MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hearing Aid Dealers 03-04
Hearing and Speech Centers 03-04

Issued: December 1, 2003

Subject: Hearing Aid Dealer Coverages and Limitations Chapter

Effective: January 1, 2004

Programs Affected: Medicaid, Children's Special Health Care Services

This bulletin transmits the revised Hearing Aid Dealer Coverages and Limitations Chapter. As part of the chapter revision process, previously issued policy bulletins have been incorporated. Rewording and clarification of existing policy, as well as policy changes have been included to reflect issues raised and clarifications requested by the provider community and from within the Michigan Department of Community Health (MDCH). In addition, the revisions to this chapter further refine the uniform billing project goal of consistency between Medicaid and other payers.

Hearing Aid Dealer services are not currently a benefit for beneficiaries age 21 and over and will continue to be non-covered until funding is restored and a bulletin is distributed notifying providers of the effective date of coverage. The attached chapter becomes effective on January 1, 2004 for beneficiaries under age 21only.

In reviewing this chapter, please note the following:

- Reorganization of information to include "Standards of Coverage", "Prior Authorization Requirements" and "Payment Rules" sections for each major service area.
- Hearing aids have been defined for purposes of administering and clarifying Medicaid coverage.
- Changes in prior authorization criteria for digital/programmable hearing aids.

Manual Maintenance

The current Hearing Aid Dealers Chapter III should be replaced with the attached Chapter effective January 1, 2004.

The following bulletins are obsolete and should be discarded: MSA 03-02, AP 02-05, AP 02-04, AP 02-03, MSA 02-04, MSA 02-02, AP 00-11, AP 00-10, MSA 00-06, AP 00-07, AP 99-06, AP 99-04, AP 99-03, MSA 98-07, AP 97-08, AP 97-03, Hearing & Speech Centers 96-11, MSA 95-06, 5310.1-86-08, 5310.1-88-15.

This bulletin may be discarded after manual maintenance is completed.

Questions

Any questions regarding this bulletin should be directed to Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration

HEARING AID DEALERS

TABLE OF CONTENTS

SECTION 1 - COVERAGE OVERVIEW

The primary objective of Medicaid is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services, recommended and supported by a pediatric subspecialist, with care coordination that relates to the CSHCS qualifying diagnosis. Policies are aimed at maximizing the health care services obtained for this population with the limited number of dollars available.

The term Medicaid throughout this chapter refers to both the Medicaid Program and the CSHCS Program.

1.1 PROVIDER LICENSURE REQUIREMENT

Services must be provided by a Medicaid-enrolled hearing aid dealer licensed in the state of Michigan and must conform to the standards of practice described in the current Michigan Occupational Code (Act 299 of 1980, Article 13).

1.2 HCPCS CODES, PARAMETERS AND MODIFIERS

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the Hearing Aid Dealers Database on the MDCH website. (Refer to the Directory Appendix for website information.) The database includes HCPCS codes, short descriptions, current activity status, fee screens, quantity limits, prior authorization (PA) indicators and age limits.

If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code. All NOC codes require PA.

The "LT" or "RT" modifiers must be reported for all monaural hearing aids, hearing aid repairs/modifications and earmolds to designate either the left or right side of the body.

1.3 COVERED SERVICES

Medicaid covers the following services when provided by a licensed hearing aid dealer:

- Hearing aids and delivery
- Hearing aid repairs and modifications
- Replacement earmolds
- Hearing aid supplies and accessories
- Replacement of hearing aid batteries
- Alternative listening devices for beneficiaries over age 21 years

1.4 NONCOVERED ITEMS

Noncovered items include, but are not limited to, the following:

- Hearing aids that do not meet U.S. Food and Drug Administration (FDA) and Federal Trade Commission requirements
- Spare equipment (e.g., an old hearing aid in working condition for back-up use in emergencies)
- Personal FM Amplification Systems
- Alerting devices
- Hearing aids requested solely or primarily for the elimination of tinnitus
- Equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics
- Hearing aids delivered more than 30 days after a beneficiary becomes ineligible for Medicaid

1.5 Mandatory Hearing Aid Manufacturer's Warranty

Medicaid requires that all hearing aids include a manufacturer's warranty that guarantees replacement of a lost, broken or stolen hearing aid one time within the first 12 months after the hearing aid is dispensed. This guarantee must be provided at no cost to the beneficiary or to Medicaid.

