

Audiology Services (age 21 and over)

Definition: Audiology Services are included in the ID/RD Waiver as an extension to the audiology services included in the State plan. In the State Plan, specified audiology services are only available to Medicaid beneficiaries who are under age 21. The ID/RD Waiver removes the age restriction, making the same audiology services available to those who are over age 21 and enrolled in the ID/RD Waiver. This service will not duplicate any services available to adults in the State Plan.

For evaluations, one unit equals one evaluation and one evaluation every twelve (12) months can be provided.

Providers: Providers of Audiology Services must be licensed and enrolled with the South Carolina Department of Health and Human Services (SCDHHS).

Arranging for and Authorizing Services: Once it is determined that a hearing evaluation or reevaluation is needed, you must update the plan to reflect the specific concerns and recommendation for the evaluation. The listing of enrolled providers must be shared with the participant or his/her family and assistance provided as needed in selecting a provider. This offering of choice must be documented.

The need for the evaluation or reevaluation must be added to the Waiver Tracking System under Audiology Evaluation (S33). Once approved, the evaluation or reevaluation can be authorized by the individual's Medicaid Card. The individual must present their Medicaid Card to the audiologist. This directs the provider to bill Medicaid (SCDHHS) for the evaluation or re-evaluation.

1. **Hearing Aids:** Hearing aids can be provided when the participant is likely to comply with the recommended use of the hearing aid (i.e. he/she will wear it consistently), the need is established through an audiology evaluation, and there is a physician's statement completed within the past six months indicating that there is no medical contraindication to the use of a hearing aid. Upon receiving a copy of the evaluation, if the participant needs a hearing aid or aids, the plan should be updated to include the need for the hearing aid or aids. The Waiver Tracking System must be updated to reflect the cost of the hearing aid or aids. **The cost cannot exceed \$750.00/aid unless justification is provided from the audiologist and is approved by DHEC-CRS/SCDHHS.** The cost of the needed hearing aid or aids should be entered onto the Waiver Tracking System under Audiology Services (S25) and approved. You must assist the family as needed in obtaining a statement from the physician indicating that the use of a hearing aid is not contraindicated. This is called "Medical Clearance." Medical Clearance cannot be given more than six (6) months prior to requesting the hearing aid. The "**Medical Clearance**" (ID/RD Form M) should be used or a statement from the physician will suffice, but it must state that the use of a hearing aid is not contraindicated. In addition, the participant/legal guardian must sign the **Assignment of Benefits Allowing DHEC to Bill for Audiology Services Provided (ID/RD Form Z)**, which allows the Division of Children with Special Health Care Needs/South Carolina Department of Health and Environmental Control (CRS/DHEC) to bill SCDHHS for the services. Once the physician gives "Medical Clearance" it should be forwarded to DHEC/CRS (Division of Children with Special Health Care Needs; South Carolina Department of Health and Environmental Control; Box 101106; Columbia, SC 29211) along with the **Audiology/Hearing Aid Services Referral Form (ID/RD Form A-21)** and **Assignment of Benefits Allowing DHEC to Bill for Audiology Services Provided (ID/RD Form Z)**. CRS/DHEC will coordinate with the identified Audiologist to provide the hearing aid/aids.
2. **Ear Molds, Hearing Aid Repair, and/or Batteries:** Upon receiving a copy of the evaluation, if the participant needs ear molds, hearing aid repair, or batteries for their hearing aid (or if the participant requests batteries or repair), the plan should be updated to include the need. The cost of the needed ear

molds, hearing aid repair, or batteries should be entered onto the Waiver Tracking System under Audiology Services (S25) and approved. The cost for hearing aid repair cannot exceed \$250.00/aid. The cost of the molds cannot exceed \$77.00/mold. The cost of batteries varies depending on the size of the package. The cost used for batteries should be based on the price quote from the provider of choice. In addition, the participant/legal guardian must sign the **Assignment of Benefits Allowing DHEC to Bill for Audiology Services Provided (ID/RD Form Z)**, which allows the Division of Children with Special Health Care Needs/South Carolina Department of Health and Environmental Control (CRS/DHEC) to bill SCDHHS for the services. Once the request is approved, the **Audiology/Hearing Aid Services Referral Form (ID/RD Form A-21)** and **Assignment of Benefits Allowing DHEC to Bill for Audiology Services Provided (ID/RD Form Z)** should be forwarded to DHEC/CRS (Division of Children with Special Health Care Needs; South Carolina Department of Health and Environmental Control; Box 101106; Columbia, SC 29211). CRS/DHEC will coordinate with the identified Audiologist to provide the needed service or services. The Audiologist will contact the case manager for any follow-up appointments needed.

