DHS Oregon Department of Human Services

Division of Medical Assistance Programs

Speech-Language Pathology, Audiology and Hearing Aid Services Rulebook

Includes:

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2) Current Update Information (changes since last update)

3) Other Provider Resource Information

4) Complete set of Speech-Language Pathology, Audiology and Hearing Aid Services Administrative Rules

Speech-Language Pathology, Audiology and Hearing Aid Services Rulebook

Update Information

July 1, 2007

DMAP updated this Rulebook by amending administrative rule 410-129-0060.This amendment clarifies that the prescription for prior authorization of a hearing aid must specify the ICD-9CM diagnosis code.

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 129

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

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Other Provider Resources

DMAP has developed the following additional materials to help you bill accurately and receive timely payment for your services.

Supplemental Information

The Speech-Language Pathology, Audiology and Hearing Aid Services Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Billing instructions
- ✓ Third Party Resource codes
- ✓ Prior authorization and adjustment forms
- ✓ Prior authorization information
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the Hospital Services Supplemental Information booklet at:

http://www.dhs.state.or.us/policy/healthplan/guides/speech/main.html

Note: DMAP revises the supplement booklet throughout the year, without notice. Check the Web page regularly for changes to this document.

Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf

Other Resources

We have posted other helpful information, including provider announcements, at:

http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

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http://www.oregon.gov/DHS/govdelivery.shtml

410-129-0020 Therapy Goals/Outcome

(1) Therapy will be based on a prescribing practitioner's written order and a therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation.

(2) The therapy regimen will be taught to the patient, family, foster parents, and/or caregiver to assist in the achievement of the goals and objectives.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.060
1-1-07

410-129-0040 Maintenance

(1) Therapy becomes maintenance when any one of the following occur:

(a) The therapy treatment plan goals and objectives are reached; or

(b) There is no progress toward the therapy treatment plan goals and objectives; or

(c) The therapy treatment plan does not require the skills of a therapist; or

(d) The patient, family, foster parents, and/or caregiver have been taught and can carry out the therapy regimen and are responsible for the maintenance therapy.

(2) Therapy that becomes maintenance is not a covered service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-129-0060 Prescription Required

(1) The prescription is the written order by the prescribing practitioner pursuant to state law governing speech-pathology, audiology and hearing aid services. Prescription must specify the ICD-9-CM diagnosis code for all speech-pathology, audiology and hearing aid services that require payment/prior authorization.

(2) The provision of speech therapy services must be supported by a written order and a therapy treatment plan signed by the prescribing practitioner. A practitioner means a person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(3) A written order:

(a) Is required for the initial evaluation;

(b) For therapy, must specify the ICD-9-CM diagnosis code, service, amount and duration required.

(4) Written orders must be submitted with the payment (prior) authorization request and a copy must be on file in the provider's therapy record. The written order and the treatment plan must be reviewed and signed by the prescribing practitioner every six months.

(5) Authorization of payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate is an orthopedic specialist, chiropractor, gynecologist, etc.).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.096
7-1-07

410-129-0065 Licensing Requirements

(1) Speech Pathologists:

(a) ORS 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology Chapter 335, will govern the practice of licensed speech pathologists. Licensed speech pathologists may enroll as providers and be reimbursed for services;

(b) Services of graduate students in speech-language pathology, under supervision of a licensed Speech Pathologist during training or during the Clinical Fellowship Year are reimbursable to the licensed supervising speech pathologist. Graduate speech-language pathologists who are performing a clinical fellowship year need to hold a provisional license issued by the Oregon Board of Examiners in Speech Pathology and Audiology. ORS 681.325 "Issuance of Conditional License Scope of Practice and Renewal";

(c) Services of a licensed speech pathologist while teaching or supervising students in speech pathology will not be reimbursed;

(d) Services of a certified speech-language pathology assistant are reimbursable to the supervising licensed speech-language pathologist. Only covered services within the scope of duties of a certified speech-language pathologist assistant, as defined in OAR 335-095-0060, will be reimbursed.

(2) Audiologists. ORS 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology Chapter 335, will govern the practice of licensed audiologists. Licensed audiologists may enroll as providers and be reimbursed for services.