1.6 Co-Payments

Beneficiaries are required to pay a $3.00 co-payment for a hearing aid. Exceptions to the co-payment include:

- Medicaid beneficiaries under age 21
- All CSHCS beneficiaries
- All beneficiaries residing in a nursing facility

If a beneficiary is unable to pay a required co-payment on the date of service (DOS), providers cannot refuse to render the service. Providers may bill beneficiaries for the co-payment amount, and the beneficiary is responsible for paying it. If the beneficiary fails to pay a co-payment, providers can, in the future, refuse to serve the beneficiary.

When calculating reimbursement, Medicaid deducts the co-payment from the amount billed when applicable. If the provider deducts the co-payment from his claim, an underpayment results. Addition of the co-payment amount to the acquisition cost is not allowed.

1.7 Dispensing Fee

The hearing aid dealer may only bill the dispensing fee when providing direct patient contact in delivering and instructing beneficiaries on the use and care of the hearing aid. The dispensing fee is billed separate from the hearing aid using the appropriate HCPCS code. Components of the dispensing fee are not to be billed separately. Reimbursement for the hearing aid dispensing fee includes, but is not limited to:

- Hearing aid delivery
- Modification and adjustments required within the manufacturer's warranty period
- Fitting, orientation and checking of the hearing aid

- Instructions on use and care of the hearing aid
- Initial earmolds and impressions
- All necessary components that may include cords, tubing, connectors, receivers and huggies
- One standard package of appropriate batteries per aid (or charger for rechargeable models)
- One year warranty on parts and labor repairs
- A minimum 30-day trial/adjustment period with exchange/return privilege

1.8 Medical Clearance

A medical clearance is a signed statement from the physician indicating that:

- A medical evaluation has been performed; and
- There are no contraindications to the use of a hearing aid.

For Medicaid beneficiaries under age 18, an otolaryngologist must complete the medical clearance.

For Medicaid beneficiaries age 18 years or older, the medical clearance may be completed by either an otolaryngologist or the primary care physician.

The medical clearance must include the beneficiary's name, birth date, address, Medicaid identification (ID) number, the services provided, the DOS, the provider's name and Medicaid provider ID number. When the medical clearance is provided by a physician who is not enrolled in Medicaid, it must include the physician's complete office address and phone number.

1.9 Documentation in Beneficiary File

Hearing aid dealers must maintain all applicable documentation in the beneficiary's file for six years. For audit purposes, the hearing aid dealer's records or patient's medical record must substantiate the medical necessity of the item supplied.

1.10 Measurable Benefits/Hearing Aid Conformity Check

Hearing aid dealers must instruct beneficiaries to return to the Hearing and Speech Center for the conformity evaluation during the 30-day trial period. Any delivered hearing aid(s) is expected to demonstrate measurable benefit, established either at the time of fitting or follow-up. Benefit may be established by any one of, or a combination of, commonly used procedure(s), including measures of aided hearing and understanding of speech; functional gain measures; probe-microphone measurements, and/or (minimally) the subjective impressions of the beneficiary, the beneficiary's family member(s) or guardian, or attending staff. One of, or a combination of, the following measures may demonstrate benefit in cases of severe to profound hearing loss:

- Improved functional or insertion gain in the speech frequencies.
- Increased awareness of speech and/or environmental sounds.
- Improved speech recognition performance at average or slightly raised conversational levels with or without visual cues.

- Beneficiary's or family members' subjective report of speech benefit in everyday listening situations.

When a delivered hearing aid does not provide benefit, as defined above, providers are expected to return it to the manufacturer within 30 days for circuitry modifications, remake, exchange, or credit, as recommended by the Hearing and Speech Center. The hearing aid dealer must notify the beneficiary of this when the hearing aid is dispensed.

All full or partial refunds made by a manufacturer to the hearing aid dealer when a hearing aid is returned within the 30-day trial period and replaced with a less costly aid must be returned to Medicaid via a claim replacement.

1.11 PRIOR AUTHORIZATION

Prior authorization (PA) is required for certain services before the services are rendered. To determine which services require PA, refer to the Standards of Coverage, Limitations and Payment Rules Section of this Chapter or the Hearing Aid Dealers Database on the MDCH website.

PA is required for the following situations:

- All hearing aids, except conventional analog hearing aids meeting the bilateral standards of coverage.
- Alternative Listening Devices.
- Services and items that exceed quantity limits, frequency limits, or established fee screen.
- For a NOC code.

