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**NC Division of Medical Assistance  
Soft Band and Implantable Bone  
Conduction Hearing Aid External  
Parts Replacement and Repair**

**Medicaid and Health Choice  
Clinical Coverage Policy No: 13 B  
Amended Date: October 1, 2015**

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**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:  
1A-36, Bone-Anchored Hearing Aids

## **1.0 Description of the Procedure, Product, or Service**

The NC Medicaid (Medicaid) and NC Health Choice (NCHC) programs provide soft band bone conduction hearing aids (not implanted) and replacement or repair of external parts for both soft band and implantable bone conduction hearing aids, when there is medical necessity.

Replacement and repair of components of soft band and implantable bone conduction hearing aids are necessary to maintain the device's ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals.

Refer to **Attachment A, Claims-Related Information**, for a detailed list of procedure codes and descriptions. For information regarding BAHA surgery requirements and limitations, refer to clinical coverage policy 1A-36, *Bone-Anchored Hearing Aids*, on the Division of Medical Assistance's (DMA) Website at <http://www.ncdhhs.gov/dma/mp/>.

Refer to **Section 6.0** specific criteria regarding eligible providers who may bill for services under this clinical coverage policy.

### **1.1 Definitions**

None Apply.

## **2.0 Eligibility Requirements**

### **2.1 Provisions**

#### **2.1.1 General**

*(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. Medicaid  
None Apply.
- b. NCHC  
None Apply.

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

#### a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

**3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

**3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

**3.2 Specific Criteria Covered**

**3.2.1 Specific criteria covered by both Medicaid and NCHC**

New soft band bone conduction hearing aids and repair and replacement external parts for soft band and implantable bone conduction hearing aids are covered based on the medical necessity criteria found in this clinical coverage policy.

**3.2.2 New Soft Band Bone Conduction Hearing Aid**

The osseointegrated device, external sound processor, used without osseointegration (soft band device without surgically implanted components) is

covered when the beneficiary is a candidate for bone conduction hearing aid implant surgery and has not reached the age of 5 years or is under 21 years of age and is not an appropriate surgical candidate, whose moderate to severe, bilateral, conductive or mixed hearing loss cannot be effectively restored by conventional air conduction hearing aids or a conventional bone conduction hearing aid.

Prior approval is required for all new soft band bone conduction hearing aids and the beneficiary shall meet at least one of the following conditions as stated in the Clinical Coverage Policy 1A-36, *Bone-Anchored Hearing Aid*:

- a. One or more congenital or acquired abnormalities of the middle or external ear canal that precludes the wearing of a conventional air conduction hearing aid;
- b. One or more tumors of the external canal or tympanic cavity;
- c. Dermatitis of the external ear canal; or
- d. Chronic external otitis or otitis media with persistent discharge.

**And**

The beneficiary shall meet **all** of the following criteria:

- e. The beneficiary has a bone conduction pure-tone average of 40–50 decibels or better, with no single frequency poorer than 50 decibels (at 1000 and 2000 Hz); and
- f. The beneficiary has speech discrimination of the indicated ear of 60% or more at elevated sound pressure levels (SPL) during speech discrimination testing using consonant–nucleus–consonant [CNC] words (conventional testing) except when the beneficiary is too young to perform the speech discrimination testing;

**And**

All of the following conditions are met:

- g. The soft band bone conduction hearing aid being requested is approved by the Food and Drug Administration (FDA);
- h. The treating audiologist has obtained medical clearance from an otolaryngologist regarding the soft band bone conduction hearing aid and submits it to the provider;
- i. The treating audiologist has documentation that substantiates the need for a soft band bone conduction hearing aid and submits it to the provider; and  
Refer to **Subsection 5.3** for additional information regarding required documentation from the treating audiologist for new soft band bone conduction hearing aids.
- j. The component or service is furnished at a safe, efficacious, and cost-effective level.

Refer to **Subsection 5.1.1** for additional information regarding prior approval for new soft band bone conduction hearing aids.

