

Changes to Texas Medicaid Hearing Services Benefits to Accompany PACT Transition

Effective for dates of service on or after September 1, 2009, Texas Medicaid clients who are birth through 20 years of age will be eligible to receive medically necessary hearing aid devices and services through the hearing services benefit administered by TMHP. The hearing services benefits available to Texas Medicaid clients who are birth through 20 years of age will no longer be administered by Department of State Health Services (DSHS) through the Program for Amplification for the Children of Texas (PACT). TMHP currently administers the benefit for Texas Medicaid clients 21 years of age or older, so beginning September 1, 2009, TMHP will process all claims and authorization transactions for Texas Medicaid hearing services benefits. This article covers only the changes to Texas Medicaid benefits. The changes to the CSHCN Services Program benefits are covered in a separate article.

Benefit: Hearing Services and Hearing Aid Devices

The Texas Medicaid hearing services benefit includes the following:

- An individual client assessment to identify the appropriate type of device.
- The fitting of the device.
- The re-assessment to determine whether the device allows for adequate hearing.
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories.

The following hearing services are benefits of Texas Medicaid:

Services	Provider Type
Routine newborn hearing screening that is performed before the infant is discharged from the hospital <i>Note: The routine newborn hearing screening is included in the hospital reimbursement and is not reimbursed separately.</i>	Hospitals and birthing centers
Routine Texas Health Steps (THSteps) medical checkup hearing screening <i>Note: The routine THSteps medical checkup hearing screening is included in the reimbursement for the THSteps periodic medical checkups and is not reimbursed separately.</i>	THSteps medical providers
Audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss	Audiologists and physicians
Hearing aid devices and accessories and fitting and dispensing visits and revisits	Hearing aid fitters and dispensers
Physician otology and otorhinolaryngology services	Physicians (specialties: otologists and otorhinolaryngologists)

Note: Texas Medicaid clients whose jobs are contingent on their possessing a hearing aid or who appear to have vocational potential and who need a hearing aid may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS) for hearing aids.

Reimbursement: Hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP Special Medical Prior Authorization (SMPA) department. The reimbursement will be determined based on either the manufacturer's suggested retail price (MSRP) less 18 percent or average wholesale price (AWP) less 10.5 percent (whichever is applicable) or based on the provider's documented invoice cost.

Required forms: Required forms, which are indicated in the specific sections of this article, are not submitted with the claim to TMHP, but the forms must be completed and maintained in the client's medical record and made available upon request by HHSC or TMHP for retrospective review.

Limitations: All services provided to Texas Medicaid clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations. In addition to services that always require prior authorization, providers may request prior authorization for medically necessary services that exceed benefit limitations.

Enrollment and claims filing: To be reimbursed for both audiology services and hearing aid fitting and dispensing services, audiologists must enroll with Texas Medicaid as audiologists and also as hearing aid fitters and dispensers. Audiology services must be billed using the audiologist provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter, and hearing aid and fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter.

Providers must file all claims electronically or on the appropriate Centers for Medicare & Medicaid Services (CMS) paper claim form after providing the services. 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.)

Important: *Effective for dates of service on or after September 1, 2009 audiologists (i.e., those providers whose enrollment letter indicates "Audiologist") must no longer use benefit code CCP when submitting electronic claims to TMHP. Claims may be rejected if submitted with benefit code CCP.*

Hearing services provided before September 1, 2009, to Texas Medicaid clients who are birth through 20 years of age must be submitted to PACT.

Refer to: The [Providers – Hearing Services for Children \(PACT Transition\) web page](#) for information about enrolling in Texas Medicaid.

As of June 1, 2009, PACT is not enrolling providers and is directing providers to enroll with Texas Medicaid. Providers must be appropriately enrolled with Texas Medicaid to be reimbursed for hearing services provided to Texas Medicaid clients.