1.11.A. PRIOR AUTHORIZATION FORM AND COMPLETION INSTRUCTIONS

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B). (Refer to the Forms Appendix or the MDCH website for a copy of the form.) Medical documentation (e.g., medical clearance, audiogram and hearing aid recommendation from audiologist, documentation to substantiate the acquisition cost) must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including manufacturer, model and style of the hearing aid requested, and the appropriate HCPCS procedure codes with applicable modifiers must be provided on the form. The form and all documentation must include the beneficiary name and Medicaid ID number, provider name, address and Medicaid provider ID number.

PA request forms for all eligible Medicaid beneficiaries must be mailed or faxed to MDCH Prior Authorization Division. To check the status of a PA request, contact the MDCH Prior Authorization Division via telephone. (Refer to the Directory Appendix for contact information.)

A sample of the form with additional instructions is in the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B) Section of this chapter.

1.11.B. Emergency Prior Authorization

A provider may contact MDCH to obtain a verbal PA when the physician providing the medical clearance has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain verbal PA, the provider may call or fax a request. If the provider faxes a request, the request must state, "verbal prior authorization required", and indicate the physician name and phone number in box #37 on the MSA-1653-B. (Refer to Directory Appendix for contact information.)

If a service is required during non-working hours, the provider must contact the Prior Authorization Division the next working day.

The following steps must still be completed before a PA number is issued for billing purposes:

- The MSA-1653-B must be submitted to the Prior Authorization Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted along with the PA request.
- The verbal authorization date must be entered in box #37 of the MSA-1653-B.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible when the service was provided.
- The Prior Authorization Division does not receive the completed MSA-1653-B and required documentation within 30 days of the verbal authorization.
- The required documentation is dated after the date of service.

1.11.C. Retroactive Prior Authorization

Services provided before PA is requested are not covered unless the beneficiary was not eligible on the DOS and a subsequent eligibility determination was made retroactive to the DOS. If MDCH's record does not show that retroactive eligibility was provided, then the request for retroactive PA is denied.

1.11.D. Beneficiary Eligibility

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible. To assure payment, the provider must verify eligibility for Fee For Service (FFS) Medicaid or the CSHCS Programs before initiating services. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

1.11.E. Reimbursement Amounts

Many items have established fee screens that are published in the Hearing Aid Dealers Database. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized PA request.

1.11.F. Billing Authorized Services

After authorization is issued, the information (e.g., PA number, procedure code, modifier and quantity) that was approved on the PA must match the information on the claim form. (Refer to the Billing and Reimbursement for Professionals Chapter for complete billing instructions.)

SECTION 2 - STANDARDS OF COVERAGE, LIMITATIONS AND PAYMENT RULES

2.1 HEARING AIDS- GENERAL

The following definitions are to be used for purposes of administering and clarifying Medicaid coverages and limitations for hearing aid dealers:

Hearing Aid	A hearing aid, also referred to as a hearing instrument, is an electronic device that brings amplified sound to the ear. The hearing aid usually consists of a microphone, an amplifier and a receiver.
Conventional Analog Hearing Aid	An amplification device that uses conventional, continuously varying signal processing. Includes hearing aids that are body worn, behind the ear, in the ear, in the canal and bone conduction. Does not include any hearing aid considered digitally programmable or CROS/BICROS circuitry.
CROS Hearing Aid	Contralateral routing of signal. A hearing aid with a microphone worn on an unaidable ear with a receiver worn on the better ear. The receiver cannot be worn alone.
BICROS Hearing Aid	Bilateral routing of signal. A hearing aid with microphones worn on each ear with a receiver on the better ear.
Programmable Hearing Aid	Digitally controlled analog or digital signal processing hearing aid in which the parameters of the instrument are under computer control.
Digital Hearing Aid	A hearing aid that processes signals digitally (syn:DSP).

Hearing aids are only a benefit when:

- The recommended hearing aid meets U.S. FDA and Federal Trade Commission requirements.
- Medical documentation indicates that the hearing loss is not temporary in nature due to a treatable medical middle ear effusion or that surgery is not planned until at least a year into the future for a conductive type hearing loss.
- No hearing aid has been dispensed to the beneficiary within the last three years.
- The hearing aid includes a mandatory hearing aid manufacturer's warranty

2.2 CONVENTIONAL ANALOG HEARING AIDS

2.2.A. STANDARDS OF COVERAGE - BILATERAL HEARING LOSS

The bilateral hearing loss standards of coverage are as follows:

Age Under 21 Years	Conventional analog **monaural or binaural** hearing aid: ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 25 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000 and 4000 Hz; or ▪ Results of a complete diagnostic audiological evaluation (e.g., auditory brainstem response, evoked otoacoustic emissions, soundfield testing, or any combination of these) indicating a hearing loss of 25 dB HL or greater.

