Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter AUD-16
March 2009

TO: Audiologists Participating in MassHealth

FROM: Tom Dehner, Medicaid Director

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

This letter transmits changes to the program regulations and service codes and descriptions of the *Audiologist Manual*. These changes are effective for dates of service on or after March 15, 2009.

If you wish to obtain a fee schedule, you may download the Division of Health Care Finance and Policy regulations at no cost at www.mass.gov/dhcfp. You may also purchase a paper copy of 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 paper copy of the publication. The regulation title for audiological services is 114.3 CMR 39.00: Rehabilitation Clinic Services, Audiological Services, Restorative 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

I. Changes to Program Regulations

- **Provider Eligibility (130 CMR 426.404):** These revised regulations codify existing eligibility criteria for acute hospital outpatient departments, hospital-licensed health centers, and other satellite clinics. Such providers are eligible under 130 CMR 426.000 to provide services designated as hearing aid services in the revised Subchapter 6 in accordance with 130 CMR 426.404(A).

- **Services for EPSDT-eligible members (130 CMR 426.410):** These revised regulations codify existing policy for EPSDT-eligible members. MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 426.000 and 450.000. An audiology provider may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C.1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in Subchapter 6 of the *Audiologist Manual*.

- **Dispensing Requirements (130 CMR 426.414)**
  - Audiological Evaluation: Effective for dates of service on or after March 15, 2009, the audiological evaluation for a MassHealth member aged 18 or older may be performed by either a licensed audiologist or a licensed hearing instrument specialist. An audiological evaluation performed by a hearing instrument specialist must meet the requirements of the Rules and Regulations Governing Hearing Instrument Specialists of the Massachusetts Division of Professional Licensure at 265 CMR 2.00-10.00.

    In accordance with M.G.L. c. 93, §§ 71 and 72, audiological evaluations for members under age 18 must be performed by a licensed audiologist.

    All audiological evaluations must be signed by the licensed individual(s) who personally performed the evaluation, and must include the individual's name and credentials printed clearly and legibly next to the signature.

  - Medical Clearance: Effective for dates of service on or after March 15, 2009, the medical clearance must meet the revised minimum conditions listed at 130 CMR 426.414(B). The medical clearance must include the date of the clearance; state that the member is a candidate for and has no medical conditions that would contraindicate the use of a hearing aid(s); identify which ear(s) are cleared for hearing aid use; and indicate whether or not the member, at the time of the medical examination, currently owned or used a hearing aid for the designated ear(s). The medical clearance must be obtained no more than six months prior to the dispensing date of a hearing aid and must be personally signed by the physician. The physician's name and credentials must be clearly printed on the medical clearance.

- **Reimbursable Services (130 CMR 426.416):** Effective for dates of service on or after March 15, 2009, MassHealth will pay for two audiologists working together to perform evaluations under those circumstances where the knowledge, skills and experience of the primary audiologist have identified a need for a second audiologist to aid in completing the initial test battery, such as for the testing of very young children or those with other pertinent developmental, physical, cognitive, or maturational factors.

  To receive full payment, both audiologists must use the appropriate service code with modifier TG (complex/high tech level of care). MassHealth will pay one-half of the total reimbursement for two audiologists to each individual provider.

  Clarifications have also been made about billing for earmolds and ear impressions. An ear impression for an earmold for a BTE hearing aid is not separately reimbursable. Payment for the earmold includes payment for the ear impression.

II. Changes to Service Codes and Descriptions in Subchapter 6

Effective for dates of service on or after March 15, 2009, service codes have been added for hearing screening (92551) and for ITC hearing aids. Clarifications have been made about the use of Service Codes 92592 and 92593, and the service code for a cochlear implant service plan has been changed. Service Code V5014MS has been discontinued and replaced with **L7510MS** effective for dates of service on or after March 15, 2009.

