Hearing Services

CSHCN Services Program Provider Manual

April 2026

TEXAS
Health and Human
Services

HEARING SERVICES

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20.1 Enrollment

Appropriately-licensed providers may enroll as CSHCN Services Program providers by completing the provider enrollment application available through the TMHP-CSHCN Services Program. Providers must be actively enrolled as Texas Medicaid providers before enrolling in the CSHCN Services Program. Out-of-state providers must meet all applicable enrollment requirements, and be located in the United States, within 50 miles of the Texas state border.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

20.1.1 Non-Implantable Hearing Aid Devices and Services

A provider of hearing aid fitting and dispensing services must be licensed by the Texas State Committee of Examiners for Speech, Language, Pathology, and Audiology.

Hearing aid fitters and dispensers may enroll with the CSHCN Services Program as individuals or as facilities.

20.1.2 Implantable Hearing Aid Devices and Services

To enroll in the CSHCN Services Program, hearing services professionals who provide implantable hearing devices and services must be appropriately enrolled according to their licensure and scope of practice.

20.2 Benefits, Limitations, and Authorization Requirements – Non-Implantable Devices and Services

The CSHCN Services Program hearing services benefit includes those services that are medically necessary for clients of any age who have suspected or identified hearing loss that can be improved or ameliorated using a hearing aid device.

Such services may be reimbursed to audiologists or hearing aid fitters and dispensers as follows:

- Audiologist and physician providers may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss including, but not limited to, the following:

- Hearing screening
- Audiometric testing
- Otological examination
- Vestibular evaluation
- Hearing aid evaluation

- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories, fitting and dispensing visits, and revisits including, but not limited to, the following:
  - Ear molds
  - 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

Note: *Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a non-implantable hearing aid device are not considered part of the CSHCN Services Program hearing services benefit. Providers may refer to the other CSHCN Services Program Provider Manual chapters for benefit and limitation information about other hearing-related services.*

All services provided to CSHCN Services Program clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations noted in this chapter. Providers must request prior authorization for medically necessary services that exceed benefit limitations and for those services for which prior authorization is required.

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 Texas Workforce Commission (TWC). The CSHCN Services Program may request that clients who meet these requirements apply to TWC, as the CSHCN Services Program is the payor of last resort.*

20.2.1 Hearing Screening

A hearing screening that is provided due to client concern, or at the provider's discretion, is a benefit for clients of any age when the client is referred by a CSHCN Services Program-enrolled physician, and the screening is provided by a CSHCN Services Program-enrolled provider that is licensed to perform these services.

20.2.2 Abnormal Hearing Screens

Clients with abnormal hearing screens must be referred to a CSHCN Services Program-enrolled licensed audiologist or physician that provides audiology services.

Clients who are birth through 35 months of age with suspected or confirmed hearing loss must be referred to Early Childhood Intervention (ECI) as soon as possible but no longer than 7 days after identification, even if the client is also referred to an appropriate provider for further testing. The client's responsible adult may refuse to permit the referral or decline ECI services at any time. The provider must document the client's responsible adult's decision in the client's medical record.

20.2.3 Hearing Testing, Examination, and Evaluation Services

20.2.3.1 Audiometric Testing

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

- Tympanometry and reflex threshold measurements
- Screening test, pure tone, air only
- Pure tone audiometry
- Speech audiometry threshold
- Comprehensive audiometry threshold evaluation and speech recognition

The following procedure codes may be reimbursed for a basic comprehensive audiometry survey:

Procedure Codes						
92550	92551	92552	92553	92555	92556	92557

The following additional audiometric tests may also be reimbursed by the CSHCN Services Program:

Procedure Codes									
92558	92563	92565	92567	92568	92570	92571	92572	92575	92576
92577	92579	92582	92583	92584	92587	92588	92650	92651	92652
92653									

20.2.3.2 Otological Examination

An otological examination is a benefit of the CSHCN Services Program when it is medically necessary and provided by a CSHCN Services Program-enrolled physician licensed to perform this service.