Age 21 Years or Over	Conventional analog **monaural** hearing aid: ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz. and ▪ A speech recognition score of at least 20 percent in the ear to be aided.
	Conventional analog **binaural** hearing aid: ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz. ▪ A speech recognition score must be greater than 20 percent in both ears. ▪ The four frequency average between ears must not exceed 20dB HL and ▪ The speech recognition scores must not differ between ears by more than 30 percent.

2.2.B. STANDARDS OF COVERAGE - UNILATERAL HEARING LOSS

The unilateral hearing loss standards of coverage for a conventional analog hearing aid are as follows:

Age Under 21 Years	▪ Hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Speech recognition scores must be greater than 60 percent in the ear to be aided. ▪ The beneficiary must be receiving hearing impaired services through the school system and ▪ A 30-day trial has been completed and indicates that amplification has been accepted and that auditory skills and learning capacity were enhanced or there is a documented history of prior hearing aid use.
Age 21 Years or Over	▪ Hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Speech recognition scores must be greater than 60 percent in the ear to be aided. ▪ A Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit or similar inventory indicates a need for amplification and ▪ Hearing aid is required for independent functioning (e.g., affects on employment, communication status).

2.2.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.

- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and charges

Additional applicable documentation required when a conventional analog hearing aid is dispensed for unilateral hearing loss includes:

Age Under 21 Years	▪ An audiogram documenting hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Documentation of speech recognition scores greater than 60 percent in the ear to be aided. ▪ Documentation from the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial or a documented history of prior hearing aid use.
Age 21 Years or Over	▪ An audiogram documenting hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Documentation of speech recognition scores greater than 60 percent in the ear to be aided. ▪ Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit or similar inventory indicating need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.2.D. PRIOR AUTHORIZATION REQUIREMENTS

PA is not required for either monaural or binaural conventional analog hearing aids if the bilateral standards of coverage are met.

PA is required for the following:

- Replacement aids within three years.
- Conventional analog hearing aids when the bilateral standards of coverage are not met.
- Conventional analog hearing aids for unilateral hearing loss.

The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance signed by a physician.
- Audiogram completed within the past six months, signed and dated by the audiologist and including the recommended manufacturer, model and style of hearing aid.

The following additional documentation must be submitted with all PA requests for conventional analog hearing aids provided for unilateral hearing loss:

Age Under 21 Years	▪ An audiogram documenting hearing loss of 25 dB HL or greater in the ear to be aided, with normal hearing in the better ear. ▪ Documentation that the ear to be aided has a speech recognition score greater than 60 percent. ▪ Documentation provided by the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired, and/or the educational audiologist that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial or documentation of a history of prior hearing aid use.
Age 21 Years or Over	▪ An audiogram documenting hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Documentation that the ear to be aided has a speech recognition score greater than 60 percent. ▪ Results of administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating a need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.2.E. PAYMENT RULES

Payment for a conventional analog hearing aid is the lesser of the provider's acquisition cost or Medicaid's maximum allowable amount. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.3 CROS HEARING AIDS

2.3.A. STANDARDS OF COVERAGE

CROS hearing aids are a benefit for beneficiaries of all ages when:

- There is demonstrated need for amplification.
- An audiogram indicates no residual hearing in the poorer ear (unaidable) and normal hearing in the better ear as demonstrated by thresholds less than 30 dB HL using the four frequency average of 500, 1000, 2000, and 4000 Hz.

The standards of coverage for CROS hearing aides are as follow:

Age Under 21 Years	▪ The beneficiary must be receiving hearing impaired services through the school system. ▪ A 30-day trial has been completed and indicates that amplification has been accepted and that auditory skills and learning capacity were enhanced or there is a documented

	history of prior CROS hearing aid use.
Age 21 Years or Over	▪ A Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicates a need for amplification. ▪ Hearing aid is required for independent functioning (e.g., affects on employment, communication status).