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 Texas Medicaid 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 Texas Medicaid and hearing services providers who are newly enrolled and who indicate they will provide hearing services to Texas Medicaid 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 be requested only by enrolled hearing services providers who are experienced with the pediatric population and who will offer auditory services to Texas Medicaid clients who are birth through 20 years of age.*

Hearing Screenings

Routine Newborn Hearing Screening

Form
<ul style="list-style-type: none">• To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.• No other forms are required.
Limitation
One per lifetime
Claims Filing
For more information about the newborn hearing screening, providers may refer to the 2009 <i>Texas Medicaid Provider Procedures Manual</i> section 23.3.1.1, “Newborn hearing Screening,” on page 23-2; section 43.1.7.5, “Newborn Examination,” on page 43-8; and section 43.1.7.6, “Medical Checkup, First 6 Days of Life,” on page 43-9.
Authorization
Not required

Health Safety Code, Chapter 37, mandates that a birthing facility (hospital or birthing center) offer the parents of a newborn a hearing screening for the newborn so that hearing loss can be identified before the newborn is discharged from the facility. Procedures for newborn hearing screening provided during the birth admission are considered part of the newborn delivery payment to the facility and are not reimbursed as separate procedures.

For infants born outside of a hospital or birthing facility (i.e., not admitted), the hearing screening must be performed during the initial THSteps periodic medical checkup. Providers who are not enrolled as THSteps providers must refer the infant to an enrolled THSteps provider for these services.

Routine Hearing Screening Performed As Part of THSteps Medical Checkups

Form	
<ul style="list-style-type: none"> To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form. No other forms are required. 	
Limitation	
According to the "THSteps Medical Checkups Periodicity Schedule for Infants, Children, and Adolescents (Birth through 20 years of age)"	
Claims Filing	
For more information about THSteps medical checkups, providers may refer to the 2009 <i>Texas Medicaid Provider Procedures Manual</i> Section 43, "Texas Health Steps (THSteps)," on page 43-1.	
Authorization	
Not required	

A hearing screening must be performed as part of each THSteps periodic visit. The hearing screening is included in the reimbursement for the THSteps periodic medical checkups and is not reimbursed separately.

Hearing Screenings Requested Outside of a Routine Newborn or THSteps Medical Checkup

Form	
<ul style="list-style-type: none"> To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form. No other forms are required. 	
Limitation	
As medically necessary	
Claims Filing	
92551	Procedure code 92551 may be reimbursed to audiologists, physicians, nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) in the office or outpatient hospital setting for hearing screenings performed outside of routine newborn or THSteps medical checkups.
Authorization	
Not required	

Hearing screening provided by an audiologist, physician, NP, CNS, or PA either at the request of a client or parent or guardian or at the provider's discretion is a benefit for Texas Medicaid clients. The benefit applies to clients of all ages when the screening is performed by a provider who is enrolled with Texas Medicaid and licensed to perform these services.

Reimbursement: The following information is published in the Texas Medicaid physician fee schedule available on this website:

Type of Service	Procedure Code	Client Age From	Fee	Effective Date
LAB	92551	0-20	\$15.75	9/1/2007
LAB	92551	21-999	\$15.75	4/1/2009
PROF	92551	0-20	\$15.75	9/1/2007
PROF	92551	21-999	\$15.75	4/1/2009

(LAB) Laboratory service total component. (PROF) Professional interpretation component.

Abnormal Hearing Screening Results

Form
Physician's Examination Report
Limitation
None
Claims Filing
None
Authorization
Not required

If the screening has abnormal results, the referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record. A new Physician's Examination Report must be completed whenever there is a change in the client's hearing or a new hearing aid is needed. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

The client must be referred to a Texas Medicaid provider who is a licensed audiologist or physician who provides audiology services. Clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

In addition to being referred to an appropriate provider for further testing, clients with suspected hearing loss who are 35 months of age or younger must be referred to Early Childhood Intervention (ECI) within 2 working days of the abnormal hearing screening.

For more information about ECI, providers may refer to the 2009 *Texas Medicaid Provider Procedures Manual* section 13, "Targeted Case Management for Early

Childhood Intervention (ECI),” on page 13-1, and section 43.4.6, “Early Childhood Intervention (ECI) (CCP),” on page 43-50.