Procedure codes 92502 and 92504 may be reimbursed for otological examination.

An otological examination may also include physician evaluation and management services that are provided to diagnose or treat medical conditions.

Refer to: Section 31.2.18, "Evaluation and Management (E/M) Services" in Chapter 31, "Physician" for more information about medically necessary physician evaluation and management services.

20.2.3.3 Vestibular Evaluations

A vestibular evaluation is a benefit of the CSHCN Services Program when it is medically necessary and provided by a CSHCN Services Program-enrolled physician, and the screening is provided by a CSHCN Services Program-enrolled provider licensed to perform these services.

The following procedure codes may be reimbursed for vestibular evaluations:

Procedure Codes									
92531	92532	92533	92534	92537	92538	92540	92541	92542	92544
92545	92546	92547							

20.2.3.4 Authorization/Documentation Requirements

Authorization is not required for hearing services for the evaluation and diagnosis of hearing loss. 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.

20.2.3.5 Limitations

Procedure codes 92553 and 92556 are not billable on the same day by the same provider for the same client. If both procedure codes are billed for the same date of service by the same provider for the same client, they will be denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Procedure codes 92551, 92552, and 92553 for pure tone audiometry are limited to one of any of these procedure codes per day, same provider, same client.

Procedure code 92547 is an add-on code, and must be billed with the primary procedure code (92540, 92541, 92542, 92544, 92545, or 92546) with the same date of service by the same provider to be considered for reimbursement.

Procedure codes 92558, 92587, 92588, 92650, 92651, 92652, and 92653 assume that testing is performed in both ears. If testing is only performed in one ear, use modifier 52 with 92558, 92587, 92588, 92650, 92651, 92652, and 92653 to indicate that a test has only been applied to one ear.

Procedure codes 92558, 92587, and 92588 will only be reimbursed once per day for the same provider and the same client.

Procedure codes 92650, 92651, 92652, and 92653 will only be reimbursed once per day by any provider.

Procedure codes 92620, 92621, and 92625 may be reimbursed for evaluative and therapeutic services and are limited to four services per rolling year. Providers must submit prior authorization requests with documentation of medical necessity.

Procedure code 92621 is an add-on code, and must be billed with the primary procedure code 92620, on the same day by the same provider in order to be considered for reimbursement.

Tympanometry (impedance testing) procedure code 92567 may be reimbursed as an objective diagnostic test of middle ear disease and is limited to three services per rolling year by any provider.

Procedure code 92591 may be reimbursed for a hearing screening or other hearing aid examination.

Two hearing aid revisits may be reimbursed per calendar year. Procedure code 92592 may be reimbursed for the first and second revisits for monaural hearing aid fittings. Procedure code 92593 may be reimbursed for the first and second revisits for binaural hearing aid fittings.

Additional hearing aid checks may be reimbursed within a period of six months after a second revisit. Providers must submit a prior authorization request and documentation of medical necessity for the additional hearing aid checks.

20.2.4 Hearing Aid Devices and Accessories

Nonimplantable hearing aid devices and accessories are benefits of the CSHCN Services Program.