2.3.B. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record for CROS hearing aids includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.
- A copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts and shipping charges.
- Documentation of need for amplification addressing beneficiary's communication needs.
- Additional applicable documentation includes:

Age Under 21 Years	▪ Documentation from the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial or documentation of a history of prior CROS hearing aid use.
Age 21 Years or Over	▪ Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.3.C. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all CROS hearing aids. The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance signed by a physician.
- Audiogram completed within the past six months, signed and dated by the audiologist and including the recommended manufacturer, model and style. The audiogram must

indicate no residual hearing in the poorer ear (unaidable) with normal hearing in the better ear as demonstrated by thresholds less than 30 dB HL using the four frequency average of 500, 1000, 2000, and 4000 Hz.

- Additional requirements include:

Age Under 21 Years	▪ Documentation from the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial.
Age 21 Years or Over	▪ Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.3.D. PAYMENT RULES

Medicaid's payment for a CROS hearing aid is the lesser of the acquisition cost or Medicaid's maximum allowable amount. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.4 BICROS HEARING AIDS

2.4.A. STANDARDS OF COVERAGE

BICROS hearing aids are a benefit for beneficiaries of all ages when there is demonstrated need for amplification. The standards of coverage for BICROS hearing aids are as follows:

Age Under 21 Years	An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 25 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear.
Age 21 Years or Over	▪ An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 30 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear. ▪ Hearing aid is required for independent functioning (e.g., affects on employment, communication status).

2.4.B. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record for BICROS hearing aids includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.

- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.
- A copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts and shipping charges.
- Documentation of need for amplification addressing beneficiary's communication needs.
- **For beneficiaries age 21 years or over:** Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.4.C. Prior Authorization Requirements

PA is required for all BICROS hearing aids. The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance signed by a physician.
- Audiogram completed within the past six months, signed and dated by the audiologist, and including the recommended manufacturer, model and style.
- Additional requirements include:

Age Under 21 Years	An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 25 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear.
Age 21 Years or Over	▪ The audiogram must indicate no residual hearing in the poorer ear (unaidable) and a hearing loss greater than 30 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.4.D. Payment Rules

Medicaid's payment for a BICROS hearing aid is the lesser of the acquisition cost or Medicaid's maximum allowable amount. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.5 Digital/Programmable Hearing Aids

2.5.A. Standards of Coverage

Digital/Programmable hearing aids are a benefit for beneficiaries **under 21 years of age** only when the digital/programmable aid shows superior performance over a conventional analog hearing aid.

The bilateral hearing loss standards of coverage for digital/programmable monaural or binaural hearing aides are as follows:

- Bilateral hearing loss documented by an audiogram showing hearing loss of 25 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000 and 4000 Hz; or
- Results of a complete diagnostic audiological evaluation (e.g., auditory brainstem response, evoked otoacoustic emissions, soundfield testing, or any combination of these) indicating a hearing loss of 25 dB HL or greater.

The unilateral hearing loss standards of coverage for digital/programmable monaural hearing aides are as follows:

- Hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear.
- Speech recognition scores must be greater than 60 percent in the ear to be aided.
- The beneficiary must be receiving hearing impaired services through the school system.
- A 30-day trial has been completed and indicates that digital/programmable amplification has been accepted and that auditory skills and learning capacity were enhanced.

2.5.B. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes :

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.
- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping charges.

When the acquisition cost of the digital/programmable hearing aid exceeds Medicaid's maximum allowable amount for a comparable conventional analog hearing aid, applicable documentation also includes:

- Documentation of superiority of aided thresholds and speech recognition ability in a comparison study of digital/programmable vs. conventional analog aids, including functional gain measures and probe microphone measurements.
- Letters of support from the school system, teacher consultant of the hearing impaired or educational audiologist outlining objective and subjective benefits during a 30-day trial period. Documentation from the parents may be used for supplemental support.
- For infants and young children who are unable to be tested in a comparison study, a letter of justification for advanced technology is required.

When a digital/programmable hearing aid is dispensed for unilateral hearing loss, applicable documentation also includes:

- Documentation from the educational system that the child is receiving hearing impaired services.
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist that digital/programmable amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial.

2.5.C. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all digital/programmable hearing aids. The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance.
- Audiogram completed within the past 6 months, signed and dated by the audiologist, and including the recommended manufacturer, model and style.
- Additional documentation requirements include:

When the acquisition cost exceeds Medicaid's maximum allowable amount for a comparable conventional analog hearing aid	▪ Documentation of superiority of aided thresholds and speech recognition ability in a comparison study of digital/programmable vs. conventional analog aids, including functional gain measures and probe microphone measurements. ▪ Letters of support from the school system, teacher consultant of the hearing impaired or educational audiologist outlining objective and subjective benefits during a 30-day trial period. Documentation from the parents may be used for supplemental support. ▪ For infants and young children who are unable to be tested in a comparison study, a letter of justification for advanced technology is required.
For aids provided for unilateral hearing loss regardless of acquisition cost	▪ Documentation that the ear to be aided has a speech recognition score greater than 60 percent. ▪ Documentation provided by the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired, and/or the educational audiologist that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial.