Audiology and Audiometry Evaluation and Diagnostic Services

Physicians must recommend hearing evaluations based on examination of the client.

Only physicians or licensed audiologists will be reimbursed for hearing evaluations. Hearing aid fitters and dispensers are not reimbursed for hearing evaluations.

Diagnostic Hearing Services

Form
<p>Hearing Evaluation, Fitting, and Dispensing Report (Form 3503): The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the physician or audiologist conducting the diagnostic testing. The provider who signs the report must maintain it in the client’s file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.</p>
Limitations
See below
Claims Filing
See below
Authorization
<p>Hearing screening and testing services do not require prior authorization. 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.</p>

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

Audiometry Survey Procedure Codes (Reimbursement Rates)				
92551	92552	92553	92555	92556
92557	92563	92567	92568*	92569*
92579	92582			
Limitations:				
<p>One per day may be reimbursed.</p> <p>Procedure codes 92551, 92552, 92553, 92555, and 92556 are not reimbursed on the same day by any provider as procedure code 5/l-92557. If three or more of these procedure codes are billed for the same date of service, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code (92557).</p> <p>Tympanometry (procedure code 92567) must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment. Tympanometry is limited to four services per year by the same provider and is based on medical necessity, which must be documented in the</p>				

client's medical record.

* Procedure codes 92568 and 92569 are limited to the specific diagnosis codes in the table at the end of this "Diagnostic Hearing Services" section.

Evoked Potential and Otoacoustic Emissions Screening

92585	92586	92587	92588
-------	-------	-------	-------

Limitations:

One per day may be reimbursed.

Hearing screening services with the use of auditory brainstem response (ABR) and otoacoustic emissions (OAE) audiometry are a benefit of Texas Medicaid for newborns as part of the newborn hearing screening. ABR and OAE are benefits for clients of all ages when performed to identify and diagnose hearing loss.

Evoked response testing (procedure codes 92585, 92586, 92587, and 92588) is considered a bilateral procedure. If separate charges are billed for left- and right-sided tests of the same type, the tests are combined and reimbursed as a quantity of one.

An electroencephalogram (EEG) may be reimbursed for the same date of service as evoked response testing by any provider.

Procedure code 95920 may be reimbursed in addition to each evoked potential test. Procedure code 95920 is limited to a maximum of two hours per day, per client, per provider, without documentation of medical necessity.

Service	Procedure Code	Limitation
Hearing aid examination	92591	As medically necessary
Hearing aid assessment	V5010	As medically necessary

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

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	3885	38905	38906	38913
38915	38916	38917	38920	38921
38922	7443	7804		

Reimbursement: The following information is published in the Texas Medicaid physician fee schedule available on this website and will be published in the audiologist fee schedule after September 1, 2009:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
LAB	92551	0-20	\$15.75	9/1/2007
LAB	92551	21-999	\$15.75	4/1/2009
PROF	92551	0-20	\$15.75	9/1/2007
PROF	92551	21-999	\$15.75	4/1/2009
LAB	92552	0-999	\$17.18	4/1/2009
LAB	92553	0-999	\$22.63	4/1/2009
PROF	92553	0-999	\$22.63	4/1/2009
LAB	92555	0-999	\$12.60	4/1/2009
PROF	92555	0-999	\$12.60	4/1/2009
LAB	92556	0-999	\$19.48	4/1/2009
PROF	92556	0-999	\$19.48	4/1/2009
LAB	92557	0-999	\$39.52	4/1/2009
PROF	92557	0-999	\$39.52	4/1/2009
LAB	92563	0-20	\$16.04	4/1/2009
LAB	92563	21-999	\$16.04	4/1/2009
PROF	92563	0-999	\$16.04	4/1/2009
LAB	92567	0-999	\$16.91	9/1/2007
PROF	92567	0-999	\$16.91	4/1/2009
LAB	92568	0-20	\$14.32	4/1/2009
LAB	92568	21-999	\$14.32	4/1/2009
PROF	92568	0-999	\$14.32	4/1/2009
LAB	92569	0-999	\$12.88	9/1/2007
LAB	92569	21-999	\$12.88	9/1/2007
PROF	92569	0-999	\$12.88	4/1/2009
LAB	92579	0-999	\$34.65	4/1/2009
LAB	92579	21-999	\$34.65	4/1/2009
LAB	92582	0-20	\$32.36	4/1/2009
LAB	92582	21-999	\$32.36	4/1/2009
PROF	92582	0-999	\$32.36	4/1/2009
TECH	92585	0-999	\$74.28	3/26/2009
LAB	92586	0-999	\$48.97	4/1/2009
LAB	92587	0-20	\$46.11	9/1/2007
LAB	92587	21-999	\$46.11	9/1/2007