### **3.2.3 External Parts Replacement and Repair for Soft Band and Implantable Bone Conduction Hearing Aids – Out of Warranty**

Soft band and implantable bone conduction hearing aid external parts replacement and repair that are not covered under warranty are covered when **all** of the following conditions are met:

- a. The beneficiary is approved for and is currently wearing a soft band bone conduction hearing aid prior to turning 21 years of age **or** is 5 years of age or older and implanted;
- b. The soft band bone conduction hearing aid being repaired is approved by the FDA **or** the implantable bone conduction hearing aid being repaired is approved by the FDA and meets all standards of coverage under Clinical Coverage Policy 1A-36, *Bone-Anchored Hearing Aids*;
- c. The device is in continuous use and still meets the needs of the beneficiary;
- d. Replacement or repair is necessary to allow the device to be functional;
- e. The treating audiologist has obtained medical clearance from an otolaryngologist regarding the soft band bone conduction hearing aid and submitted it to the provider **or** has obtained a physician's prescription with complete information regarding the implant system and surgery date(s) and submitted it to the provider;
- f. The treating audiologist has documentation that substantiates the need for the replacement or repair of part(s) and submitted it to the provider;  
Refer to **Subsection 5.4** for specific criteria regarding required documentation from the treating audiologist.
- g. The component or service is furnished at a safe, efficacious, and cost-effective level; **and**
- h. Additionally, all replacement sound processors, except for those covered under warranty, require prior approval.  
Refer to **Subsection 5.1.2** for additional information regarding prior approval criteria for replacement sound processors.

### 3.2.4 Sound Processor Upgrades for Soft Band and Implantable Bone Conduction Hearing Aids

Upgrades of existing sound processors for next-generation sound processors require prior approval and are considered medically necessary only when

- a. the beneficiary's response to the existing sound processor is inadequate to the point of interfering with the activities of daily living; or
- b. the sound processor is no longer functional and cannot be replaced with the same model.

**And**

Are covered only when **all** of the following criteria are met:

- c. The beneficiary is approved for and is currently wearing a soft band bone conduction hearing aid prior to turning 21 years of age **or** is 5 years of age or older and implanted;
- d. The soft band bone conduction hearing aid sound processor upgrade is approved by the FDA **or** the implantable bone conduction hearing aid sound processor upgrade is approved by the FDA and meets all standards of coverage under Clinical Coverage Policy 1A-36, *Bone-Anchored Hearing Aids*;
- e. The device is in continuous use and still meets the needs of the beneficiary;
- f. The treating audiologist has obtained medical clearance from an otolaryngologist regarding the soft band bone conduction hearing aid and submitted it to the provider **or** has obtained a physician's prescription with

complete information regarding the implant system and surgery date(s) and submitted it to the provider;

- g. The treating audiologist has documentation that substantiates the medical necessity for the sound processor upgrade and submits it to the provider; and Refer to **Subsection 5.5** for information regarding required documentation from the treating audiologist for sound processor upgrades.
- h. The component or service is furnished at a safe, efficacious, and cost-effective level.

Refer to **Subsection 5.1.3** for additional information regarding criteria for replacement sound processors.

**Note:** Upgrades to existing, functioning, replaceable sound processors to achieve aesthetic improvement are not medically necessary and will not be covered.

### **3.2.5 Medicaid Additional Criteria Covered**

None Apply.

### **3.2.6 NCHC Additional Criteria Covered**

None Apply.

## **4.0 When the Procedure, Product, or Service Is Not Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### **4.2 Specific Criteria Not Covered**

#### **4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

Soft band and implantable bone conduction hearing aid external parts replacement and repair are not covered under this policy when:

- a. the request for a sound processor, battery replacement, or repair is for spare or back-up equipment for use in emergencies;
- b. the request for a soft band bone conduction hearing aid is for unilateral sensorineural hearing loss (single sided deafness);
- c. the component or service is for a resident of a nursing facility; or
- d. the component or service is covered by another agency.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

### **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

#### **5.1 Prior Approval**

Providers shall obtain prior approval for all new soft band bone conduction hearing aids and replacement and repair for all sound processors that are not covered under warranty.