(3) Hearing Aid Dealers. ORS 694.015 through 694.199, Board of Hearing Aid Dealers licensing program Chapter 333 will govern the services by licensed hearing aid dealers. Licensed hearing aid dealers may enroll as providers and be reimbursed for services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 1-1-07

410-129-0070 Limitations

(1) The rules contained in OAR 410-129-0010 – 410-129-0080 and 410-129-0220 also apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. They do not apply to services provided to hospital inpatients. Billing and reimbursement for therapy services delivered by home health agencies and hospital outpatient departments is to be in accordance with the rules in their respective provider guides.

(2) Speech Pathology:

(a) All speech pathology services will be performed by a licensed speech pathologist or a graduate student in training or a graduate speech pathologist in the Clinical Fellowship Year being supervised by a licensed speech pathologist. Only therapy and evaluation services rendered on-site are billable under the codes listed in the Speech-Language Pathology, Audiology and Hearing Aid Services provider guide;

(b) Speech pathology therapy treatments may not exceed one hour per day, either group or individual. Treatment must be either group or individual, and cannot be combined in the authorization period;

(c) Therapy records must include:

(A) Documentation of each session;

(B) Therapy provided and amount of time spent; and

(C) Signature of the therapist.

(d) Documentation (progress notes, etc.) must be retained in the provider's records. All report and clinical notes by graduate students in training or graduate speech pathologists in the clinical fellowship year must be countersigned by the supervising licensed speech pathologist;

(e) Services of a graduate student in training or a graduate speech pathologist during the clinical fellowship year, under direct supervision of a licensed speech pathologist are reimbursable to the licensed supervisor under the following conditions:

(A) Supervision must occur on the same premises and the supervisor must be readily accessible to the resident performing the actual service;

(B) Strict supervision requirements adhering to the American Speech-Language-Hearing Association requirements must be followed, which includes a minimum amount of time the supervisor must be physically present during therapy and evaluation time. Therapy is 15 minutes per hour and evaluation time is 30 minutes per hour;

(C) Documentation of the supervisor must clearly indicate her/his level of involvement in the delivery of each service in order to assure quality of care to the client;

(D) Documentation by the graduate student in training or the Clinical Fellow must demonstrate to the satisfaction of the agency that services are medically appropriate in continuing the plan and treatment plan for the client in clear, legible notation.

(f) Services That Do Not Require Payment Authorization:

(A) Two Evaluations of Speech/Language will be reimbursed per calendar year;

(B) Two Evaluations for Dysphagia will be reimbursed per calendar year;

(C) One Evaluation for speech-generating/augmentative communication system or device will be reimbursed per recipient per calendar year;

(D) One Evaluation for voice prosthesis or artificial larynx will be reimbursed per calendar year;

(E) Purchase, repair or modification of electrolarynx;

(F) Supplies for speech therapy will be reimbursed up to two times per calendar year, not to exceed $5.00 each.

(g) Services That Require Payment Authorization:

(A) All speech pathology therapy treatments;

(B) Speech-generating/augmentative communication system or device, purchase or rental. Rental of a speech-generating/ augmentative communication system or device is limited to one month. All rental fees must be applied to the purchase price;

(C) Repair/modification of a speech-generating/augmentative communication system or device.

(h) Services Not Covered:

(A) Services of a licensed speech pathologist while teaching or supervising students of speech pathology will not be reimbursed;

(B) Maintenance therapy is not reimbursable as described in 410-129-0040.

(3) Audiology and Hearing Aid Dealer Services:

(a) All hearing services will be performed by licensed audiologists or hearing aid dealers;

(b) Reimbursement is limited to one (monaural) hearing aid every five years for adults who meet the following criteria: Loss of 45 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1000, 2000, and 3000 Hertz (Hz) in the better ear;

(c) Adults who meet the criteria above and, in addition, have vision correctable to no better than 20/200 in the better eye, may be authorized for two hearing aids for safety purposes. Submit a vision evaluation with the payment authorization request;

(d) Two (binaural) hearing aids will be reimbursed no more frequently than every three years for children who meet the following criteria:

(A) Pure tone average of 25dB for the frequencies of 500Hz, 1000Hz and 2000Hz; or

(B) High frequency average of 35dB for the frequencies of 3000Hz, 4000Hz and 6000Hz.

