TO BE RESCINDED

5101:3-10-11 **Hearing aids.**

(A) Definitions.

(1) "Audiologist."

A person licensed to practice audiology in Ohio under Chapter 4753. of the Revised Code, or who is licensed and practicing in another state and is employed by an eligible Ohio medicaid provider.

(2) "Licensed hearing aid dealer/fitter."

A person licensed in Ohio under Chapter 4747. of the Revised Code, or who is licensed and practicing in another state and is an eligible Ohio medicaid provider.

(B) To be eligible for reimbursement, hearing aids must be prior-authorized. Requests for prior authorization must include all of the following:

(1) Completed "Prior Authorization" form (ODHS 3142);

(2) A current physician's prescription which verifies the need for a hearing aid and includes a statement that medical examination has indicated that the hearing loss is not due to a temporary, correctable physical condition; e.g., ear infection or impacted wax; and

(3) Hearing evaluation results in the form of charts, an audiometric diagnosis, and the written recommendation for type of aid and fitting instructions, performed and signed by a physician specializing in otology or otolaryngology, or performed and signed by a licensed audiologist. The evaluator's name and provider type (i.e., physician or audiologist) must be legibly written or typed, and accompany the signature.

(a) Tests shall include, at a minimum, bilateral air conduction stimuli and bone conduction stimuli at 500, 1000, 2000 and 4000 Hz, speech reception threshold, speech discrimination, most comfortable listening level and uncomfortable listening level; and

(b) All tests shall be performed in an appropriate sound environment; and

(c) Test results must show a severity of loss of at least 26 db HL at two or

more frequencies in either ear to be considered for coverage. If physical or developmental limitations preclude these tests (e.g., on an infant), an explanation and alternative test results must be provided.

(d) Test results must indicate whether or not the recipient has been fitted previously for a hearing aid (by the current or any other provider), the age of the current aid, and the reason for any change being recommended.

(4) Hearing aids must be clearly designated "new" or "used" on the prior authorization request. A reconditioned hearing aid is considered used for medicaid reimbursement purposes.

(C) Binaural, "CROS", and "BiCROS" aids are not routinely covered by the medicaid program but may be authorized for persons with special documented needs; e.g., child for whom binaural hearing is necessary for development of speech.

(D) Hearing aids must be dispensed by a physician, a licensed audiologist or a licensed hearing aid dealer.

(E) All hearing aids dispensed must be covered by a one-year warranty of all parts (except earmolds and batteries) and labor. All earmolds must be warranted for ninety days. After the warranty period, necessary earmolds or repairs which are within the maximum allowances specified in rule 5101:3-10-20 of the Administrative Code will not require prior authorization. Prior authorization requests for earmolds in excess of the maximum allowed will be considered for special cases when appropriate documentation of medical necessity is provided. Visits to a hospital, home, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF-MR) for the purpose of taking an earmold impression are covered but subject to limitations specified in rule 5101:3-10-20 of the Administrative Code.

(F) Each recipient of a hearing aid shall be scheduled for a recheck to assess the performance and recipient acceptability of the aid within thirty days of receipt of the aid by the recipient. A copy of the recheck report, countersigned by the recipient or an explanation of why the recheck was not performed, shall be maintained in the provider's file for a period of four years. No claim for payment should be made prior to a recheck or thirty days from the initial fitting of the aid, whichever comes first.

(G) When a recheck is performed within thirty days and the hearing aid is deemed unacceptable by both the hearing aid fitter and the recipient, the cost of the earmold, batteries, and one month's use of the instrument will be borne by the

department. On the rare occasions that this may happen, the original authorization form must be forwarded to the bureau of medical operations for cancellation and subsequent issuance of a revised authorization reflecting the new cost. If payment has been made on the original authorization, no adjustment to payment will be authorized.

(H) Payment for a hearing aid includes:

(1) Hearing aid, cleaning kit, earmold, and a one-month supply of batteries;

(2) Shipping and handling;

(3) Hearing aid examination and selection;

(4) Earmold impression(s);

(5) Fitting(s);

(6) Up to three hours of counseling;

(7) All visits necessary for the dispensing and fitting of the aid (regardless of place of service);

(8) One year warranty to cover all repair costs; and

(9) All service calls and follow-up during the one year warranty period.

(I) In general, reimbursement for a hearing aid will be limited to a maximum of one aid in any four-year period. Requests for more frequent replacement for medically necessary reasons will be considered when appropriate documentation is provided.

(J) A copy of the manufacturer's warranty and any applicable insurance coverage shall be maintained in the provider's file for a period of four years and copies shall be provided to the department on request.

(K) No hearing aid will be authorized for replacement until the department has received proof that replacement is not covered by the manufacturer's warranty or insurance. A request for prior authorization of a replacement hearing aid outside of the warranty period must meet all the requirements of this rule. No hearing aid will be authorized for replacement if repair or reconditioning would be more cost-effective.

(L) A provider may bill medicaid for necessary repair of a hearing aid only if the following conditions exist:

(1) The aid had been acquired through the medicaid program; or

(2) The medicaid program has determined that the aid, not acquired through the program, is medically necessary; and

(3) The repair is not covered by warranty or insurance.

Effective:

R.C. 119.032 review dates: 04/19/2005

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Certification

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Date

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