##### **5.1.1 Prior Approval for a New Soft Band Bone Conduction Hearing Aid**

When the request is for a new soft band bone conduction hearing aid, the provider shall obtain prior approval from DMA. The provider shall obtain prior approval at <http://www.nctracks.nc.gov>. The provider shall submit an electronic prior approval request with a copy of the medical clearance from an otolaryngologist, a letter of medical necessity from the treating audiologist, an audiology report to include audiogram, evaluation, speech and sound tests, history of hearing aid use, future surgery information, and documentation substantiating that hearing loss cannot be effectively restored by conventional air conduction or conventional bone conduction hearing aids. Consideration will be given to the request and a decision will be returned to the provider. Beneficiaries will be notified in writing if the request is denied.

Refer to **Subsection 5.3** for additional information regarding documentation requirements for new soft band bone conduction hearing aids.

##### **5.1.2 Prior Approval for Identical Replacement Sound Processor—Out of Warranty**

When the requested replacement sound processor is identical to the existing sound processor, the provider shall obtain prior approval from DMA. The provider shall obtain prior approval at <http://www.nctracks.nc.gov>. The provider shall submit an electronic prior approval request with a copy of the medical clearance from the otolaryngologist regarding the soft band bone conduction hearing aid **or** a copy of the prescribing physician’s original prescription with surgery for the implanted device, and a letter of medical necessity from the

treating audiologist. Consideration will be given to the request and a decision will be returned to the provider. Beneficiaries will be notified in writing if the request is denied.

Refer to **Subsection 5.4** for additional information regarding documentation requirements for out of warranty sound processor replacement.

### **5.1.3 Prior Approval for Replacement Sound Processor—Upgrade**

When the requested replacement sound processor is an upgrade, the provider shall obtain prior approval from DMA. The provider shall obtain prior approval at <http://www.nctracks.nc.gov>. The provider shall submit an electronic prior approval request and shall include documentation that the sound processor is no longer functional and cannot be replaced with the same model or documentation which substantiates that the beneficiary's response to the existing sound processor is inadequate to the point of interfering with the activities of daily living. The provider shall include a copy of the medical clearance from the otolaryngologist regarding the soft band bone conduction hearing aid **or** a copy of the prescribing physician's original prescription with surgery information for implanted device, a letter of medical necessity from the treating audiologist, and the treating audiologist's documentation supporting the medical necessity for the upgrade with the prior approval request.

Consideration will be given to the request and a decision will be returned to the provider. Beneficiaries will be notified in writing if the request is denied.

Refer to **Subsection 5.5** for additional information regarding specific documentation requirements for sound processor upgrades.

### **5.1.4 Prior Approval for Identical Replacement Sound Processors—Under Warranty**

When the requested replacement sound processor is identical to the existing sound processor and the existing sound processor is under warranty, prior approval is not required.

## **5.2 Prior Approval Requirements**

### **5.2.1 General**

(DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

### **5.2.2 Specific**

None Apply.

## **5.3 Documentation of Medical Necessity for New Soft Band Bone Conduction Hearing Aid**

For every new soft band bone conduction hearing aid, the provider shall keep the following on file from the treating audiologist:

### **5.3.1 Audiologist's Letter**

The provider shall keep on file a letter signed by the treating audiologist and shall ensure that this letter includes the following:

- a. Audiologist's name, business name, address, and telephone number;
- b. Beneficiary's name and Medicaid identification number;
- c. Verification that the soft band bone conduction hearing aid is FDA approved and currently being used in a functional manner by the beneficiary; and
- d. Specific information regarding the medical necessity for the beneficiary.

### **5.3.2 Additional Documentation**

The provider shall keep on file the following additional documentation obtained from the treating audiologist:

- a. Medical clearance from an otolaryngologist;
- b. Audiology report to include audiogram, sound field audiogram, speech perception test, sound awareness test, speech awareness test, and history of hearing aid use;
- c. Documentation that includes information regarding future bone conduction hearing aid surgery or inappropriateness of candidate for surgical implant; and
- d. Documentation that supports that hearing loss cannot be effectively restored by conventional air conduction or bone conduction hearing aids.

Refer to **Subsection 3.2.1** for additional information regarding specific beneficiary criteria for new soft band bone conduction hearing aids.