In addition to evaluation and re-evaluation and hearing aids, molds, repairs, and batteries, all of the services that are available to children through the State Plan can be covered through the waiver (Provider direct bills Medicaid). See the Hearing Program Fee Schedule for the associated fees.

<http://www.scdhec.gov/Health/ChildTeenHealth/ServicesforChildrenwithSpecialHealthCareNeeds/HearingProgram/>

The Waiver Tracking System must be updated to reflect the cost of needed audiology services under Audiology Services (S25) on the Waiver Tracking System using the above noted prices. Once the service is approved the **Authorization for Services (ID/RD Form A-31)** will be forwarded to the Audiologist. The **Authorization for Services (ID/RD Form A-31)** instructs the provider to bill Medicaid for these services. The Audiologist will contact the case manager for any follow-up appointments needed. The case manager/early interventionist must obtain all results from any of the above services that are utilized by the participant.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the participant's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Audiology Services:

- Within two weeks of completion or notification of service by participant

This service may be monitored during a contact with the individual/family or service provider. It must also involve a review of the evaluation. Some items to consider during monitoring includes:

- What are the recommendations from the evaluation?
- If hearing aides, etc., are being recommended, is the person's hearing expected to increase or are the recommendations aimed at maintenance activities?

Audiology Services (i.e. Hearing Aids)

- If a hearing aid is provided, you must see the participant with the hearing aid in his/her possession (within 2-3 weeks) after receipt.
- If other service provided, within two weeks of receipt of service

This service may be monitored during a contact with the individual/family or service provider. Some items to consider during monitoring includes:

- If hearing aides are provided, how are they working? Is the individual having difficulty using them or caring for them?
- Have the hearing aides improved their hearing?
- Do the ear molds fit comfortably?
- If a repair is made, is it complete and satisfactory for the individual?
- Was the provider of service professional and helpful?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the participant or his/her legal guardian **including the details** regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s).

NOTE: See Chapter 9 for specific details and procedures regarding written notification and the appeals process.

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS ID/RD WAIVER
AUDIOLOGY/HEARING AID SERVICES REFERRAL FORM
AUTHORIZATION FOR SERVICES**

AUDIOLOGIST: _____

ADDRESS: _____

RE: _____

Participant's Name

/

Date of Birth

Address

Medicaid #: / / / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the costs indicated may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / / / / /

Hearing Aid Related Audiology Services:

_____	Hearing Aid, In the Ear (V5050) () left ear () right ear	Cost_____	(up to \$750.00/each)
_____	Hearing Aid, Behind the Ear (V5060) () left ear () right ear	Cost_____	(up to \$750.00/each)
_____	Hearing Aid, Body Worn, Bone Conduction (V5040) () left ear () right ear	Cost_____	(up to \$750.00/each)
_____	Hearing Aid, Body Worn, Air Conduction (V5030) () left ear () right ear	Cost_____	(up to \$750.00/each)
_____	Repair of Hearing Aid (V5014) () left ear () right ear	Cost_____	(up to \$250.00/each)
_____	Batteries for Hearing Aid (V5266)	Cost_____	(up to \$80/month)
_____	Ear Mold (V5264) () left ear () right ear	Cost_____	(up to \$77.00/each)
_____	Tubing (V5014-000)	Cost_____	(up to \$5.00)
_____	Hearing Aid Accessories (V5267)	_____	_____

*Hearing Aids over \$750.00 require special justification from the audiologist and prior approval by CRS.

Case manager: Name / Address / Phone # (Please Print):

Case manager: After coordinating services with the Audiologist and budget approval, complete this form and send along with a copy of the Medical Clearance (if a hearing aid) and Assignment Benefits Statement to: Division of Children with Special Health Care Needs; South Carolina Department of Health and Environmental Control; Box 101106; Columbia, SC 29211

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER**

**AUTHORIZATION FOR AUDIOLOGY SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

TO: _____
Audiologist/Audiology Company

For: Participant's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Medicaid # _____

Prior Authorization # _____

You are hereby authorized to provide the following service(s). Please note: This nullifies any previous authorization to this provider for this service.

Service (code): Fee

- Pure Tone Audiometry (92552):** \$15.49
- Hearing Eval– comprehensive Audiometry Threshold evaluation & Speech Recognition (92557):** \$42.06
- Hearing Re-Evaluation (92557-52):** \$28.75
- Tympanometry/Impedance Testing (92567):** \$18.49
- Evoked otoacoustic emissions: limited (92587) :** \$53.08
- Evoked otoacoustic emissions: comprehensive Eval (92588) :** \$70.90
- Hearing Aid Exam & Selection – Monaural (92590):** \$49.00
- Hearing Aid Check – Monaural:** \$20.00
- Hearing Aid Re-Check - Monaural:** \$12.50
- Ear Impression (each) (V5275):** \$25.00
- Fitting/Orientation/Checking Hearing Aid (V5011):** \$35.00
- Dispensing (handling) Fee (V5090):** \$105.00

Case Management Provider: _____ **Case Manager Name:** _____

Address: _____

Phone # _____

Signature of Person Authorizing Services

Date

MEDICAL CLEARANCE

Name: _____
Address: _____ _____
Date of Birth: _____

Medicaid # / / / / / / / / / / /

The use of the hearing aid or aids is not contraindicated for the above named person.

