

Ohio Department of Medicaid  
Appendix  
660-10-01

## CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION HEARING AIDS

<b>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.</b>			
Name of Consumer		Billing Number	
Street Address		City/State/Zip	Date of Birth
Does recipient own any other hearing aids? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the age of the hearing aid(s)?	
If yes, how many does he/she own?		Hearing aid #1	Hearing aid #2
Describe the hearing aid(s)		Were hearing aid(s) purchased through Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Why is recipient requesting new hearing aid(s)			
<b>Section A - Completed by Prescriber and/or Audiologist</b>			
<b>Hearing aid evaluation</b> <input type="checkbox"/> Supports consumer's need for a hearing aid <input type="checkbox"/> Performed and signed by a physician specializing in otology or otolaryngology, an audiologist, or a hearing aid fitter <input type="checkbox"/> Reflects the specific hearing values resulting from the test <input type="checkbox"/> Includes a written summation of the hearing test results, performed and signed by a physician specializing in otology or otolaryngology, or an audiologist		<input type="checkbox"/> Documentation includes a <b>legible name and provider type</b> for person performing either the hearing test, the written summation of the hearing test results, or both. This information accompanies the provider signature.  <input type="checkbox"/> <b>Testing performed not more than 6 months prior to the date of the prior authorization request.</b>	
<b>For consumer's 21 years of age or older</b> , the evaluation includes <input type="checkbox"/> At least 4 thresholds for air conducted stimuli or <b>500 Hz, 1000 Hz, 2000 Hz and 4000 Hz</b> <input type="checkbox"/> Best pure-tone average of <b>31 dB HL or greater</b> <input type="checkbox"/> Air conducted speech awareness, or speech reception threshold <input type="checkbox"/> Most comfortable and uncomfortable listening level <input type="checkbox"/> Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing <input type="checkbox"/> Hearing test is obtained bilaterally unless recipient's behavior/condition does not permit bilateral evaluation <input type="checkbox"/> Supporting documentation is provided as to why bilateral test is not done.		<b>For consumer's 20 years of age or younger</b> , the evaluation includes <input type="checkbox"/> At least 4 thresholds for air conducted stimuli or <b>500 Hz, 1000 Hz, 2000 Hz and 4000 Hz</b> <input type="checkbox"/> Best pure-tone average of <b>26 dB HL or greater</b> <input type="checkbox"/> Air conducted speech awareness, or speech reception threshold <input type="checkbox"/> Most comfortable and uncomfortable listening level <input type="checkbox"/> Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing <input type="checkbox"/> Tympanometry Acoustic reflex <input type="checkbox"/> battery Otoacoustic emissions <input type="checkbox"/> testing <input type="checkbox"/> Hearing test is obtained bilaterally unless recipient's behavior/condition does not permit bilateral evaluation <input type="checkbox"/> Supporting documentation is provided as to why bilateral test is not done.	
<b>Digital/programmable hearing aid and physician documents</b> <input type="checkbox"/> Digital/programmable hearing aid will offer superior performance over a conventional hearing aid for the specific consumer <input type="checkbox"/> The digital/programmable hearing aid is necessary for the consumer's success in educational development <input type="checkbox"/> This particular consumer requires functions that are not found in a conventional hearing aid (i.e., automatic feedback reduction, automatic noise reduction, programmable control)		<b>This consumer requires the following <u>digital hearing aid</u> features</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> Adaptive directionality, automatically changing polar plot  <input type="checkbox"/> Adjust MPO without affecting gain curve  <input type="checkbox"/> Automatic directionality  <input type="checkbox"/> Data logging, collection of user's wearing history and program use  <input type="checkbox"/> Digital feedback management, phase cancellation  <input type="checkbox"/> Digital noise reduction  <input type="checkbox"/> Digital wide dynamic range compression           </div> <div style="width: 35%;"> <input type="checkbox"/> Digital volume control with an option to disable  <input type="checkbox"/> Low battery warning indicator  <input type="checkbox"/> Multiple bands or channels  <input type="checkbox"/> Multiple programs  <input type="checkbox"/> Multiple signal processing strategies  <input type="checkbox"/> Open ear fitting  <input type="checkbox"/> In-situ hearing thresholds to determine gain  <input type="checkbox"/> Switchless telephone or telecoil program  <input type="checkbox"/> Wide fitting range to accommodate progressive hearing changes  <input type="checkbox"/> Other:           </div> </div>	

**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:**

**Section B - Prescriber Attestation and Signature/Date**

Prescriber Name ( <i>printed</i> )	Prescriber signature and date are no more than 90 days prior to the stamped date of the PA Request.
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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.

_____ Signature (No stamps)	_____ Ohio Medicaid Provider #
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