Easy Choice Health Plan

Missouri Care

‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Florida Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Therapy

Policy Number: HS-260

Original Effective Date: 5/26/2017

Revised Date(s): 4/5/2018

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

BACKGROUND

Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years. The EPSDT benefit for this population is designed to assure that children receive early detection and care in order to address health problems as soon as early as possible. Additional information is provided below regarding EPSDT:1

- **IFSP.** For children up to 3 years old and enrolled in the Early Steps Program - if there is an IFSP, providers are asked to provide a copy if available.

- **Standardized test results** will NOT be used as the sole determinant as to the medical necessity of the requested services. Standard tests will not be required when such tests are inappropriate due to the
condition of the member or when no such standardized test is generally available to evaluate the condition for which therapy services are requested.

- **Group Speech Therapy.** To be reimbursed by Medicaid, a group speech therapy session is limited to six children. All the children do not have to be Medicaid members. The group must receive a minimum of 30 minutes of therapy. Medicaid will not reimburse for both group and individual speech therapy sessions for a member on the same day.

- **Other Services and Goods.** The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services do not in itself make such care, goods or services medically necessary or a covered service.

- **Duplication of Services.** Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

- **Travel.** Reimbursement is NOT allowed as part of any early intervention session.

- **Reimbursement.** Only one type of early intervention session per day, per child is allowed. A session cannot be split between providers, nor can more than one type of provider conduct a session in a given day for the same child.

### POSITION STATEMENT

**Applicable To:**
- ✔ Medicaid – Florida
- ✔ Medicare – Florida

For all other markets, refer to Pediatric Skilled Therapy Services for Developmental Delay (HS-201).

NOTE: Refer authorizations to vendor, as applicable.

### Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) ¹

EPSDT services are a covered benefit for Members ≤ age 21 years when the treatment or procedure fits within the following categories of Medicaid-covered services if it is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions. For example, services must be:

- Needed to protect life, prevent significant illness or disability, or alleviate severe pain; AND/OR
- Individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the Member’s needs; AND/OR
- In alignment with accepted medical standards and not be experimental or investigational; AND/OR
- The level of service that can be safely furnished and for which no equally effective and more conservative or less costly treatment is available in the State of Florida; AND/OR
- Furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

Services include, but are not limited to:
- Behavioral Health Overlay Services
- Child Health Check-Up Services
- Chiropractic Services
- Dental Services
- Durable Medical Equipment/ Medical Supply Services
- Early Intervention Services
- Hearing Services
- Home Health Services
- Hospital Services, including Psychiatric Services
- Nursing Facility Services
- Optometric Services
- Physician Services
• Podiatry Services
• Prescribed Drug Services
• Targeted Case Management Services

NOTE: Medicaid must provide any other medical or remedial care, even if the agency does not otherwise provide for these services or provides for them in a lesser amount, duration, or scope.¹

Also included under EPSDT are diagnostic services, treatment, equipment, supplies, and other measures. As such, services for recipients < age 21 years exceeding the coverage described within Florida Medicaid policy or the associated fee schedule may be approved, if medically necessary.

Prior Authorization

Prior authorization is required in order to receive reimbursement for special services that meet one or more of the following conditions.
• Service is not listed in the service-specific Medicaid Coverage and Limitations Handbook as a covered service; AND/OR
• Service is not included in the applicable fee schedule; AND/OR
• Service is described in the service-specific handbook as an “excluded service”; AND/OR
• The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the fee schedule.

The following services are carved out of managed care and available to members based upon the eligibility criteria for each service:¹
• Home and Community-Based Waiver services (excluding services provided under the LTC program)
• Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services
• Nursing facility services (for children under the age of 18 years)
• Medical Foster Care services
• Prescribed Pediatric Extended Care (PPEC) services
• Newborn hearing screening
• Early intervention services
• Applied behavior analysis (for children diagnosed with autism or autism spectrum disorders)
• Program for All-inclusive Care for Children (PACC)

WellCare is responsible for arranging, coordinating, and referring the enrollee to the appropriate program to meet the Member’s needs. WellCare is required to provide basic information to assist the Member in understanding the type of service available and, when appropriate, arrange an appointment for the enrollee to obtain the service. For more information, refer to the specific coverage policies found here.²

Physical and Occupational Therapy

Exclusions ³,⁴

The following services related to PT and OT are not covered when any of the following apply:
• The service does not meet the medical necessity criteria listed below; OR
• The recipient does not meet the eligibility requirements listed below; OR
• The service unnecessarily duplicates another provider’s service.

