



## DATABASE INSTRUCTIONS

### Hearing Aid Dealers

This document contains information for interpreting this Michigan Medicaid database. Providers are instructed to refer to the Michigan Medicaid Provider Manual and/or MSA Bulletins for specific coverage, reimbursement policies, and required forms. To access this information via the MDCH website, click hyperlink: [Medicaid Policy & Forms](#).

The database is available in two formats:

- PDF excel file for viewing and/or printing a page
- An Excel file for downloading data onto your computer

Data elements and descriptions for this database are as follows:

| Data Element             | Description  |
|--------------------------|--|
| HCPCS Code               | The HCPCS Level I (CPT) or Level II code used to denote a service.   |
| Modifier (Mod)           | Completed when a modifier is required for monaural aids, hearing aid repairs/modification and ear molds/inserts.<br>LT = left side<br>RT = right side  |
| Short Description        | The short description of the service associated with the HCPCS code.   |
| HCPCS Action Code        | Action code indicates the new action taken since last published database, if applicable. If cell is blank, no change has occurred.<br>A = Add procedure or modifier code<br>D = Discontinue procedure or modifier code<br>P = Payment change<br>R = Re-activate discontinue/deleted procedure or modifier code   |
| Maximum Fee              | Represents the maximum fee screen Medicaid will pay for the service. If there is an "M" in the fee field, the code is manually priced and requires additional information. Prices for hearing aids covered under the bulk purchase contract are listed separately on the MDCH Contract Hearing Aid Definitions.<br><br>*V5014 - Payment for hearing aid supplies and accessories includes the acquisition cost plus 9.2 percent. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs. |
| Age                      | Age range in which coverage of the item is considered.   |
| Limits                   | Indicates the maximum quantity of a service that may be reimbursed within the time frame indicated unless an additional quantity has been prior authorized. This field may also indicate the maximum dollar amount that may be reimbursed within the time frame designated.  |
| Prior Authorization (PA) | Indicates "Y" if code requires Prior Authorization.<br><br>*V5014 – PA is required if the amount billed on the claim is greater than \$150.00.   |



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|--------------|--|
| Comments     | <p>Indicates if additional pertinent data and/or documentation is required for claim submission (or) provides clarification of HCPCS code revisions.</p> <ul style="list-style-type: none"><li>• Documentation Required = Additional information required to process the claim (e.g. description of service, operative report)</li><li>• Revised = Denotes revisions to HCPCS codes other than reflected by an action code since last published database, if applicable.</li></ul> |

Questions on the database should be directed to Provider Inquiry by phone at 1-800-292-2550 or e-mail to [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov). Include your name, affiliation and phone number for contact information.