

Supplemental Hearing Benefit

Applies to:

Blue Cross and Blue Shield of Nebraska Medicare Advantage Plans

Overview

Hearing care includes 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 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 hearing 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, 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 & 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 malformation, chronic disease, severe sensorineural hearing loss, or surgery. The following are prosthetic devices:

- Cochlear implants
- Auditory brainstem implants
- Osseointegrated implants



Enhanced Benefit

The Blue Cross and Blue Shield of Nebraska Medicare Advantage plans provide 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 and Blue Shield of Nebraska 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 the BCBSNE Medicare Advantage plans.

Because 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 Blue Cross and Blue Shield of Nebraska Medicare Advantage.

Hearing providers may choose to participate in the Blue Cross and Blue Shield of Nebraska Medicare Advantage networks on an individual basis. Providers who choose to participate in the Blue Cross and Blue Shield of Nebraska Medicare Advantage network are considered to be in-network.

The BCBSNE Medicare Advantage plans offer the following coverage:

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

Medical Evaluation

A medical evaluation to determine the cause of the hearing loss and if it can be improved with a hearing aid is required if the member 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. This evaluation is covered up to once per year.

The following additional hearing tests and exams that are specifically excluded under Original Medicare are covered under the medical evaluation component of the hearing services benefit and are covered up to once every three years per ear:

- An audiometric examination that 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 that 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 that 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 hearing aids (as defined below in the conditions for payment section) are subject to a 36-month frequency limitation per ear.

The hearing aid coverage benefit offers a flat dollar allowance that will apply toward the cost of a standard hearing aid (analog or digital). Members are responsible for the costs of any non-standard upgrades (i.e., Blue Tooth compatibility, noise cancelling volume spikes, etc.) that exceed the benefit allowance.

Please refer to the Blue Cross and Blue Shield of Nebraska Medicare Advantage EOCs for the specific amounts.

Excluded Services

The following services are excluded from the BCBSNE Medicare Advantage 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
- Hearing aids that do not carry FDA approval
- Unnecessary services not prescribed by the physician specialist, audiologist or hearing aid dealer
- Hearing aids ordered while the member has BCBSNE Medicare Advantage coverage, however, delivered more than 60 days after coverage ends.

Conditions for Payment

The table below specifies the 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	BCBSNE covers the following: S0618, V5010, V5020-V5080, V5100, V5120-V5150, V5170-V5190, V5210-V5230, V5242-V5261, V5298-V5299
Diagnosis Restrictions	Restrictions
Age Restrictions	No restrictions

Reimbursement

BCBSNE Medicare Advantage plans are subject to maximum defined benefit allowances for hearing aids as indicated above in the Standard Hearing Aid Coverage section. Total payment to the contracted provider for standard hearing aids must not exceed the Blue Cross and Blue Shield of Nebraska allowed amount. The provider will be paid the lesser of the BCBSNE Medicare Advantage allowed payment amount and 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 the BCBSNE Medicare Advantage allowed amount and the provider's charge.

Providers may bill the member for the difference between the plan's defined benefit allowance amount and the BCBSNE Medicare Advantage allowed amount. Providers must explain to the member any 'upgraded' features included on the hearing aid for which they will be fully financially responsible during the selection and ordering process. Providers should bill upgraded features using a NOC code.

Exceptions

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

Member cost-sharing

- BCBSNE Medicare Advantage members are liable for costs in excess of the defined benefit allowance amount up to the lesser of the BCBSNE Medicare Advantage allowed amount or the provider's charge.
- BCBSNE Medicare Advantage 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. Providers can only collect the appropriate BCBSNE Medicare Advantage cost-sharing amount from the member.
- 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.

To verify benefits and cost-share, providers may call 1 888-505-2022.

Billing Instructions for Providers

1. Bill services on the CMS 1500 (02/12) claim form or the 837 equivalent claim.
2. Use the BCBSNE Medicare Advantage 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 BCBS plan.

Revision History:

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