Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER AUD-10
September 2003

TO: Audiologists Participating in MassHealth

FROM: Douglas S. Brown, Acting Commissioner

RE: *Audiologist Manual* (Changes to Program Regulations and Service Codes)

This letter transmits revisions to the *Audiologist Manual* program regulations and service codes and descriptions. These revisions are effective for dates of service on or after October 1, 2003.

The Centers for Medicare and Medicaid Services (CMS) have revised the Healthcare Common Procedure Coding System (HCPCS) for 2003. New national service codes have been added, and MassHealth local service codes have been removed from the *Audiologist Manual*. Please note that you must use a modifier with some codes to accurately reflect the service provided. The attached Subchapter 6 contains codes with modifiers, where applicable.

If you wish to obtain a fee schedule, you may purchase Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). You must contact them first to find out the price of the regulation. The Division of Health Care Finance and Policy also has the regulations available on disk. The regulation title for audiologist services is 114.3 CMR 39.00: Audiological Services. The regulation title for hearing aid dispensing services is 114.3 CMR 23.00: Hearing Aid Dispensers.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

Changes to the Audiologist Regulations

I. Office Visits

Effective for dates of service beginning October 1, 2003, the Division will pay for office visits for evaluation and management services when certain procedures are required and provided as part of the office visit. These procedures include minor office repairs for which the provider customarily charges non-MassHealth patients, cleaning of the hearing aid, and the replacement of parts such as tubing and battery doors.

II. Refitting Services
Effective for dates of service beginning October 1, 2003, the Division will pay for additional professional fitting/refitting services for members for whom the hearing aid was dispensed more than two years prior to the date of the refitting services. These professional services must include a face-to-face encounter with the member. The Division will pay for a maximum of three visits per year.

Please see the attached revised Subchapter 4 of the *Audiologist Manual* for complete information on covered services and any limits that may apply.

III. Cochlear Implant Service Plan
The Division will pay for an extended service/maintenance plan for cochlear implant users, once the initial manufacturer's warranty has expired. Please see the revised Subchapter 4 of the *Audiologist Manual* for service limitations, and the revised Subchapter 6 for applicable codes and modifiers.

Updated Service Codes and Descriptions

I. Payment for Out-of-Office Services
For dates of service on or after October 1, 2003, providers will no longer be required to bill using MassHealth local modifier **XX** to receive enhanced payment for certain services provided in an out-of-office location. Providers must bill using the appropriate place-of-service code for the location where services were provided. The Division will automatically pay for out-of-office services in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy.

II. Infant Testing
Effective for dates of service beginning October 1, 2003, the MassHealth local code for infant testing (**X9662**) will be replaced by Current Procedural Terminology (CPT) codes **92585**, **92586**, **92587**, and **92588**. Providers must bill the applicable CPT codes for the individual tests that are performed.

III. Unlisted Otorhinolaryngological Services
Service Code **92599** has been deleted from the CPT 2003. Effective October 1, 2003, providers must bill using replacement Service Code **92700**.

Billing Guidelines

I. Service Code Crosswalk
Attached is a crosswalk that shows the obsolete MassHealth service codes and the new national service codes for the revised Subchapter 6.

II. Place-of-Service Codes
Providers must use the Division's place-of-service (POS) code set when submitting on paper claim form no. 9 or on proprietary electronic media claim (EMC) format. Providers should refer to the billing instructions in Subchapter 5 of the *Audiologist Manual* for a complete listing of all allowable Division POS codes. For 837 professional claims, please coordinate the Division's POS code list with the CMS POS list that is compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and that is available at www.cms.hhs.gov/states/posdata.pdf.

III. Billing Procedures for HIPAA Electronic Claims Requiring Attachments
Please refer to **All Provider Bulletin 125**, issued September 2003, for new procedures for submitting HIPAA-compliant 837 professional claims that require attachments such as manufacturer's invoices.

