

471-000-508 Nebraska Medicaid Hearing Aid (HA) Fee Schedule

Note: Prior to using information provided in this fee schedule, review the following on-line tools for the latest in hearing aid policy and billing guidance:

Hearing Aid Services Provider Handbook: http://dhhs.ne.gov/medicaid/Pages/med_phhear.aspx

Provider Information: http://dhhs.ne.gov/medicaid/Pages/med_provhome.aspx

Provider Bulletins: http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx

National Correct Coding Initiative (NCCI): http://dhhs.ne.gov/medicaid/Pages/med_ncci.aspx

Client Eligibility: Call the NMES Line at 1-800-642-6092 for client's Medicaid eligibility & enrollment in Managed Care, or use http://dhhs.ne.gov/medicaid/Pages/med_eligibility.aspx

Hearing Aid Limitations: Call the Inquiry Line, 1-877-255-3092

Claim Inquiries: Call the Inquiry Line, 1-877-255-3092, please have your claim number ready.

Claims Processing: http://dhhs.ne.gov/medicaid/Pages/med_claimsfaq.aspx

Copayments: http://dhhs.ne.gov/medicaid/Pages/med_medcopay.aspx

DMEPOS Fee Schedule: <http://dhhs.ne.gov/Documents/471-000-507.pdf>

This fee schedule does not address the various coverage limitations routinely applied by Nebraska Medicaid before final payment is determined (e.g., beneficiary and provider eligibility, benefit limits, billing instructions, frequency of services, third part liability, age restrictions, prior authorization, co-payments/coinsurance where applicable, etc.). Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.

Although every effort is made to ensure the accuracy of this information, discrepancies and time lag may occur. All information may be changed or updated at any time to correct a discrepancy and/or error. The reimbursement rates reflected in this fee schedule are in effect as of the date of this report. The reimbursement rate made on a claim will depend on the date of service, since reimbursement rates are date of service effective.

For billing instructions for Hearing Aid Services, please see Appendix 471-000-56:
<http://dhhs.ne.gov/Documents/471-000-56.pdf>

All claims are subject to post payment review. If it is determined that any hearing aid or related service was not to have been covered then the provider's repayment of funds will occur. See 471 NAC 3-004.09, Provider Refunds to the Department and 3-004.09A, Department Requests for Refunds.

The dollar amounts listed are the Medicaid maximum allowable. Payment is the lesser amount of the maximum allowable amount or the provider's submitted charge.

Claims must be in compliance with NE Medicaid Policies for payment to occur. Medicaid does not pay separately for provider's mileage or postage, or supplier's shipping and handling; see dispensing fee.

For Questions on Hearing Aid Policy Issues: Contact the Program Specialist at
DHHS.hearingaid@nebraska.gov

TO DETERMINE MEDICAID ALLOWABLE:

1. IDENTIFY THE CODE.

- A. First, identify the correct code for the HA item or service you are dispensing. Refer to the latest Health Care Common Procedure Coding System (HCPCS) Level II Expert book for code descriptions. Every HA provider should have this guide, it is updated annually.
- B. If a type of item has a specific HCPCS code assigned, the provider must use that specific code when billing and not use a "miscellaneous" code or one that is not applicable.
- C. If a code has no assigned code then there is a possibility that it is a non-covered item, check with the Program Specialist before sending in a prior authorization request or dispensing. Email the Program Specialist at DHHS.hearingaid@nebraska.gov
- D. Miscellaneous codes may not be used to for an item that Medicaid doesn't cover, or to exceed the Medicaid allowable for a type of item with a specific code and allowance.

2. FIND THE CODE/MODIFIER COMBINATION. The procedure code and modifier (next pages) combinations listed are what is covered by Medicaid. Click on the "binoculars" search tool located in the left chimney, and search for the code or press control + F and search for the code.

- A. Generally, if the code or code/modifier combination is not listed, it is not covered. If in doubt, email the program specialist at DHHS.hearingaid@nebraska.gov
- B. If there is not a HCPCS code for an item that you are aware of or if it is considered a miscellaneous code by the manufacturer or by the FDA that does not mean that it is covered by Medicaid. Again check with the Program Specialist to see if it is covered or not via email at DHHS.hearingaid@nebraska.gov

3. LOCATE THE MEDICAID ALLOWABLE.

- A. Medicaid reimbursement is up to this amount for the procedure code and modifier combination of the item dispensed.

