

# Audiology

Hearing Aids, Cochlear Devices, Audiology Services  
Overview/Reminders 2017

## General Information



- Cochlear Devices and Hearing aids are review areas that are authorized per calendar year.
  - A calendar year is between January 1<sup>st</sup> and December 31<sup>st</sup>.
  - Prior authorizations cannot be extended into the next year. A new request must be made.
    - A copy for correction will not work in this instance.
- Services are available to members up to 21 years of age. Services provided on or after the 21<sup>st</sup> birthday are not available for reimbursement.
- Monaural hearing aids cannot be billed separately for each ear. If hearing aids are needed for both ears, the binaural code must be used.
- Audiology services may be provided in an outpatient setting by Medicaid enrolled speech language pathologists and audiologists. Acute care and critical access hospitals are not eligible for direct reimbursement for outpatient therapy services or hearing aids/cochlear devices.

## Provider Enrollment



- Audiology services may be provided in an outpatient setting by Medicaid enrolled speech language pathologists and audiologists.
- Please be sure that the Audiologist performing the service(s) be enrolled as a participating provider with WV Medicaid.
- It may result in billing issues if the Audiologist performing the service(s) is not enrolled under your organization as a participating provider with WV Medicaid.
- If there are issues or concerns regarding billing and claims, please call Molina at 888-483-0793 to receive further instructions to ensure claims will pay under the prior authorization.

## Requests for Hearing Aids



- The most economical hearing aid that meets the member's basic healthcare need must be provided.
- When the hearing aid is initially provided, the selection, ordering, modification, fitting, dispensing, cleaning, calibration, re-calibration, evaluation of appropriate amplification, orientation to use, adjustment, and batteries are included in the cost of the hearing aid.

## Hearing Aid Repairs



- Repair of hearing aids is covered when the medical need is expected to continue.
- The repair is more economical than a new purchase.
- The two-year warranty has expired.
  - When the warranty is in effect, the hearing aid repair will not be reimbursed.
- For any request for hearing aid repairs, please send information to determine if there is a warranty in place for the repairs.
- A prior authorization is only required if 4 repairs have been completed in a calendar year.
- Medical necessity review is still needed to determine if the member still requires the hearing aids.

## Hearing Aid Replacement



- Replacement of hearing aids is covered due to growth or changes in the member's physical condition, wear, theft (submission of police report required), irreparable damage, or loss by disaster.
- If member is currently utilizing hearing aids please document current instruments, date of placement, and status of instruments.
- Medical necessity review is still needed to determine if the member still requires the hearing aids.

## Cochlear Devices



- Cochlear implants, approved by the FDA, are covered for members up to 21 years of age with severe to profound nerve deafness when there is reasonable expectation that a significant benefit must be achieved from the implant.
- The implant includes all internal and external components when initially provided and components must not be billed separately.
- Replacement of cochlear accessories (headset, headpiece, microphone, transmitting coil and transmitter cable) is covered for Medicaid members up to 21 years of age AND Medicaid members 21 years of age and older IF the member received a cochlear implant and BMS paid for it before they reached the age of 21 years.
- Batteries for the implant/hearing device requires prior authorization when service limits are exceeded.
- Cochlear devices have a sole source contract.
  - This mean only a BMS contracted provider may provide this service.

## Documentation Requirements



- Supporting documentation must not be more than six months old
- Written referral from the ORP.
- The plan of care which must include, but is not limited to:
  - The date the plan was developed, diagnosis, short and long-term functional goals, measurable treatment objectives, frequency and duration of treatment, or hearing devices for the member to attain maximum rehabilitation, prognosis, date discussed with member or legal representative, signature and date of the member or legal representative agreeing to the treatment, date, and signature and title of the individual providing treatment.
- The hearing aid description, make, model, date of purchase, instructions for use and care, measurement and narrative of the fitting, and the signature and title of the individual providing a hearing aid to Medicaid members.
- Any supplies or accessories for the aid must be documented.
- An audiology evaluation with audiometric results which cannot be more than six months old prior to dispensing the hearing aid.
- All hearing aids must come with a two year warranty.
- When billing for hearing aids, all discounts given to dispensers must also be reflected on the cost invoice submitted to the UMC.



# KEPRO Contact Information



**1-800-346-8272**

**MEDICAL SERVICES GENERAL VOICEMAIL- EXT. 7996**

**MEDICAL SERVICES EMAIL: [WVMEDICALSERVICES@KEPRO.COM](mailto:WVMEDICALSERVICES@KEPRO.COM)**

HELEN SNYDER	DIRECTOR	<a href="mailto:HCSNYDER@KEPRO.COM">HCSNYDER@KEPRO.COM</a>	EXT. 4463
KAREN WILKINSON	UM NURSE SUPERVISOR	<a href="mailto:KAREN.WILKINSON@KEPRO.COM">KAREN.WILKINSON@KEPRO.COM</a>	EXT. 4474
ALICIA PERRY	OFFICE MANAGER	<a href="mailto:APERRY@KEPRO.COM">APERRY@KEPRO.COM</a>	EXT. 4452
CINDY BUNCH	CS SUPERVISOR	<a href="mailto:CINDY.BUNCH@KEPRO.COM">CINDY.BUNCH@KEPRO.COM</a>	EXT. 4408
JUSTIN VANWYCK	TRAINING SPECIALIST	<a href="mailto:JVANWYCK@KEPRO.COM">JVANWYCK@KEPRO.COM</a>	EXT. 4448
SIERRA HALL	TRAINING SPECIALIST	<a href="mailto:SIERRA.HALL@KEPRO.COM">SIERRA.HALL@KEPRO.COM</a>	EXT. 4454
JASPER SMITH	ELIGIBILITY SPECIALIST	<a href="mailto:JASPER.SMITH@KEPRO.COM">JASPER.SMITH@KEPRO.COM</a>	EXT. 4490
CHELSEY ADKINS	ELIGIBILITY SPECIALIST	<a href="mailto:CADKINS@KEPRO.COM">CADKINS@KEPRO.COM</a>	EXT. 4492
JAMI PLANTIN	ELIGIBILITY SPECIALIST	<a href="mailto:JAMI.PLANTIN@KEPRO.COM">JAMI.PLANTIN@KEPRO.COM</a>	EXT. 4502

GENERAL KEPRO INFORMATION: [WWW.WVASO.KEPRO.COM](http://WWW.WVASO.KEPRO.COM)  
 FAX #: 866-209-9632 (REGISTRATION AND TECHNICAL SUPPORT ONLY)  
 WEBSITE FOR SUBMITTING AUTHORIZATIONS: [HTTPS://PROVIDERPORTAL.KEPRO.COM](https://PROVIDERPORTAL.KEPRO.COM)  
 WEBSITE FOR ORG MANAGERS TO ADD/MODIFY USERS: [HTTPS://C3WV.KEPRO.COM](https://C3WV.KEPRO.COM)

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# Questions?