Changes to Prior Authorization Process

I. Monaural Dispensing Fees
Effective for dates of service beginning October 1, 2003, providers must submit all requests for prior authorization (PA) for a monaural dispensing using the new national code, **V5241** (dispensing fee, monaural hearing aid, any type). The Division will not accept service code **V5090** for monaural dispensing for prior-authorization requests submitted on or after October 1, 2003.

Monaural dispensing services provided under any PA for **V5090**, that the Division has approved before October 1, 2003, may be billed under **V5090** until the expiration date of the PA. All other claims for monaural dispensing, regardless of whether PA is required, must be submitted using **V5241** for dates of service on or after October 1, 2003.

II. Transition Period for Other Services
The Division is eliminating MassHealth-specific local service codes in compliance with HIPAA. For all prior-authorization requests that the Division has approved before October 1, 2003, that include approval for local service codes beginning with the letter "X," providers may continue to bill for these services using the approved "X" codes for dates of service up to and including **December 31, 2003**. The Division will not accept any local "X" codes for dates of service beginning **January 1, 2004**.

The Division will transition any remaining approved PAs for local "X" codes where services have not yet been provided and the PA expires on or after **January 1, 2004**. Providers will be notified of any changes to their existing approved PAs. Providers will not be required to resubmit for a new PA.

III. New Prior Authorization Request Process
Effective for dates of service on or after October 1, 2003, providers must submit all requests for prior authorization for hearing aids using the most specific HCPCS service code that is available. For example, if you are requesting PA for a monaural behind the ear (BTE) aid, the PA request should be submitted using Service Code V5060 (hearing aid, monaural, behind the ear), instead of V5299 (hearing service, miscellaneous). If you are requesting PA for binaural, digitally programmable BTE aids, the PA request should be submitted using V5253, instead of V5299.

Service Code **V5274** is available **only** for pocket-talkers.

Service Code **V5298** is available for aids or devices that are not otherwise classified under the allowable HCPCS.

Service Code **V5299** is available for other hearing-related services that are not otherwise classified under the allowable HCPCS.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Audiologist Manual

Pages iv, vi, 4-1 through 4-10, and 6-1 through 6-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Audiologist Manual

Pages iv, 4-5, 4-6, 4-9, and 4-10 — transmitted by Transmittal Letter AUD-9

Pages vi, 4-1 through 4-4, 4-7, and 4-8 — transmitted by Transmittal Letter AUD-7

Pages 6-1 through 6-4 — transmitted by Transmittal Letter AUD-8

Audiologist Service Code Crosswalk

Effective October 1, 2003

Obsolete Code – Description	New Code	New Code Description	Guideline
92599 - Unlisted otorhinolaryngological service or procedure	92700	Unlisted otorhinolaryngological service or procedure	
V5090 - Dispensing fee; unspecified hearing aid (monaural)	V5241	Dispensing fee, monaural hearing aid, any type	
X9662 - Infant testing	92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	Bill individual tests that were performed.
	92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	
	92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	
	92588	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	
X9666 - Aural rehabilitation therapy; individual	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	Bill in 15-minute increments, up to the maximum of 1 hour.
X9667 - Aural rehabilitation therapy; group (up to 60 minutes) (per member)	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group	Bill in 15-minute increments, up to the maximum of 1 hour.
X3400 - Batteries, not otherwise classified	V5266	Battery for use in hearing device	Bill per individual battery, regardless of package or battery size.
X3402 - Batteries, 4 pack, sizes 13, 312, 675			
X3403 - Batteries, 4 pack, size 10, 230			
X3404 - Batteries, 6 pack, sizes 13, 312, 675			
X3405 - Batteries, 6 pack, size 230			
X3406 - Batteries, 8 pack, sizes 13, 312			
X3407 - Batteries, 8 pack, sizes 10, 230			
X3408 - Batteries, 8 pack, size 5			

