Ohio Department of Job and Family Services

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION HEARING AIDS

Instructions: The Certificate of Medical Necessity (CMN) must be used for all hearing aid fittings under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer		Billing Number
Street Address	City/State/Zip	Date of Birth

Does recipient own any other hearing aids? ☐ Yes ☐ No

If yes, how many does he/she own?

If yes, what is the age of the hearing aid(s)?

Hearing aid #1 ##### Hearing aid #2

Describe the hearing aid(s)

Were hearing aid(s) purchased through Medicaid? ☐ Yes ☐ No

Why is recipient requesting new hearing aid(s)

Section A - Completed by person performing hearing evaluation

Hearing aid evaluation

- ☐ Supports consumer's need for a hearing aid
- ☐ Performed and signed by a physician specializing in otology or otolaryngology, an audiologist, or a hearing aid fitter
- ☐ Reflects the specific hearing values resulting from the test
- ☐ Includes a written summation of the hearing test results, performed and signed by a physician specializing in otology or otolaryngology, or an audiologist
- ☐ Documentation includes a **legible name and provider type** for person performing either the hearing test, the written summation of the hearing test results, or both. This information accompanies the provider signature.
- ☐ **Testing performed not more than 6 months prior to the date of the prior authorization request.**

For consumer's 21 years of age or older, the evaluation includes

- ☐ At least 4 thresholds for air conducted stimuli or **500 Hz, 1000 Hz, 2000 Hz and 4000 Hz**
- ☐ Best pure-tone average of **31 dB HL or greater**
- ☐ Air conducted speech awareness, or speech reception threshold
- ☐ Most comfortable and uncomfortable listening level
- ☐ Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing
- ☐ Hearing test is obtained bilaterally unless recipient's behavior/condition does not permit bilateral evaluation
- ☐ Supporting documentation is provided as to why bilateral test is not done.

For consumer's 20 years of age or younger, the evaluation includes

- ☐ At least 4 thresholds for air conducted stimuli or **500 Hz, 1000 Hz, 2000 Hz and 4000 Hz**
- ☐ Best pure-tone average of **26 dB HL or greater**
- ☐ Air conducted speech awareness, or speech reception threshold
- ☐ Most comfortable and uncomfortable listening level
- ☐ Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing
- ☐ Tympanometry
- ☐ Acoustic reflex battery
- ☐ Otoacoustic emissions testing
- ☐ Hearing test is obtained bilaterally unless recipient's behavior/condition does not permit bilateral evaluation
- ☐ Supporting documentation is provided as to why bilateral test is not done.

Digital/programmable hearing aid and physician documents

- ☐ Digital/programmable hearing aid will offer superior performance over a conventional hearing aid for the specific consumer
- ☐ The digital/programmable hearing aid is necessary for the consumer's success in educational development
- ☐ This particular consumer requires functions that are not found in a conventional hearing aid (i.e., automatic feedback reduction, automatic noise reduction, programmable control)

This consumer requires the following digital hearing aid features

- ☐ Adaptive directionality, automatically changing polar plot
- ☐ Adjust MPO without affecting gain curve
- ☐ Automatic directionality
- ☐ Data logging, collection of user's wearing history and program use
- ☐ Digital feedback management, phase cancellation
- ☐ Digital noise reduction
- ☐ Digital wide dynamic range compression
- ☐ Digital volume control with an option to disable
- ☐ Low battery warning indicator
- ☐ Multiple bands or channels
- ☐ Multiple programs
- ☐ Multiple signal processing strategies
- ☐ Open ear fitting
- ☐ In-situ hearing thresholds to determine gain
- ☐ Switchless telephone or telecoil program
- ☐ Wide fitting range to accommodate progressive hearing changes
- ☐ Other:

APPENDIX p(103618) pa(189499) d(417340) ra(348870)
print date: 08/19/2013 9:01 PM

Medical Clearance	
	☐ The consumer needs a hearing aid based on the hearing test results which clearly demonstrate hearing loss. ☐ If consumer needs a digital/programmable hearing aid, I have checked the Medicaid guidelines in Section A which support this type of hearing aid. ☐ The above patient has been medically evaluated and his/her hearing loss is not due to a temporary, correctable physical condition, e.g., ear infection or impacted wax. **Additional Information to include name and signature of the person performing hearing evaluation if different from prescriber:**

Section B - Prescriber Attestation and Signature/Date

Prescriber Name with Credential *(printed)*	***Prescriber signature in accordance with OAC 5101:3-10-02 and dated no more than 90 days prior to the date of the PA Request.***

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature (No stamps)	Date	Ohio Medicaid Provider #