4. PAYMENT IS THE LOWER OF THE MEDICAID ALLOWABLE OR THE PROVIDER'S SUBMITTED CHARGE.

- A. Provider's submitted charge must reflect its charge to the general public.
- B. Provider must not bill Medicaid more than it charges the general public.

5. SPECIAL PRICING.

- A. "BR" (By Report) - Paid at "reasonable charge" based on the service and circumstances. A complete description of the service and cost invoice (along with additional documentation, if applicable) must be included for review and pricing
- B. "IC" (Invoice Cost) - Paid at actual invoice cost, up to maximum allowable. An invoice must be attached to the claim and reflect provider's actual cost minus any discounts, rebates or cost reductions.

MODIFIERS & BILLING TERMINOLOGY:

1. Use RT for Right side and LT for Left side with monaural hearing aid codes and conformity evaluations.

2. MODIFIER DEFINITIONS FOR HA's:

22	(Special) ear mold/insert for RIC/RITE not included with aid on invoice
LT	Left ear
RA	Replacement ear molds and dispensing fee when under warranty
RB	Repair of aid
RT	Right ear

3. REPLACEMENT: A replacement hearing aid is not a covered item. A subsequent or later hearing aid provided according to Criteria in 471 NAC 8-000 is not considered a replacement

- a. All manufacturer and provider warranties must be pursued.
- b. Hearing Aids replaced/repared under warranty are not a covered item.
- c. Dispensing fees for hearing aids under warranty are a covered service, use RA modifier.
- d. Hearing aids replaced (not under warranty) more frequently than every 4 years for adults (see 471NAC Chapter 8) and any related dispensing fees are not a covered item.

4. REPAIR: All manufacturer and provider warranties must be pursued. Repair involves fixing or replacement any of all of the interior/exterior components including the outer shell (re-case).

- a. If at any time the manufacturer's usual business practice is to provide a replacement when it is more practical than a repair, the provider will submit a claim for a repair because it was sent to the manufacturer for repair.
- b. Use V5014 when billing an outside-lab's/manufacture's actual cost invoice for a repair to a hearing aid,
- c. Use the RB modifier with V5160 or V5241, when billing a dispensing fee in conjunction with a repair to a hearing aid by an outside Lab/ manufacturer.

5. CONFORMITY EVALUATION: V5020, is a hearing aid check performed for the purpose of evaluating the performance of the hearing aid, evaluating the benefit to the client and assuring the unit continues to meet the original prescription and benefit to the client.

6. RIC/RITE: based on Manufacturer's invoice may be included in the cost of the aid. If billed separately, those at \$45.00 or less use V5267; and those over \$45.00 /aid, need both modifier 22 and prior authorization.

7. DISPENSING FEE: All-inclusive of the provider's services, incurred with the costs of providing the hearing aid(s), repairs, ear molds, and initial batteries (to allow aids to work). These services include but are not limited to: conformity evaluation(s), checking aid, shipping & handling costs. Only additional batteries are billed separately.

8. RETURNS: Are between the provider & client. Any payment adjustments related to a return must be completed according to the Payment Adjustment Policy; see 471NAC 3-000.

9. OTHER:

A. Assistive Listening Devices used with Hearing Aids to control the environment or other equipment, e.g. FM receivers, are not covered in this chapter.

B. For equipment related to cochlear implants, other than V5273, See Durable Medical Equipment Prosthetics, Orthotics & Supplies (DMEPOS) Fee Schedule: <http://dhhs.ne.gov/Documents/471-000-507.pdf>

Prior Authorization (PA): See 471 NAC 8-007.03 Prior Authorization Procedures for what information must be submitted when requesting prior authorization for a hearing aid or assisted listening device. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-08.pdf