Obsolete Code – Description	New Code	New Code Description	Guideline
X5200 - Hearing aid cleaning	99499	Unlisted evaluation and management service	Bill only one E/M service per member per date of service.
X5294 - Accessories; costing $35.00 or less	V5267	Hearing aid supplies/accessories	Now only one service code for all accessories/options, regardless of unit cost.
X5295 - Nubbin replacement	99499	Unlisted evaluation and management service	Bill only one E/M service per member per date of service.
X5296 - Tubing replacement	99499	Unlisted evaluation and management service	Bill only one E/M service per member per date of service.
X5298 - Earmold; costing $35.00 or less per unit	V5264	Ear mold/insert, not disposable, any type	Use appropriate HCPCS code, regardless of unit cost.
	V5265	Ear mold/insert, disposable, any type	
X5299 - Earmold; costing more than $35.00 per unit	V5264	Ear mold/insert, not disposable, any type	Use appropriate HCPCS code, regardless of unit cost.
	V5265	Ear mold/insert, disposable, any type	
X5300 - Accessories; costing more than $35.00	V5267	Hearing aid supplies/accessories	Now only one service code for all accessories/options, regardless of unit cost.
X5301 - Ear impression	V5275	Ear impression, each	
Modifier XX - Out-of-office services	None	None. Use appropriate POS code for automatic payment.	

DMA place-of-service (POS) codes must be used on paper claim form no. 9 or proprietary EMC transactions.

01 Office, facility, or business location
02 Member's home
03 Hospital inpatient
04 Hospital outpatient
05 Emergency room
06 Nursing home
07 Rest home
99 Other location

CMS POS codes must be used on HIPAA-compliant 837 Professional transactions. Please see www.cms.hhs.gov/states/posdata.pdf.

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426.401: Introduction

130 CMR 426.000 governs services provided by audiologists under MassHealth. An independent audiologist who is licensed and certified in accordance with 130 CMR 426.404 and engages in the practice of audiology is eligible to become a provider in MassHealth. All audiologists participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations set forth in 130 CMR 426.000 and 450.000.

426.402: Definitions

The following terms used in 130 CMR 426.000 have the meanings given in 130 CMR 426.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 426.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 426.000 and in 130 CMR 450.000.

Accessories — those essential items or options on a hearing aid, including circuitry, purchased by an audiologist that are not intrinsic components of the basic hearing-aid unit. Accessories do not include nonessential items such as carrying cases.

Adjusted Acquisition Cost — the unit price paid to a manufacturer by an audiologist for a hearing aid or accessories, excluding postal-insurance charges. The adjusted acquisition cost does not exceed the manufacturer's current catalog price and is verified by a copy of the manufacturer's invoice retained by the audiologist in the member's health-care record as described under 130 CMR 426.419.

Audiological Services — these services include, but are not limited to, testing related to the determination of hearing loss, evaluation for hearing aids, prescription for hearing-aid devices, and aural rehabilitation.

Auditory Training — the training of the auditory modality to improve understanding of the speech or language of other speakers. Auditory training is one of the components of aural rehabilitation.

Aural Rehabilitation — therapy, including, but not limited to, speech reading and auditory training, provided by a licensed certified audiologist either in a group or individually.

BICROS — a contralateral routing of signal (CROS) fitting with the addition of a second microphone for amplification in the better ear. Both microphones feed to a single receiver on the better ear, which is also hearing-impaired and requires amplification.

Binaural — the type of fitting or hearing aid necessitated by varying degrees of hearing loss in both ears that requires unparalleled amplification via the use of two microphones and two receivers.

Binaural Fitting — the fitting of two hearing aids, one to each ear, by the audiologist; the fitting to the second ear taking place no later than six months after the fitting to the first ear.

Complete Audiological Evaluation — an evaluation that includes a routine audiological examination (air and bone conduction, spondee thresholds, and word discrimination testing) as recommended by a physician.

CROS — contralateral routing of signal, which refers to the hearing-aid configuration that routes sounds from the unaidable hearing-impaired ear to the hearing ear through a microphone on the hearing-impaired ear and a receiver on the hearing ear. The hearing ear could have normal hearing to mild hearing loss.

