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 PPO℠ ☐ Medicare Plus Blue Group PPO℠ ☒ Both

Hearing services

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

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 are not permanent and may be treatable with medication or surgery. Some examples of causes of conductive loss are 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 of normal function of these cells results in poor transmission of the messages sent to the brain for interpretation of sound. Some causes of this type of loss include noise damage, presbyacusis (age–related loss), viral inner ear infections or the use of ototoxic medication (medicine that is harmful to the ear). This is a permanent kind of loss that is best addressed by the fitting of hearing aids for sound stimulation.

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

Original Medicare

According to the Code of Federal Regulations and 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 cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss or surgery. The following are prosthetic devices:

- cochlear implants
- auditory brainstem implants
- osseointegrated implants

Medicare Plus Blue

Medicare Plus Blue plans provide at least the same level of benefit coverage as Original Medicare (Parts A/B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM 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 is provided to members under select individual plans and standard Medicare Plus Blue Group PPO plans. Since Original Medicare does not cover these services, the scope of the benefit, reimbursement methodology, maximum payment amounts, and the member's cost–sharing are determined by the group.

Hearing providers choose to participate in the Medicare Plus Blue network on an individual basis — there is no hearing provider network.

Hearing services

- Diagnostic hearing exam
- Routine hearing test
- Fitting and evaluation for hearing aids

Medical evaluation (Optional benefit for select standard Medicare Plus Blue PPO Groups)

A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is required if the patient has never had 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 tests and exams are covered under the hearing services benefit:

- An audiometric examination, which measures hearing ability, and includes tests for air and bone conduction, speech reception and speech discrimination and must include a summary of exam findings.
- A hearing aid evaluation test which 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 which 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 otolaryngolist (physician specialist), audiologist, or hearing aid dealer who prescribed the hearing aid.

Hearing aid coverage (Optional benefit for select standard Medicare Plus Blue PPO Groups)

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. Hearing aids are subject to a 36 month frequency limitation.

Excluded services

The following services are excluded from the Medicare Plus Blue routine hearing services benefit:

- Testing of different devices
- Drugs
- Medical treatment – evaluation
- Replacement parts or spare hearing aids
- Examinations related to medical surgical procedures or hearing aid fittings
- Non–governmental approved hearing aids
- Unnecessary services not prescribed by the physician specialist, audiologist or hearing aid dealer
- Hearing aids ordered while the patient 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, audiologist, hearing aid dealer, M.D. or D.O.
Payable location	No restrictions
CPT codes	S0618, V5010, V5020-V5080, V5100, V5120-V5150, V5170-V5190, V5210-V5230, V5242-V5261, V5298-V5299
Frequency	• Once every 36 months unless significant change in hearing loss. (Documentation required)
Diagnosis restrictions	No restrictions
Age restrictions	

Reimbursement

Medicare Plus Blue plan's maximum amount for the hearing services (audiometry for hearing evaluation) benefit is available on our provider website, **bcbsm.com/provider/ma** in the MA enhanced benefit s fee schedule.

Medicare Plus Blue maximum allowed amounts for hearing aids are listed below. The maximum reimbursement amount is based on a dollar amount chosen by the group. The provider will be paid the lesser of the Medicare Plus Blue allowed amount, the group's maximum reimbursement amount or the provider's charge, minus the member's cost–share. This represents payment in full and providers are not allowed to balance bill the member for the difference between Medicare Plus Blue allowed amount and the provider's charge.

Contracted providers may balance bill the member for the difference between the group's maximum reimbursement amount and the lesser of the Medicare Plus Blue allowed amount and the provider's charge. Examples appear under the member cost–sharing section below. Non–contracted hearing aid providers may balance bill the member for the difference up to the provider's charge.

Hearing aid – five product options:

Effective January 1, 2013, hearing benefit allowances are available for members. This enhancement offers a dollar maximum that will apply toward the cost of the hearing aids. Standard 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)

These standard group reimbursement allowances apply regardless of the type or number of hearing aids obtained.

For Medicare Plus Blue PPO individual plans, the maximum reimbursement amount for hearing aids is $500 per ear. The three–year frequency limit applies, per ear.

Member cost–sharing

- Medicare Plus Blue members are liable for costs in excess of the group's maximum reimbursement amount up to the lesser of the Medicare Plus Blue allowed amount or the provider's charge.
- Medicare Plus Blue 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, a percentage coinsurance or a deductible. You can only collect the applicable Medicare Plus Blue cost–sharing amounts from the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

Example for a member with a group defined reimbursement maximum of $1000.00:

1. Provider billed amount $3000.00
2. MA allowed amount $2500.00
3. Provider paid amount (group defined reimbursement maximum) $1000.00
4. Provider may balance bill the member for $1500.00 (the difference between the group defined reimbursement maximum and MA allowed amount)

For detailed information about a Medicare Plus Blue member's benefits and cost–share, providers may verify member benefits via web–DENIS or call CAREN at 1–866–309–1719.

Billing instructions for members

1. Bill services on the CMS 1500 (8/05) claim form or the 837 equivalent claim.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/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 BCBS plan.
6. Use electronic billing:
   a. Michigan providers
      — A copy of the BCBSM EDI Professional 837/835 Companion Document is available at: ***bcbsm.com/pdf/systems_resources_prof_837_835.pdf***
   b. Providers outside of Michigan should contact their local BCBS plan.