MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 28, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2000, AUDIOLOGY SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2000 – Audiology Services are being proposed to clarify the coverage and limitations for hearing aid batteries for persons age 21 and older. No changes are being proposed, just clarifying services already covered for recipients.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Hospital, Outpatient (Provider Type (PT) 12), Special Clinics (PT 17), Physician, M.D., Osteopath, D.O. (PT 20), Hearing Aid Dispenser (PT 23), Advanced Registered Nurses (PT 24), Durable Medical Equipment (PT 33), School Based Services (PT 60), Audiologist (PT 76) and Physician's Assistant (PT 77).

Financial Impact on Local Government: There will be no financial impact on local government.

These changes are effective June 29, 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 13/17 Audiology Services	MTL 12/09, 12/12 Audiology Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2003.3A(3)	**Coverage and Limitations**	Revised language clarifying hearing aid battery limitations.
2003.3C(2)(3)(4)	**Recipient Responsibility**	Revised language clarifying additional batteries criteria.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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AUDIOLOGY SERVICES

2000 INTRODUCTION

The Nevada Medicaid Audiology program reimburses medically necessary audiology services to eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions described in this chapter.

All providers participating in the Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program. Audiology services are an optional benefit within the Nevada Medicaid program. All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of three areas where Medicaid and NCU policies differ. For further clarification, please refer to the NCU Manual, Chapter 1000.

2001 AUTHORITY

The citation denoting the amount, duration and scope of services are found in the Code of Federal Regulations (CFR) Part 440.110 and the Nevada Medicaid State Plan Attachment 3.1-A.

The State Legislature grants authority to the relevant professional licensure boards to set the standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

- NRS – Chapter 630 – Physicians
- NRS – Chapter 637A – Hearing Aid Specialists
- NRS – Chapter 637B – Audiologists and Speech Pathlogists

2002 RESERVED

2003 AUDIOLOGY POLICY

2003.1 COVERAGE AND LIMITATIONS

Audiology services and supplies are covered by Nevada Medicaid for eligible recipients. Audiological services must be performed by a certified and licensed audiologist as described in the NRS 637B. Refer to specific coverage and limitations for each service.

2003.1A PROVIDER RESPONSIBILITY

Providers must verify recipient eligibility before rendering services. The presence of a Medicaid and NCU identification card does not guarantee eligibility. It is the provider's responsibility to ask the recipient if there is additional audiology coverage through third party payers.

The provider will allow, upon request of proper representatives of the Division of Health Care Financing and Policy (DHCFP), access to all records which pertain to Medicaid or NCU recipients for regular review, audit or utilization review. Providers must inform Nevada Medicaid of any misuse of the Medicaid or NCU card or inappropriate utilization.

2003.1B RECIPIENT RESPONSIBILITY

Services requested by the recipient, but for which Medicaid makes no payment are the responsibility of, and may be billed to, the recipient. Nevada Medicaid recipients are only responsible for payment of services not covered by Medicaid. Prior to service, the recipient must be informed in writing he/she will be responsible for payment. The recipient is responsible for:

1. presenting a valid Nevada Medicaid and NCU card to the provider at each visit;
2. presenting any form or identification necessary to utilize other health insurance coverage;
3. making and keeping appointments with the provider; and
4. notifying providers immediately of any change in eligibility status, e.g., eligibility changes from Fee-for-Service (FFS) to managed care.

2003.2 AUDIOLOGICAL TESTING

2003.2A COVERAGE AND LIMITATIONS

1. Audiological testing is limited to once per 12 rolling months for eligible recipients and must be referred by an M.D.

2. A physician must examine the hearing aid beneficiary for pathology or disease no more than six months prior to the fitting of the aid(s) and submit a statement certifying the medical necessity of the evaluation to the audiologist.

3. One audiogram testing per 12 rolling months does not require prior authorization. The audiogram should be no more than six months old.

4. To qualify for coverage by Medicaid, the report must show levels of hearing loss as follows:

   a. Adults: at least 30 decibels for the frequency range of 500-3000 Hz.

   b. Children: at least 20 decibels for the frequency range of 500-3000 Hz.

2003.2B PRIOR AUTHORIZATION

1. A prior authorization request is needed for any hearing aid(s) exceeding the allowed amount of $350.00 per aid. The audiologist's testing reports must be attached and show the following:

   a. hearing levels and discrimination scores including the type of hearing loss conductive or neuron-sensory; and

   b. a copy of the audiogram which should be no older than six months; and

   c. patient's capabilities for use of the hearing aid(s), physical dexterity, mental capabilities and motivation; and

   d. type of hearing aid(s) recommended including the cost.