Physician's Signature

Date

Physician's Printed Name

Name of Practice

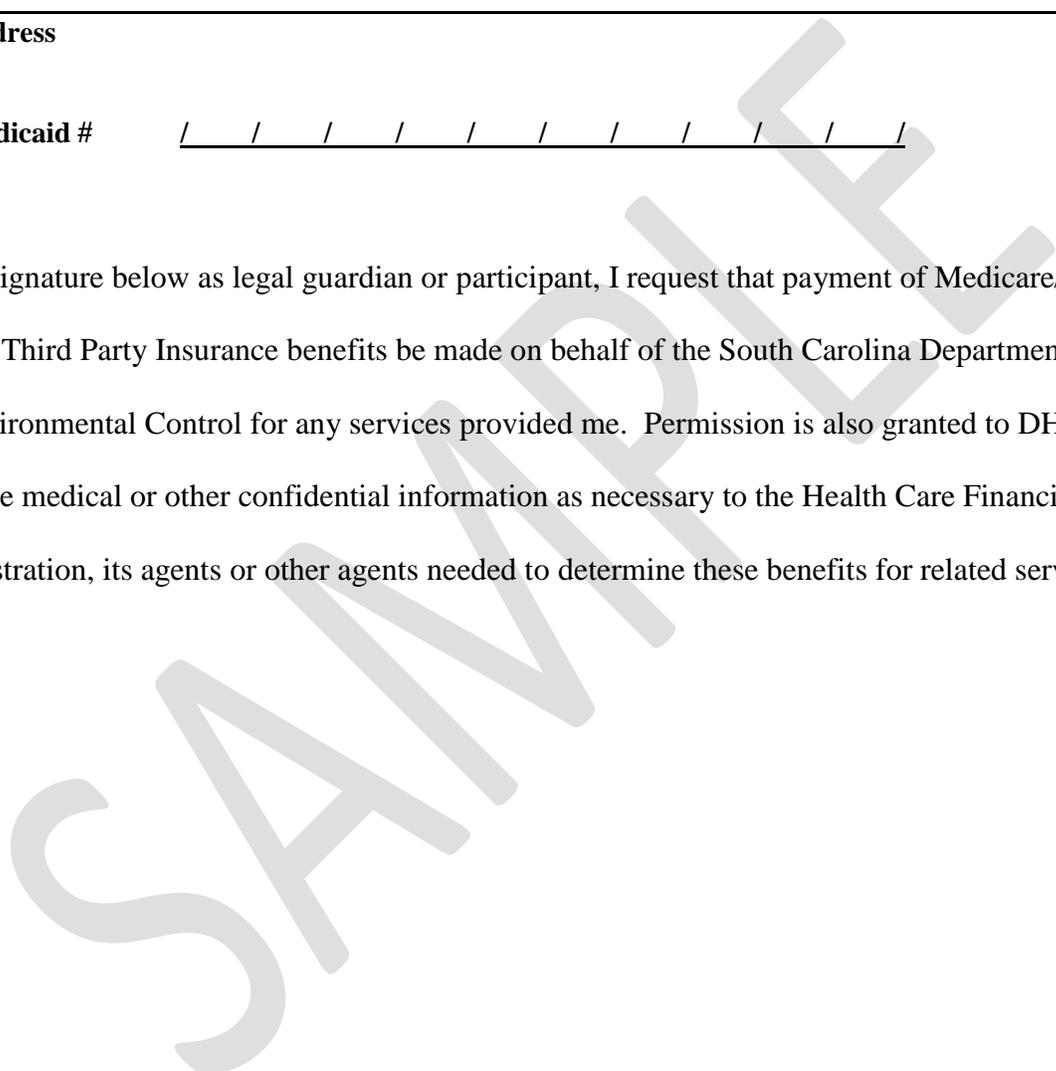
**ASSIGNMENT OF BENEFITS ALLOWING DHEC TO BILL FOR
AUDIOLOGY SERVICES PROVIDED**

RE: _____
Participant's Name / **Date of Birth**

Address

Medicaid # / / / / / / / / / / /

By my signature below as legal guardian or participant, I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for any services provided me. Permission is also granted to DHEC to exchange medical or other confidential information as necessary to the Health Care Financing Administration, its agents or other agents needed to determine these benefits for related services.



Participant / Legal Guardian Signature

Date