Important: *TMHP does 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	Limitation
Hearing aid devices	**Limitation:** One per ear every five rolling years. One of the following may be reimbursed: • If only one ear requires a hearing aid device, one monaural hearing aid procedure code with the appropriate modifier LT or RT may be reimbursed without prior authorization once every five years from the dispensing date of the initial services. • If within the same five-year period, the other ear requires a hearing aid device, a second monaural hearing aid device procedure code with the appropriate modifier LT or RT may be reimbursed without prior authorization and a separate five-year period will begin for the second device. • If both ears require a hearing aid device at the same time, one binaural hearing aid procedure code may be reimbursed once every five years from the dispensing date of the initial services without prior authorization. For binaural procedure codes, bill a quantity of one. Replacement hearing aid devices that are required within the same five-year period must be prior authorized. Repairs or modifications may be reimbursed once per rolling year after the one-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. If repairs are required more than once per year, additional repairs or modifications may be reimbursed with prior authorization if medical necessity can be demonstrated. **Procedure codes:** See below for monaural and binaural procedure codes. Procedure code V5014 may be reimbursed for repairs and modifications. **Date of service:** The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. The date of service for the repair or modification is the date the client receives the repaired or modified hearing aid device. **Warranty note:** During the warranty period, the CSHCN Services Program may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. The CSHCN Services Program will not reimburse hearing aid repairs or modifications that are rendered during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.
Hearing aid accessories	**Limitation:** As often as is medically necessary with prior authorization. ***Note:*** *Hearing aid accessories that are not part of the hearing aid package include, but are not limited to, chin straps, clips, boots, and headbands. The items are not supplied by TMHP; the accessories must be purchased from a vendor of the provider's choice.* **Procedure code:** V5267 **Date of service:** The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device, or the date the client receives the replacement accessory item.

Service	Limitation
Ear impression	**Limitation:** One each per hearing aid device as follows: • For monaural procedure codes, bill a quantity of one. • For binaural procedure codes, bill a quantity of two. Replacement ear molds may be reimbursed as often as is medically necessary. **Procedure codes:** V5275 **Date of service:** The date of service for the ear impression is the date the ear impression is taken.
Ear molds	**Limitation:** For clients who are 20 years of age or younger - as medically necessary. (Documentation that supports medical necessity must be maintained in the client's medical record.) For clients who are 21 years of age or older - custom ear molds are limited to 3 ear molds per ear, per rolling year, any provider; disposable ear molds are limited to 4 ear molds per ear, per 30 days, any provider. **Procedure codes:** V5264 and V5265 (billed with modifier LT or RT) **Date of service:** The date of service for the ear mold is the date the ear mold is dispensed to the client.
Batteries (replacement only)	**Limitation:** Replacement batteries may be reimbursed as often as is medically necessary when a hearing aid device has been previously reimbursed by the CSHCN Services Program. If a hearing aid has not been reimbursed by the CSHCN Services Program in the last five years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity. **Procedure code:** V5266 **Date of service:** The date of service is the date the client receives the replacement batteries. **Warranty note:** Replacement batteries that are supplied as part of the manufacturer's warranty will not be reimbursed separately by the CSHCN Services Program.

The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements when they are billed with the appropriate modifier LT or RT to indicate for which ear the hearing aid device was purchased and fitted:

Procedure Codes									
V5030	V5040	V5171	V5172	V5181	V5244	V5246	V5247	V5254	V5255
V5256	V5257	V5298							

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements:

Procedure Codes									
V5100	V5211	V5212	V5213	V5214	V5215	V5221	V5249	V5250	V5251
V5252	V5253	V5258	V5259	V5260	V5261	V5298			

20.2.4.1 Documentation Requirements

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.

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

20.2.4.2 Prior Authorization Requirements

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the previous table.

Prior authorization is required for the following:

- Replacement hearing aid devices that are required within the same five-year period

  A replacement hearing aid device may be considered for prior authorization when loss or irreparable damage has occurred. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.
- Hearing aid accessories that are not part of the hearing aid package including, but not limited to, chin straps, clips, boots, and headbands

  Requests for prior authorization for hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands will be considered when the requests are submitted with documentation that shows that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.
- Hearing aid devices that are not currently a benefit of the CSHCN Services Program but that are medically necessary.

The prior authorization request must include:

- The medical necessity for the requested hearing aid device.
- The name of the manufacturer.
- The manufacturer's suggested retail price (MSRP) or the provider's documented invoice cost if the MSRP is not available.
- The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
- For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair or modification.

For services that require prior authorization, prior authorization must be obtained before the services are rendered. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization requests must be submitted to the TMHP-CSHCN Services Program Authorization Department using the CSHCN Services Program Authorization and Prior Authorization Request Form. Documentation that supports medical necessity for the requested device, service, or supply must be included with the form. See Chapter 4, "Prior Authorizations and Authorizations" for more information about the authorizations and claims filing processes.