2. Additional hearing evaluations outside the normal program guidelines must be prior authorized. The audiologist must keep a copy of the referral and test results in the recipient's medical record

2003.3 HEARING AIDS

2003.3A COVERAGE AND LIMITATIONS

Medicaid will reimburse only licensed physicians, licensed audiologists and certified hearing aid dispensers for hearing aid fitting and dispensing.

1. Hearing aids and related supplies are covered by Nevada Medicaid for eligible recipients. Coverage is limited to once every 24 rolling months. This may be exceeded through Early

and Periodic Screening, Diagnostic and Treatment (EPSDT) Healthy Kids if it is determined to be medically necessary by the Quality Improvement Organization (QIO)-like vendor. Refer to Chapter 1500 of the MSM for more information.

2. The manufacturer must be willing to accept the payment for the hearing aid(s) from the Medicaid hearing aid dispensers. Such payment constitutes payment in full. Shipping and handling for the hearing aid(s) is not a covered benefit. Recipients are not to be billed for any additional charges.

3. Hearing Aid Batteries: Hearing aid batteries are limited to one package of four per hearing aid per month. Requests for batteries more frequently for recipients age 21 and older require prior authorization. Children under age 21 may exceed the limitation, when medically necessary.

4. Ear Molds: Ear molds are to be provided with each new behind-the-ear hearing aid. Replacement for children is covered without prior authorization through Healthy Kids (EPSDT). Replacement for adults and children on NCU is covered when medically necessary without prior authorization up to two in 24 months.

5. Hearing Aid Fitting and Dispensing: Hearing aid fitting and dispensing includes selecting, ordering, fitting, evaluating of appropriate amplification and dispensing the hearing aid(s). It also includes an initial supply of batteries. Medicaid reimburses for ear impressions and ear molds as a separate procedure.

   Non-audiology providers of hearing aids (Durable Medical Equipment (DME) providers) may provide hearing aids and hearing aid related services and items but no professional audiology services for which an audiologist's academic credentials and licensing are required.

   Non-audiology providers of hearing aids are covered to provide hearing aid counseling, hearing aid fitting and sale of the hearing aid(s) itself. Coverage also includes revision of hearing aid accessories, replacement of parts and repairs.

   The provider must allow the recipient to have a 30-day trial period with a money back guarantee if the aid(s) does not benefit the patient. A recheck of the patient with the aid(s) must be offered two weeks or sooner following dispensing to determine if there are improved hearing levels and discrimination scores. The visit(s) should also include counseling on the use and care of the hearing aid(s) and ensure proper fit of the ear molds.

6. Warranty: Hearing aids must include a minimum 12-month warranty from the manufacturer that covers repair, damage and loss of the hearing aid(s). The provider must maintain the warranty in the recipient's medical record. A second-year warranty or

insurance is required. If the manufacturer does not include a second year warranty, the provider should request a prior authorization for additional insurance.

7. Replacement: Hearing aids may be replaced when:

   a. the current aid(s) cannot be repaired as determined by the Medicaid provider;

   b. the recipient's hearing deficit requires a different type of device for maximum benefit;

   c. the manufacturer's warranty has expired; or

   d. there is no other insurance.

8. Broken or Lost Hearing Aids: If replacement of a hearing aid(s) becomes necessary after 12 rolling months or more, the recipient will have a reevaluation by the audiologist prior to fitting of the replacement aid(s). The replacement aid(s) must be prior authorized if the aid(s) is no longer covered by a manufacturer's warranty or other insurance.

9. Supplies/Accessories: Hearing aid supplies/accessories (i.e. ear hooks, tubes) do not need prior authorization.

10. Testing/Repairs: Reimbursement will not be made for repairs covered by the manufacturer's warranty or other insurance.

    If testing/repair of the hearing aid(s) is needed after this time period, it is limited to once every 12 rolling months per aid. The provider will need to identify which aid (right or left) is being repaired. Repairs must be covered by a six-month warranty.

    Medicaid will reimburse for repairs on hearing aids that were not purchased by Medicaid. Medicaid does not reimburse for repairs if the hearing aid was damaged by tampering or misuse. Recipients are not to be billed for any additional charges.

11. Non-Covered Hearing Aids: Semi-implantable middle ear hearing aids are not a covered benefit as they are considered investigational.