1. The following must be submitted with a PAR in addition to the list in 471 NAC 8-007.03:
 - a) Providers must submit a manufacturer's quote (not a MSRP or cost invoice) with the client's information clearly noted on it by the manufacturer and not the provider. There are some instances where the manufacturer is the provider. This is used for Unit Price and other processing purposes to include medical necessity and coverage determination.
 - b) A letter of medical necessity must be submitted. See 471 NAC 8-000 for the requirements for a letter of medical necessity. Medical necessity is good for one year. Stamped signatures are not accepted. 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 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. See: <http://dhhs.ne.gov/Documents/471-000-3.pdf>
 - c) A doctor's order.
 - d) Attach any other required documentation required pursuant to 471 NAC 8-000 or the following pages.
2. Form MC-9S, "Prior Authorization Document for Hearing Aids" (see 471-000-205 for completion instructions): <http://dhhs.ne.gov/Documents/471-000-205.pdf>
3. Submit authorization requests ONLY for items needing authorization.
4. Any "miscellaneous" code billed at \$500 or more requires an approved PAR. See 471 NAC 7-008.
5. Prior authorizations are good for one year unless otherwise noted for specific equipment. Medical necessity may expire within that year period therefore new medical necessity must be obtained if the medical necessity expires within the service dates of the claim.
6. *Prior authorizations are done beforehand not after.* The only time prior authorizations are reviewed retroactively is when there is a ward of the state situation or if someone becomes retroactively eligible for Medicaid.
7. *A copy of the prior authorization must be submitted with the claim.*

Claim Submission:

The following must be submitted with a claim:

- A. A detailed physician's order for the item; and
- B. A copy of the prior authorization; and
- C. A clear description of the item dispensed such as brand/model; and
- D. A copy of any Medicaid forms used; and
- E. A copy of the quote; and
- F. The actual cost invoice from the manufacturer with the client's name on it. An actual cost invoice is the supplier's invoice that the provider actually paid, and includes any discounts and rebates to the provider. Generally, Medicaid pays 130 percent of the actual cost invoice, up to a reasonable amount determined by Medicaid.

CODE	MOD	DESCRIPTION	Prior Auth. For 20 and Below	Prior Auth. For 21 and Above	COMMENTS	MEDICAID ALLOWABLE
V5014		REPAIR MODIFICATION OF AID (BY OUTSIDE LAB OR MANUFACTURER)	Over \$150	Over \$150		IC
V5020	LT	CONFORMITY EVALUATION			RIGHT AID; 1 UNIT OF SERVICE FOR 1 AID	\$21.83
V5020	RT	CONFORMITY EVALUATION			LEFT AID; 1 UNIT OF SERVICE FOR 1 AID	\$21.83
V5030	LT	HEARING AID, MONAURAL, BODY WORN, AIR CONDUCTION	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE. 1 UNIT = 1 AID.	\$756.00
V5030	RT	HEARING AID, MONAURAL, BODY WORN, AIR CONDUCTION	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE. 1 UNIT = 1 AID.	\$756.00
V5040	LT	HEARING AID, MONAURAL, BODY WORN, BONE CONDUCTION	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE. 1 UNIT = 1 AID.	\$756.00
V5040	RT	HEARING AID, MONAURAL, BODY WORN, BONE CONDUCTION	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE. 1 UNIT = 1 AID.	\$756.00
V5050	LT	HEARING AID, MONAURAL, IN THE EAR	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE, INCLUDES RITE/RIC EAR PIECES IF PRICED ON INVOICE AS PART OF AID. 1 UNIT = 1 AID.	\$756.00

CODE	MOD	DESCRIPTION	Prior Auth. For 20 and Below	Prior Auth. For 21 and Above	COMMENTS	MEDICAID ALLOWABLE
V5050	RT	HEARING AID, MONAURAL, IN THE EAR	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE, INCLUDES RITE/RIC EAR PIECES IF PRICED ON INVOICE AS PART OF AID. 1 UNIT = 1 AID.	\$756.00
V5060	LT	HEARING AID, MONAURAL, BEHIND THE EAR	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE, INCLUDES RITE/RIC EAR PIECES IF PRICED ON INVOICE AS PART OF AID. 1 UNIT = 1 AID.	\$756.00
V5060	RT	HEARING AID, MONAURAL, BEHIND THE EAR	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE, INCLUDES RITE/RIC EAR PIECES IF PRICED ON INVOICE AS PART OF AID. 1 UNIT = 1 AID.	\$756.00
V5070		GLASSES, AIR CONDUCTION	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE	\$756.00
V5080		GLASSES, BONE CONDUCTION	Always	Over \$500.00	IC UP TO MEDICAID ALLOWABLE	\$756.00
V5100		HEARING AID, BILATERAL, BODY WORN	Always	Over \$1000.00	IC UP TO MEDICAID ALLOWABLE	\$1,512.01
V5120		BINAURAL, BODY WORN	Always	Over \$1000.00	IC UP TO MEDICAID ALLOWABLE. 1 UNIT = 2 AIDS.	\$1,512.01
V5130		BINAURAL, IN THE EAR	Always	Over \$1000.00	IC UP TO MEDICAID ALLOWABLE, INCLUDES RITE/RIC EAR PIECES IF PRICED ON INVOICE AS PART OF AID. 1 UNIT = 2 AIDS.	\$1,512.01