## **5.4 Documentation of Medical Necessity for External Parts Replacement and Repair – Out of Warranty**

For every soft band or implantable bone conduction hearing aid external parts replacement and repair that is no longer covered under warranty, the provider shall keep the following documentation on file:

### **5.4.1 Audiologist's Letter**

The provider shall keep on file a letter signed by the treating audiologist and shall ensure that this letter includes the following:

- a. Audiologist's name, business name, address, and telephone number;
- b. Beneficiary's name and Medicaid identification number;
- c. Original surgery date(s) if device is implanted;
- d. Verification that the soft band or implantable bone conduction hearing aid is FDA approved and currently being used in a functional manner by the beneficiary; and
- e. Specific information regarding the repair or replacement external parts, and quantity of external parts, that are medically necessary for the beneficiary.

### **5.4.2 Physician's Medical Clearance or Prescription**

Additionally, for soft band bone conduction hearing aids, a copy of the medical clearance from the otolaryngologists **or** for implantable bone conduction hearing aid systems, a copy of the physician's signed prescription with complete

information regarding the implanted system and surgery date(s) shall be kept on file with the provider.

## **5.5 Documentation of Medical Necessity for Replacement Sound Processor – Upgrade**

### **5.5.1 Audiologist’s Letter**

The provider shall keep on file a letter signed by the treating audiologist and shall ensure that this letter includes the following:

- a. Audiologist’s name, business name, address, and telephone number;
- b. Beneficiary’s name and Medicaid identification number;
- c. Original surgery date(s) if device is implanted;
- d. Verification that the soft band or implantable bone conduction hearing aid is FDA approved and currently being used in a functional manner by the beneficiary; and
- e. Specific information regarding the medical necessity of the upgrade, such as the current sound processor is no longer functional and cannot be replaced with the same model.

### **5.5.2 Physician’s Medical Clearance or Prescription**

Additionally, for soft band bone conduction hearing aids, a copy of the medical clearance from the otolaryngologists **or** for implantable bone conduction hearing aid systems, a copy of the physician’s signed prescription with complete information regarding the implanted system and surgery date(s) shall be kept on file with the provider.

### **5.5.3 Additional Documentation for Sound Processor Upgrade**

If the current sound processor is functional or can be replaced with the same model, the provider shall provide the following additional documentation that substantiates that the beneficiary’s response to the existing sound processor is inadequate to the point of interfering with the activities of daily living:

- a. Sound field audiogram, aided
- b. Speech perception test, aided
- c. Sound awareness test, aided
- d. Speech awareness test, aided

## **5.6 Replacing or Repairing External Parts - Under Warranty**

Replacement and repair are handled under any warranty coverage an item may have. No charge to Medicaid or NCHC is allowed for replacement and repairs covered under warranty, pick-up or delivery of the item, or the assembly of Medicaid-reimbursed parts.

## **5.7 Delivery of Service**

Providers shall dispense soft band and implantable bone conduction hearing aid external parts replacement and repairs as quickly as possible due to the medical necessity identified for an item.

**NOTE:** Providers who deliver an item requiring prior approval before approval has been received do so at their own risk.

Refer to **Subsection 5.1** for additional information regarding prior approval for services.

## 6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### 6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

### 6.2 Provider Certifications

None Apply.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

### 7.2 Medical Record Documentation

Depending upon the service being provided, the providers shall maintain some or all of the following documentation of their services:

- a. A copy of the medical clearance from an otolaryngologist regarding the soft band bone conduction hearing aid **or** a copy of the physician's signed prescription with complete information regarding the bone conduction implant system and surgery date(s);
- b. The signed letter documenting medical necessity from the treating audiologist;
- c. All tests, evaluations, and documentation submitted by the treating audiologist;
- d. A full description of all item(s) supplied to a beneficiary;
- e. The dates the items were supplied and to whom they were shipped; and
- f. A full description of any services or repairs, including details of external parts and labor, applicable warranty information, and the date of the service or repair.

The provider shall maintain all records and documentation through the life of the implant or for five years, whichever is greater and ten years for soft band bone conduction hearing aids. The provider shall furnish records and documentation upon request.

**Note:** The provider shall keep all beneficiary information, confidential including the beneficiary’s Medicaid or NCHC status, and share only with those who are authorized to receive it.

**7.3 Disclosing Ownership Information**

Providers shall disclose ownership and control information, and information about the owners or employees who have been convicted of criminal offenses against Medicare, Medicaid, and the Title XX services program.

