Hearing Aid and Hearing Aid Exam Payment Policy

Policy

The Plan will pay for hearing aids and/or hearing aid exams when provided by a Plan-contracted vendor provided that such coverage is included in the member's benefit package.

Coverage varies by Plan product:

Fallon Medicare Plus Plan Products – Hearing aids and exams to fit hearing aids are not covered for Medicare Plus Plan members as a standard benefit, please consult supplemental benefits for any coverage.

MassHealth, the Plan follows MassHealth reimbursement and billing guidelines (available at http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-manual/).

Commercial Products – Coverage is detailed below.

NaviCare Members – Coverage is detailed below

Reimbursement for Specific Products

NaviCare: Hearing exams and hearing aids are covered for NaviCare members that are provided by Plan-Contracted Providers. NaviCare does not pay for more than one hearing aid per ear per member in a 60-month period without prior authorization as outlined below. One hearing aid per ear consists of either one binaural hearing-aid fitting, or two monaural hearing aids dispensed more than six months apart, with one aid dispensed for the left ear and the other dispensed for the right ear.

Replacement of the Hearing aid prior to 60 months must be for one of the following:

1. A medical change
2. Loss of the Hearing Aid
3. Damage beyond repair to the Hearing Aid

The following documentation should be submitted to support this request:

1. The audiological evaluation
2. The previous audiological evaluation if the replacement hearing aid is needed because of a medical change
3. A comprehensive report that justifies the medical necessity for the hearing aid;
4. A statement of the circumstances of the loss or destruction of the hearing aid (where applicable)
5. An itemized estimate of the anticipated cost of the hearing aid.

Hearing aids and accessories should be provided in accordance with the member's specific medical needs and should not be replaced before their medical useful life or expiration of any warranty. Limits are subjected to Contractual reimbursement rates.

Effective January 1, 2019 prior authorization will no longer be required.

Commercial Products: In accordance with Chapter 233 of the Acts of 2012 (The Children's Hearing Aid Bill) provides coverage for one hearing aid, as defined in Section 196 of Chapter 112 of the Massachusetts General Laws (MGL), per hearing impaired ear for children 21 years of age or younger covered under an insurance policy issued under Chapter 175 of the MGL or HMO

policy issued under Chapter 176G of the MGL. Coverage is limited to $2,000 per hearing aid, every 36 months. The Children's Hearing Aid Bill also provides coverage for related services, including the initial evaluation, fitting and adjustments, and related supplies prescribed by a licensed audiologist or hearing instrument specialist (as defined in Section 196 of Chapter 112 of the Massachusetts General Laws).

The Plan reimburses one hearing aid per hearing impaired ear, up to $2,000 for each hearing aid, every 36 months, for plan members 21 years of age or younger. Plan members may choose a higher priced hearing aid and may pay the difference in cost above the $2,000 benefit limit.

Cost-sharing for hearing aids and related services and supplies is subject to the terms and conditions of the plan member's Evidence of Coverage/Member Handbook. Hearing aids and related accessories are covered under the durable medical equipment/prosthetics and orthotics benefit and as such are subject to durable medical equipment/prosthetics and orthotics cost-sharing as described in the plan member's Schedule of Benefits.

Dispensing requirements for hearing aids:

1. The Plan member must have medical clearance. Medical clearance is a signed statement from the treating physician that concludes that the plan member has been examined and that the physician has determined that the plan member is a candidate for a hearing aid and that there are no medical conditions to contraindicate the use of a hearing aid. The written statement must include the date of the medical examination, and whether or not the plan member, at the time of the medical examination, owns or uses a hearing aid for the designated ear. The medical examination by the physician must have been performed no more than six months prior to the date of dispensing of the hearing aid(s).
2. The Plan member must have had a hearing aid evaluation no more than six months prior to the date of dispensing of the hearing aid(s). A hearing aid evaluation is a written statement from a licensed audiologist, based on testing conducted by that audiologist that includes the following information: The ear or ears to be fitted and the date of the testing. For Plan members age 18 through 21 years of age, the hearing aid evaluation may also be performed by a licensed hearing instrument specialist.

A hearing aid purchase includes:

1. The hearing aid and standard accessories and options required for the proper operation of the hearing aid;
2. The proper fitting and instruction in the use, care, and maintenance of the hearing aid;
3. Maintenance, minor repair, and servicing provided during the operational lifetime of the hearing aid;
4. The initial one-year manufacturer's warranty and/or insurance against loss or damage, and;
5. The loan of a hearing aid in the event that repairs are required that cannot be performed on-site and while the member is present in the provider's office.

Hearing aid dispensers (audiologist or hearing instrument specialist) will be reimbursed for hearing aids at acquisition cost. Acquisition cost is the unit price paid by a hearing aid dispenser for the hearing aid, plus shipping and handling, excluding postal insurance charges. A copy of the manufacturer's invoice must be retained by the hearing aid dispenser in the Plan member's medical record and made available upon request by the Plan.

The Plan reimburses the following related services and supplies for Commercial products:

- Initial hearing aid evaluation. The minimal components of a hearing aid evaluation include a comprehensive history, otoscopic evaluation, and audiologic assessment. The latter includes thresholds of discomfort (TD) using frequency-specific stimuli (e.g., puretones) or estimating TD for later verification. (CPT code 92590 or 92591.)
- Hearing aid dispensing fee. A dispensing fee is a one-time only fee for dispensing a hearing aid (as defined in Section 196 of Chapter 112 of the Massachusetts General Laws).

Dispensing includes the prescription of the hearing aid, its modification, it's fitting, orientation to its use, and any adjustments required within the manufacturer's warranty period.