Type of Service	Procedure Code	Client Age	Fee	Effective Date
PROF	92587	0-20	\$7.16	9/1/2007
PROF	92587	21-999	\$8.21	4/1/2009
LAB	92588	0-20	\$63.58	9/1/2007
LAB	92588	21-999	\$63.58	9/1/2007
PROF	92588	0-20	\$18.03	4/1/2009
PROF	92588	21-999	\$18.03	4/1/2009
MED	92591	0-20	\$38.05	9/1/2007
MED	92591	21-999	\$38.96	9/1/2007
HA	V5010*	0-999	\$44.35	8/24/2005

(LAB) Laboratory service total component; (PROF) Professional interpretation component; (TECH) Technical component; (MED) Medical service; (HA) Hearing aid service.

* Effective for dates of service on or after September 1, 2009, procedure code V5010 may be reimbursed to hearing aid providers and audiologists. Effective for dates of service on or before August 31, 2009, procedure code V5010 may be reimbursed to hearing aid providers only.

Physician Diagnostic Hearing Services

Form	
Providers must maintain documentation of medical necessity 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.	
Limitations	
As medically necessary	
Claims Filing	
92502 92504	Texas Medicaid reimburses physicians for ear and throat examination procedure codes 92502 and 92504. Important: Examination procedure codes 92502 and 92504 will be payable to physicians only and not to audiologists as they are under PACT.
Authorization	
Not required	

Reimbursement: The following information is published in the Texas Medicaid physician fee schedule available on this website:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
MED	92502	0-999	\$82.48	9/1/2007

MED	92504	0-999	\$21.19	9/1/2007
(MED) Medical service.				

Noncovered Services

Texas Medicaid does not reimburse for hearing screening completed for day care, Head Start, or school. Separate procedure codes should not be billed for these services.

Hearing Aid Devices and Accessories

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

Texas Medicaid reimburses 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)
Hearing aid assessment	V5010	As medically necessary
Hearing aid accessories*	V5267	Prior authorization required
Fitting and dispensing visit	Refer to the hearing aid fee schedule for payable codes.	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: <i>If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed upon appeal with a statement documenting medical necessity.</i>
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

Service	Procedure Code(s)	Limitation
---------	-------------------	------------

* Hearing aid accessories include chin straps, clips, boots, and headbands for clients who are birth through 20 years of age.

** Procedure code 92592 may be reimbursed for the first and second revisits for monaural fittings. Procedure code 92593 may be reimbursed for the first and second revisits for binaural fittings.

Reimbursement: The following information is published in the Texas Medicaid hearing aid and audiometric services fee schedule available on this website:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
HA	V5010	0-999	\$44.35	8/24/2005
HA	V5264	0-999	\$67.50	7/1/2008
HA	V5265	0-999	\$60.00	7/1/2008
HA	V5275	0-999	\$45.00	7/1/2008

(HA) Hearing aid device/service.

Hearing Aid Devices

Form

To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.

No other forms are required.

Limitation

One hearing aid procedure code and modifier combination if applicable (i.e., 1 monaural procedure code with modifier LT and 1 monaural procedure code with modifier RT, or 1 binaural procedure code) may be reimbursed once every five years from the dispensing month without prior authorization. Exceptions are considered on a case-by-case basis through the prior authorization process.