Date of Service — the date on which the medical service is furnished to a member or, in the case of hearing aids and accessories, the date on which the goods are delivered to a member.

Dispense — the prescription of a hearing aid, its modification, its fitting, orientation to its use, and any adjustments required within the manufacturer's trial warranty period.

Dispensing Fee — a one-time-only fee for dispensing monaural or binaural hearing aids.

Electroacoustical Analysis — an objective measurement of a hearing aid's specifications that may include, but is not limited to, acoustical gain, SSPL 90, frequency response, and harmonic distortion.

Group Session — therapeutic services directed by the audiologist toward more than one patient in a single encounter, using group participation as a treatment technique.

Hearing-Aid Evaluation — a procedure conducted by an audiologist that may include an assessment of the member's response to appropriate tests (real ear measurements or functional gain measurements).

Impedance — an evaluation that includes tympanometry, stapedial acoustic reflex testing, and acoustic reflex decay.

Independent Audiologist — an audiologist who is licensed and certified in accordance with 130 CMR 426.404(A) and who is engaged in the practice of audiology through a private practice or self-employment, or both.

Major Repair — a repair to a hearing aid that must be made at a repair facility other than the audiologist's place of business.

Minor Repair — a repair to a hearing aid performed at the audiologist's place of business, such as, but not limited to, the replacement or cleaning of tubing.

Monaural Fitting — the fitting of one hearing aid by an audiologist.

Nonorganic Test Battery — a series of tests that determines functional hearing loss.

Out-of-Office Visit — treatment provided in a nursing facility or at the member's residence rather than at the audiologist's usual place of business.

Speech Reading — the training of the visual modality to improve the understanding of the speech or language of other speakers. Speech reading is one of the components of aural rehabilitation.

426.403: Eligible Members

(A) (1) MassHealth Members. The Division covers audiological services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

426.404: Provider Eligibility

Payment for services described in 130 CMR 426.000 will be made only to an independent audiologist who is participating in MassHealth on the date of service.

(A) In State. To participate in MassHealth, an independent audiologist in Massachusetts must currently be:
(1) certified by the American Speech-Language-Hearing Association (ASHA); and
(2) licensed by the Commonwealth of Massachusetts, Division of Professional Licensure, Board of Registration in Speech-Language Pathology and Audiology.

(B) Out of State. To participate in MassHealth, an independent audiologist located outside Massachusetts must:
(1) meet the certification requirements of 130 CMR 426.404(A)(1);
(2) be licensed by the appropriate licensing agency in its own state (as applicable); and
(3) participate in the medical assistance program in its own state.

426.405: Out-of-State Services

The Division pays out-of-state audiologists in accordance with 130 CMR 450.109.

426.406: Maximum Allowable Fees

The Division pays the lowest of the following for audiological services, hearing aids, and related batteries and accessories:

(A) the audiologist's usual and customary fee;

(B) the adjusted acquisition cost; or

(C) the maximum fee listed in the applicable fee schedule of the Massachusetts Division of Health Care Finance and Policy.

426.407: Individual Consideration

Services designated "I.C." in the list of service codes and descriptions in Subchapter 6 of the *Audiologist Manual* are given individual consideration by the Division to determine the amount of payment to be made to the audiologist. The Division determines the amount of payment using the following criteria:

(A) the time required to perform the procedure;

(B) the degree of skill required to perform the procedure;

(C) the severity or complexity of the member's hearing disorder or disability;

(D) the policies, procedures, and practices of other third-party purchasers of health care; and

(E) the reasonable and customary practices of audiologists.

426.408: Prior Authorization

(A) Services designated "P.A." in the list of service codes and descriptions in Subchapter 6 of the *Audiologist Manual* require prior authorization from the Division. The Division requires prior authorization for:

(1) any hearing aid that costs more than the amount indicated in the applicable service description in Subchapter 6 of the *Audiologist Manual*; and

(2) the replacement of a hearing aid, regardless of the cost of the hearing aid, due to:

(a) a medical change;

(b) loss of the hearing aid; or

(c) damage beyond repair to the hearing aid.

