

Hearing services Applies to:



**Blue Cross
Blue Shield**
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Medicare Plus Blue PPOSM Medicare Plus Blue Group PPOSM Both

Hearing services

Hearing care involves the diagnosis and treatment of hearing loss. Hearing loss can be categorized by what part of the auditory system is damaged. There are three basic types of hearing loss: conductive, sensorineural and mixed.

Conductive hearing loss affects the outer or middle ear and causes a barrier to the sound waves that need to be passed to the inner ear. Most conductive losses aren't permanent and may be treatable with medication or surgery. Causes include total wax occlusion, otitis media (middle ear infection), perforation of the ear drum or otosclerosis (a disease in which the middle ear bones fuse and affect the vibrations needed to transmit sound to the inner ear).

Sensorineural hearing loss is caused by damage to the inner ear affecting the tiny outer and inner hair cells. The disruption results in poor transmission of the messages sent to the brain for interpretation of sound. Some causes include noise damage, presbycusis (age-related loss), viral inner ear infections or the use of ototoxic medication (medicine that is harmful to the ear). Sensorineural hearing loss is permanent. The best way to address it is by the fitting of hearing aids for sound stimulation.

Mixed hearing loss is a combination of conductive and sensorineural hearing loss.

Original Medicare

According to the Code of Federal Regulations and the Centers for Medicare and Medicaid Services guidelines, hearing aids or examinations for the purpose of prescribing, fitting, or changing hearing aids are excluded from coverage under Original Medicare.

Certain devices that produce the perception of sound by replacing the functions of the middle ear, cochlea, or auditory nerve are payable by Medicare as prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or can't be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss, or surgery. The following are prosthetic devices:

- Cochlear implants
- Auditory brainstem implants
- Osseointegrated implants

Medicare Plus Blue PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross Blue Shield of Michigan to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for various procedures that fall into the generic category of routine hearing services under Medicare regulations is provided to members under select Medicare Plus Blue individual and Medicare Plus Blue Group PPO plans that include this benefit. Because Original Medicare doesn't cover these services, the scope of the benefit, reimbursement methodology, maximum payment amounts, and the member's cost sharing are determined by Blue Cross for individual coverage, and by the group for those with group-based coverage.

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Hearing providers may participate in the Medicare Plus Blue PPO network on an individual basis. Providers who participate in the Medicare Plus Blue PPO network are considered to be in-network.

Two levels of benefit options are available to both select individual and group Medicare Plus Blue PPO plans. These options are:

- Medical evaluation for the specific purpose of prescribing and fitting of a hearing aid
- Standard hearing aid coverage

Medical evaluation

For patients who've never had a hearing aid, a medical evaluation is required to determine the cause of the hearing loss and whether it can be improved with a hearing aid. This evaluation is covered under the base Medicare office visit benefit and member cost sharing applies consistent with that benefit.

The following additional hearing tests and exams (specifically excluded under Original Medicare) are covered under the medical evaluation component of the hearing services benefit option:

- An audiometric examination measures hearing ability. This exam includes tests for air and bone conduction, speech reception and discrimination, and must include a summary of exam findings.
- A hearing aid evaluation test determines what type of hearing aid should be prescribed to compensate for loss of hearing, based on the results of the audiometric exam.
- A conformity test is conducted to evaluate the performance of a hearing aid and its conformity to the original prescription after it has been fitted. This is a follow-up test by the otolaryngologist (physician specialist), audiologist, or hearing aid dealer who prescribed the hearing aid.

Standard hearing aid coverage

Hearing aids must be prescribed by a physician, audiologist, or hearing aid dealer based on the most recent audiometric examination and hearing aid evaluation test. Standard (analog or basic digital) hearing aids (as defined below in the conditions for payment section) are subject to a 36-month frequency limitation, per ear.

Standard hearing aid – five benefit allowance options

Effective January 1, 2019, the following hearing benefit allowance options are available to groups. This supplemental benefit offers a dollar allowance that will apply toward the cost of the standard hearing aids. For Medicare Plus Blue PPO individual plans with the hearing aid coverage option, the benefit allowance amount for standard (analog or basic digital) hearing aids is \$750 per ear – every three years (doesn't apply to Essential), from any provider (in- or out-of-network). Groups may select one of the following dollar amounts:

- \$500
- \$1,000
- \$1,500 (approximate value of monaural hearing benefit)
- \$2,000
- \$2,500 (approximate value of binaural hearing benefit)
- \$5,000 UA Local 190 Medicare Retiree Health and Welfare Fund only

These group benefit allowances apply regardless of the type or number of standard (analog or basic digital) hearing aids obtained from any provider (in- or out-of-network).

Excluded services

The following services are excluded from the Medicare Plus Blue enhanced Hearing Services benefit:

- Testing of different devices
- Drugs
- Medical treatment and evaluation that is appropriately covered under Medicare Parts A or B
- Replacement parts or spare hearing aids
- Examinations related to medical surgical procedures or hearing aid fittings

- Enhanced features on a digital hearing aid
- Hearing aids that don't carry FDA approval
- Unnecessary services not prescribed by the physician specialist, audiologist or hearing aid dealer
- Hearing aids ordered while the member has Medicare Plus Blue coverage, however, delivered more than 60 days after coverage ends

Conditions for payment

The table below specifies payment conditions for hearing services.