(e) An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear, or who cannot benefit from, a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a particular listening situation. It is restricted to a hand-held amplifier and headphones;

(f) Services That Do Not Require Payment Authorization:

(A) One basic audiologic assessment in a calendar year;

(B) One Basic comprehensive audiometry (audiologic evaluation) -- per calendar year;

(C) One Hearing aid evaluation/tests/selection -- per calendar year;

(D) One Electroacoustic evaluation for hearing aid; monaural – per calendar year;

(E) One Electroacoustic evaluation for hearing aid; binaural – per calendar year;

(F) Hearing aid batteries -- maximum of 60 individual batteries per 12 month period. Must meet the criteria for a hearing aid.

(g) Services That Require Payment Authorization:

(A) Hearing aids;

(B) Repair of hearing aids, including ear mold replacement;

(C) Hearing aid dispensing and fitting fees;

(D) Assistive listening devices;

(E) Cochlear implant batteries.

(h) Services Not Covered:

(A) FM systems -- vibro-tactile aids;

(B) Earplugs;

(C) Adjustment of hearing aids is included in the fitting and dispensing fee, and is not reimbursable separately;

(D) Aural rehabilitation therapy is included in the fitting and dispensing fee, and is not reimbursable separately;

(E) Tinnitis masker(s).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-129-0080 Prior Authorization of Payment

(1) Payment authorization (PA) is approval by Division of Medical Assistance Programs (DMAP), the Medically Fragile Children's Unit (MFCU), the Fee-For-Service (FFS) Medical Case Management (MCM) Contractor or the Managed Care Organizations (MCOs) for services that are medically appropriate.

(2) Payment authorization is required for speech-language pathology, audiology and hearing aid services as indicated in the Procedure Codes section of the DMAP Speech-Language Pathology, Audiology and Hearing Aid Services rules. For services requiring authorization from DMAP or MFCU, providers must contact DMAP or MFCU for authorization within five working days following initiation of services. Requests for payment authorization for speech-language pathology services and audiology and hearing aid services must be submitted on the appropriate DMAP 3071 form or reasonable facsimile. Authorization will be given based on medical appropriateness and appropriateness of the therapy given. Hearing aids and other devices must be authorized prior to delivery of any services. For services requiring payment authorization from the FFS Medical Case Management (MCM) Contractor, authorization must be obtained prior to the initiation of services. For FFS MCM clients, DMAP will not reimburse for a service that requires payment authorization if provided prior to receiving authorization from the Medical Case Management Contractor. It is the provider's responsibility to obtain a payment authorization.

(3) Services for clients identified on the DMAP Medical Care Identification as having a "DMAP Contracted Plan" will be authorized by the plan. Contact the Managed Care Organization to determine their procedures.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-129-0100 Medicare/Medicaid Claims

(1) When an individual, not in managed care, has both Medicare and Medicaid coverage, audiologists must bill audiometry and all diagnostic testings to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 (General Rules) for information on DMAP reimbursement. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

(2) Audiologists must bill all hearing aids and related services directly to DMAP on a DMAP 505. Payment authorization is required on most of these services. (See OARs 410-129-0240 and 410-129-0260)

(3) If Medicare transmits incorrect information to DMAP, or if an out-of-state Medicare carrier or intermediary was billed, providers must bill DMAP using a DMAP 505 form. If any payment is made by DMAP, an Adjustment Request must be submitted to correct payment, if necessary.

(4) Send all completed DMAP 505 forms to the Division of Medical Assistance Programs.

(5) Hearing Aid Dealers must bill all services directly to DMAP on a CMS-1500. Payment authorization is required on most services (See OARs 410-129-0240 and 410-129-0260).

(6) When a client, not in managed care, has both Medicare and Medicaid coverage, speech-language pathologists must bill services to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 (General Rules) for information on DMAP reimbursement. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-07

410-129-0180 Procedure Codes

(1) Procedure codes listed in the Speech-Language Pathology, Audiology and Hearing Aid Services Provider Guide are intended for use by licensed speech-language pathologists, licensed audiologists and certified hearing aid dealers.