(B) The Division requires the following documents from the provider requesting prior authorization:

(1) the audiological evaluation required under 130 CMR 426.414(A);

(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) the medical clearance required under 130 CMR 426.414(B); and

(6) an itemized estimate of the anticipated cost of the hearing aid.

(C) All prior-authorization requests must be submitted in accordance with the billing instructions in Subchapter 5 of the *Audiologist Manual*. Prior authorization determines only the health-care necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

426.409: Separate Procedures

Some procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it is designated as a "separate procedure" or "S.P." in the list of service codes and descriptions in Subchapter 6 of the *Audiologist Manual*. Thus, when a procedure is performed alone for a specific purpose, it must be considered a separate procedure.

(130 CMR 426.410 through 426.413 Reserved)

426.414: Dispensing Requirements

An audiologist may dispense a hearing aid only after receiving the following documentation.

(A) Audiological Evaluation.

(1) The audiologist must have personally completed or received an audiological evaluation performed by one of the following:

(a) an independent audiologist who is licensed and certified according to 130 CMR 426.404 and who is a MassHealth provider;

(b) a licensed, certified audiologist employed at a speech and hearing clinic that is a MassHealth provider; or

(c) an audiologist who is licensed and certified according to 130 CMR 426.404 and who is employed by a physician or hospital outpatient department that is a MassHealth provider.

(2) This evaluation must contain the following information:

(a) the date of the evaluation;

(b) a favorable prognosis for adaptation to the hearing aid that ensures that:

(i) any previous use of a hearing aid was successful; and

(ii) no physiological causes exist that make the member unable to use a hearing aid;

(c) the hearing aid make and model; and

(d) whether or not the amplification should be monaural or binaural.

(3) The evaluation must have been performed no more than six months before the dispensing date of the hearing aid.

(4) The make, model, and specifications such as maximum output, frequency response configuration, and any other special requirements of the hearing aid dispensed must be the same as or comparable to that recommended in the audiological evaluation.

(B) Medical Clearance. The audiologist must have received a medical clearance from a physician that states that the member has no medical conditions that would prohibit the use of a hearing aid. The medical examination by the physician must have been performed no more than six months before the dispensing date of the hearing aid.

426.415: Conditions of Payment

(A) To receive payment for dispensing the hearing aid, the audiologist must submit with the completed claim form a copy of the entire manufacturer's invoice, including all discounts. Manufacturers' invoices must contain a date of service, the member's name, and the serial numbers of the hearing aids that were dispensed to the MassHealth member. If the invoice is for a bulk order, the audiologist must indicate on the copy of the invoice which hearing aids have been dispensed to the MassHealth member.

(B) All claims must be submitted in accordance with the billing instructions in Subchapter 5 of the *Audiologist Manual*.

426.416: Reimbursable Services

(A) Complete Audiological Evaluation. Payment for a complete audiological evaluation will be made only if the evaluation is recommended by a physician.

(B) Hearing-Aid Purchase. Payment for a hearing-aid purchase includes the following:
(1) the hearing aid and standard accessories/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) the maintenance, minor repair, and servicing provided during the operational lifetime of the hearing aid that is furnished free of charge to non-MassHealth patients;
(4) the initial one-year manufacturer's warranty against loss or damage; and
(5) the loan to the member of a hearing aid by the audiologist, when necessary.

(C) Earmold. An earmold is not reimbursable if it is included in the manufacturer's price of the hearing aid or if the member already has an appropriate earmold. Payment for an earmold includes the following:
(1) the proper fitting of the earmold; and
(2) any adjustments that may be needed during the operational life of the earmold.

(D) Ear Impression.
(1) For a Hearing Aid. Payment for an ear impression for a hearing aid includes one properly formed ear impression for each in-the-ear hearing aid purchased. The provider may not claim payment for an ear impression for a hearing aid until the hearing aid has actually been delivered to the member.
(2) For an Earmold. The provider may not claim payment for an ear impression for an earmold until the earmold has actually been delivered to the member.