20.2.4.3 Limitations

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 that receives the device

Providers must dispense each hearing aid reimbursed through the CSHCN Services Program with all necessary hearing aid accessories and supplies, including a one-month supply of batteries. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- 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

Note: *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.*

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of the CSHCN Services Program but that are medically necessary.

Procedure code V5251 may be reimbursed with prior authorization.

A monaural hearing aid device procedure code and a binaural hearing aid device procedure code will not be reimbursed within the same five-year period.

20.2.5 * Hearing Aid Services

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

Service	[Revised] Limitation
Hearing aid examination and evaluation	**Limitation:** As often as is medically necessary. **Procedure code:** 92628, 92629, 92631, and 92632 **Date of service:** The date of service is the date the service is rendered to the client.

Service	[Revised] Limitation
Hearing aid assessment	**Limitation:** As often as is medically necessary. **Procedure code:** V5010 **Date of service:** The date of service is the date the service is rendered to the client.
Fitting and dispensing visits	**Limitation:** One fitting per hearing aid procedure code, regardless of the number of times a device is returned as unacceptable during a 30-day trial period. **Procedure code:** 92634, 92635, or V5011 **Date of service:** The date of service for the fitting, orientation, and checking visit is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. A fitting follow-up check should be performed within 5 weeks of the initial hearing aid fitting visit. This evaluation is considered part of the hearing aid fitting visit and is not reimbursed separately. **Limitation:** One dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins. **Procedure codes:** V5090, V5110, V5160, V5200, V5240, and V5241 **Date of service:** The date of service for the dispensing visit is the date the client receives the hearing aid device and a new 30-day trial period begins. The dispensing fee may be reimbursed separately from the fitting of the hearing aid.
Revisit(s)	**Limitation:** Two per calendar year when billed by any provider. Additional hearing aid checks may be reimbursed with prior authorization. **Procedure codes:** 92636 and 92637 **Date of service:** The date of service is the date the service is rendered to the client.

Claims for procedure codes 92638, 92639, and 92641 may be reimbursed when they are submitted by physician, audiologist, or hearing aid providers for services rendered in the office setting.

Report codes 92628, 92631, 92634, and 92636 with modifier RT and/or LT to indicate laterality, or which ear the service is performed on. If the service is bilateral, procedure codes 92628, 92631, 92634, and 92636 must be reported with both modifiers RT and LT.

20.2.5.1 Documentation Requirements

Client Acknowledgment Statement (created by the provider)-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 acknowledgment statement 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 that the documentation supports the medical necessity of the device, service, or supply.

30-Day Trial Period Certification Statement (created by the provider)-To confirm that the client was allowed a 30-consecutive-day trial period that began with the dispensing date, the hearing aid fitter/dispenser must provide the client with 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.

A new certification statement must be provided each time a new trial period begins.

The fitter/dispenser must allow 30 days to elapse from the hearing aid dispensing date before completing the 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.

For hearing aids that are dispensed in a provider's office, if a client fails to return by the end date of the trial period, the provider must contact the client. After three attempts have been made, if the client does not return to the provider's office, the provider must document all contact attempts with the client and maintain this documentation in the client's file. Retrospective review may be performed to ensure documentation supports the contact attempts and the client's failure to return to the provider's office.

20.2.5.2 Prior Authorization Requirements

Prior authorization is not required for fitting and dispensing visits and revisits.

20.2.5.3 Limitations

The following hearing aid visits may be reimbursed by the CSHCN Services Program:

- The fitting and dispensing visits that encompass a 30-day trial period and include a post-fitting check 5 weeks after the trial period has been successfully completed
- A first revisit as needed after the post-fitting check
- A second revisit as needed after the first revisit

The fitting visit includes the fitting, dispensing, and post-fitting check of the hearing aid.