In addition, Florida Medicaid does not cover the following as part of the service benefit:
• Developing and updating the plan of care (POC)
• Mileage and travel expenses
• Multiple AAC fitting, adjustment, and training visits on the same day
• Securing, installing, or maintaining therapy equipment
• Services not listed on the fee schedule
• Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy
• Time spent supervising assistants and students
• Treatment visits provided on the same day as an evaluation service

Coverage

Physical and occupational therapy is a covered benefit when followed in accordance with the applicable fee schedule(s) set by Florida Medicaid, or as specified in this policy:

• Wheelchair evaluations:
  ▪ One initial wheelchair evaluation every five years, per recipient
  ▪ One follow-up wheelchair evaluation including adjustments and fittings when the wheelchair is delivered
  ▪ One follow-up wheelchair evaluation including adjustments and fittings six months after the wheelchair has been delivered

• Services for recipients under the age of 21 years:
  ▪ One initial therapy evaluation per year, per recipient
  ▪ One therapy re-evaluation every five months, per recipient
  ▪ Up to 14 therapy treatment units per week (Sunday-Saturday), per recipient (max of 4 units per day)
  ▪ Up to two casting and strapping applications per day, per recipient

Speech Therapy (ST)

Additional information for ST may be found in Augmentative Alternative Communication Devices for Developmental Delay (E/I): HS-205.

Exclusions

Speech therapy related treatments for stuttering are not medically necessary and not a covered benefit when:

• The service does not meet the medical necessity criteria listed below; OR
• The recipient does not meet the eligibility requirements listed below; OR
• The service unnecessarily duplicates another provider’s service.

In addition, Florida Medicaid does not cover the following as part of the service benefit:

• Developing and updating the plan of care (POC)
• Mileage and travel expenses
• Multiple AAC fitting, adjustment, and training visits on the same day
• Securing, installing, or maintaining therapy equipment
• Services not listed on the fee schedule
• Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy
• Time spent supervising assistants and students
• Treatment visits provided on the same day as an evaluation service

Coverage

Speech Therapy is a covered benefit when followed in accordance with the applicable fee schedule(s), or as specified in this policy:

• One initial AAC evaluation every five years, per recipient
• For recipients under the age of 21 years:
  ▪ One initial speech-language pathology evaluation per year, per recipient
• One speech-language re-evaluation every five months, per recipient
• Up to 14 therapy treatment units per week (Sunday-Saturday), per recipient (max of 4 units per day)
  o Group therapy must be at least 30 minutes in duration, and may include no more than six participants (the group may include non-Medicaid recipients)
• One follow-up AAC evaluation upon delivery of the device, per recipient
• Up to eight 30-minute AAC fitting, adjustment, and training sessions per year, per recipient
• Up to two AAC reevaluations per year, per recipient with an AAC device

For initial and ongoing ST services, the following elements should be included in the medical necessity review:
In addition, criteria is met and visits are approved according to the following scores:

- **Mild** (-1 to -1.5 standard deviation from the mean [or a score of 85 to 78]). Approval of 1 visit weekly up to 26 weeks.
- **Moderate** (-1.5 to -2 standard deviation from the mean [or a score of 77 to 71]). Approval of 2 visits weekly up to 26 weeks.
- **Severe and Profound** (>2 standard deviation from the mean [or a score of 70 or below]). Approval of 3 visits weekly up to 26 weeks.

In addition, members who have been receiving speech therapy services for ≥18 months must undergo a secondary medical necessity review by a medical director.