Note: Hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) setting.

Claims Filing

See below

Authorization

Prior authorization is not required for hearing aids that are within benefit limitations. Prior authorization is required for additional medically necessary hearing aid devices within a five-year period. For details about submitting prior authorization requests, providers may refer to the "Prior Authorization" section of this article.

Important: For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet criteria as outlined in this article, the SMPA department will refer the request to the TMHP CCP department for consideration under

the Comprehensive Care Program (CCP). The provider is not required to complete additional forms or request referral to CCP.

Reimbursement

The reimbursement for the monaural and binaural procedure codes includes 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

Claims filing: Texas Medicaid reimburses hearing aid providers for the following hearing aid procedure codes:

Monaural Hearing Aid Procedure Codes*

V5030	V5040	V5170	V5180	V5244
V5245	V5246	V5247	V5254	V5255
V5256	V5257	V5298**		

* Monaural hearing aid procedure codes must be billed with modifier LT (left ear) or modifier RT (right ear) to indicate which ear is fitted with the hearing aid device.

** For clients who are birth through 20 years of age, procedure code V5298 may be reimbursed with prior authorization through the TMHP SMPA department for hearing aids that are medically necessary but are not currently benefits of Texas Medicaid. Procedure code V5298 may be reimbursed to hearing aid fitters and dispensers in the office, home, and other location settings.

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 documentation of medical necessity 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 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher.
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance.

Providers must also include the model number, serial number, and warranty dates of the purchased hearing aid device in the client’s medical record.

Binaural Hearing Aid Procedure Codes*

V5100	V5210	V5220	V5249	V5250
V5251**	V5252	V5253	V5258	V5259
V5260	V5261	V5298***		

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

** Procedure code V5251 is restricted to clients who are birth through 20 years of age and is reimbursed to hearing aid fitters and dispensers in the office, home, and other location settings.

*** For clients who are birth through 20 years of age, procedure code V5298 may be reimbursed with prior authorization through the TMHP SMPA department for hearing aids that are medically necessary but are not currently benefits of Texas Medicaid. Procedure code V5298 may be reimbursed to hearing aid fitters and dispensers in the office, home, and other location settings.

Medical necessity: Clients meet the criteria for binaural aids if they meet the conditions for a monaural hearing aid and have at least a 35-dBHL hearing loss in both ears.

Providers must include the medical necessity criteria and the model number, serial number, and warranty dates of the purchased hearing aid device in the client's medical record.

For more information about coding place of service for "other locations," providers may refer to the 2009 *Texas Medicaid Provider Procedures Manual* section 5.3.1.1, "Place of Service (POS) Coding," on page 5-18.

Replacement of hearing aid devices: Replacement devices must be prior authorized. Replacement is considered for prior authorization when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the prior authorization request. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.

For clients who are birth through 20 years of age, in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, the Special Medical Prior Authorization (SMPA) department will submit a referral to the DSHS Health Screening and Case Management unit. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Reimbursement: The following information is published in the Texas Medicaid hearing aid and audiometric services fee schedule available on this website:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
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
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

Type of Service	Procedure Code	Client Age	Fee	Effective Date
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	V5251*	0-999	\$2,392.82	9/1/2009
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	V5298*	0-20	MP	9/1/2009

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

*** Effective for dates of service on or before August 31, 2009, procedure codes V5251 and V5298 are not reimbursed. The reimbursement rates for these codes as noted in this table are effective for dates of service on or after September 1, 2009.**

Supplies and Accessories

Form

- To file claims after providing services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.
- No other forms are required.

Limitation

Providers must dispense each hearing aid reimbursed through Texas Medicaid with all necessary hearing aid accessories and supplies, including a one-month supply of batteries. Batteries may be replaced as medically necessary without prior authorization.