A trial period of up to 30 days is authorized by Texas Occupations Code §402.401. The 30-day trial period, and any charged rental fee, must meet the Texas Department of Licensing and Regulation (TDLR) rule requirements in 16 TAC §112.140.

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. During the 30-day trial period, if the client is not satisfied with the purchased hearing aid or if hearing is not improved with the 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 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.

A fitting follow-up check should be performed within 5 weeks of the initial hearing aid fitting visit. This evaluation is considered part of the hearing aid fitting visit and is not reimbursed separately.

20.3 Benefits, Limitations, and Authorization Requirements – Implantable Devices and Services

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone-anchored hearing device (BAHD), are benefits of the CSHCN Services Program for clients of all ages.

20.3.1 Bone-Anchored Hearing Device (BAHD)

A bone-anchored hearing device (BAHD) may be reimbursed by the CSHCN Services Program for clients who are five years of age or older and who meet the medical necessity criteria. The following procedure codes may be reimbursed with prior authorization for the BAHD and related components:

Procedure Codes									
L8690	L8691	L8692	L8693	L8694	69711	69714	69716	69717	69719
69726	69727	69728	69729	69730	V5266				

20.3.1.1 Electromagnetic Bone Conduction Hearing Device

Removal or repair of an electromagnetic bone conduction hearing device may be reimbursed using procedure code 69711. This service is limited to two procedures per lifetime when billed by any provider.

The implantation or replacement of an electromagnetic bone conduction hearing device is not a benefit.

20.3.1.2 Prior Authorization Requirements

Prior authorization is required. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request form and may be granted if the client is five years of age or older and all of the following documentation is provided:

- Previous attempts at hearing aids and why these devices are inadequate or have failed.
- Scores on hearing tests for bone conduction thresholds and on maximum speech discrimination.
- Audiological testing showing good inner ear function.
- Assessment that shows the client is motivated, is able to follow given instructions, and is willing to participate in follow-up therapy.
- Appropriate indication that may be causing hearing impairment. Indications include, but are not limited to, one of the following:
  - Acquired deformities of auricle or pinna
  - Congenital anomalies of the external ear canal, middle ear or skull and face bones
  - Malignant neoplasm, benign neoplasm or carcinoma of the external ear canal and/or tympanic cavity
  - Otosclerosis in clients who cannot undergo stapedectomy
  - Severe chronic conductive or sensorineural hearing loss (i.e., otitis media, malformations of the inner ear)

20.3.1.3 Limitations

Replacement batteries for the BAHD may be reimbursed without prior authorization as follows:

- Using procedure code V5266
- Limited to clients with a previously-paid BAHD

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

The BAHD is Food and Drug Administration (FDA)-approved for clients who are 5 years of age or older. Clients who are younger than 5 years of age do not have sufficient bone density for implantation of the device.

BAHD procedure codes are subject to NCCI relationships with the following exceptions. The procedure codes in Column A of the following table will be denied if they are billed with the same date of service by the same provider as procedure codes in Column B:

Column A (Denied)	Column B
L8691, L8692, L8693, and L8694	L8690

20.3.2 Cochlear Implants

Cochlear implants, auditory brain implants (ABIs), and auditory rehabilitation are benefits of the CSHCN Services Program.

20.3.2.1 Device, Implantation and Supplies

Procedure codes 69930 and S2235 may be reimbursed for the cochlear implant and the ABI devices and implantation.

The following procedure codes may be reimbursed for equipment:

Procedure Codes									
L7368	L8499	L8614	L8615	L8616	L8617	L8618	L8619	L8623	L8624
L8625	L8627	L8628	L8629						

Procedure codes 92601, 92602, 92603, 92604, 92622, and 92623 may be reimbursed for diagnostic analysis and subsequent programming of the implant. Procedure code 92623 is an add-on procedure code and must be billed with primary procedure code 92622 on the same day, by the same provider in order to be considered for reimbursement.

