Clinical Policy: Hearing Aid Services In Members Under Age 21

Reference Number: WNC.CP.106 Coding Implications
Last Review Date: 02/2025 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This policy addresses covered and non-covered hearing aid services in members ages 20 years and younger.

WellCare of North Carolina provides coverage for **Hearing Aids In Adults Members Aged 21 And Older** as a value added benefit, please see Clinical Policy WNC.CP.276 Hearing Aid Services In Members Aged 21 years and older, at https://www.wellcarenc.com/providers/tools/clinical-guidelines.html

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that covered hearing aid products and services include:

- **A.** Covered hearing aid products and services include:
  1. Hearing Aids
     - a. In-the-Ear Hearing Aids
       - i. In-the-ear hearing aids are not appropriate for infants and young children as they are less adaptable to FM systems and are more likely to pose a danger (falls, hit or struck in the ear, etc.) resulting in damage to the ear and ear canal.
       - ii. Within standard audiology practice, children 12 years of age and older are considered for in-the-ear devices. Based on this standard, in-the-ear hearing aids may be approved for children 12 years of age and older if the prescribing physician or audiologist documents and verifies medical necessity with improved test results or audiograms.
       - iii. In-the-ear hearing aids cannot be requested or approved for cosmetic purposes only.
     - b. Analog and Digital Programmable Hearing Aids
       - i. Analog and digital programmable hearing aids may be approved based on medical necessity and the ability of the device to meet the Member's basic needs.
       - ii. The type of aid that is needed must be included in the prior approval request.

iii. Each request is reviewed on a case-by-case basis.

2. FM Systems
   a. The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three.
   b. For consideration of FM systems not covered through IDEA, providers shall submit documentation of medical necessity.
   c. Each request is reviewed on a case-by-case basis.
3. Care Kit
4. Batteries
5. Repairs
6. Cords, replacement tubes, retention straps, retention garments, harnesses, baby covers, "Huggies."
7. Custom ear molds
8. Dispensing fees

II. It is the policy of WellCare of North Carolina® that **non-covered** hearing aid products and services include*:

A. Non-covered hearing aid products and services include:
1. Battery charger or tester
2. Adapter for telephone, television, or radio
3. Shipping, handling, postage, or insurance fee
4. Loss and damage insurance
5. In-the-ear hearing aid that is requested for primarily cosmetic purpose
6. Extended warranty policy

*This list is not all inclusive.

Background[1]

The NC Medicaid (Medicaid) programs provide hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.
This policy does **not** address cochlear or auditory brainstem implant coverage. For eligible members with profound hearing impairment requiring cochlear or auditory brainstem implantation, refer to clinical coverage policy WNC.CP.112*, Cochlear and Auditory Brainstem Implants.*

I. **Limitations / Requirements** - The Member shall receive a medical examination from a physician (including Otologist, Otolaryngologist and Otorhinolaryngologist) and documentation of medical clearance for the initiation of the hearing aid selection process. Providers who are eligible to dispense hearing aids and related items shall be a Doctor of Audiology licensed by the state of North Carolina as an audiologist or an individual licensed by the state of North Carolina as a hearing aid dealer and fitter. Facility providers

shall also enroll as an individual Doctor of Audiology providers or hearing aid dealer and fitter providers.

A. Initial Evaluation

1. The Member shall receive a hearing evaluation by a licensed audiologist, including an audiogram.

B. Trial Period

The Member shall be given a **30 calendar-day trial period** for hearing aids and hearing aid accessories prior to the post-dispensing evaluation. Post-Dispensing Evaluation

1. If the hearing aid and related items are acceptable to both the provider and the Member or guardian, the provider shall submit documentation to WellCare of NC to indicate the hearing aid and related items are acceptable, and that documentation must include the signature of the Member or guardian and the provider.
2. If the dispensed aid and related items are not acceptable to the provider or the Member or guardian, the provider shall contact WellCare of NC's Hearing Vendor to void the previously approved request and submit a request for the more appropriate hearing aid.
3. If the Member evaluation cannot be done within 30 calendar days after the aids a dispensed, the provider shall document in the medical record the dates of attempts to contact the Member and the reason there was no follow-up (no transportation, broken appointments, lack of cooperation by parent, etc.).