Claims Filing

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

V5266	Replacement hearing aid batteries may be reimbursed as medically necessary without prior authorization and are limited to clients with a
-------	--

	previously billed hearing aid. Replacement batteries for clients who did not receive the hearing aid through Texas Medicaid are considered for reimbursement on appeal with a physician's statement documenting medical necessity.
V5267	For clients who are birth through 20 years of age, Texas Medicaid may also reimburse children's hearing aid accessories, including, but not limited to, chin straps, clips, boots, and headbands with prior authorization. Providers may purchase the accessories from a vendor of their choice and submit a claim to TMHP for reimbursement.

Authorization

Procedure code V5267 requires prior authorization. For details about submitting prior authorization requests, providers may refer to the "Prior Authorization" section of this article.

Reimbursement: The following information is published in the Texas Medicaid hearing aid and audiometric services fee schedule available on this website:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
HA	V5266	0-999	\$1.30	12/2/2008
HA	V5267*	0-20	MP	9/1/2009

(MED) Medical service. (HA) Hearing aid device/service. (MP) Manually priced.
*** Effective for dates of service on or before August 31, 2009, procedure code V5267 is not reimbursed. The reimbursement for this procedure code as noted in this table is effective for dates of service on or after September 1, 2009.**

Hearing Aid Warranty: Repairs and Modifications

Form

- To file claims after providing services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.
- No other forms are required.

Limitation

After the warranty period has lapsed, repair or modification of a hearing aid may be reimbursed once per year if repair or modification is a better alternative than a new purchase.

Claims Filing

V5014	Repair or modification may be reimbursed using procedure code R-V5014.
-------	--

Authorization

Additional repairs 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.

For details about submitting prior authorization requests, providers may refer to the

“Prior Authorization” section of this article.

A hearing aid dispensed through Texas Medicaid 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.

During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid will not reimburse hearing aid repair during the 12-month manufacturer’s warranty period. Providers must follow the manufacturer’s repair process as outlined in their warranty contract.

Reimbursement: The following information is published in the Texas Medicaid hearing aid and audiometric services fee schedule available on this website:

Type of Service	Procedure Code	Client Age	Fee	Effective Date
HA	V5014	0-999	\$300.02	12/2/2008

(HA) Hearing aid device/service.

Noncovered Services

The following hearing aid procedure codes are not reimbursed by Texas Medicaid:

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

Fitting and Dispensing Visits and Revisits

Forms

The forms required for the fitting and dispensing visits are as follows:

Hearing Evaluation, Fitting, and Dispensing Report (Form 3503): The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the fitter/dispenser that conducts the fitting and dispensing visit. The provider who signs the report must maintain it in the client’s file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Client acknowledgement statement (created by the provider): At the time the hearing aid device and supplies are dispensed, the client must sign a client acknowledgement statement to verify the client was evaluated and offered an appropriate hearing aid that meets the client’s hearing need. The acknowledgement statement must include language that indicates the client is responsible for paying any hearing aid rental fees if charged. The provider must obtain the signed acknowledgment statement before dispensing the hearing aid device and supplies and must keep the signed acknowledgment statement in the client’s file. Retrospective review may be

performed to ensure documentation supports the medical necessity of the device, service, or supply.

30-day trial period certification statement (created by the provider): Providers must inform clients of the trial period lasting 30 consecutive days with a written contract that was created by the provider. The contract, which must be signed by the client, must contain the beginning and ending dates of the trial period, all charges and fees associated with the trial period, an acknowledgment that the client accepts responsibility for any assessed rental fees, and 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.

After at least 30 days and the successful completion of the trial period, the provider must update the statement to indicate that the trial was successful and the client accepted the dispensed hearing aid device. The updated statement must be maintained in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Additional necessary documentation: Medical record documentation maintained in the client's medical record

Limitation

See below

Note: *Hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the SNF, ICF, or ECF setting.*

Claims Filing

See below

Authorization

Not required

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

Visit (Procedure Code)	Procedure Code(s)	Limitations
Fitting and dispensing visit	V5011 Note: <i>Refer to the Texas Medicaid fee schedules for payable procedure codes effective September 1, 2009.</i>	Includes the fitting, dispensing, and post-fitting check of the hearing aid. The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within five weeks of the initial fitting. The post-fitting check is part of the dispensing procedure and is not 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
Second revisit*	92592** 92593**	

		scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry readings from the first evaluation.
--	--	---