The following procedure codes may be reimbursed for batteries:

Procedure Codes			
L8621	L8622	L8623	L8624

Replacement batteries for the cochlear device (procedure codes L8621, L8622, L8623, and L8624) are limited to clients with a previously billed cochlear implant procedure, device, or supply.

Note: *Replacement batteries beyond the limit of two batteries per calendar year require prior authorization and may be considered with documentation that supports the need for additional batteries.*

20.3.2.2 Auditory Rehabilitation

Auditory rehabilitation may be a benefit of the CSHCN Services Program when medically necessary for clients who have received a surgically implanted hearing device, or clients who have prelingual or postlingual hearing loss if the treating physician has determined that auditory rehabilitation would be beneficial.

The following procedure codes may be reimbursed for auditory rehabilitation services:

Procedure Codes			
92626	92627	92630	92633

Procedure code 92627 is an add-on procedure and must be billed with primary procedure code 92626, on the same day, by the same provider in order to be considered for reimbursement.

The benefit for auditory rehabilitation is one evaluation and 12 visits per 180-day period, without prior authorization. Additional therapy services may be available through the speech therapy benefit.

Refer to: Chapter 37, "Speech-Language Pathology (SLP) Services" for additional information about the CSHCN Services Program speech therapy benefit.

20.3.2.3 Frequency Modulation (FM) Systems

An FM system may be a benefit of the CSHCN Services Program for clients who are 12 months of age and older when it is needed as an assistive listening device for use with a cochlear implant and the following criteria are met:

- At least three months have elapsed since the surgical implantation of the cochlear device
- The client is unable to obtain the FM device through any other source

The assistive listening device (FM system) for use with a cochlear implant may be reimbursed with prior authorization using procedure code V5273.

Replacement or repair of an FM system will not be considered for coverage during the manufacturer's warranty period.

20.3.2.4 Authorization Requirements

All implants must be prior authorized. Requests for prior authorization must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request form. The following information must accompany the request for prior authorization:

- Documentation from the audiologist and otolaryngologist that indicates the client is a good candidate for the procedure and meets the requirements outlined earlier in this chapter.
- Documentation that a referral to an appropriate auditory rehabilitation provider is in place.
- Documentation from the client's primary physician, neurologist, or school diagnostician that the client has the cognitive ability to use the implant.

The battery charger unit for the lithium-ion battery procedure code L7368 is limited to one replacement per five rolling years with prior authorization.

The prior authorization request will not be granted if one or more of the following situations exist:

- The client has an active ear infection.
- The client is deaf due to lesions of the acoustic nerve or central auditory pathways.
- There is radiological documentation of absent cochlear development.
- The client or the client's parents lack the cognitive ability or willingness to complete auditory rehabilitation.

The purchase, replacement, or repair of an assistive listening device (FM system) for use with a cochlear implant must be prior authorized.

Auditory rehabilitation services beyond the limit of 12 visits per180-day period must be prior authorized and will be considered for clients who are 12 months of age through 20 years of age with documentation that supports the medical necessity of continued services.

20.3.2.5 Limitations

Clients must meet the following criteria:

- The client is 12 months of age or older.
- The client has a profound, bilateral, sensorineural hearing loss.

- The client who requests the cochlear implant has had limited or no benefit from a trial with appropriately fitted hearing aids. A trial of three to six months is required for clients who do not have previous experience with hearing aids unless there is a documented reason that hearing aids will not work for that particular client.
- The client has the cognitive ability to use auditory cues.
- The client or parents are willing and able to comply with auditory rehabilitation.
- The client is assessed by both an audiologist and an otolaryngologist experienced in the implantation of cochlear implants or ABIs and who indicate that the client is a good candidate for the procedure.

ABI is an adaptation of a cochlear implant and may be reimbursed for services rendered to clients who are 12 years of age and older.

The cochlear implant or ABI device must be approved by the FDA and must be age-appropriate for the client.

