Audiological Services

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This section contains information about audiological services and program coverage (*California Code of Regulations*, [CCR], Title 22, Section 51309). For additional help, refer to the audiological services billing example section in this manual.

Program Coverage

Medi-Cal covers audiological services only when ordered on the written referral of a physician. (CCR, Title 22, 51309 [a]).

Eligibility Requirements

Providers should verify the recipient's Medi-Cal eligibility for the month of service.

Medi-Services

A Medi-Service reservation is necessary for each outpatient audiological treatment visit provided by an independent practitioner. Visits to a Medi-Cal recipient in a nursing facility do not require a Medi-Service reservation; however, authorization is required.

Information about how to reserve a Medi-Service is contained in the following documents:

- If using the Automated Eligibility Verification System (AEVS), refer to the *AEVS: Transactions* section in the Part 1 manual.
- If using the Internet, refer to the *Medi-Cal Web Site Quick Start Guide*.

"Visit" Defined

"Visit" is defined as any covered audiological treatment procedure or combination of procedures performed on the same day.

"Date of Service" Defined

"Date of Service" is defined as the date that the hearing aid or service was ordered and applies to HCPCS codes V5000 thru V5299.

Recipients Under Age 21

Additional audiological treatment services for full-scope Medi-Cal recipients under 21 years of age are available through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services, subject to authorization, where medically necessary.

Per CCR, Title 22, Section 51013, Medi-Cal eligible recipients under 21 years of age with hearing loss are to be referred to California Children's Services (CCS) for case management and authorization of services. Medical eligibility for the CCS program for hearing loss is defined in CCR, Title 22, Section 41839. Refer to the *California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP)* section in the appropriate Part 2 manual for additional information.

Written Referral Requirements

Audiologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.

The Medi-Cal program definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. It is important that the referring practitioner supply the audiologist with the information required to document the medical necessity.

The following information must be included on the written referral:

- The signature of the referring practitioner
- Name, address and telephone number of the referring practitioner
- Date of the referral
- Medical condition necessitating the service(s) (diagnosis)
- A supplemental summary of the medical condition or functional limitations attached or included in the referral
- Specific services (for example, evaluation, treatments and modalities) requested
- Frequency of services
- Duration of medical necessity for services – specific dates and length of treatment should be identified if possible. Duration of therapy should be set by the referring practitioner; however, referrals are limited to six months.
- Anticipated outcome as a result of the treatment (goals)
- Date of progress review (when applicable)

Authorization

Treatment Authorization Requests (TARs) for audiological services for Medi-Cal-only recipients must be submitted to the TAR Processing Center.

Audiological services rendered in an outpatient setting are limited to a maximum of two services per month subject to the availability of Medi-Service reservations. Initial and six-month evaluations do not require authorization.

Certified Rehabilitation Centers and Nursing Facilities

The following information applies to audiological services rendered in a certified rehabilitation center or Nursing Facility (NF) Level A or B:

- The Medi-Service reservation limitation of two services per month does not apply.
- Initial and six-month evaluations do not require authorization.
- For billing instructions, refer to “Initial and Six-Month Evaluations” in this section.
- Authorization is required for any additional audiological treatment service beyond the initial and six-month evaluation.

Initial and Six-Month Evaluations

Initial and six-month evaluations billed with HCPCS code X4502 (audiology) require that the recipient be eligible for Medi-Cal during the month that the service is performed in a certified rehabilitation center, Skilled Nursing Facility (NF) Level A or B or pediatric subacute care facility on the written order of the attending physician.

Hearing Aid Evaluations

Providers may bill Medi-Cal for audiological procedure codes X4500 thru X4504, X4520, X4522, X4530, X4535, X4540 and X4544 without providing Medicare documentation if the procedures are part of a hearing aid evaluation for a Medicare eligible recipient. When billing for these procedures, providers must enter “hearing aid evaluation” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. Refer to the *Medicare Non-Covered Services: HCPCS Codes* section in the appropriate Medi-Cal Part 2 manual.

Unlisted Audiological Services

The following HCPCS codes should be used for "unlisted" audiological services.

HCPCS Code	Description
X4530	Impedance audiometry (bilateral)
X4540	Tympanometry
X4542	Electroacoustic analysis of hearing aid (performed with a binaural aid consisting of two monaural hearing aids)
X4544	Diagnostic evaluation for severely physically/mentally handicapped person over age 7

Pure Tone Audiometry

Diagnostic audiological evaluation (HCPCS code X4500) includes payment for pure tone audiometry (HCPCS code X4501). When a claim is submitted for code X4501 in addition to code X4500, reimbursement for code X4501 is denied.

Evoked Response Testing

Medi-Cal covers auditory, visual, and somatosensory evoked response testing.

Billing Procedure

To bill evoked response testing, audiologists must use the following HCPCS and CPT® codes:

Test	‹‹HCPCS Code(s)	CPT Code(s)››
Visual	X4520	95930
Auditory	X4522	‹‹92650 thru 92653››
Somatosensory	None	95925 thru 95927

If more than one evoked response test is performed on the same recipient for the same date of service, the second and subsequent tests will be reimbursed at a reduced amount. In addition, medical justification must be entered in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or submitted as an attachment. Additional claims without justification will be denied.

Electronystagmography

Electronystagmography (ENG) is a "By Report" procedure that may be billed by a licensed audiologist (upon written physician referral) or a physician. Medical justification for ENG must be entered in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment. (For physician billing, refer to the *Medicine: Otorhinolaryngologic Services* section in the appropriate Part 2 manual).

Tympanometry

Reimbursement for tympanometry performed by an audiologist (HCPCS code X4540) is limited to once every six months when billed by the same provider for the same recipient. This code is a Medi-Cal benefit only when performed as part of a comprehensive audiological evaluation.