2003.3B PRIOR AUTHORIZATION

1. Hearing aids exceeding the allowed amount of $350.00 per aid require prior authorization from the QIO-like vendor and need to include medical necessity for the more expensive aids, including cost.

2. Prior authorization with medical necessity is required for any additional aid(s) needed during the 24-rolling month period.

3. Additional evaluations, fitting and dispensing, ear molds, testing/repair, replacement of broken or lost hearing aid(s), supplies or insurance outside the normal program guidelines will require prior authorization from the QIO-like vendor. Each request must have the appropriate documentation attached.

2003.3C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. routine maintenance;

2. purchase of additional batteries beyond the limitation of one package of four per hearing aid per month when a prior authorization has been denied; however, children under age 21 may exceed the limitation, when medically necessary;

3. repairs and replacement of the hearing aid(s) if the recipient loses Medicaid eligibility; and

4. picking up the hearing aid(s) and returning for any necessary adjustments within the hearing aid trial period established with the provider.

2003.4 COCHLEAR AND AUDITORY BRAINSTEM IMPLANTS

2003.4A COVERAGE AND LIMITATIONS

1. Bilateral and unilateral cochlear implants are a Nevada Medicaid covered benefit when determined to be medically necessary for eligible recipients with profound hearing impairment. Covered services include but are not limited to:

   a. otologic examination.

   b. audiological evaluation.

   c. physical examination.

   d. psychological evaluation.

   e. surgical implantation of the device.

   f. postoperative follow-up evaluation and rehabilitation.

2. Coverage is restricted to those recipients who meet the following audiologic/medical criteria as determined by a physician or audiologist:

   a. recipient must be referred by an M.D. or Ear, Nose and Throat specialist with documentation to determine medical candidacy for such a device. This is to include recent (within six months) results of a CT or MRI scan to evaluate the anatomy of the inner ear; and

   b. must be at least 12 months of age or older; and

   c. must suffer from severe to profound pre-or-post lingual hearing loss (70 decibels or greater) confirmed by audiologic testing that obtains limited or no benefit from appropriate hearing aids for six months or greater; and

   d. must have the cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation; and

   e. must be free of middle ear infection; and

   f. must have an accessible cochlear lumen that is structurally suited to implantation; and

   g. be free of lesions in the auditory nerve and acoustic areas of the central nervous system; and

   h. have no contraindications for the surgery.

3. Use of the device must be in accordance with the Food and Drug Administration (FDA) approved labeling.

4. There must be good family support with self-motivation, as determined by a physician or audiologist. Education of families/caregiver and the recipient must be conducted to ensure understanding of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the therapeutic program and the ability to adequately care for the external equipment.

5. Adults

   Cochlear implants may be covered for prelinguistically (before the development of language), perilinguistically (during the development of language), and postlinguistically (after language has fully developed) deafened adults (over age 21). Postlinguistically deafened adults must demonstrate test scores of 40% or less on sentence recognition scores from tape recorded tests in the recipient's best listening condition.

6. Children

Cochlear implants may be covered for prelinguistically and postlinguistically deafened children from 12 months through 20 years of age. Bilateral profound sensorineural deafness must be demonstrated by the inability to improve on age appropriate closed set word identification tasks with amplification.

7. Rehabilitation Program

A post-cochlear implant rehabilitation program is necessary to achieve benefit from the cochlear implant for both children and adults. The program is performed by an audiologist and speech-language pathologists. The rehabilitation program includes development of skills in understanding running speech, recognition of consonants, vowels and tests of speech perception ability. Refer to Chapter 1700 for Therapy Services of the MSM.

8. Warranty

The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.

9. Damage and Loss

Damage and loss insurance is required at the time of implant. Insurance must be all-inclusive for replacement and loss, no deductibles or co-pays are allowed. There must be continuous insurance coverage for five years. Insurance is not to exceed $250/year.

2003.4B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the cochlear implant.

2003.4C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. wearing a helmet while bicycling, roller blading, playing football and soccer; players must not “head” the ball.

2. keeping equipment out of reach of animals.

3. removing the speech processor and headset before entering a room where an MRI scanner is located.

4. wearing the special harness that secures the speech processor during active sports. For water sports and activities that generate high levels of static electricity, such as playing on trampoline and plastic slides, the equipment must be removed.