**Augmentative and Alternative Communication (AAC)**

AACs are designed to allow individuals the capability to communicate. As defined by the American Speech-Language Hearing Association (ASHA), an AAC attempts to compensate for the impairment and disability patterns of individuals with severe, expressive communication disorders, i.e., individuals with severe speech-language and writing impairments. Dedicated systems are designed specifically for a disabled population. Non-dedicated systems are commercially available devices such as laptop computers with special software.

AAC evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for members under the age of 21. AACs are reimbursed through the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program. For coverage for an AAC system, the member must:

- Be unable to communicate basic needs without the use of an AAC; **AND**
- Have the physical, cognitive and language abilities necessary to use the AAC system.

Medicaid reimburses home health agencies for OT, PT, and SLP services through their home health agency provider numbers. Medicaid **does not reimburse** home health agencies for respiratory therapy services through their home health agency provider number. Home health agencies may enroll as group therapy providers with a specialty in respiratory therapy. The home health agency must have at least two licensed registered respiratory therapists in the group that are enrolled as individual providers in Medicaid.

**Additional Guidance for PT, OT, and ST**

Children with a developmental delay (all ages) have development delayed in **one or more** of the following domains:

- Cognition;
- Physical or motor;
- Sensory (including vision and hearing);
- Communication;
- Social;
- Emotional;
- Adaptive development
Services for children with chronic conditions are considered medically necessary when the following are met in cases where initial OR continuing authorization requests are not accompanied by case history records:

- Therapy services must be prescribed by a primary care physician (PCP), advanced registered nurse practitioner (ARNP), physician assistant (PA), physical therapist (PT), occupational therapist (OT), respiratory therapist (RT), speech-language pathologist (SLP) or other designated physician specialist**.
- Prescription for services must include the following:
  - Member’s diagnosis; **AND**
  - Specific type of evaluation requested or the specific type of service; **AND**
  - Duration and frequency of the therapy treatment period; **AND**
  - Physician’s MediPass authorization number, if applicable.

- For ongoing services, a multidisciplinary evaluation and Plan of Care (POC) must:
  - Be evaluated and signed by the treating therapist and child’s PCP; **AND**
  - Outline the current level of function, the appropriate services, frequencies and goals for each therapy modality for the child; **AND**
  - Be current within the six months prior to the request*; **AND**
  - For members in Early Steps, the level of function should be expressed as a percentile rank on a standard functional assessment OR standard deviation from the mean on a standard functional assessment*

NOTE: Please see Definitions section for description of Plan of Care.

* The primary care provider must review the member’s renewed plan of care every one to six months depending on the authorization period for which the services were approved. If the services continue to be medically necessary, the primary care provider can prescribe the reauthorization of services. The plan of care, with the primary care provider’s, ARNP’s or PA designee’s, or designated physician specialist’s signature authorizing the continuation of services, must be received prior to beginning services for the next authorization period.

** Authorizations (including those by a vendor contracted by WellCare) must follow a specialty-specific review process for reviewing pediatric therapy cases. For example, therapy cases must be reviewed by the same specialty (e.g., OT cases are to be reviewed by and OT, PT cases are to be reviewed by PT except in cases when a Physiatrist (PM&R) can review such cases. In Florida, initial therapy evaluations generally can only be initiated by a PT or OT or SLP as part of their scope of practice. Medicaid does not reimburse for evaluations performed by therapy assistants. See Reference section for applicable Florida Statutes.

Evaluations determine the member’s level of function and competencies through therapeutic observation and testing; to develop baseline data to identify the need for early intervention; and to address the member’s functional abilities, capabilities, activities performance, deficits and limitations. Additional information may be required:

- Tests may be standardized or may be composed of the professionally acceptable techniques.

**Criteria for Services**

Services must meet the following criteria:

- Provided by:
  - Licensed physical, occupational and registered respiratory therapists;
  - Licensed speech-language pathologists and provisionally licensed speech-language pathologists; and
  - Home health agencies that employ or contract with licensed physical and occupational therapists, licensed speech-language pathologists, and provisionally licensed speech-language pathologists.
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member’s needs;
- Cannot be experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker, or the provider.

