



KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

Audiology

PART II
AUDIOLOGY FEE-FOR-SERVICE PROVIDER MANUAL

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FORMS All forms pertaining to this provider manual can be found on the [public](#) website and on the [secure](#) website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare Managed Care Organizations, reference the [KanCare](#) website. Contact the specific health plan for managed care assistance.

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PART II

AUDIOLOGY FEE-FOR-SERVICE PROVIDER MANUAL

Updated 01/18

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to audiology providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection gives information on accessing the forms and directions applicable to audiology services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of audiology services allowed within the Kansas Medical Assistance Program (KMAP).

The **Appendix** subsection contains information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

BILLING INSTRUCTIONS

7000. AUDIOLOGY BILLING INSTRUCTIONS Updated 12/23

Introduction to the CMS 1500 Claim Form

Audiology providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website or billed through Provider Electronic Solutions (PES). When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider. The **Kansas Modular Medicaid System (KMMS)** ~~MMMS~~ uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

Billing for audiology services now requires the use of left (LT) and right (RT) modifiers on all monaural services. If services are binaural, the use of left and right modifiers is not allowed.

An example of the CMS 1500 Claim Form and instructions are available on the KMAP [public](#) and [secure](#) websites under the Publications tab on the [Forms](#) page under the Claims (Sample Forms and Instructions) heading.

Any of the following billing errors may cause a CMS 1500 claim to deny or be sent back to the provider:

- Sending a KanCare paper claim to KMAP.
- Sending a CMS 1500 Claim Form carbon copy.
- Using a PO Box in the Service Facility Location Information field.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers.

Submission of a Claim

Send completed claim and any necessary attachments to:
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

BILLING INSTRUCTIONS

7010. EXPLANATION OF NECESSITY OF HEARING AID FORM Updated 04/12

Introduction to the Explanation of Necessity for Hearing Aid

Audiology providers must submit the Explanation of Necessity for Hearing Aids form with the General Prior Authorization Request Form to Medicaid before approval for a **replacement hearing aid** is considered. Providers may photocopy this form from the KMAP website. The form and instructions are on the [public website](#) and on the [secure website](#).

Note: Please note the asterisk statement at the bottom of pages 1 and 2 of the Explanation of Necessity for Hearing Aids form, which reads "Failure to complete this form in its entirety will result in the return of the prior authorization."

BILLING INSTRUCTIONS

7020. AUDIOLOGY SPECIFIC BILLING INFORMATION Updated 11/10

Dispensing Fees

Only one dispensing fee is allowed for monaural or binaural services. The appropriate dispensing fee must be used. **DO NOT BILL TWO DISPENSING FEES.** If services are monaural, the left or right modifier must be submitted on the claim. If the services are binaural, the left and right modifiers are not allowed. **For binaural aids, providers are required to use the binaural dispensing fee code.** Hearing aid dispensing services include adjusting the aid to meet the member's medical need. If the aid cannot be adjusted to meet the member's need within the one-month trial period, the aid is to be replaced or returned to the dispenser.

Hearing Aid Batteries

If the hearing aid batteries exceed six per month, indicate in Field 21 if services are for a binaural hearing aid.

When dispensing a supply of batteries for multiple months, note this in Field 19. Enter the number of months, the manufacturer's battery stock number, and whether silver or mercury.

One unit equals one battery.

Ordering Date

The date of receipt of the prescription (ordering date) is considered the date of service, and the provider may bill Medicaid before the actual dispensing of the item(s), since the intent to render service has been confirmed by the acceptance of the prescription.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 12/23

Audiology services require a copayment of \$3 per date of service.

Bill all services that occur on the same date on the same claim form. Do **not** reduce charges or balance due by the copayment amount. The fiscal agent makes this reduction automatically.

~~If multiple claims are submitted for the same date(s) of service, the copayment is deducted for each claim submitted.~~

Exception: Hearing aid batteries are exempt from copayment if no other audiological services are provided on the same date of service.

Effective with dates of service on and after January 1, 2024, copayments will no longer apply to Kansas Medicaid Fee-for-Service (FFS) members. The mandatory managed care authority for KanCare is transitioning from the 1115 Waiver to the Medicaid State Plan and a 1915b Waiver. Copayments are being removed from the Medicaid State Plan and will not apply to FFS members.