2003.5 AUDITORY BRAINSTEM IMPLANT (ABI)

2003.5A COVERAGE AND LIMITATIONS

1. An ABI is a covered benefit as medically necessary when all of the following criteria are met;

   a. the recipient is 12 years of age or older; and

   b. the recipient has been diagnosed with Neurofibromatosis Type 2 (NF2); and

   c. the recipient is undergoing bilateral removal of tumors of the auditory nerves; and

   d. it is anticipated that the recipient will become completely deaf as a result of surgery; or

   e. the recipient had bilateral auditory nerve tumors removed and is now bilaterally deaf.

2. Warranty: The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.

3. Rehabilitation Program: The recipient must have multiple sessions with the audiologist to test, adjust the sound processor and learn to interpret new sounds.

2003.5B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the auditory brainstem implant.

The physician who performs the cochlear implant or auditory brainstem implant surgery must obtain prior authorization from the QIO-like vendor before providing the service. Authorization is determined based on medical necessity. Each request must include documentation to show the recipient has met Medicaid guidelines for the procedure.

2003.6 BONE-ANCHORED HEARING AID (BAHA) SYSTEM

2003.6A COVERAGE AND LIMITATIONS

Bone Anchored Hearing Aid (BAHA), also called an implantable bone conduction hearing aid, is a Nevada Medicaid covered benefit when it is determined medically necessary for eligible recipients five years and older. The BAHA is an alternative hearing device for recipients unable to use conventional hearing instruments.

BAHA Softbands and BAHA Headbands are a covered benefit for children of any age who have conditions that are eligible for a BAHA implant. The BAHA system is designed to treat:

1. Conductive or Mixed Hearing Loss from possible causes of:
    a. chronic otitis media.
    b. congenital malformations where the cochlear function is good but there are no ear canals.
    c. Cholesteatoma.
    d. middle ear dysfunction/disease.
    e. external otitis.
2. Unilateral Sensorineural Deafness or Single Sided Deafness (SSD) from possible causes of:
    a. acoustic neuroma tumors, other surgical intervention.
    b. sudden deafness.
    c. neurological degenerative disease.
    d. trauma.
    e. ototoxic treatments.
    f. genetic.
    g. Meniere's Disease.

3. Audiologic/Medical criteria:

Recipients must be referred by an M.D. or Ear, Nose and Throat Specialist with documentation to determine medical candidacy for such a device. This may include a radiology report. Assessment by an audiologist to determine if the type and degree of hearing loss meet the necessary criteria is also required.

a. Mixed and Conductive Hearing Loss with the following criteria:

1. >5 years of age.

2. <45 dB HL BC pure tone average (PTA) (measured at 0.5, 1, 2 and 3K Hz).

3. >or equal to 60% speech discrimination scores (using standardized test).

4. bilateral fitting-symmetric bone conduction thresholds are defined as no more than 10 dB difference of the PTA or less than 15 dB individual frequencies.

b. Single Sided Deafness with the following criteria:

1. >5 years of age.

2. normal hearing in contralateral ear. (Normal hearing is defined as pure tone average air conduction (PTAAC) threshold equal to or better than 20 dB HL [measured at 0.5, 2 and 3 kHz]).

3. Functions by transcranial routing of the signal.

c. Additional qualifying criteria should include:

1. sufficient bone volume and bone quality present for successful implant placement; and

2. no contraindications to anesthesia or surgery; and

3. careful consideration given to the recipient's physical, psychological and emotional state as determined by physician or audiologist; and

4. well informed recipients who have the right expectations of the BAHA system and are highly motivated, as determined by physician or audiologist; and

5. recipients who are able to maintain and clean the skin around the abutment or with the aid of others. For children, the responsibility falls on the parents or guardians; and

6. recipients trained in the care, use of the device and comfortable with connecting and disconnecting the sound processor from the abutment, prior to the fitting of the speech processor.

4. Warranty: The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.

5. Follow-Up: It is important the audiologist provides a follow-up program for the recipient.

2003.6B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the BAHA implant, softband or headband.

The physician who performs the BAHA implant surgery must obtain prior authorization from the QIO-like vendor before providing the service. Authorization is based on medical necessity. Each request must include documentation to show the recipient has met Medicaid criteria for the procedure.

2003.6C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. removing the sound processor prior to bathing, showering, swimming or engaging in any water activities, as it is not water proof;

2. never exposing the sound processor to extreme heat or cold; and

3. avoiding the loss of the sound processor during physical activity by removing it or using the safety line provided.

2004 APPEALS AND HEARINGS

Please reference MSM Chapter 3100 for Medicaid Recipient Hearings.