Conditions for payment	
Eligible provider	Primary care doctors (M.D. or D.O.), audiologist, hearing aid dealer
Payable location	No restrictions
Frequency	Once every 36 months (per ear) unless significant change in hearing loss (documentation required)
HCPCS Codes	S0618, V5010, V5020, V5030, V5040, V5050, V5060, V5070, V5080, V5100, V5120, V5130, V5140, V5150, V5171, V5172, V5181, V5190, V5211-V5215, V5221, V5230, V5242-V5261, V5299 State Health Plan MA only: V5008
Diagnosis restrictions	Restrictions
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue PPO's plan maximum payment amount to providers for all hearing services (i.e., tests, exams, and standard hearing aids) is available on our provider website, bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/enhanced-benefits.html in the MA enhanced benefits fee schedule.

Medicare Plus Blue's maximum defined benefit allowances for hearing aids are listed above in the Standard Hearing Aid Coverage section under the five benefit allowance options. The group's defined benefit allowance is based on a dollar amount chosen by the group. Total payment to the contracted provider for standard hearing aids must not exceed the Blue Cross allowed amount. The provider will be paid the lesser of the Medicare Plus Blue allowed payment amount, the group's defined benefit allowance amount, and the provider's charge, minus the member's cost share. This represents payment in full and providers aren't allowed to balance bill the member for the difference between the Medicare Plus Blue allowed amount and the provider's charge.

Contracted providers may bill the member for the difference between the group's defined benefit allowance amount and the Medicare Plus Blue allowed amount.

Exceptions:

1. If the provider's charge is less than the Medicare Plus Blue allowed amount and less than the group's defined benefit allowance amount, the provider must accept the Medicare Plus Blue paid amount as payment in full and may not bill the member.
2. If the provider's charge is less than the Medicare Plus Blue allowed amount but is more than the group's defined benefit allowance amount, the provider may bill the member the difference between the group's defined benefit allowance amount and the provider's charged amount.

The total payment to a contracted provider must not exceed the Medicare Plus Blue allowed amount. (See the Member cost sharing section below for examples.)

Member cost sharing

- Medicare Plus Blue members are liable for costs in excess of the group's defined benefit allowance amount up to the lesser of the Medicare Plus Blue allowed amount or the provider's charge.
- Medicare Plus Blue Group PPO providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat-dollar copayment, percentage coinsurance or deductible. Providers can only collect the appropriate Medicare Plus Blue cost-sharing amount from the member.

- For the individual Vitality product, the applicable copays are applied to the member’s combined maximum out-of-pocket amount.
- For the individual Signature and Assure products, the applicable copays aren’t applied to the member’s combined maximum out-of-pocket amount.
- For all individual products, the applicable copays don’t apply to the plan deductible.
- If the member elects to receive a non-covered service, he or she is responsible for the entire charge associated with the non-covered service.

Item	Examples			Exception #1	Exception #2
Group defined benefit allowance	\$2,000	\$2,000	\$1,000	\$2,000	\$1,000
Provider billed amount	\$3,000	\$3,000	\$3,000	\$1,500	\$1,500
Medicare Plus Blue total provider allowed amount	\$2,500	\$1,500	\$2,500	\$2,500	\$2,000
Provider paid amount	\$2,000	\$1,500	\$1,000	\$1,500	\$1,000
Member billed	\$500	\$0	\$1,500	\$0	\$500

To verify benefits and cost share, providers may utilize web-DENIS or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form or the 837-equivalent claim form.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your national provider identifier number on all claims.
5. Submit claims to your local Blue Cross plan.
6. Use electronic billing:
 - a. Michigan providers
Copies of the ANSI ASC X 12N 837 AMD 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at: <http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html>
 - b. Providers outside of Michigan should contact their local Blue Cross plan.

Revision history

Policy number: MAPPO 1009

Reviewed: 11/13/2019, 09/10/2019

Revised: 11/13/2019, 09/10/2019, 06/28/2018, 06/22/2017, 08/22/2016, 07/09/2015, 12/2004,

11/13/2019: Added new code V5008 to accommodate State Health Plan MA members only. Added a \$5,000 hearing aid allowance to UA Local 190 Medicare Retiree Health and Welfare Fund.

09/10/2019: Updated new hearing codes for 2019.

06/28/2018: Updated hearing aid allowance from \$500 per ear to \$750 per ear – every three years (doesn’t apply to Essential) to align with EOC.

06/22/2017: Clarified definition of ‘standard’ hearing aid to include analog or basic digital, added enhanced features to a digital hearing aid to the list of excluded services.

08/22/2016: Removed references to ICD-9 coding, defined in and out of network providers, added details of cost sharing applied to member deductible and maximum out-of-pocket responsibility for individual products.

07/09/2015: Updated formatting and billing instructions, added revision history section, clarified benefit levels and member cost-sharing content.