The device and separate components include the following:

- Cochlear device
- Headpiece or headset
- Microphone
- Transmitting coil
- Transmitter cable
- External speech processor
- Zinc air batteries
- Alkaline AA batteries
- Recharger units
- Rechargeable AA batteries.

Replacement equipment and components are also a benefit of the CSHCN Services Program. Replacement equipment includes batteries, sound processors, cables, coils, headsets, and microphones.

Non-rechargeable batteries are limited to a maximum of 15 zinc air or a maximum of 31 alkaline batteries may be reimbursed per month without prior authorization. Rechargeable lithium-ion batteries (procedure codes L8623 and L8624) are limited to 2 batteries per calendar year.

Prior authorization is required for replacement of external sound processors and rechargeable AA batteries for a cochlear implant or ABI device.

20.3.2.6 Sound Processor Replacement Guidelines

Unless ordered by a physician, a processor must be used for 12 months before the replacement of a unit is considered for reimbursement. The replacement of a sound processor requires prior authorization with adjustment to reimbursement based on the manufacturer's trade-in policy. The physician must submit documentation of medical necessity when requesting prior authorization for the replacement of the sound processor.

20.4 Claims Information

Hearing services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements. To avoid claim denials, providers billing as a group must use the performing NPI number on their claims.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

20.4.1 Claims Filing for Non-Implantable Hearing Devices and Services

Audiology services must be billed using the audiology provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Audiologist." Hearing aid 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 that indicates "Hearing Aid."

20.4.1.1 Claims Filing for Non-implantable Hearing Aid Devices

To be reimbursed for a non-implantable hearing aid device, providers must submit paper claims with documentation that shows the provider's cost for the hearing aid device. The documentation submitted with the claim must be a manufacturer invoice that shows the net acquisition cost of the non-implantable hearing aid device.

An invoice printed from an email or the internet will not be accepted and should not be submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice shows the actual price the provider paid for the hearing aid device.

Providers are required to submit non-implantable hearing aid claims using the CMS-1500 paper claim form because electronic claim submission does not allow for the submission of attachments.

As the amount billed on a claim, providers must use the net acquisition cost, which is the actual price the provider paid for the device, including the wholesale cost plus sales tax, shipping and handling, and any reductions resulting from discounts or rebates. Providers must not use usual and customary fees as the amount billed.

Note: *The requirement to submit the net acquisition cost of the hearing aid device applies only to non-implantable monaural and binaural hearing aid devices including, but not limited to, procedure code V5298.*

20.4.2 Claims Filing for Implantable Hearing Devices and Services

Claims for implantable hearing devices must be billed using the appropriate provider number and benefit code (for electronic claims only, if applicable).

20.5 Reimbursement

For fee information, providers can refer to the OFL on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

20.5.1 Reimbursement for Hearing Tests

The CSHCN Services Program may reimburse physicians 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. Services are reimbursed at the lesser of the billed charges or the amount allowed by Texas Medicaid.

20.5.2 Reimbursement for Non-Implantable Hearing Devices and Services

The CSHCN Services Program may reimburse hearing aid devices the lesser of the following:

- The invoice cost of the hearing aid device
- The acquisition cost of the hearing aid device
- The maximum allowable Texas Medicaid fee for the hearing aid device procedure code

Procedure code V5267 is manually priced and may be reimbursed the lower of the billed amount or the MSRP less 18 percent when purchased.

20.5.3 Reimbursement for Implantable Hearing Devices and Services

Cochlear implants or ABIs may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

BAHD devices and services may be reimbursed as follows:

- Noncustom durable medical equipment (DME) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- Expendable medical supplies may be reimbursed the lower of the billed amount or the amount allowed by CMS, when available, or Texas Medicaid.
- Ambulatory surgical centers (ASCs) may be reimbursed the lower of the billed amount or the maximum fee established by the Texas Health and Human Services Commission.
- Inpatient hospital care may be reimbursed at 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment.
- Orthotics and prosthetics may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- Physicians and audiologists may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

20.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.