Managed Care members will continue to be exempt from copayments.

BENEFITS AND LIMITATIONS

8300. BENEFIT PLANS Updated 01/18

KMAP members are assigned to one or more benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 06/16

Accessories

Medically necessary accessories, after supplied as part of the initial cost, are not covered.

Exceptions:

1. Ear molds are considered content of service of the hearing aid for three months after the dispensing date.
2. When two ear molds are ordered by the physician or audiologist for a monaural aid, the first ear mold is considered part of the dispensing fee. However, a reasonable fee will be allowed for the second mold.

Batteries

- Only 6 batteries are covered per month for monaural aids and 12 per month for binaural aids. Batteries for use with cochlear devices are limited to lithium ion (3 per 30 days) and zinc air (6 per 30 days). Batteries for cochlear devices are covered for KAN Be Healthy-Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT)-eligible members only. Only one type of battery is allowed every 30 days.
- Prior authorization (PA) in excess of these limitations will not be approved.

Binaural

- Fitting of binaural hearing aids are covered, with documentation on the hearing evaluation form, for the following:
 - Children under 21 years of age, KBH-EPSDT not required
 - A legally blind adult with significant bilateral hearing loss
 - A previous binaural hearing aid user
 - An occupational requirement for binaural listening
- Specific medical necessity documentation must be provided supporting the need for a binaural versus a monaural aid. The documentation must include tests conducted in a commercially available sound suite (or equivalent quiet room), including the member's speech reception threshold and speech discrimination ability under the following conditions:
 - Standard listening conditions with earphones
 - Listening with a monaural fitting
 - Listening with a binaural fitting

Note: Improvement beyond a chance level of variation must be demonstrated for both speech reception threshold and speech discrimination ability.

Bone Anchored Hearing Aid

- A bone anchored hearing aid (BAHA) is covered by KMAP with the following specifications and limitations. A BAHA is limited to one every four years, with one replacement. PA is required for all BAHA services. All providers must obtain a PA prior to providing service.

Note: When a BAHA procedure is done in two stages, the charge for the procedure should only be billed once. If it is billed once for each stage, the second charge will be denied.

8400. Updated 01/23

Bone Anchored Hearing Aid continued

- BAHA procedure codes are as follows:

69710	69711	69714	69716	69717	69719	69726
69727	69728	69729	69730	L8690	L8691	L8694

- A BAHA is covered with PA for a KBH-EPSDT member who meets all following criteria:
 - **Each of items one, two, three, and four**
 1. The member must be five years of age or older.
 2. Standard hearing aids cannot be used due to a medical condition.
 3. The member must have good manual dexterity or have assistance to snap the device onto the abutment.
 4. The member must maintain proper hygiene at the site of the fixture.
 - **Either items five or six**
 5. Tumors of the external canal and/or tympanic cavity are present.
 6. Congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear are present.
 - **At least one of items seven, eight, or nine**
 7. There is unilateral conductive or mixed hearing loss.
 - Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Member must have:
 - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear
 - Speech Discrimination score greater than 60% in the indicated ear
 8. There is **bilateral conductive hearing loss**.
 - Conductive and mixed hearing loss involving both ears which is not able to be treated with reconstructive surgery or conventional hearing aids. Member must meet all the following:
 - Moderate (40dB) to severe (70dB) conductive hearing loss symmetrically
 - Less than 10dB difference in average bone conduction (at 500, 1000, 2000, 4000 Hz) or less than 15 dB difference in bone conduction at individual frequencies
 - Mixed hearing loss with an average bone conduction better (less) than 45dB in either ear (at 500, 1000, 2000, 4000 Hz)
 9. There is unilateral sensorineural hearing loss (single-sided deafness).
 - Nerve deafness in the indicated ear making conventional hearing aids no longer useful. The implant is designed to stimulate the opposite (good ear) by bone conduction through the bones of the skull. Therefore, the audiometric criteria are for the good ear. Member must meet all the following:
 - Severe (70 dB) to profound (90dB) hearing loss on one side with poor speech discrimination and the inability to use a conventional hearing aid in that ear
 - Normal hearing in the good ear as defined by an air conduction threshold equal to or better (less) than 20 dB (at 500, 1000, 2000, 3000 Hz)