*** 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.**

Reimbursement: The following information is published in the Texas Medicaid hearing aid and audiometric services fee schedule available on this website:

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	V5011	0-999	\$50.00	8/24/2005
HA	V5090	0-999	\$200.00	7/1/2008
HA	V5110	0-999	\$250.00	7/1/2008
HA	V5160	0-999	\$270.00	7/1/2008
HA	V5200	0-999	\$270.00	7/1/2008
HA	V5240	0-999	\$270.00	7/1/2008
HA	V5241	0-999	\$215.00	7/1/2008

(MED) Medical service.

30-Day Trial Period

Providers must allow each Texas Medicaid client a 30-consecutive-day trial period that begins with the dispensing date. This trial period gives the client time to determine whether the hearing aid device meets the client's needs. If the client is not satisfied with the purchased hearing aid, the client may return it to the provider, who must accept it. If the device is returned within 30 days of the date it was dispensed, the provider may charge the client a rental fee not to exceed \$2.00 per day. This fee is not a benefit of Texas Medicaid and will not be reimbursed. The client is responsible for paying the hearing aid rental fees if the provider chooses to charge a fee for the rental of returned hearing aid devices.

During the trial period, providers may dispense additional hearing aids as medically necessary until either the client is satisfied with the results of the hearing aid or the provider determines that the client cannot benefit from the dispensing of another hearing aid. The dispensing date of each additional hearing aid starts a new trial period.

Facility Visits and Home Visits

Home visit hearing evaluations and fittings are permitted only with the physician's written recommendation.

For clients who are birth through 20 years of age, hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the SNF, ICF, or ECF setting.

For clients who are 21 years of age or older, services for residents in a SNF, ICF, or ECF must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

Prior Authorization Requirements

Forms

No form (Providers may use the form of their choice to submit the required information.)

Note: *Unless otherwise indicated, Texas Medicaid does 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. See below for those services that require prior authorization.*

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 the claim is submitted to TMHP.

Prior authorization is 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.

- Replacement of hearing aids within a five-year period.

For clients who are birth through 20 years of age, prior authorization is also required for the following services:

- Hearing aids that are medically necessary but are not currently benefits of Texas Medicaid.
- Children's 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:

Procedure Code	Description	Prior Authorization Requirements
V5298*	Hearing aids that are medically necessary but are	The prior authorization request must include:

Procedure Code	Description	Prior Authorization Requirements
	not currently benefits of Texas Medicaid	<ul style="list-style-type: none"> The medical necessity for the requested hearing aid device The name of the manufacturer The MSRP or 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.
V5251*	Analog hearing aid not reimbursed for clients who are 21 years of age or older	Medical necessity documentation required.
Appropriate hearing aid device procedure code	Replacement of hearing aids within a 5-year period	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.
V5267*	Children's hearing aid accessories currently available through PACT, including, but not limited to, chin straps, clips, boots, and headbands	Requests for prior authorization for hearing aid supplies will be considered when the requests are submitted with documentation that shows that the client is birth through 20 years of age and that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.
<p>* Procedure codes V5298, V5251, and V5267 are benefits for clients who are birth through 20 years of age only.</p>		

Providers must submit requests for prior authorization to the SMPA 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:	1-512-514-4213
Mail:	Texas Medicaid & Healthcare Partnership Special Medical Prior Authorization Department 12357-B Riata Trace Parkway, Suite 150 Austin TX 78727
Request form:	None (Providers may use the form of their choice to submit the required information to the SMPA department.)

Important: For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet criteria as outlined in this article, the SMPA department will refer the request to the TMHP CCP department for consideration under CCP. The provider is not required to complete additional forms or request referral to CCP.

Refer to: The 2009 *Texas Medicaid Provider Procedures Manual* section 5, "Claims Filing," on page 5-1, for more information about the authorizations and claims filing processes.