- One earmold impression (HCPCS code V5275) and one custom earmold (HCPCS code V5264) per covered BTE hearing aid. If a custom earmold is included in the manufacturer's price of the hearing aid, an earmold will not be covered/reimbursed separately.
- Replacement custom earmolds when the earmold is irreparably damaged, lost or stolen, or because of a change in the plan member's condition, for example, it is not uncommon for young children to need a new earmold every 6-12 months or so because as the child grows, the earmold doesn't fit tightly any longer.
- Refitting when the hearing aid was dispensed more than two years prior to the date of the refitting service. These professional services must include a face-to-face encounter with the plan member, refitting of the hearing aid, orientation to its use, and similar services. (HCPCS code V5011.)

Repairs and replacements of covered hearing aids for Commercial products:

- Major repairs are covered (after the manufacturer's warranty and/or insurance expires) to the extent that the benefit limit for the hearing aid has not been exhausted. Major repairs must be made at a repair facility other than the hearing aid dispenser's place of business. The repair service must include a written warranty against all defects for a minimum of six months. All major repairs are billed with HCPCS code V5014 and must include invoice documentation.
- Replacement of a damaged, lost, or stolen hearing aid (after the manufacturer's warranty and/or insurance expires) to the extent that the benefit limit for the hearing aid has not been exhausted.
- Replacement of a hearing aid due to a change in hearing aid prescription to the extent that the benefit limit for the hearing aid has not been exhausted.

The Plan does **NOT** reimburse the following services for Commercial products:

- Disposable hearing aids, any type, are not covered (HCPCS codes V5262, V5263).
- Implantable or semi-implantable hearing aids/hearing systems (middle ear implants), (HCPCS codes V5095, S2230).
- Frequency modulated (FM) systems.
- Hearing aids/hearing systems when any part thereof is surgically implanted, such as bone-anchored hearing aids (see related medical policy for *Bone-Anchored Hearing Aids*).
- Accessories, such as carrying cases, and other nonessential items are not covered.

Billing/coding guidelines for Commercial Products

The following codes are reimbursed and are covered under the durable medical equipment/prosthetics and orthotics benefit and subject to a $2,000 benefit limit per hearing aid per hearing impaired ear.

Codes	Number	Description
HCPCS	V5030	Hearing aid, monaural, body worn, air conduction
	V5040	Hearing aid, monaural, body worn, bone conduction
	V5050	Hearing aid, monaural, in the ear (ITE)
	V5060	Hearing aid, monaural, behind the ear (BTE)
	V5171	Hearing aid, contralateral routing device, monaural, in the ear (ITE)
	V5172	Hearing aid, contralateral routing device, monaural, in the canal

		(ITC)
	V5181	Hearing aid, contralateral routing device, monaural, behind the ear (bte)
	V5211	Hearing aid, contralateral routing system, binaural, ite/ite
	V5212	Hearing aid, contralateral routing system, binaural, ite/itc
	V5213	Hearing aid, contralateral routing system, binaural, ite/bte
	V5214	Hearing aid, contralateral routing system, binaural, itc/itc
	V5215	Hearing aid, contralateral routing system, binaural, itc/bte
	V5221	Hearing aid, contralateral routing system, binaural, bte/bte
	V5242	Hearing aid, analog, monaural, completely in the ear canal (CIC)
	V5243	Hearing aid, analog, monaural, in the canal (ITC)
	V5244	Hearing aid, digitally programmable analog, monaural, CIC
	V5245	Hearing aid, digitally programmable, analog, monaural, ITC
	V5247	Hearing aid, digitally programmable analog, monaural, behind the ear
	V5254	Hearing aid, digital, monaural, CIC
	V5255	Hearing aid, digital, monaural, ITC
	V5256	Hearing aid, digital, monaural, ITE
	V5257	Hearing aid, digital, monaural, BTE

The following codes are not subject to the $2,000 hearing aid benefit limit. The binaural dispensing fee (V5160) should be used when binaural hearing aids are dispensed.

Codes	Number	Description
CPT	92590	Hearing aid examination and selection; monaural
	92591	Hearing aid examination and selection; binaural
HCPCS	V5011	Fitting/orientation/checking of hearing aid (use to bill for refitting only)
	V5014	Repair/modification of a hearing aid (use to bill for major repairs not covered by manufacturer's warranty/insurance; requires invoice documentation)
	V5090	Dispensing fee, unspecified hearing aid
	V5100	Hearing aid, bilateral, body worn
	V5110	Dispensing fee, bilateral
	V5120	Binaural, body
	V5130	Binaural, in the ear
	V5140	Binaural, behind the ear
	V5150	Binaural, glasses
	V5160	Dispensing fee, binaural
	V5200	Dispensing fee, CROS
	V5240	Dispensing fee, BICROS
	V5241	Dispensing fee, monaural hearing aid, any type

	V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear)
	V5264	Earmold/insert, not disposable, any type
	V5265	Ear mold/insert, disposable, any type
	V5266	Battery for use in hearing device
	V5275	Ear impression, each

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	4/24/2002
Previous revision date(s):	5/14/2003, 04/28/2004, 04/26/2006, 03/14/2007 5/1/2013 - Moved to new format and updated in response to Massachusetts mandated benefit. 11/1/2014 - Added codes to the list of codes that are not subject to the benefit limit. 03/01/2016 - Moved to Fallon Health template and added V5090 into Commercial billing/coding guidelines. Added coverage information for other Plan products.
Connection date & details:	January 2017 – Annual review. November 2017 – Added NaviCare Specific Requirements October 2018 – Updated NaviCare authorization requirements. January 2019 – Removed exclusion for code V5266, added new 2019 HCPCS codes. January 2020 – Updated coding in Commercial section.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.