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.

(3) "Programmable."

A hearing aid that utilizes analog technology that is controlled by modifying the frequency and output characteristics using a computer. It may contain multiple microphones, multiple memories, multiple channels, and may operate with a remote control.

(4) "Digital."

A digital hearing aid will analyze the incoming sound, transform it by converting the sound into digital bits, manipulate the frequency and output characteristics before the sound is amplified. Digital hearing aids are programmed with a computer and contain multiple memories, microphones, and channels. The digital processor permits the hearing aid to change its parameters, to reduce background noise, and/or eliminate feedback without adversely affecting the benefits for the user.

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

(1) Completed "Prior Authorization" form (~~ODHS~~ JFS ~~3142~~ 03142);

(2) A current physician's prescription which verifies the need for a hearing aid and includes a statement that a medical examination/evaluation 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~~ Test results ~~in the form of charts, an audiometric diagnosis,~~

and the written recommendation for type of aid and fitting instructions, performed, ~~and~~ signed and dated by a physician ~~specializing in otology or otolaryngology~~, ~~or performed and signed by~~, by a licensed audiologist, or a licensed hearing aid fitter. The ~~evaluator's~~ tester's name and provider type (i.e., physician, ~~or~~ audiologist, or hearing aid fitter) 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;~~ at least three of four thresholds for air conducted stimuli of 500 Hz, 1000 Hz, 2000 Hz, 4000 Hz , air conducted speech awareness, or speech reception threshold. Tests shall also include air-conduction most comfortable listening level and uncomfortable listening level and bone-conducted pure tone testing, unless the patient's cognitive abilities do not permit. Test results shall be obtained bilaterally unless the recipient's behavior/condition does not permit bilateral tests; ~~and~~

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

~~(c)~~(b) ~~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~~ Test results for children age birth to twenty-one must show a best pure-tone average of twenty-six dB HL or greater in at least one ear. Test results for adults must show a best pure-tone average of thirty-one dB HL or greater. Pure-tones may be averaged across any three of four frequencies of the same ear (500 Hz, 1000 Hz, 2000 Hz, 4000 Hz) or any two adjacent frequencies for the same ear (i.e., 500 Hz and 1000 Hz; 1000 Hz and 2000 Hz; 2000 Hz and 3000 Hz; 3000 Hz and 4000 Hz). If physical or developmental limitations preclude these behavioral test results (e.g., on an infant), an explanation and alternative test results must be provided;~~.~~

(c) Tests performed by hearing aid fitters for a medicaid recipient are limited to those tests allowed in accordance with Chapter 4747. of the Revised Code. The tests performed by audiologists for a medicaid recipient are limited to those tests allowed in accordance with Chapter 4753. of the Revised Code.

(d) Test results must indicate whether or not the recipient has been fitted previously for a hearing aid (by the current or by 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.~~

(5) A copy of the written results of the medical examination/evaluation signed and dated by the physician who performed the medical examination/evaluation. The evaluator's name must be legibly written or typed, and accompany the signature.

For the purposes of medicaid reimbursement, the exception for a medical referral or medical evaluation for a medicaid recipient eighteen years of age or older allowing the opportunity to waive the medical evaluation specified in paragraph (A) (10) of rule 4747-1-19 of the Administrative Code or rule 4753-8-03 of the Administrative Code must not be applied to medicaid recipients; and,

(6) The date of birth of the recipient needing the hearing aid.

(C) The following types of hearing aids are not covered by ODJFS:

(1) All types of "in the canal" and "completely in the canal" hearing aids listed in rule 5101:3-1-60 of the Administrative Code; and,

(2) All types of disposable hearing aids listed in rule 5101:3-1-60 of the Administrative Code.

(D) Digitally programmable analog and digital hearing aids.

(1) The following criteria must be met for hearing aids described in this paragraph to be considered for coverage:

(a) Documentation that the digital/programmable hearing aid will offer superior performance over a conventional hearing aid for the individual. Information must show that the recipient requesting the digital/programmable aid needs functions that are not found in a conventional hearing aid, i.e., automatic feedback reduction, automatic noise reduction, programmable volume control, programmable telephone coil;

(b) Test results referenced in paragraph (B) of this rule must show the need for a hearing aid; and,

(c) If the hearing aid is for a child age twenty or younger, the following criteria must be met in addition to the criteria specified in paragraphs

(D) (1) (a) to (D) (1) (b) of this rule:

(i) Documentation that the digital/programmable hearing aid is necessary for speech development i.e. that the child has two or more uniquely different listening environments that reasonably would require the functional features of digital/programmable hearing aids; and/or,

(ii) Documentation supports that the digital/programmable hearing aid is necessary for the child's success in school (including pre-school), e.g., letters of support from a teacher for the hearing impaired and/or from an educational audiologist.

(2) Programmable/digital hearing aids may be covered for adults age twenty-one and over if prior authorization determines that criteria for coverage are met for a programmable/digital hearing aid and all of the requirements in paragraph (D) (1) of this rule are met, as long as the programmable/digital hearing aid is a cost-effective alternative to a conventional hearing aid. The payment maximum for hearing aids for adults is described in paragraph (D) (5) (b) of this rule.