III. Other Reminders

Effective for dates of service on and after August 1, 2006, providers must use either modifier **LT** (left ear) or **RT** (right ear) when billing for the purchase of a new monaural hearing aid and monaural dispensing fee. (See MassHealth Transmittal Letter AUD-14.) Failure to use these modifiers may result in a denied claim.

Do not use these modifiers for services other than monaural hearing aid purchases and monaural dispensing. Use of these modifiers on other services will result in a denied claim.

When billing on the CMS-1500 paper claim form, enter both the service code and the modifier in the appropriate boxes in Item 24D. When billing the 837P transaction, enter the five-character service code in Loop 2400 – SV101-2 and the two-character modifier in Loop 2400 – SV101-3.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL

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

Audiologist Manual

Pages iv, vi, vii, 4-1 through 4-12, and 6-1 through 6-4

OBSOLETE MATERIAL

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

Audiologist Manual

Pages iv and vi — transmitted by Transmittal Letter AUD-10

Page vii — transmitted by Transmittal Letter AUD-11

Pages 4-1 through 4-10 and 6-1 through 6-4 — transmitted by Transmittal Letter AUD-14

4. Program Regulations

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, administrative and billing instructions, and general information. MassHealth regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. MassHealth regulations are assigned Title 130 of the Code. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For audiologists, those matters are covered in 130 CMR Chapter 426.000, reproduced as Subchapter 4 in the *Audiologist Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen-and-ink" revisions), and by substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth’s effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

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 MassHealth regulations, including but not limited to those 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 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 medical 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 custom-made goods, 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 in accordance with 130 CMR 426.404 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.

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 MassHealth agency covers audiological services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. MassHealth 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

(A) In State. The following requirements apply when the audiology practice is located in Massachusetts.
(1) Independent Audiologist. An independent audiologist engaged in private practice in Massachusetts is eligible to participate in MassHealth only if the individual is licensed as an audiologist by the Commonwealth of Massachusetts, Division of Professional Licensure, Board of Registration in Speech-Language Pathology and Audiology.
(2) Acute Hospital Outpatient Department, Hospital-Licensed Health Center, or Other Satellite Clinic. An acute hospital’s outpatient department, hospital-licensed health center, or other satellite clinic that participates in MassHealth pursuant to the Executive Office of Health and Human Services (EOHHS) Acute Hospital Request for Applications (RFA) and contract is eligible to provide services designated as hearing aid services in Subchapter 6 of the MassHealth *Audiologist Manual* for providers under 130 CMR 426.000.

(B) Out of State. To participate in MassHealth, an independent audiologist practicing outside of Massachusetts must:

(1) participate in the Title XIX medical assistance program in the audiologist's own state;

(2) in a state that licenses independent audiologists, be licensed by the appropriate licensing agency in its own state; and

(3) possess a Certificate of Clinical Competence in Audiology (CCC-A) issued by the American Speech-Language-Hearing Association (ASHA), if any of the following conditions apply:

(a) the audiologist's own state does not license independent audiologists;

(b) the audiologist's own state does license independent audiologists, but such licensure is not in full compliance with minimum state licensure requirements, specified in 42 CFR 440.110(3); or

(c) the audiologist's own state does license independent audiologists, but such licensure does not, at minimum, meet the academic and clinical requirements of the CCC-A.

426.405: Out-of-State Services

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

426.406: Maximum Allowable Fees

The MassHealth agency pays the lower of the following for audiological services, hearing aids, and related services:

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

(B) 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 MassHealth agency to determine the amount of payment to be made to the audiologist. The MassHealth agency 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 MassHealth agency. The MassHealth agency 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 MassHealth agency 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 administrative and billing instructions in Subchapter 5 of the *Audiologist Manual*. Prior authorization determines only the medical 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.

(D) Providers may submit a prior authorization request pursuant to 130 CMR 450.144(A) for medically necessary services.

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.

426.410: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary audiological services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 426.000, and with prior authorization.

