

CHAPTER 8-000 HEARING AIDS

8-001 Standards for Participation: Hearing aid dispensers must be licensed by the Nebraska Department of Health and Human Services ~~Regulation and Licensure~~ or if the services are provided outside Nebraska, the dispenser must be licensed by the appropriate agency of the state in which s/he practices. To participate in the Nebraska Medical Assistance Program (NMAP), hearing aid dispensers ~~shall~~ **must** complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval.

8-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

8-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider ~~shall~~ **must** provide services only under arrangement with the HMO.

8-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. For services which require NMAP prior authorization (see 471 NAC 8-007), the provider ~~shall~~ **must** contact the PCCM plan and request authorization as directed by the plan. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

8-003 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the ~~Medicaid~~-Division of Medicaid and Long-Term Care.

8-004 Covered Services: NMAP considers coverage for hearing aids, hearing aid repairs, hearing aid rental, assistive listening devices, and other hearing aid services when the services are medically necessary and are prescribed by a physician.

NMAP covers standard in-the-ear, behind the ear, or body hearing aids. Bone ~~condition~~ conduction aids will be approved with a-Ear, Nose, and Throat (E.N.T.) Specialist approval.

8-005 Non-Covered Services: NMAP does not cover hearing aid batteries for residents of a nursing facility except with the initial fitting. NMAP does not cover accessories which are for convenience and not medically necessary, or in-the-canal (ITC) or completely in the canal (CIC) hearing aids.

8-006 Ear, Nose and Throat (E.N.T.) Evaluations: NMAP requires that a client be evaluated by a E.N.T. when the following criteria is met:

1. The client has a conductive hearing loss;
2. The client has a unilateral hearing loss; or
3. The client is age 16 or younger.

8-007 Limitations and Requirements for Certain Services

8-007.01 Number of Hearing Aids NMAP May Consider for Payment:

1. For clients age 20 and younger: Hearing aids required by medical necessity are considered.
2. For clients age 21 and older: Hearing aids are limited to not more than one aid(s) (monaural or binaural) every four years and then only if medically necessary.

8-007.042 Prior Authorization: The Department requires prior authorization for hearing aids and assistive listening devices billed at \$500.01 or greater. Prior authorization is also required for all hearing aid repairs and accessories ~~which exceed~~ of \$150 or greater per line item. If the cost of the repair and batteries is less than \$150, no prior authorization is required.

Note: For hearing aids and assistive listening devices billed at \$500 or less, prior authorization is not required. However, the provider must secure all the information required by 471NAC 8-007.03, including Form DM-5H. Rather than submit with a prior authorization, the provider must retain this information for four years, subject to Department review.

8-007.023 Prior Authorization Procedures: NMAP requires that the following information be submitted when requesting prior authorization for a hearing aid or assistive listening device.:

1. A complete audiogram (pure tone, air bone, masking, speech);
2. The name of the examiner or dispenser performing the audiogram;
3. The type of hearing aid or assistive listening device being recommended and any accessories;
4. The estimated cost of the hearing aid or assistive listening device;
5. The estimated cost of each accessory;
6. The hearing aid dispenser's provider number; and
7. The hearing aid dispenser's name, address and phone number.

Form DM-5H "Physician's Report on Hearing Loss," (see 471-000-3) must be used when submitting a request for prior authorization. The examining physician shall must complete the front portion of Form DM-5H. The back portion of Form DM-5H must be completed by either the examiner or the hearing aid dispenser.

The provider shall must submit requests for prior authorization using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or by completing and submitting Form MC-9S, "Prior Authorization Document for Hearing Aids" (see 471-000-205 for completion instructions).

Prior authorization is obtained from the ~~Medicaid~~ Division of Medicaid and Long-Term Care.

8-007.034 Replacement of Hearing Aids and Assistive Listening Devices: The provider ~~shall~~ must obtain prior authorization from the ~~Medicaid~~ Division of Medicaid and Long-Term Care for all replacements of lost or stolen hearing aids or assistive listening devices.

8-008 Payment for Hearing Aid Services: The Nebraska Medical Assistance Program (NMAP) pays for covered hearing aid services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
 - ~~a. The unit value multiplied by the conversion factor;~~
 - ~~ba.~~ The invoice cost (indicated as "IC" in the fee schedule);
 - ~~eb.~~ The maximum allowable dollar amount; or
 - ~~ec.~~ The reasonable charge for the procedure as determined by the ~~Medicaid~~ Division of Medicaid and Long-Term Care (indicated as "BR" - by report ~~or "RNE" - rate not established~~ in the fee schedule).

The Nebraska Medicaid ~~Practitioner~~ Practitioner Fee Schedule is effective July 1 through June 30 of each year.

8-008.01 Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the ~~Medicaid~~ Division of Medicaid and Long-Term Care determines that the current allowable amount is -
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation.

Providers will be notified of revisions and their effective dates.

8-009 Billing Requirements: Hearing aid providers ~~shall~~ must submit claims to the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The provider or the provider's authorized agent ~~shall~~ must submit the provider's usual and customary charge for each procedure code listed on the claim.

8-010 Procedure Codes: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-508).