C. Mandatory Services Included in a New Hearing Aid Dispense - The following services are included in a new hearing aid dispense:

1. The Member shall receive delivery and fitting of the new hearing aid or aids, FM system, custom ear molds, other approved accessories and a one-month supply of batteries.
2. The recipient shall receive instructions and counseling on the use and care of the hearing aid or aids and accessories.
3. The recipient shall receive service and regular maintenance as recommended by the manufacturer for a period of at least one year from the date of dispensing at no extra cost to the hearing aid provider, recipient, or plan.

D. Hearing Aid Accessories

1. Care Kit
    a. An initial care kit is covered as a separate accessory, to include a stethoscope, forced air blower, and dry aid kit. Providers shall give the recipient or guardian instructions on the use and care of the instruments. If an additional care kit, or any component of the care kit, is needed providers shall submit a request that outlines the following:
        i. The circumstances surrounding the loss or damage of the kit/component,
        ii. Steps that have been taken to recover the kit/component.
2. Dry and Store Kit

a. Dry and Store Kits may be requested for members with moisture special needs. Providers shall submit a request with documentation of medical necessity. Each request is reviewed on a case-by-case basis.

3. Ear Molds
   a. Providers shall submit a request for all ear molds.
4. Batteries
   a. Up to six claims for batteries ($35.00 maximum per claim) per year do not require approval.
   b. If additional batteries are needed, providers shall submit a request with documentation of medical necessity. Each request is reviewed on a case-by-case basis.
5. Miscellaneous Accessories
   a. Cords, replacement tubes, retention straps, retention garments, baby covers, harnesses, and "Huggies" are covered accessories and the providers shall submit a request for these accessories. Other accessories are evaluated on a case-by-case basis.

E. Manufacturer Repairs

1. Approval is required for all hearing aid repairs, or dispensing fees for repairs billed to the plan.
2. Providers shall record an explanation of the necessary manufacturer or factory repair with the request.
3. All manufacturer or factory repairs must be covered under warranty for six months following the repair.

F. Replacement Aids

1. Approval specialists carefully review all requests and approval is granted or denied based on the responsibility in the loss or damage, extenuating circumstances, frequency of other replacements, medical necessity, etc. Improper care or negligence does not constitute extenuating circumstances.
2. The following documentation guidelines apply when requesting replacement hearing aids:
   a. Medicaid members needing replacement hearing aids because they were lost or damaged shall obtain a letter from a case manager or eligibility worker at the local DSS office. The letter should explain:
      i. The circumstances surrounding the loss or damage of the aid;
      ii. Steps that have been taken to recover the aid; **and**
      iii. The DSS recommendation for replacement.

      A copy of the letter must accompany the request.
   b. Medicaid members receiving Social Security Income (SSI) or who are legally adopted are not required to obtain a letter from a DSS case manager or eligibility worker. Instead, providers shall note on the request that the recipient receives SSI or is legally adopted.

G. Previous Hearing Aids

1. Hearing aids are the property of the State of North Carolina. Providers may collect the previous Medicaid hearing aids when dispensing the new hearing aids

for a recipient. The collected hearing aids may be used in the provider's office as loaner hearing aids.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description
V5014	Repair or modify hearing aid
V5050	Any newly fit monaural hearing aid
V5060	Any replacement hearing aid
V5090	Dispensing new monaural hearing aid
V5110	Dispensing new binaural hearing aids
V5130	All newly fit binaural hearing aids
V5160	Dispensing assistive listening/FM system
V5240	Dispensing hearing aid repair
V5241	Dispensing hearing aid replacement
V5264	Ear molds
V5266	Battery (bill one unit per claim)
V5267	Supplies and accessories
V5274	FM system only
V5299	Dispensing accessories and ear molds

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	01/21	05/21
Reviewed HCPCS codes.	02/22	05/22
Annual Review. HCPCS codes reviewed.	11/22	02/23
Policy name changed to "Hearing Aid Services in Members Under Age 21". NCHC verbiage removed from NC Guidance Verbiage and throughout policy.	05/23	05/23
Annual Review. ICD-10-CM code table removed.	02/24	02/24
Annual Review. CPT code box removed. Removed "Medicaid and health choice' verbiage from References.	02/25	02/25

References
State of North Carolina Medicaid Clinical Coverage Policy No: 7 Hearing Aid Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published April 1, 2023. Accessed December 5, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid 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.

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.

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: https://medicaid.ncdhhs.gov/

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 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.

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 NC Medicaid'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).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)
Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

b. International Classification of Diseases and Related Health Problems, 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.
   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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.