Bone Anchored Hearing Aid continued

Definitions

- **Unilateral conductive or mixed hearing loss:** Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Member must have:
 - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear
 - Speech Discrimination score greater than 60 percent in the indicated ear
- **Bilateral conductive hearing loss:** Conductive and mixed hearing loss involving both ears which is not able to be treated with reconstructive surgery or conventional hearing aids. Member must meet all the following:
 - Moderate (40dB) to severe (70dB) conductive hearing loss symmetrically
 - Less than 10dB difference in average bone conduction (at 500, 1000, 2000, 4000 Hz) or less than 15 dB difference in bone conduction at individual frequencies
 - Mixed hearing loss with an average bone conduction better (less) than 45dB in either ear (at 500, 1000, 2000, 4000 Hz)
- **Unilateral sensorineural hearing loss (single-sided deafness):** Nerve deafness in the indicated ear making conventional hearing aids no longer useful. The implant is designed to stimulate the opposite (good ear) by bone conduction through the bones of the skull. Therefore, the audiometric criteria are for the good ear. Member must meet all of the following:
 - Severe (70dB) to profound (90dB) hearing loss on one side with poor speech discrimination and the inability to use a conventional hearing aid in that ear
 - Normal hearing in the good ear as defined by an air conduction threshold equal to or better (less) than 20dB (at 500, 1000, 2000, 3000 Hz)
- A child younger than five years of age with unilateral congenital atresia of the ear canal or middle ear in the presence of a maximum conductive hearing loss and adequate cochlear (inner ear) function may be considered on an individual basis. Adequate cochlear function is demonstrated audiologically when stimulation through bone conduction results in significantly improved and functional hearing in the involved ear.
- For a child with congenital malformations, a sufficient amount of bone volume and quality must be present for a successful fixture implantation. Alternative treatments, such as a conventional bone conduction hearing aid, should be considered for a child with a disease state that might jeopardize osseointegration.

Replacements

- One replacement BAHA is covered for a KBH-EPSDT member who meets the initial placement criteria.
- PA is required for all BAHA replacement services. All providers must obtain a PA prior to providing service.
- A replacement processor cannot be billed at the same time as the original processor or the original surgery.
- Replacements are limited to one every four years if lost, stolen, or broken.
- A replacement is not allowed for the purpose of upgrading. A BAHA can only be replaced if the current processor has an expired warranty, is malfunctioning, and cannot be repaired.

8400. Updated 11/21

Cochlear Implant

- Cochlear implants, devices, accessories, repairs, and batteries are a covered service for KBH-EPSTD-eligible members. These services are no longer restricted to one provider. Code 69930 is allowed without PA.
- Before cochlear services can be provided out of state, providers must request and receive approval (PA) from KMAP. Diagnostic analysis of cochlear implants may be a covered service for KBH-EPSTD-eligible members.
- Use of the left (LT) or right (RT) modifier is required on all claims for cochlear implantation, original device, headset/headpiece, microphone, transmitting coil, transmitting cable, replacement processors, accessories, and repairs, regardless of the provider. Headset/headpiece, microphone, and transmitting coils may be replaced once per year for KBH-EPSTD-eligible members.
- Cochlear external speech processor replacements are allowed no more than one time every four years with PA for KBH-EPSTD-eligible members. Cochlear external speech processor replacements will only be allowed if current processor is malfunctioning out of warranty and cannot be repaired. Replacements for upgrades will not be allowed. Replacements for lost cochlear external speech processors will be allowed one time during the four-year period for KBH-EPSTD-eligible members.
- Three lithium ion batteries for codes L8623, L8624, and L8625 are allowed for KBH-EPSTD-eligible members per 30 days. Codes L8621 and L8622 for cochlear implant devices are allowed for KBH-EPSTD-eligible members per 30 days. Only one type of battery is allowed every 30 days.

Dispensing

- Only one dispensing fee is allowed for monaural or binaural services. The appropriate dispensing fee must be used. **DO NOT BILL TWO DISPENSING FEES.** If services are monaural, the left or right modifier must be submitted on the claim. If the services are binaural, the left and right modifiers are not allowed. **For binaural aids, providers are required to use the binaural dispensing fee code.** Hearing aid dispensing services include adjusting the aid to meet the member's medical need. If the aid cannot be adjusted to meet the member's need within the one-month trial period, the aid is to be replaced or returned to the dispenser.
- Should the member return the hearing aid during the one-month trial rental period, reimbursement will be made for rental of the hearing aid and ear mold only. Reimbursement for the hearing aid should be recouped if the hearing aid is returned and the provider should initiate the adjustment to recoup the cost of the hearing aid. Medicaid will cover one month's rental, regardless of whether or not the aid is returned.