Note: Medicaid does not reimburse for evaluations performed by therapy assistants.
Services can be provided in the member’s home or other community setting, such as schools, prescribed pediatric extended care centers or day care centers. Services for children ages 4 and up may be performed in the home setting if the member is classified as homebound.

Services can also be provided in a nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), and an inpatient and outpatient hospital. Payment for these services is included in the facility’s per diem. The therapist cannot be reimbursed directly by fee-for-service for services provided in these locations.

Establishing Developmental Delay

The following criteria must be used to establish developmental delay using appropriate standardized instruments:

- For children up to 3 years old and enrolled in the Early Steps Program:
  - Score that equals or exceeds 1.5 standard deviations below the mean in at least one of the identified domains**; OR
  - A twenty-five (25) percent delay or greater on measures yielding scores in months in at least one of the identified domains**

CODING

Covered CPT® Codes (For Speech-Language Pathology Services)

*See handbook for modifiers that apply. This list may not be all inclusive.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92521</td>
<td>Evaluation of speech fluency (eg, stuttering, cluttering)</td>
</tr>
<tr>
<td>92522</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);</td>
</tr>
<tr>
<td>92523</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)</td>
</tr>
<tr>
<td>92524</td>
<td>Behavioral and qualitative analysis of voice and resonance</td>
</tr>
<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</td>
</tr>
<tr>
<td>92508</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals</td>
</tr>
<tr>
<td>92597</td>
<td>Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech</td>
</tr>
<tr>
<td>92609</td>
<td>Therapeutic services for the use of speech-generating device, including programming and modification</td>
</tr>
</tbody>
</table>

Covered CPT Codes (For Occupational Therapy Services)

*See handbook for modifiers that apply. This list may not be all inclusive.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>29799</td>
<td>Unlisted procedure, casting or strapping</td>
</tr>
<tr>
<td>92597</td>
<td>Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech</td>
</tr>
<tr>
<td>97165</td>
<td>Occupational therapy evaluation, low complexity, requiring these components…</td>
</tr>
<tr>
<td>97166</td>
<td>Occupational therapy evaluation, moderate complexity, requiring these components…</td>
</tr>
<tr>
<td>97167</td>
<td>Occupational therapy evaluation, high complexity, requiring these components…</td>
</tr>
<tr>
<td>97168</td>
<td>Re-evaluation of occupational therapy established plan of care, requiring these components…</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes</td>
</tr>
<tr>
<td>97542</td>
<td>Wheelchair management (eg, assessment, fitting, training), each 15 minutes</td>
</tr>
</tbody>
</table>

Covered HCPCS Codes (for Behavioral Health Overlay Services)

*See handbook for modifiers that apply. This list may not be all inclusive.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>H0001</td>
<td>Alcohol and/or drug assessment</td>
</tr>
<tr>
<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
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<tr>
<td>H0020</td>
<td>Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)</td>
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<tr>
<td>H0031</td>
<td>Mental health assessment, by nonphysician</td>
</tr>
<tr>
<td>H0032</td>
<td>Mental health service plan development by nonphysician</td>
</tr>
<tr>
<td>H0046</td>
<td>Mental health services, not otherwise specified</td>
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</tbody>
</table>
FLORIDA EPSDT THERAPY
HS-260

H0047 Alcohol and/or other drug abuse services, not otherwise specified
H2000 Comprehensive multidisciplinary evaluation
H2010 Comprehensive medication services, per 15 minutes
H2012 Behavioral health day treatment, per hour
H2017 Psychosocial rehabilitation services, per 15 minutes
H2019 Therapeutic behavioral services, per 15 minutes
H2030 Mental health clubhouse services, per 15 minutes
T1007 Alcohol and/or substance abuse services, treatment plan development and/or modification
T1015 Clinic visit/encounter, all-inclusive
T1023 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter
S5145 Foster care, therapeutic, child; per diem

Covered HCPCS Codes (For CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT)
*See handbook for modifiers that apply. This list may not be all inclusive.
T1017 Targeted case management, each 15 minutes