(2) Physicians and nurse practitioners are subject to the administrative rules contained in the Division of Medical Assistance Programs (DMAP) Medical-Surgical Services Provider Guide and must bill DMAP using the processes and procedure codes identified in that Guide.

.Stat. Auth.: ORS 184.750, ORS 184.770, ORS 409.010 & ORS 409.110
Stats. Implemented: 414.065
1-1-07

410-129-0190 Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-07

410-129-0195 Standard Benefit Package

(1) Hearing aids, hearing aid repairs, and examinations and audiological diagnostic services only performed to determine the need for or the appropriate type of hearing aid(s) are not covered under the Standard Benefit Package.

(2) Diagnostic testing, including hearing and balance assessment services, performed by an audiologist is covered under the Standard Benefit Package when a physician orders testing to obtain information as part of the physician's diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. Audiological diagnostic services are not covered under the Standard Benefit Package when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for or the appropriate type of hearing aid.

(3) Speech-language pathology services are not covered under the Standard Benefit Package.

Stat. Authority: ORS Chapter 409

Stats. Implemented: 414.065

1-1-07

410-129-0200 Speech-Language Pathology Procedure Codes

(1) Inclusion of a CPT/HCPCS code in the following tables does not imply a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Speech Therapy Services codes: Table 200-1.

(3) Other Speech Services codes: Table 200-2.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 0200-1 Speech Therapy Services

92506	Evaluation of speech, language, voice, communication, and/or auditory processing—limited to two per calendar year
92526	Treatment of swallowing dysfunction and/or oral function for feeding- Requires payment authorization prior to provision of services
92507	Treatment of speech/language, voice, communication and/or auditory processing disorder; individual—requires payment authorization prior to provision of services
92508	Group, two or more individuals—requires payment authorization prior to provision of services
92610	Evaluation of oral and pharyngeal swallowing function -. Limited to two per calendar year
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording—limited to two per calendar year

Table 0200-2 Other Speech Services

92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Each additional 30 minutes (List separately in addition to code for primary procedure)
92609	Therapeutic services for the use of speech-generating device, including programming and modification
E2500	Speech Generating Device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time - requires payment authorization prior to the provision of services
E2502	Speech Generating Device, digitized speech, using prerecorded messages, greater than 8 minutes but less than 20 minutes - requires payment authorization prior to the provision of services
E2504	Speech Generating Device, digitized speech, using prerecorded messages, greater than 20 minutes but less than 40 minutes - requires payment authorization prior to the provision of services
E2506	Speech Generating Device, digitized speech, using prerecorded messages, greater than 40 minutes recording time - requires payment authorization prior to the provision of services
E2508	Speech Generating Device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device - requires payment authorization prior to the provision of services
E2510	Speech Generating Device, synthesized speech, permitting multiple methods of message formulation and multiple methods

	of device access - requires payment authorization prior to the provision of services
E2511	Speech Generating Software Program, for personal computer or personal digital assistant - requires payment authorization prior to the provision of services
E2512	Accessory for Speech Generating Device, mounting system - requires payment authorization prior to the provision of services
E2599	Accessory for Speech Generating Device, not otherwise classified - requires payment authorization prior to the provision of services
V5336	Repair/Modification of Augmentative Communication System or Device (excludes adaptive hearing aid) — requires payment authorization prior to provision of services
A4649	Supplies for speech therapy—Limited to two per calendar year, not to exceed $4.75 each
L8501	Tracheostomy Speaking Valve
L8500	Artificial larynx, any type
L7510	Repair of prosthetic device, repair or replace minor parts—requires payment authorization prior to provision of services
L7520	Repair prosthetic device, labor component, per 15 minutes—requires payment authorization prior to provision of services
L9900	Orthotic and prosthetic supply necessary and/or service component of another HCPCS L code
L8507	Tracheo-esophageal voice prosthesis, patient inserted, any type, each
L8509	Tracheo-esophageal voice prosthesis, inserted by a licensed health provider, any type

L8515	Gelatin capsule, application device for use with tracheoesphageal voice prosthesis, each
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
L8510	Voice amplifier- requires payment authorization prior to the provision of services

410-129-0220 Augmentative Communications System or Device

(1) The Division of Medical Assistance Programs (DMAP) will cover dedicated communication systems or devices and necessary attachments, (i.e. to bed or wheelchair).