(3) The department's payment for a programmable or digital hearing aid includes two adjustments per year for the duration of the first-year warranty for comprehensive loss, damage and repair, and two adjustments per year under a second-year warranty for comprehensive loss, damage and repair. If adjustment is necessary due to documented changes in measured hearing sensitivity because of growth of the ear canal, payment for adjustment will be authorized as a repair if and only if this is the third adjustment during a warranty period for comprehensive loss, damage, and repair. In addition, the repair provisions stated in rule 5101:3-10-08 of the Administrative Code must be met. The price of a programmable or digital hearing aid includes the price of the second year warranty for comprehensive loss, damage, and repair.

(4) The following documentation must be submitted with any prior authorization request for a programmable or digital hearing aid:

(a) All documentation listed in paragraph (B) of this rule;

(b) Documentation showing the following:

(i) The code for the type of hearing aid billed;

(ii) The manufacturer's cost estimate for the hearing aid;

(iii) The provider's discount; and,

(iv) Shipping costs.

(c) Documentation of a medical examination/evaluation by a physician within the six months of the date of the prior authorization request;

(d) Results of an audiogram performed by an audiologist or a hearing aid fitter within six months of the date of the prior authorization request;

(e) Documentation of the superiority of a digital/programmable aid as described in paragraph (D) (1) (a) of this rule;

(f) Letters of support from the school system and/or educational audiologist outlining the objective and subjective benefits described in paragraph (D) (1)(c)(ii)of this rule. Documentation from parents may be used as supplemental documentation;

(g) For infants and young children, a letter of justification for a digital/programmable hearing aid is required; and,

(h) Documentation of a second year warranty including the price (if any) must be included in the prior authorization request for the hearing aid.

(5) Medicaid's payment for a digital or programmable hearing aid.

(a) For a child up to age twenty-one, the department's payment for a digital or programmable hearing aid is the lesser of the medicaid maximum listed in rule 5101:3-1-60 of the Administrative Code for a programmable or digital aid or the provider's acquisition cost. Acquisition cost consists of the manufacturer's invoice price minus any discounts, plus actual shipping costs, and the cost of a second year warranty for comprehensive loss, damage, and repair. The department will pay dispensing fees for professional services listed in rule 5101:3-1-60 of the Administrative Code.

(b) For an adult, age twenty-one and older, the department's payment for a digital or programmable hearing aid is the lesser of the medicaid maximum for a conventional hearing aid listed in rule 5101:3-1-60 of the Administrative Code or the provider's acquisition cost defined in paragraph (D) (5)(a) of this rule. The department will pay dispensing fees for professional services listed in rule 5101:3-1-60 of the Administrative Code.

(c) If the manufacturer's final invoice price does not match the hearing aid cost estimate submitted as part of the prior authorization request, the provider must submit a new prior authorization reflecting the final invoice price and acquisition amount defined in paragraph (D)(5)(a) of this rule before reimbursement can be made.

(d) Providers must maintain copies of the manufacturer's cost estimate and the final manufacturer's invoice including discounts and shipping costs in the patient's record and make them available to the department upon request.

(6) When billing for a digital or programmable hearing aid for a child, the provider must use the code for the digital or programmable hearing and use the modifier U1 to signify that the aid is for a child.

~~(C)~~(E) 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)~~(F) Hearing aids must be dispensed by a physician, a licensed audiologist, or a licensed hearing aid dealer.

~~(E)~~(G) All conventional hearing aids dispensed must be covered by a one-year warranty of all parts (except earmolds and batteries) and labor. All programmable and digital hearing aids must be covered by a two-year warranty for comprehensive loss, damage, and repair. 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)~~(H) 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)~~(I) 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)~~(J) 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 and tests necessary for the dispensing and fitting of the aid (regardless of place of service);

(8) One year warranty for a conventional hearing aid to cover all repair costs. For a digital or programmable hearing aid, a two year warranty for comprehensive loss, damage, and repair for a digital and programmable hearing aid; and,

(9) All service calls and follow-up during the one year warranty period for conventional hearing aids and for the two year warranty period described in paragraph (J)(8) of this rule for programmable or digital hearing aids.

~~(I)~~(K) In general, reimbursement for a hearing aid will be limited to a maximum of one aid in any ~~four-year~~ five year period. Requests for more frequent replacement for medically necessary reasons will be considered when appropriate documentation is provided. A request for replacement of a hearing aid for non-medical reasons will be considered if the hearing aid is not covered under a warranty. However, cases suggesting malicious damage, neglect, culpable irresponsibility, or wrongful disposition of the hearing aid will be investigated and denied where the department determines it is unreasonable to make program payment under the circumstances. If a hearing aid is lost and it is covered by warranty, the department will not cover any deductible or replacement charge not covered by the warranty. This deductible or replacement charge is considered a non-covered service and will be the recipient's responsibility.

~~(J)~~(L) 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~~ five years and copies shall be provided to the department on request.

~~(K)~~(M) 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)~~(N) 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~~.~~; and,

(4) All of the requirements for repairs listed in paragraph (B) of rule 5101:3-10-08 of the Administrative Code are met.

(O) The department will pay for only one hearing aid code and only one unit.

(P) Effective for dates of service on and after the effective date of this rule, the department will pay a separate fee for dispensing a hearing aid listed in 5101:3-1-60 of the Administrative Code. The department will reimburse only one dispensing fee per recipient every five years.

Effective:

R.C. 119.032 review dates: 07/16/2004

WITHDRAWN ELECTRONICALLY

Certification

04/20/2005

Date

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