests for prior authorization must be submitted by the provider to the TMHP-CSHCN Services Program Authorization Department using the CSHCN Services Program Authorization and Prior Authorization Request form. Requests must include documentation that supports the medical necessity of the requested device, service, or supply.

Prior authorization will be required only for the following devices and services:

- Additional devices and services that exceed benefit limitations as outlined in this article.

Refer to: The specific sections throughout this article for information about submitting the prior authorization requests for devices and services beyond benefit limitations.

- Hearing aids that are medically necessary but are not currently benefits of the CSHCN Services Program.
- Replacement of hearing aids within five years of the initial purchase.
- Hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands.

The following table summarizes the documentation requirements for the items that require prior authorization:

Description	Prior Authorization Requirements
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Hearing aids that are medically necessary but are not currently benefits of the CSHCN Services Program	<p>The prior authorization request must include:</p> <ul style="list-style-type: none"> • The medical necessity for the requested hearing aid device. • The name of the manufacturer. • The manufacturer's suggested retail price (MSRP) or average wholesale price (AWP) or the provider's documented invoice cost. • The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
Replacement of hearing aids within a 5-year period using the appropriate hearing aid device procedure code	Requests for prior authorization must include documentation that supports medical necessity which may include documentation that loss or irreparable damage has occurred, a copy of the police or fire report (if applicable), and measures to be taken to prevent reoccurrence.
Hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands.	Requests for prior authorization for hearing aid supplies will be considered when submitted with documentation that shows that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.

Requests for prior authorization must be submitted by the provider to the TMHP-CSHCN Services Program Authorization Department with documentation that supports medical necessity for the requested device, service, or supply. Authorizations may be submitted online, by fax, or by mail at:

Online: www.tmhp.com

Fax: 1-512-514-4222

Mail: Texas Medicaid & Healthcare Partnership
 TMHP-CSHCN Services Program Authorization Department
 12357-B Riata Trace Parkway, Suite 150
 Austin, TX 78727

Request form: CSHCN Services Program Authorization and Prior Authorization Request Form

Refer to: The 2009 *CSHCN Services Program Provider Manual*, section 4.2, "Authorizations," on page 4-2, for more information about the authorization process.