CODE	MOD	DESCRIPTION	Prior Auth. For 20 and Below	Prior Auth. For 21 and Above	COMMENTS	MEDICAID ALLOWABLE
V5140		BINAURAL, BEHIND THE EAR	Always	Over \$1000.00	IC UP TO MEDICAID ALLOWABLE, INCLUDES RITE/RIC EAR PIECES IF PRICED ON INVOICE AS PART OF AID. 1 UNIT = 2 AIDS.	\$1,512.01
V5150		BINAURAL, BEHIND THE GLASSES	Always	Over \$1000.00	IC UP TO MEDICAID ALLOWABLE. 1 UNIT = 2 AIDS.	\$1,512.01
V5160		DISPENSING FEE, BINAURAL			1 UNIT = 2 AIDS.	\$561.99
V5160	RA	DISPENSING FEE, BINAURAL, REPLACEMENT UNDER WARRANTY			ONLY WITH INVOICE. NO PAYMENT TO MANUFACTURER.1 UNIT = 2 AIDS.	\$109.80
V5160	RB	DISPENSING FEE, BINAURAL, REPAIR			REPAIR BY OUTSIDE LAB. COVERED IF REPAIR IS UNDER WARRANTY OR LAB REPLACES ITEM SUBMITTED AS A REPAIR. 1 UNIT = REPAIR OF 2 AIDS.	\$109.80
V5241		DISPENSING FEE, MONAURAL HEARING AID, ANY TYPE			1 UNIT = 1 AID.	\$281.00
V5241	RA	DISPENSING FEE , MONAURAL HEARING AID, ANY TYPE, REPLACEMENT UNDER WARRANTY			ONLY WHEN AID IS REPLACED UNDER WARRANTY; NEEDS INVOICE. 1 UNIT = 1 AID.	\$54.90
V5241	RB	DISPENSING FEE, MONAURAL HEARING AID, ANY TYPE, REPAIR			REPAIR BY OUTSIDE LAB. COVERED IF REPAIR IS UNDER WARRANTY OR LAB REPLACES ITEM SUBMITTED AS A REPAIR. 1 UNIT = 1 REPAIR OF 1 AID.	\$54.90
V5264		EAR MOLD/INSERT, NOT DISPOSABLE, ANY TYPE, INCLUDING RIC/RITE WHEN NOT PART OF HEARING AID, ON INVOICE			PAY UP TO \$45.90. IC FOR IMPRESSIONS, SEE V5275.	\$45.90

CODE	MOD	DESCRIPTION	Prior Auth. For 20 and Below	Prior Auth. For 21 and Above	COMMENTS	MEDICAID ALLOWABLE
V5264	22	EAR MOLD/INSERT WITH RECEIVER IN THE EAR, RIC or RITE, OVER \$45.00/EAR WHEN NOT PART OF HEARING AID INVOICE	Always	Always		IC
V5266		BATTERY FOR USE IN HEARING DEVICE, EACH			UP TO (32 UNITS PER CLAIM), 1 UNIT = 1 BATTERY. PHARMACIES CAN SUBMIT FOR UNDER THEIR DMEPOS TAXONOMY.	\$1.10
V5267		HEARING AID SUPPLIES / ACCESSORIES (ITEMS NOT DISPENSED WITH THE INTIAL AID; E.G. DRY BRICK, CASE, WAX GUARDS)			PRIOR AUTH IF OVER \$150.	IC
V5273		ASSISTIVE LISTENING DEVICE, FOR USE WITH COCHLEAR IMPLANT	Always	Always	PRIOR AUTHORIZE. ALL OTHER RELATED EQUIPMENT SEE LINK TO DMEPOS FEE SCHEDULE.	IC
V5275	RA	EAR IMPRESSION, EACH, REPLACEMENT ONLY				\$20.86
V5298		HEARING AID, NOT OTHERWISE CLASSIFIED	Always	Over \$500.00	POCKET TALKER ONLY.	IC
V5299		HEARING SERVICE, MISCELLANEOUS (MINOR CLEANING, REPAIR & REPLACEMENT OF MINOR PARTS BY THE PROVIDER)			PRIOR AUTH OVER \$150. FOR BATTERIES USE V5266.	BR