(E) Batteries. Batteries must be new at the time of purchase.

(F) Accessories. Payment for accessories and hearing-aid options includes proper fitting and adjustment of the accessory as needed. Accessories must be billed separately from the basic hearing-aid unit. The costs of accessories, such as audio input cords and telephone coils, must be combined into one single total charge and billed as one unit of service.

(G) Major Repairs. The provider of a repair service is responsible for the quality of the workmanship and parts, and for ensuring that the repaired hearing aid is in proper working condition. The audiologist is responsible for ensuring that the repaired hearing aid is in proper working condition upon returning the aid to the member. Payment for a major repair to a hearing aid is limited to the following conditions.

(1) All warranties and insurance must have expired.
(2) The hearing aid must be sent directly to the repair facility or manufacturer that will perform the repair. (The handling charges of an intermediary are not reimbursable.)
(3) The repair service must include a written warranty against all defects for a minimum of six months.
(4) A copy of the invoice from the repair facility or manufacturer for the cost of the repair must accompany the claim form.

(H) Office Visits for Evaluation and Management Services.
(1) The Division pays for an office visit for evaluation and management services only when one or more of the following services is required and is provided as part of the visit:
(a) minor adjustments to the hearing aid to assure a proper fitting, such as an earmold adjustment, when the provider is not the provider who initially fit the hearing aid, and the provider who initially fit the hearing aid is no longer a MassHealth provider;
(b) minor office repairs for which the provider customarily charges non-MassHealth patients;
(c) cleaning of the hearing aid; or
(d) replacement of parts such as, but not limited to, tubing, hooks, battery doors, and recasing.
(2) The Division pays for only one office visit per member per date of service.

(I) Refitting Services/Other Professional Services. The Division pays for additional fitting/refitting services only where the hearing aid was dispensed more than two years prior to the date of service of the refitting services. These professional services include refitting of the aid, orientation, counseling with the member or member's family, contact with interpreters, fitting of a loaner aid, and similar services. Payment for these services must include a face-to-face encounter with the member. Payment is made for a maximum of three visits per year.

(J) Cochlear Implant Service Contract. The Division pays for a service/maintenance contract from the manufacturer of a cochlear implant device that is approved by the U.S. Department of Health and Human Services Food and Drug Administration (FDA), which covers certain costs for repair and replacement parts for an eligible member's existing cochlear implant system. This does not include contracts for the sole purpose of replacement due to loss, theft, or accidental damage. The following restrictions apply to the service contract.
(1) The service contract must be for a minimum period of two years, paid in full with the enrollment. The Division does not pay for a service contract purchased under an installment payment plan, where payment in full at enrollment is also an option.
(2) The service contract, when available as a combined option, must include repair and replacement coverage for both the headpiece and speech processor.
(3) The service contract is not covered until the manufacturer's original warranty, which is obtained at the time of initial implantation, expires.
(4) A copy of the invoice from the manufacturer for the cost of the service contract must accompany the claim form.

426.417: Nonreimbursable Services

The Division does not pay for any of the following services:

(A) the rental of hearing aids;

(B) hearing aids that are completely in the ear canal (CIC);

(C) personal FM Systems; or

(D) assistive technology devices provided under 34 CFR 300.308, where such devices are maintained at the school facility for the general use of disabled students, and assistive technology services provided under 34 CFR 300.308 relating to the use of such devices.

426.418: Service Limitations

The Division does not pay for more than one hearing aid per ear per member in a 60-month period without prior authorization in accordance with 130 CMR 426.408. 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 dispensed for the left ear and the other dispensed for the right ear.

426.419: Recordkeeping Requirements

An audiologist must maintain a medical record for each member for a period of at least six years following the date of service. The record must contain all pertinent information about the services provided, including the date of service and the dates on which materials were ordered and dispensed. The recordkeeping requirements are specific to each type of service and are described as follows.