(2) All requests for these systems, devices and necessary attachments will be reviewed for medical appropriateness.

(3) All required supporting documentation must be submitted prior to review. A form has been developed that outlines the necessary information required for review. A written narrative should be attached to provide a sufficient level of detail.

(4) If, in the opinion of DMAP, the clinical documentation furnished does not support the services requested, the request will be denied.

(5) Criteria: The following criteria must be met before any request for an augmentative communication system or device will be considered:

(a) A physician's statement of diagnosis and medical prognosis including the necessity to communicate medical needs must be submitted;

(b) A reliable and consistent motor response which can be used to communicate must be identified;

(c) As measured by standardized or observational tools, the individual must have the cognitive ability of:

(A) Object permanence -- ability to remember objects and realize they exist when they are not seen;

(B) Means end -- ability to anticipate events independent of those currently in progress. The ability to associate certain behaviors with actions that will follow.

(d) The client must be assessed by a team consisting of a Speech Pathologist and when appropriate an Occupational Therapist and/or Physical Therapist. Formal evaluation reports should be included;

(e) Devices evaluated must be documented with an explanation of why this particular device is best suited for this individual and why the device is the lowest level which will meet basic functional communication needs;

(f) There must be a documented trial of the selected device and a report on the success in using this device;

(g) A therapy treatment plan must be developed stating who will program the device, monitor and reevaluate the user on a periodic basis. Indicate the individual who will be responsible for carrying out the plan;

(h) Requests for Augmentative Communications Systems or Devices are sent to DMAP;

(i) A vendor's price quotation for the device must accompany each request including where the device is to be shipped;

(j) Submit with the request for authorization for an augmentative communication system or device:

(A) A formal augmentative communication assessment report -- required elements are listed on the reverse of the DMAP 3047 form;

(B) A physician's prescription of diagnosis and prognosis (not a prescription for an augmentative device).

(6) DMAP will reimburse for the lowest level of service that meets the medical need.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 1-1-07

410-129-0240 Audiologist and Hearing Aid Procedure Codes

(1) Inclusion of a CPT/HCPCS code on the following tables does not imply that a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Audiologist and Hearing Aid Procedure Codes: Table 0240-1.

(3) Special Otorhinolaryngologic Services codes: Table 0240-2. These codes only apply to services for cochlear implants. These services include medical diagnosis evaluation by the otology physician.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 129-0240-1 Audiologist and Hearing Aid Procedure Codes

92553 Pure tone audiometry, air and bone - limited to one per calendar year

92557 Comprehensive audiometry threshold evaluation and speech recognition

Includes pure tone, air and bone, and speech threshold and discrimination. Also includes testing necessary to determine feasibility of amplification

92590 Hearing aid examination and selection; monaural

May include sound field speech reception tests, speech discrimination tests, determination of appropriate style of hearing aid, and to determine if the ear should receive amplification

92591 Hearing aid examination and selection; binaural

May include sound field speech reception tests, speech discrimination tests, determination of appropriate style of hearing aid, and which ear should receive amplification

V5011 Fitting/orientation/checking of hearing aid. Includes adjusting aid to the wearer, instructions to wearer, and follow-up care - requires payment authorization prior to provision of services

V5160 Hearing aid dispensing fee, binaural - requires payment authorization prior to provision of services

V5200 Hearing aid dispensing fee, CROS - requires payment authorization prior to provision of services

V5240 Hearing aid dispensing fee, BICROS - requires payment authorization prior to provision of services

V5241 Hearing aid dispensing fee, monaural hearing aid, any type - requires payment authorization prior to provision of services