Documentation

To verify services provided in the course of a postpayment review, documentation in the member's medical record must support the service billed.

Eyeglasses

- The cost of the **hearing aid only** is covered in eyeglasses with hearing aids for members not participating in the KBH-EPSTD program.
- Reimbursement for incorporation of the eyeglasses with the hearing aid is covered with PA for KBH-EPSTD participants.

8400. Updated 04/17

Hearing Aids

- Initial hearing aids do not require PA. Documentation supporting the need for the hearing aid still needs to be available in the member's record.
- All hearing aid replacements require the use of modifier RA. Modifier RA must be present on all claims for replacement hearing aids. Replacement hearing aids continue to require PA.
- The use of the left or right modifier with monaural services is required. Claims will be denied if the appropriate modifier is not used. The use of the left or right modifier with binaural services is not allowed. Claims will be denied if the modifiers are used.
- All hearing aids must be covered by a six-month warranty. Hearing aid replacements may be reimbursed only once in a four-year period. The four-year period starts with the initial hearing aid and does not begin again if the aid is replaced.
- Hearing aids that are lost, broken, or destroyed may be replaced (with PA) once during the four-year period when documentation of the circumstances demonstrates the need. The Explanation of Necessity for Hearing Aids form and General Prior Authorization Request Form must be submitted for PA. (Refer to **Section 4300** of the *General Special Fee-for-Service Requirements Provider Manual* and **Section 7010** of this manual for complete instructions.)

Miscellaneous Hearing Services

Unlisted procedure code V5299 can be billed for any hearing service for which there is not a more specific code available.

- When billed with a description of replacement cord for analog of digital hearing aids, reimbursement will be \$21.06.
- When billed with any other description, the claim will be manually priced, and reimbursement will be based on the service provided.
- In all instances in which V5299 is submitted, sufficient documentation must be submitted with the claim to describe the service being rendered and to support medical necessity.
- If V5299 is submitted for a service for which there is a more specific procedure code, the charges for the unlisted code will be denied and the claim must be resubmitted with the appropriate pure code for consideration of payment.

Repairs

- Repairs must be covered by a six-month warranty.
- Repairs of \$14.99 or less are not covered.
- Repairs of \$15 to \$75 are covered without PA.
- Repairs exceeding \$75 require PA. Authorization will be given only when, in the consultant's opinion, the repairs are not extensive enough to warrant the fitting and dispensing of a new hearing aid.

Replacement Supplies

Replacement cords for hearing instruments and cochlear implants are covered with medical necessity documentation.

Testing, Examination, and Fitting

- Enrolled physicians and licensed or certified audiologists will be reimbursed for hearing tests. Certified program for otolaryngology personnel (CPOP) technicians are not allowed to enroll. All services performed by a CPOP technician must be billed through an otolaryngologist.

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8400. Updated 04/17

Testing, Examination, and Fitting continued

- Basic hearing services can be performed by CPOP technicians under the following guidelines:
 - The CPOP technician must be certified by the American Academy of Otolaryngology which includes sponsorship by an otolaryngologist. Certification documentation must be on file in the ear, nose, and throat (ENT) facility.
 - Services may only be performed in the office of an enrolled ENT specialist.
 - The CPOP technician must be directly supervised by an otolaryngologist.
 - All CPOP services must be signed off by an otolaryngologist. The otolaryngologist assumes all responsibility for CPOP technicians and services provided.
- The audiology hearing tests listed below can be performed by hearing instrument specialists, also known as hearing aid dealers (PT/PS 22/220), so long as they are licensed as a hearing instrument fitter and dispenser within the State of Kansas. The hearing instrument specialist must be enrolled as a Medicaid provider to perform and bill the following codes:

92552	92553	92555	92556	92557*
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** 92553 and 92556 combined*

Note: For KBH-EPSDT screening guidelines, see the *KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Fee-for-Service Provider Manual*.

