



State of California-Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGER
Governor

June 13, 2005

N.L.: 12-0605
Index: Benefits

TO: ALL CALIFORNIA CHILDREN'S SERVICES (CCS) ADMINISTRATORS,
MEDICAL CONSULTANTS, STATE CHILDREN'S MEDICAL SERVICES
(CMS) BRANCH AND REGIONAL OFFICE STAFF

SUBJECT: DELEGATION OF AUTHORITY FOR AUTHORIZATION OF HEARING
AIDS PREVIOUSLY REVIEWED AS "NON-CONVENTIONAL HEARING
AIDS" TO COUNTY CCS PROGRAMS AND CMS REGIONAL OFFICES.

PURPOSE

The purpose of this Numbered Letter (NL) is to provide policy for CCS Independent County programs, CMS Regional Offices, and CCS Dependent County programs participating in Level III of the Case Management Improvement Project (CMIP) for authorization of hearing aids that are not Medi-Cal benefits. The services require authorization as Early and Periodic Screening Diagnosis and Treatment Supplemental Services (EPSDT SS) for children enrolled in the CCS program who are full scope, no share of cost, Medi-Cal beneficiaries. These services also require separate authorization as CCS services for CCS/Healthy Families (HF) and CCS only clients.

BACKGROUND

Hearing aids are a benefit for CCS clients regardless of payer source. The changes that the Medi-Cal program adopted in 1994 that allow the program to cover all medically necessary services to treat any disease or condition for individuals under 21 years of age, allowed for reimbursement through the Medi-Cal program for hearing aids that are beyond the scope of Medi-Cal benefits. In November 2000, a new state-only Healthcare Common Procedure Code System (HCPCS) code was introduced which allows providers to bill a range of hearing aids when authorized as an EPSDT SS by CCS.

In October 2003, Medi-Cal made digital and programmable analog hearing aids a regular benefit of the Medi-Cal program and provided an interim HCPCS code for billing. Due to budgetary constraints, the reimbursement for these hearing aids is subject to the pricing limitations contained in Title 22, California Code of Regulations, Section 51517. Many of the hearing aids that are medically necessary for CCS-eligible children with a hearing loss have features, such as directional microphones and expanded programming flexibility, that are not found in the hearing aids reimbursed within the pricing limitations of Section 51517 and listed in the Medi-Cal Allied Health Manual.

POLICY

- A. Effective the date of this letter, when documentation of medical necessity is provided, CCS program staff as listed above, shall authorize all hearing aids requested by a CCS approved Communications Disorder Center (CDC) and prescribed for a CCS client's hearing loss, including those that are beyond the scope of Medi-Cal benefits.
- B. Hearing aids that are beyond the scope of Medi-Cal benefits must be authorized as EPSDT SS for full-scope, no share of cost Medi-Cal beneficiaries.

IMPLEMENTATION

The CCS program case management staff shall:

- A. Review the client's case and submitted documentation as follows:
 - 1. The "Request for Hearing Aids and Assistive Listening Devices" attached within this letter to verify:
 - a. The degree of hearing loss continues to meet CCS program eligibility for treatment services.
 - b. The documentation as to the need for the requested amplification method.
 - c. Medical clearance has been obtained from a CCS-approved otolaryngologist. (If a child, 16 years of age or older, does not have access to an approved ENT in his/her community, medical clearance may be provided by a pediatrician or primary care physician.)

- d. The presence of a denial letter from a commercial HMO stating that hearing aids are not a benefit of the child's coverage, if the CCS client/applicant has commercial HMO coverage.
- e. Medical clearance for the provision of a hearing aid may be provided by a non-CCS paneled, board certified ENT participating in the provider network of the child's HMO.

B. Issuance of authorizations

1. The authorization shall be issued to the Medi-Cal Provider number of the CDC, the CCS approved audiologist or the hearing aid dispenser. The authorization must not be issued to the CDC's Special Care Center number.
2. The authorization for hearing aids that are not regular Medi-Cal benefits, shall be issued as EPSDT SS, using HCPCS service code Z5946 with the appropriate modifier and the number of units, for those CCS clients with full-scope, no share of cost, Medi-Cal.
 - "EPSDT SS" must be indicated on the SAR with the following special instructions selected from the drop-down menu.
 - "EPSDT-SS: Provider must submit claims for EPSDT Supplemental Services on a separate claim form from any other Medi-Cal benefit item/service. Include pricing attachment, if appropriate."
3. Authorizations for hearing aids that are not regular Medi-Cal benefits shall be issued using HCPCS service code Z5946 with the appropriate modifier and number of units CCS-only and CCS/HF. **Do not** indicate EPSDT SS on the SAR.
4. The following information must be included in the Special Instructions on the authorization.
 - a. The name of the manufacturer, model and type of hearing aid authorized and indication of the number of units authorized. (Example: Two Oticon Gaia Behind-The-Ear hearing aids).

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- b. An instruction to the audiologist or hearing aid dispenser to submit a copy of the patient specific invoice, along with the claim directly to Electronic Data Systems (EDS).

If you have questions regarding these policy changes, please contact the nurse consultant in your CMS Regional Office.

Original Signed by Marian Dalsey, M.D., M.P.H.

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Children's Medical Services Branch

DEPARTMENT OF HEALTH SERVICES
CHILDREN'S MEDICAL SERVICES BRANCH CALIFORNIA
CHILDREN'S SERVICES (CCS) PROGRAM

REQUEST For
Hearing Aids and Assistive Listening Devices

Date: _____ County: _____

Patient's Name: _____ DOB: _____

Requesting Audiologist's Name _____

Business Name _____

Location/Address _____

Telephone number _____ FAX _____

E-Mail Address _____

Signature and License # _____

Hearing aid dispenser (if other than above) _____

Business Name _____

Location/Address _____

Telephone number _____ FAX _____

Current amplification/system, if any _____ age of system _____

Serial Number/s _____

Type of hearing aid/device requested (FM, BTE, ITE, CIC etc.) _____

Fitting (circle one) Right Ear Left Ear Binaural

Manufacturer _____

Model _____

A current wholesale catalog page must be submitted with this request

The following MUST be enclosed with the request:

1. Audiologist's narrative report including etiology (if known), age of onset, other contributing diagnoses, educational placement, communication mode, prior treatment and treatment plan.
2. Current audiogram including air and bone thresholds, speech detection and reception thresholds, word recognition/discrimination scores, most comfortable and uncomfortable listening levels.
3. And/or results of other related diagnostic assessments including ABR, OAE, Tympanometry, CT scan, etc. (when available).
4. Aided results including, speech information and results of prescriptive measures.
5. Circumstances requiring the selection of the requested device.