(A) Earmolds. The audiologist must maintain the manufacturer's invoice indicating the actual acquisition cost for the earmold.

(B) Hearing Aids. The audiologist must maintain the following information in the member's medical record:

(1) a history of the member's hearing loss and use of hearing aids. The history must contain the following information:

(a) the etiology and chronology of the member's hearing loss, including the member's age at the onset of the loss and an indication of whether the hearing loss is progressive;

(b) the make, model number, type, and date of purchase of each hearing aid previously worn by the member;

(c) a description of any speech and hearing therapy received by the member; and

(d) a description of any handicap that the member has that may impair vision or affect hearing-aid use;

(2) all audiological evaluations. The evaluations must have been performed no more than six months before the dispensing dates of the hearing aid;
(3) a medical clearance from a physician that states that the member has no medical conditions that would prohibit the use of a hearing aid. The medical examination must have been performed no more than six months before the dispensing date of the hearing aid; and
(4) the manufacturer's invoice indicating the actual acquisition cost of the hearing aid, including all discounts, and the warranty indicating the terms of repair or replacement in the event of loss of or damage to the hearing aid.

(C) Replacement Hearing Aids.
(1) If the member's hearing aid has been lost, the audiologist must maintain in the member's medical record a statement from the member or someone acting on the member's behalf (for example, an immediate family member or other legal representative) that describes the circumstances of the loss of the hearing aid.
(2) If the member's hearing aid has been irreparably damaged, the audiologist must maintain in the member's medical record a statement from the manufacturer documenting that the hearing aid cannot be repaired.

(D) Batteries and Accessories/Options. The audiologist must maintain in the member's record the manufacturer's invoice indicating the actual acquisition cost of batteries or accessories/options, or both, if the cost of any item is more than $35.00.

(E) Audiological Evaluation. The results of all audiological evaluations must be fully documented in the member's record.

REGULATORY AUTHORITY

130 CMR 426.000: M.G.L. c. 118E, §§ 7 and 12.

601 Service Codes and Descriptions

Service Code-Modifier	Service Description
	AUDIOLOGICAL SERVICES
	Vestibular Function Tests, with Recording and Medical Diagnostic Evaluation
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Sinusoidal vertical axis rotational testing
92547	Use of vertical electrodes (List separately in addition to code for primary procedure.)
	Audiologic Function Tests with Medical Diagnostic Evaluation
92552	Pure tone audiometry (threshold); air only (S.P. 92553)
92553	air and bone
92555	Speech audiometry threshold (S.P. 92556)
92556	with speech recognition
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92563	Tone decay test
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92572	Staggered spondaic word test (S.P. 92589)
92576	Synthetic sentence identification test (S.P. 92589)
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	Conditioning play audiometry (I.C.)
92583	Select picture audiometry (I.C.)
92584	Electrocochleography (I.C.)
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	limited
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)

601 Service Codes and Descriptions (cont.)

Service Code-Modifier	Service Description
92589	Central auditory function test(s) (specify) (per hour with a maximum of three hours)
92590	Hearing aid examination and selection; monaural
92591	binaural
92592	Hearing aid check; monaural (provider was not the original dispenser and the instrument is older than one year) (listening check of the instrument plus sound field testing of the instrument on the patient; may or may not be performed together with a diagnostic evaluation)
92593	binaural
92594	Electroacoustic evaluation for hearing aid; monaural (real ear measurement (REM) objective test of hearing instrument performance in the patient's ear as compared to a target response and electroacoustical assessment of the performance evaluation of the hearing instrument as compared to its original factory specifications)
92595	binaural
92596	Ear protector attenuation measurements (I.C.)
	Other Audiological Procedures
92700	Unlisted otorhinolaryngological service or procedure (I.C.)
	Aural Rehabilitation: Lip Reading or Auditory Training
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual (bill in 15-minute units, up to a maximum of one hour)
92508	group, two or more individuals (per member, up to 60 minutes) (bill in 15-minute units, up to a maximum of one hour)
	Cochlear Implant Service Contract
V5014-MS	Repair/modification of a hearing aid — six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty (I.C.)