(130 CMR 426.411 through 426.413 Reserved)

426.414: Dispensing Requirements

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

(A) Complete Audiological Evaluation.

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

(a) an independent audiologist who personally performed and completed the audiological evaluation;

(b) a licensed audiologist who is employed at a speech and hearing clinic and who personally performed and completed the audiological evaluation; or

(c) a licensed audiologist who is employed by a physician, or by an acute hospital's outpatient department, hospital-licensed health center, or other satellite clinic.

(2) Audiological evaluations for members under age 18 must be performed by a licensed audiologist pursuant to M.G.L. c. 93 §§ 71 and 72. For members aged 18 or older, the audiological evaluation may also be performed by a licensed hearing instrument specialist. Hearing testing performed by a hearing instrument specialist must meet the requirements of the Massachusetts Rules and Regulations Governing Hearing Instrument Specialists of the Division of Professional Licensure at 265 CMR 2.00 through 10.00.

(3) This evaluation must contain the following information:

(a) the date of the evaluation;

(b) a written summary of findings and impressions, which would include a favorable prognosis for hearing aid use and an assurance that no physiological causes exist that would make the member unable to use a hearing aid;

(c) the recommended hearing aid make and model;

(d) whether or not the amplification should be monaural (and if so, for which ear) or binaural; and

(e) the signature of the audiologist or hearing instrument specialist who performed the evaluation, including the individual's name and credentials printed clearly and legibly next to the signature.

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

(5) 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 and must maintain in the member's medical record pursuant to 130 CMR 426.419(B) a medical clearance from a physician that meets the following conditions:

(1) the medical clearance must state that the member is a candidate for and has no medical conditions that would contraindicate the use of a hearing aid;

(2) the medical examination by the physician must have been performed no more than six months before the dispensing date of the hearing aid;

(3) the medical clearance must be signed by the physician. If the medical clearance is not printed on the physician's letterhead, the physician's name and credentials must also be printed clearly and legibly on the medical clearance; and

(4) the medical clearance must include the date of the medical clearance, identify which ears are cleared, and indicate whether or not the member, at the time of the medical examination, currently owns or uses a hearing aid for the designated ear.

426.415: Conditions of Payment

All claims must be submitted in accordance with the administrative and billing instructions in Subchapter 5 of the *Audiologist Manual*.

426.416: Reimbursable Services

(A) Complete Audiological Evaluation.

(1) Payment for a complete audiological evaluation will be made only if the evaluation is recommended by a physician.

(2) Two Audiologists. The MassHealth agency will pay for two audiologists working together to perform an evaluation of an individual member under those circumstances where the knowledge, skills, and experience of the primary audiologist have identified a need for a second audiologist to aid in completing the initial test battery, such as for the testing of very young children or those with other pertinent developmental, physical, cognitive, or maturational factors. Circumstances warranting the services of two audiologists must be fully documented in the member's medical record. To receive full payment, both audiologists must use the appropriate service code and modifier combination listed in Subchapter 6 of the *Audiologist Manual*. The MassHealth agency pays one-half of the total reimbursement for two audiologists to each individual provider.

(B) Hearing-Aid Purchase. Payment for a hearing-aid purchase includes the following:

(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 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 of a hearing aid to the member by the audiologist, when necessary.

(C) Earmold. The provider may not claim payment for an earmold until the earmold has actually been delivered to the member. The date of service for the earmold is the date on which the earmold was delivered to the member. 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 ear impression;
(2) the proper fitting of the earmold; and
(3) any adjustments that may be needed during the operational life of the earmold.

(D) Ear Impression.

(1) Ear Impression for an ITE/ITC Hearing Aid. Payment for an ear impression for a hearing aid includes one properly formed ear impression for each in-the-ear (ITE) or in-the-canal (ITC) 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) Ear Impression for an Earmold for a BTE Hearing Aid. An ear impression for an earmold for a behind-the-ear (BTE) hearing aid is not separately reimbursable. Payment for the earmold includes payment for the ear impression.