**7.4 Seeking Other Sources of Payment**

The provider shall take all reasonable measures to determine the legal liabilities of third parties, including Medicare and private insurance, to pay for services. If third-party liability is established, providers shall bill the third party before billing Medicaid (10A NCAC 22J.0106).

**Note:** There is no third party payment for NCHC services. NCHC is the sole insurer and payor.

Refer to *NCTracks Provider Claims and Billing Assistance Guide*:  
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html> for additional information regarding Medicare crossover claims and third-party insurance.

**7.5 Accepting Payment**

Providers shall agree to accept Medicaid payment as payment in full (10A NCAC 22J.0106).

**8.0 Policy Implementation/Revision Information**

**Original Effective Date:** February 1, 2013

**Revision Information:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
02/01/2013	All sections and attachments	Promulgation of new coverage under NC Medicaid and NC Health Choice
07/01/2013	All sections and attachments	Changed “HP” to “CSC.” Updated websites and contact information. Updated Prior Approval instructions to match CSC technology.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

### Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Professional (CMS-1500/837P transaction)

**B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**C. Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code	Use When Billing For The Following Service(s)	Lifetime Expectancy
L8691	Replacement external sound processor for auditory osseointegrated device	Once every 5 years
L8692	Replacement body worn (headband or other means of external attachment) external sound processor for auditory osseointegrated device used without osseointegration	Once every 5 years
L8621	Replacement zinc air battery for use with cochlear implant device, each	N/A
L7510	Repair or replacement of minor prosthetic device parts	As necessary; requires invoice

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Medicaid and NCHC pay for services in specific units that measure the amount of service provided to the beneficiary.

For soft band and implantable bone conduction hearing aid external parts replacement and repair, the units of service are as follows:

1. Purchased Equipment: The unit of service is **1** for each item provided.
2. Service and Repair: The unit of service is **1** for each service or repair.

Refer to **Attachment B, Instructions for Completing Claims**, for additional information regarding units.

**F. Place of Service**

Beneficiary's home.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <http://www.ncdhhs.gov/dma/fee/>

Payment is calculated based on the lower of the provider's billed charge or the maximum amount allowed by Medicaid or NCHC.

## **Attachment B: Instructions for Completing Claims**

Refer to the following information for completing an electronic 857 or CMS-1500 claim form for DME/cochlear and auditory brainstem implant external parts replacement and repair.

### **A. Billing Instructions Specific to Soft Band and Implantable Bone Conduction Hearing Aids**

There are several fields or lines for listing services. Each field or line is called a “detail.” When completing these blocks, observe the following conventions:

1. Use one line for each HCPCS code billed on a given date.
2. If more than one unit of the same item is provided on one day, include all the items on the same line. For example, for 60 batteries provided on May 1, include 60 on one line. Enter 60 units in 24G for that date of service.
3. If multiple miscellaneous items are provided on the same day, enter L7510 on one line, enter one unit, and enter the total invoice cost of all the items. Do not bill each miscellaneous item separately.
4. Claims for L7510 do not require prior approval but shall include an invoice with the manufacturer’s item number for each miscellaneous item being billed.
5. Include only those dates of service on which the recipient is eligible for Medicaid or NCHC.

### **B. Instructions for Submitting Attachments Specific to Soft Band and Implantable Bone Conduction Hearing Aids Claims**

Required attachments for claims must be submitted in one of the following ways:

- Via the web at <http://www.nctracks.nc.gov>
- Fax to (919) 859-9703

## **Attachment C: Instructions for Prior Approval Request for Replacement Sound Processors**

Prior approval requests for replacement sound processors must be submitted electronically and must include required documentation.

### **A. Electronic Submission of Prior Approval Requests for Replacement Sound Processors**

Prior approval requests for replacement sound processors be submitted electronically at <http://www.nctracks.nc.gov>.

### **B. Submission of Prior Approval Required Documentation**

Providers shall submit required documentation as attachments through either:

- The web, at <http://www.nctracks.nc.gov>
- Fax to (919) 233-6845, ATTN: AI Parts

Refer to **Subsection 5.3, Prior Approval for Replacement Sound Processors**, for specific information regarding required documentation.