601 Service Codes and Descriptions (cont.)

Service Code-Modifier	Service Description
	HEARING AID SERVICES
	Office Visits for Evaluation and Management Services
99499	Unlisted evaluation and management service
	Refitting Services/Other Professional Services
V5011	Fitting/orientation/checking of hearing aid
	Hearing Aid Purchases-Monaural
V5030	Hearing aid, monaural, body worn, air conduction (P.A. if cost exceeds $500) (I.C.)
V5040	Hearing aid, monaural, body worn, bone conduction (P.A. if cost exceeds $500) (I.C.)
V5050	Hearing aid, monaural, in the ear (P.A. if cost exceeds $500) (I.C.)
V5060	Hearing aid, monaural, behind the ear (P.A. if cost exceeds $500) (I.C.)
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear) (P.A. if cost exceeds $500) (I.C.)
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear) (P.A. if cost exceeds $500) (I.C.)
V5256	Hearing aid, digital, monaural, ITE (P.A. if cost exceeds $500) (I.C.)
V5257	Hearing aid, digital, monaural, BTE (P.A. if cost exceeds $500) (I.C.)
	Hearing Aid Purchases-Binaural
V5130	Binaural, in the ear (P.A. if cost exceeds $1,000) (I.C.)
V5140	Binaural, behind the ear (P.A. if cost exceeds $1,000) (I.C.)
V5150	Binaural, glasses (P.A. if cost exceeds $1,000) (I.C.)
V5252	Hearing aid, digitally programmable, binaural, ITE (P.A. if cost exceeds $1,000) (I.C.)
V5253	Hearing aid, digitally programmable, binaural, BTE (P.A. if cost exceeds $1,000) (I.C.)
V5260	Hearing aid, digital, binaural, ITE (P.A. if cost exceeds $1,000) (I.C.)
V5261	Hearing aid, digital, binaural, BTE (P.A. if cost exceeds $1,000) (I.C.)

601 Service Codes and Descriptions (cont.)

Service Code-Modifier	Service Description
	Hearing Aid Purchases-CROS and BICROS
V5170	Hearing aid, CROS, in the ear (P.A. if cost exceeds $1,000) (I.C.)
V5180	Hearing aid, CROS, behind the ear (P.A. if cost exceeds $1,000) (I.C.)
V5190	Hearing aid, CROS, glasses (P.A. if cost exceeds $1,000) (I.C.)
V5210	Hearing aid, BICROS, in the ear (P.A. if cost exceeds $1,000) (I.C.)
V5220	Hearing aid, BICROS, behind the ear (P.A. if cost exceeds $1,000) (I.C.)
V5230	Hearing aid, BICROS, glasses (P.A. if cost exceeds $1,000) (I.C.)
	Hearing Aid Purchases-Other
V5070	Glasses, air conduction (I.C.)
V5080	Glasses, bone conduction (I.C.)
V5100	Hearing aid, bilateral, body worn (I.C.)
V5274	Assistive listening device, not otherwise specified (I.C.) (Use this code only for pocket-talkers.)
V5298	Hearing aid, not otherwise classified (P.A.) (I.C.)
	Hearing Aid Repairs, Accessories, and Related Services
V5014	Repair/modification of a hearing aid (I.C.)
V5264	Ear mold/insert, not disposable, any type (I.C.)
V5265	Ear mold/insert, disposable, any type (I.C.)
V5266	Battery for use in hearing device (per battery)
V5267	Hearing aid supplies/accessories (I.C.)
V5275	Ear impression, each
V5299	Hearing service, miscellaneous (P.A.) (I.C.)
	Hearing Aid Dispensing Fees
V5160	Dispensing fee, binaural
V5200	Dispensing fee, CROS
V5240	Dispensing fee, BICROS
V5241	Dispensing fee, monaural hearing aid, any type