

Billing Guidelines for:

76 Audiologist

A certified and licensed audiologist (as described in the Medicaid Services Manual (MSM)) must perform all audiological services.

Coverage and Prior Authorization Requirements



Prior authorization requirements apply to all recipients regardless of their primary insurance carrier. Required documentation showing medical necessity must be submitted with the authorization request and not with the claim.

Audiological testing is limited to once per 12 rolling months and must be referred by an M.D. One test per 12 rolling months does not require prior authorization (use [form FH-6](#) to request additional testing).

Hearing aids and related supplies are covered for eligible recipients. Use [form FH-1](#) to request prior authorization when required. See [Chapter 1300](#), section 1303.6 for State policy and the [DME Fee Schedule](#) for covered codes and rates.

- **Hearing aids:** Coverage for hearing aid(s) is limited to once every 24 rolling months plus any aids/supplies referred by a Healthy Kids Screening. Hearing aids exceeding \$350.00 per aid require prior authorization.
- **Accessories:** Hearing aid accessories are covered. Prior authorization is required.
- **Ear molds:** Ear molds are to be provided with each new hearing aid. Replacement is covered only when referred by a Healthy Kids Screening.
- **Supplies:** Hearing aid supplies do not require prior authorization, but are limited to coverage restrictions. Hearing aid batteries are limited to one package per aid per rolling 30 days. Batteries must be dispensed per rolling 30 days and do not require prior authorization.
- **Testing/Repair:** Testing/repair of hearing aid(s) is limited to once every 12 rolling months. Replacement of broken or lost hearing aid(s) must be prior authorized if the aid(s) is not covered by the manufacturer's warranty.
- **Cochlear implants:** Medicaid covers cochlear implants in certain circumstances for recipients with profound hearing impairment. Please refer to Medicaid Service Manual [Chapter 1700](#), section 1703.3 and [Chapter 1300](#), section 1303.7 for further information.



Table 76A: Other Covered Codes for Audiologists

Code	Description	Other Instructions
92551 - 92596	Audiologic Function Tests With Medical Diagnostic Evaluation	More than one code in this range may be used during the session. Prior authorization is <u>not</u> required.
92601	Diagnostic analysis of cochlear implant, patient under 7 yrs of age; with programming	Prior authorization is <u>not</u> required.
92602	Diagnostic analysis of cochlear implant, patient under 7 yrs of age; subsequent reprogramming	Prior authorization is <u>not</u> required.
92603	Diagnostic analysis of cochlear implant, age 7 yrs or older; with programming	Prior authorization is <u>not</u> required.
92604	Diagnostic analysis of cochlear implant, age 7 yrs or older; subsequent reprogramming	Prior authorization is <u>not</u> required.
92620	Evaluation of central auditory function, with report; initial 60 min.	Prior authorization is <u>not</u> required.
92621	Evaluation of central auditory function, with report; each additional 15 min.	Enter the primary code (92620) and this code on separate claim lines. Prior authorization is <u>not</u> required.
92625	Assessment of tinnitus (includes pitch, loudness, matching and masking)	Prior authorization is <u>not</u> required.
92626	Evaluation of auditory rehabilitation status; first hour	PA is always required.
92627	Evaluation of auditory rehabilitation status; each additional 15 min.	PA is always required. Enter the primary code (92626) and this code on separate claim lines.
92630	Auditory rehabilitation; pre-lingual hearing loss	PA is always required
92633	Auditory rehabilitation; post-lingual hearing loss	PA is always required

Notes

Providers are required to keep any records necessary to disclose the extent of services rendered and provide these records, upon request, to Nevada Medicaid.

Reference

Please refer to Medicaid Services Manual [Chapter 1700](#), section 1703.3 and [Chapter 1300](#) sections 1303.6 and 1303.7 for State policy. See the [DME Fee Schedule](#) for covered codes and rates.