Screening tympanometry performed as part of an initial or follow-up visit for detection of conditions such as otitis media, other middle ear disorders and/or hearing loss is not considered a comprehensive audiological evaluation and is not separately reimbursable. (For physician billing, refer to the *Medicine: Otorhinolaryngologic Services* section in the appropriate Part 2 manual).

Impedance Audiometry

Audiologists may bill for impedance audiometry with HCPCS code X4530 (bilateral). This code is reimbursable only when performed as part of a comprehensive audiological evaluation. Reimbursement for code X4530 is limited to once a month when billed by the same provider for the same recipient.

Cochlear Implantation (CI)

Cochlear implantation (CI) is reimbursable for recipients who meet specific criteria for medical necessity.

Implantation Criteria

CI candidates must meet all of the following criteria:

- Diagnosis of bilateral sensorineural deafness, established by audiologic and medical evaluation
- If recipient is a child, age appropriateness, as per current Food and Drug Administration (FDA) recommendations, up to age 20
- Post-lingual deafness (if recipient is 21 years or older)
- For post-lingual candidates, a score of less than 30 percent on an open-set sentence recognition test (tape-recorded speech comprehension) as well as indications of cognitive ability to use auditory cues.
- An accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by a CT scan or other appropriate radiologic evaluation
- No infection or other active disease of the middle ear
- No contraindications to anesthesia/surgery
- Cognitive ability to use auditory clues
- Motivation of candidate, and/or commitment of family/care-giver(s), to undergo a program of prosthetic fitting, training and long-term rehabilitation
- Realistic expectations of candidate, and/or family/caregiver(s), for post-implant educational/vocational rehabilitation, as appropriate
- Reasonable anticipation by treating providers that CI will confer awareness of speech at conversational levels

Authorization

TAR approvals are required for many of the services rendered by the various providers involved in the total CI program. Although the TARs are submitted to the TAR Processing Center, CI authorization for adults may be given by the San Francisco or Los Angeles Medi-Cal field offices. Requests for evaluation for the medical necessity of cochlear implants for Medi-Cal recipients under 21 years of age must be forwarded to the appropriate CCS program office.

Note: CI in the contralateral ear (that is, a second implant) is not a Medi-Cal benefit.

Billing for Physician Services

Physician services (surgeon and anesthesiologist) are billed “By Report” using CPT code 69930 (cochlear device implantation, with or without mastoidectomy).

Billing for CI Devices or Replacement Processors

When billing for a CI device/system (HCPCS code L8614) implanted on an outpatient basis or replacement external speech processor (code L8619), facilities must use their outpatient provider number and an outpatient claim format (UB-04) using facility type “14,” “24,” “34,” “44,” “54” or “64.” Cochlear implant devices are not separately reimbursable when provided as an inpatient service unless the cost of the devices has been specifically excluded from the facility’s negotiated per diem inpatient contract. When a facility has cochlear implantation devices specifically excluded from the per diem contract, the facility may use the outpatient code for billing the cost of the device. Physicians should not bill the Medi-Cal program for cochlear implantation devices that are implanted on an inpatient basis. Reimbursement for the device or the external speech processor will be made at invoice price unless a price was previously negotiated. Providers must attach a copy of the invoice for the CI device to the claim.

Billing for Post-Implantation Rehabilitation

Claims for procedures necessary to achieve optimal benefit from CI must be submitted under the “Unlisted By Report” HCPCS codes for audiology (X4535) or “Unlisted EPSDT Service” (Z5999). For continued authorization of post-implant aural rehabilitation language services, a treatment plan should be submitted for review or case management at approximately six-month intervals.

Note: A facility providing an allied health service is required to bill using a TAR Control Number separate from that used for physician services.

Minor Repairs, Replacement Batteries and Accessories

Audiology providers currently reimbursed for HCPCS “L” codes used for minor repairs (code L7510) or cochlear implant replacement parts and batteries, codes L8615 thru L8619, L8623, L8624, L8625 and L8627 thru L8629 for cochlear implants may also be reimbursed for codes L8621, L8622 and L9900 (orthotic and prosthetic supply, accessory and/or service component of another HCPCS “L” code). Claims submitted by specific audiology providers require a manufacturer invoice for payment. Documentation must accompany code L7510 indicating the repair is “not a limb prosthesis repair,” either in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) or as a separate report, when necessary.

Note: Claims submitted by DME providers require a catalog page.

Supplies

The following HCPCS codes for cochlear implant replacement supplies require authorization:

HCPCS Code	Description
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant or auditory osseointegrated device, replacement
L8619	Cochlear implant, external speech processor and controller, integrated system, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each
L8624	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each
L8627	Cochlear implant; external speech processor, component, replacement
L8628	Cochlear implant; external controller component, replacement
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another L code. (Specifically L9900 allows reimbursement for cochlear implant accessories such as ear hooks, ear bands, harnesses and magnets.)

Frequency Restrictions

The following HCPCS codes for cochlear implant replacement supplies have the following frequency restrictions:

HCPCS Code	Frequency Restriction
L8615	2 per year
L8616	2 per year
L8617	2 per year
L8618	8 per year
L8619	1 every 5 years
L8621	900 batteries per year
L8622	900 batteries per year
L8623	4 per year
L8624	4 per year
L8625	1 per year

In addition, the following guidelines apply when billing for these codes:

- Supplies needed beyond these limits may be authorized by a *Treatment Authorization Request*/Service Authorization Request (TAR/SAR).
- Frequency limitations are based on one unilateral cochlear implantation.
- Frequency will be controlled by the TAR/SAR.
- Modifiers LT or RT are required when billing for HCPCS code L8625.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.