Covered HCPCS Codes (For Dental)  **This list may not be all inclusive.
D0120 Periodic oral evaluation
D0140 Limited oral evaluation
D0150 Comprehensive oral evaluation
D0190 Screening of a patient
D0191 Assessment of a patient
99188 Application of topical fluoride varnish by a physician or other qualified health care professional
D1206 Topical application of fluoride varnish
D1208 Topical application of fluoride excluding varnish

Covered HCPCS Codes (For Early Intervention Services).
*See handbook for modifiers that apply. This list may not be all inclusive.
T1023 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter
T1024 Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter
T1027 Family training and counseling for child development, per 15 minutes

Covered HCPCS Codes (For Hearing Services)
*See handbook for modifiers that apply. This list may not be all inclusive.
69210 Removal impacted cerumen requiring instrumentation, unilateral
92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542 Positional nystagmus test, minimum of 4 positions, with recording
92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545 Oscillating tracking test, with recording
92546 Sinusoidal vertical axis rotational testing
92547 Use of vertical electrodes (List separately in addition to code for primary procedure)
92550 Tympanometry and reflex threshold measurements
92552 Pure tone audiometry (threshold); air only
92553 Pure tone audiometry (threshold); air and bone
92555 Speech audiometry threshold;
92556 Speech audiometry threshold; with speech recognition
92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92567 Tympanometry (impedance testing)
92568 Acoustic reflex testing, threshold
92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
92571 Filtered speech test
92572  Staggered spondaic word test
92579  Visual reinforcement audiometry (VRA)
92582  Conditioning play 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  Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
92588  Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
92601  Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602  Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603  Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604  Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming
92620  Evaluation of central auditory function, with report; initial 60 minutes
92621  Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)
92626  Evaluation of auditory rehabilitation status; first hour
92627  Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)
92630  Auditory rehabilitation; prelingual hearing loss
92633  Auditory rehabilitation; postlingual hearing loss
92640  Diagnostic analysis with programming of auditory brainstem implant, per hour
92700  Unlisted otorhinolaryngological service or procedure
L7510  Repair of prosthetic device, repair or replace minor parts
L8614  Cochlear device, includes all internal and external components
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 or auditory osseointegrated device, replacement
L8619  Cochlear implant, external speech processor and controller, integrated system, replacement
L8623  Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each
L8624  Lithium ion battery for use with cochlear implant device or auditory osseointegrated device speech processor, ear level, replacement, each
L8627  Cochlear implant, external speech processor, component, replacement
L8628  Cochlear implant, external controller component, replacement
L8629  Transmitting coil and cable, integrated, for use with cochlear implant device, replacement
L8691  Auditory osseointegrated device, external sound processor, replacement
L8692  Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment
V5010  Assessment for hearing aid
V5014  Repair/modification of a hearing aid
V5050  Hearing aid, monaural, in the ear
V5060  Hearing aid, monaural, behind the ear
V5090  Dispensing fee, unspecified hearing aid
V5130  Binaural, in the ear
V5140  Binaural, behind the ear
V5160  Dispensing fee, binaural
V5180  Hearing aid, CROS, behind the ear
V5200  Dispensing fee, CROS
V5220  Hearing aid, BICROS, behind the ear
Covered HCPCS Codes (For Home Health Services)
*See handbook for modifiers that apply. This list may not be all inclusive.
T1021 Home health aide or certified nurse assistant, per visit
T1030 Nursing care, in the home, by registered nurse, per diem
T1031 Nursing care, in the home, by licensed practical nurse, per diem

Covered HCPCS Codes (For Child Health Services Targeted Case Management, Mental Health Targeted Case Management, and Targeted Case Management for Children at Risk of Abuse and Neglect Handbooks)
*See handbook for modifiers that apply. This list may not be all inclusive.
T1017 Targeted case management, each 15 minutes
T2023 Targeted case management; per month

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>4/5/2018</td>
<td>• Approved by MPC. No changes.</td>
</tr>
<tr>
<td>5/26/2017</td>
<td>• Approved by MPC. New.</td>
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Clinical Coverage Guideline  page 10

Original Effective Date: 5/26/2017 - Revised: 4/5/2018