(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.

(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 be kept in the member's medical record.

(H) Office Visits for Evaluation and Management Services. The MassHealth agency 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:

(1) minor adjustments to the hearing aid to ensure 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;
(2) minor office repairs for which the provider customarily charges non-MassHealth members;
(3) cleaning of the hearing aid; or
(4) replacement of parts such as, but not limited to, tubing, hooks, battery doors, and recasing.

(I) Refitting Services/Other Professional Services. The MassHealth agency pays for additional fitting or 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.

(J) Cochlear Implant Service Contract. The MassHealth agency pays for a service or 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 MassHealth agency 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 MassHealth agency 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

(A) The MassHealth agency 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.

(B) Two monaural fittings dispensed within a six-month period, with one aid dispensed for the left ear and the other for the right ear, are defined as a single binaural fitting. The MassHealth agency will not pay two monaural dispensing fees for this service. MassHealth pays only one binaural dispensing fee for this service.

426.419: Recordkeeping Requirements

An audiologist must maintain a medical record for each member for a period of at least as long as the minimum period required by 130 CMR 450.205(G). The MassHealth agency will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. The medical 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. In no instance will the completion of the appropriate MassHealth claim form, the maintenance of a copy of such a claim, or the simple notation of service codes constitute sufficient documentation for the purposes of 130 CMR 426.419.

(A) Earmolds. The audiologist must maintain the manufacturer's invoice in the member's medical record, 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 date of the hearing aid;

(3) the medical clearance from a physician obtained in accordance with 130 CMR 426.414(B); 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) Accessories/Options. The audiologist must maintain in the member's medical record the manufacturer's invoice indicating the actual acquisition cost of all accessories/options.

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

(F) Office Visits for Evaluation and Management Services. The audiologist must maintain in the member's medical record documentation substantiating the necessity of the office visit and detailing the services provided.

(G) Refitting Services/Other Professional Services. The audiologist must maintain in the member's medical record documentation substantiating the necessity of the office visit and detailing the services provided.

REGULATORY AUTHORITY

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

This page is reserved.

601 Introduction

MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 426.000 and 450.000. An audiology provider may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in Subchapter 6 of the *Audiologist Manual*.

602 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) (Use 92547 in conjunction with 92541-92546.)
	Audiological Function Tests with Medical Diagnostic Evaluation
	Use modifier **TG** (complex/high tech level of care) when billing for services provided by two audiologists in accordance with 130 CMR 426.416.
92551	Screening test, pure tone, air only
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; threshold
92569	decay
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.)

602 Service Codes and Descriptions (cont.)

Service Code-Modifier	Service Description
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)
92590	Hearing aid examination and selection; monaural
92591	binaural
92592	Hearing aid check; monaural (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) (only if the instrument is older than two years; or if the provider was not the original dispenser, regardless of the age of the instrument)
92593	binaural (only if the instruments are older than two years; or if the provider was not the original dispenser, regardless of the age of the instrument)
92594	Electroacoustic evaluation for hearing aid; monaural
92595	binaural
92596	Ear protector attenuation measurements
92620	Evaluation of central auditory function, with report; initial 60 minutes
92621	each additional 15 minutes (maximum of three hours total, including the initial 60 minutes billed under 92620)
	Other Audiological Procedures
92700	Unlisted otorhinolaryngological service or procedure (I.C.)
	Aural Rehabilitation: Lip Reading or Auditory Training
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals (per member, up to 60 minutes) (bill in 15-minute units, up to a maximum of one hour)
92630	Auditory rehabilitation; pre-lingual hearing loss (may not be billed with 92633) (bill in 15-minute units, up to a maximum of one hour)
92633	post-lingual hearing loss (may not be billed with 92630) (bill in 15-minute units, up to a maximum of one hour)
	OFFICE VISITS FOR EVALUATION AND MANAGEMENT SERVICES
99499	Unlisted evaluation and management service (up to a maximum of six services per member per date of service)
	HEARING AID SERVICES
	Refitting Services/Other Professional Services
V5011	Fitting/orientation/checking of hearing aid