- A physician must examine the hearing aid member for pathology or disease no more than six months prior to the fitting of the aid.
- An otologist, certified audiologist, or hearing aid dealer must perform hearing tests on the member **prior** to the fitting and dispensing date.
- Codes 92555 and 92557 may be repeated one time for hearing aid fit evaluation.
- Codes 92551 and 92587 are limited to one service per day.

APPENDIX

CODES Updated 07/22

The following codes represent a list of covered audiology services billable to KMAP.

Please use the following resources to determine current coverage and pricing information. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan.

- Information from the [public](#) website
- Information from the [secure](#) website under Pricing and Limitations

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The [Coding Modifiers Table](#) and [Ambulance Coding Modifiers Table](#) are available on both the [public](#) and [secure](#) websites. They can be accessed from the Reference Codes link under the Interactive Tools heading on the [Provider](#) page and Pricing and Limitations on the secure portion. Information is available on the [American Medical Association](#) website.

COVERAGE INDICATORS

KBH-EPSDT	=	KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment medical participation is required
MN	=	Medical necessity documentation is required
PA	=	Prior authorization is required
PA*	=	Refer to Repairs, Section 8400
PA**	=	PA for replacement only
RR	=	One month trial rental

Refer to **Section 8400** for additional benefits and limitations.

SERVICES

Coverage	Code	Coverage	Code
	92537		92562
	92538		92563
	92540		92565
	92541		92567
	92542		92568
	92544		92570
	92545		92575
KBH-EPSDT	92546		92577
KBH-EPSDT	92548		92620
	92549		92626
	92550		92627
KBH-EPSDT	92551		92700
	92552		0725T
	92553		0726T
	92555		0727T
	92556		0728T
	92557		0729T

CODES Updated 08/21

SUPPLIES

Coverage	Code	Coverage	Code
	92517	PA**	V5160
	92518	PA**, RR	V5171
	92519	PA**, RR	V5172
	92571	PA**, RR	V5181
	92577	KBH-EPSDT, PA**, RR	V5190
	92579	PA**	V5200
KBH-EPSDT	92582	PA**, RR	V5211
KBH-EPSDT	92584	PA**, RR	V5212
	92587	PA**, RR	V5213
	92588	PA**, RR	V5214
KBH-EPSDT	92601	PA**, RR	V5215
KBH-EPSDT	92602	PA**, RR	V5221
KBH-EPSDT	92603	KBH-EPSDT, PA**, RR	V5230
KBH-EPSDT	92604	PA**	V5240
	92625	PA**	V5241
	92650	PA**, RR	V5242
	92651	PA**, RR	V5243
	92652	PA**, RR	V5244
	92653	PA**, RR	V5245
	L7510	PA**, RR	V5246
KBH-EPSDT	L8614	PA**, RR	V5247
KBH-EPSDT	L8615	PA**, RR	V5248
KBH-EPSDT	L8616	PA**, RR	V5249
KBH-EPSDT	L8617	PA**, RR	V5250
KBH-EPSDT	L8618	PA**, RR	V5251
KBH-EPSDT, PA	L8619	PA**, RR	V5252
KBH-EPSDT	L8621	PA**, RR	V5253
KBH-EPSDT	L8622	PA**, RR	V5254
KBH-EPSDT	L8623	PA**, RR	V5255
KBH-EPSDT	L8624	PA**, RR	V5256
KBH-EPSDT	L8625	PA**, RR	V5257
KBH-EPSDT, PA	L8627	PA**, RR	V5258
KBH-EPSDT, PA	L8628	PA**, RR	V5259
KBH-EPSDT	L8629	PA**, RR	V5260
KBH-EPSDT, PA	L8690	PA**, RR	V5261
KBH-EPSDT, PA	L8691		V5264
KBH-EPSDT, PA	L8692		V5266
KBH-EPSDT, PA	L8694	MN	V5274
PA*	V5014	MN	V5298
PA**, RR	V5030	MN	V5299
PA**, RR	V5040		
PA**, RR	V5050		
PA**, RR	V5060		
KBH-EPSDT, PA**, RR	V5070		
KBH-EPSDT, PA**, RR	V5080		
PA**	V5090		
PA**, RR	V5120		
PA**, RR	V5130		
PA**, RR	V5140		
KBH-EPSDT, PA**, RR	V5150		

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