S9092 Canolith repositioning, per visit, limited to one per calendar year

Table 129-0240-2 Special Otorhinolaryngologic Services codes

92601	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming
92602	Subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Subsequent reprogramming
92626	Evaluation of auditory rehabilitation status; first hour
92627	Each additional 15 minutes
92630	Auditory rehabilitation; pre-lingual hearing loss
92633	Post-lingual hearing loss
L8614	Cochlear device/system (only reimbursed to hospitals)
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L8619	Cochlear implant external speech processor, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each (maximum of 420 batteries per 12 months)
L8622	Alkaline battery for use with cochlear implant device, replacement, each (maximum of 420 batteries per 12 months)

L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each (maximum of two rechargeable per 12 months)
L8624	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each (maximum of two rechargeable per 12 months)
L7510	Repair of prosthetic device, repair or replace minor parts — requires payment authorization prior to provision of services
L7520	Repair prosthetic device, labor component, per 15 minutes— requires payment authorization prior to provision of services

410-129-0260 Hearing Aids and Hearing Aid Technical Service and Repair

(1) Hearing Aids must be billed to the Division of Medical Assistance Programs (DMAP) at the provider's Acquisition Cost, and will be reimbursed at such rate. For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item.

(2) Submit history of hearing aid use and an audiogram when requesting payment authorization for hearing aids.

(3) Procedure codes: Table 129-0260.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414

1-1-07

Table 129-0260

92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
V5014	Repair/modification of hearing aid - requires payment authorization prior to provision of services
V5266	Hearing aid batteries - limited to 60 individual batteries per calendar year
V5264	Ear mold/insert, not disposable, any type - requires payment authorization prior to provision of services
V5274	Assistive listening device, not otherwise specified - requires payment authorization prior to provision of services
V5030	Hearing aid, monaural, body worn, air conduction - requires payment authorization prior to provision of services
V5040	Hearing aid, monaural, body worn, bone conduction – requires payment authorization prior to provision of services
V5050	Hearing aid, monaural, in the ear - requires payment authorization prior to provision of services
V5060	Hearing aid, monaural, behind the ear - requires payment authorization prior to provision of services
V5130	Hearing aid, binaural, in the ear - requires payment authorization prior to provision of services
V5140	Hearing aid, binaural, behind the ear - requires payment authorization prior to provision of services

V5170	Hearing aid, CROS, in the ear - requires payment authorization prior to provision of services
V5180	Hearing aid, CROS, behind the ear - requires payment authorization prior to provision of services
V5210	Hearing aid, BICROS, in the ear - requires payment authorization prior to provision of services
V5220	Hearing aid, BICROS, behind the ear - requires payment authorization prior to provision of services
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear) – requires payment authorization prior to provision of services
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear) – requires payment authorization prior to provision of services
V5252	Hearing aid, digital programmable, binaural, ITE, requires payment authorization prior to provision of services
V5253	Hearing aid, digital programmable, binaural, BTE, requires payment authorization prior to provision of services
V5256	Hearing aid, digital, monaural, ITE, requires payment authorization prior to provision of services
V5257	Hearing aid, digital, monaural, BTE, requires payment authorization prior to provision of services
V5260	Hearing aid, digital, binaural, ITE, requires payment authorization prior to provision of services
V5261	Hearing aid, digital, binaural, BTE, requires payment authorization prior to provision of services

410-129-0280 Hearing Testing for Diagnostic Purposes (On Physician's Referral Only)

A physician's referral is required for the tests shown in this rule. The tests may only be performed and billed by a licensed audiologist or a licensed physician. Procedure codes: Table 0280.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

Table 0280 Hearing Testing

92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of four positions, with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Sinussoidal vertical axis rotational testing
92547	Use of vertical electrodes in any or all of above tests counts as one additional test
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92555	Speech audiometry; threshold only
92556	With speech recognition
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone

92567	Tympanometry
92568	Acoustic reflex testing; threshold
92569	Acoustic reflex testing; decay
92571	Filtered speech tests
92572	Staggered spondaic word test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	Conditioning play audiometry
92583	Select picture audiometry
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	Evoked Otacoustic Emissions - limited (single stimulus level, either transient or distortion products)
92588	Evoked Otacoustic Emissions - comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
92589	Central auditory function test(s) (specify)