602 Service Codes and Descriptions (cont.)

Service Code-Modifier	Service Description
	Hearing Aid Purchases-Monaural (Must use with modifier LT or RT.)
	Prior authorization (P.A.) is required where the adjusted acquisition cost (A.A.C.), not including shipping charges, exceeds $500.00. One of the modifiers **LT** (left side) or **RT** (right side) must be used with these service codes.
V5030	Hearing aid, monaural, body worn, air conduction (I.C.)
V5040	Hearing aid, monaural, body worn, bone conduction (I.C.)
V5050	Hearing aid, monaural, in the ear (I.C.)
V5060	Hearing aid, monaural, behind the ear (I.C.)
V5243	Hearing aid, analog, monaural, ITC (in the canal) (I.C.)
V5245	Hearing aid, digitally programmable analog, monaural, ITC (in the canal) (I.C.)
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear) (I.C.)
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear) (I.C.)
V5255	Hearing aid, digital, monaural, ITC (I.C.)
V5256	Hearing aid, digital, monaural, ITE (I.C.)
V5257	Hearing aid, digital, monaural, BTE (I.C.)
	Hearing Aid Purchases-Binaural
	Prior authorization (P.A.) is required where the A.A.C., not including shipping charges, exceeds $1,000.00.
V5130	Binaural, in the ear (I.C.)
V5140	Binaural, behind the ear (I.C.)
V5150	Binaural, glasses (I.C.)
V5249	Hearing aid, analog, binaural, ITC (I.C.)
V5251	Hearing aid, digitally programmable analog, binaural, ITC (I.C.)
V5252	Hearing aid, digitally programmable, binaural, ITE (I.C.)
V5253	Hearing aid, digitally programmable, binaural, BTE (I.C.)
V5259	Hearing aid, digital, binaural, ITC (I.C.)
V5260	Hearing aid, digital, binaural, ITE (I.C.)
V5261	Hearing aid, digital, binaural, BTE (I.C.)
	Hearing Aid Purchases-CROS and BICROS
	Prior authorization (P.A.) is required where the A.A.C., not including shipping charges, exceeds $1,000.00.
V5170	Hearing aid, CROS, in the ear (I.C.)
V5180	Hearing aid, CROS, behind the ear (I.C.)
V5190	Hearing aid, CROS, glasses (I.C.)
V5210	Hearing aid, BICROS, in the ear (I.C.)
V5220	Hearing aid, BICROS, behind the ear (I.C.)
V5230	Hearing aid, BICROS, glasses (I.C.)

602 Service Codes and Descriptions (cont.)

Service Code-Modifier	Service Description
	Hearing Aid Purchases-Other
	Except where otherwise indicated, prior authorization (P.A.) is required where the A.A.C., not including shipping charges, exceeds $1,000.00.
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.) (P.A. if A.A.C., not including shipping charges, exceeds $500.00) (Use this code only for pocket talkers or similar single-unit amplifiers.)
V5298	Hearing aid, not otherwise classified (P.A. always required) (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.)
	Cochlear Implant Services
L8621	Zinc air battery for use with cochlear implant device, replacement, each (I.C.)
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each (I.C.)
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each (I.C.)
L8624	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each (I.C.)
L7510 MS	Repair of prosthetic device, repair or replace minor parts (six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturer or supplier warranty) (I.C.) (for use only for the purchase of a cochlear implant service contract in accordance with 130 CMR 426.416.)
	Hearing Aid Dispensing Fees
V5160	Dispensing fee, binaural
V5200	Dispensing fee, CROS
V5240	Dispensing fee, BICROS
V5241	Dispensing fee, monaural hearing aid, any type (Must use with modifier **LT** or **RT**.)