2.5.D. PAYMENT RULES

Payment for a digital/programmable hearing aid may not exceed Medicaid's maximum allowable amount for a comparable conventional analog hearing aid unless the documentation submitted with the PA request supports the need for the more advanced technology found with a digital/programmable hearing aid. When documentation of the need for a digital/programmable hearing aid is provided, the payment is the acquisition

cost for the digital/programmable hearing aid. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.6 Hearing Aid Supplies and Accessories Replacement

2.6.A. Standards of Coverage

The following hearing aid supplies and accessories are considered a benefit, if necessary, at a maximum of:

Item	Maximum
Hearing Aid Dry Aid Kit	Two per year per hearing aid
Hearing Aid Earhook	Four per year per hearing aid
Hearing Aid Superseals	Two per year per hearing aid
Hearing Aid Holster/Huggies	Four per year per hearing aid
Stetheset (Under 21 years old)	One with initial hearing aid only
Hearing Aid Battery Tester	One with initial hearing aid only
Hearing Aid Earmold Blower	One with initial hearing aid only

2.6.B. Documentation

Applicable documentation to be maintained by the provider includes:

- A list of hearing aid supplies/accessories provided to the beneficiary within the past 365 days; and
- A copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges.

2.6.C. Prior Authorization Requirements

PA is **not** required for hearing aid supplies and accessories if the sum of all payments for accessories/supplies billed within the past 365 days is $40 or less.

PA **is** required for hearing aid supplies and accessories if:

- Any single item is billed with requested payment amounts of over $40.
- The sum of all payments for accessories/supplies billed within the past 365 days is over $40.
- An item exceeds the standards of coverage.

Hearing aid supplies/accessories that exceed either the maximum payment limit of $40 or the standards of coverage require PA. A list of supplies/accessories provided within the past 365 days must be submitted with the MSA-1653-B PA request.

2.6.D. Payment Rules

Payment for hearing aid supplies and accessories includes the acquisition cost plus 10 percent. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.7 Replacement of Disposable Hearing Aid Batteries

2.7.A. Standards of Coverage

Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 25 batteries per hearing aid per six months. All batteries must be dispensed in the original packaging and must be dispensed at least one year before the expiration date shown on the package. The establishment of a "battery club", where batteries are automatically mailed to a beneficiary, regardless of need, is not allowed.

Hearing Aid Dealers may not bill for replacement of disposable batteries for cochlear implant devices.

2.7.B. Prior Authorization Requirements

PA is required for quantities exceeding the standards of coverage. Documentation must accompany the MSA-1653-B PA request to substantiate the need for additional batteries.

2.7.C. Payment Rules

Medicaid's payment for disposable hearing aid batteries is the lesser of Medicaid's maximum allowable amount or the acquisition cost plus 10 percent. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.8 Replacement Earmolds

2.8.A. Standards of Coverage

13 years and over	Beneficiaries who use hearing aids that require custom earmolds are eligible for replacement earmolds every 12 months without prior approval.
3 to 12 years	Beneficiaries are eligible for replacement every six months without prior approval.
Under age 3 years	Beneficiaries eligible for replacement every three months without prior approval.

2.8.B. Prior Authorization Requirements

PA is required for replacements exceeding the standards of coverage. Documentation must accompany the MSA-1653-B PA request to substantiate the need for additional earmold replacements.

2.8.C. Payment Rules

Medicaid's payment for replacement earmolds is the lesser of Medicaid's maximum allowable amount or the provider's usual or customary charges.

2.9 Hearing Aid Repairs and Modifications

2.9.A. Standards of Coverage

Providers may bill for repairs and modifications only to the most recently dispensed out-of-warranty hearing aid. Repairs are not covered for "back-up" aids or devices. Services under warranty may not be billed to Medicaid.

2.9.B. Documentation

Applicable documentation to be maintained in the beneficiary's record includes an itemization of materials used to repair the hearing aid and related labor costs.

2.9.C. Prior Authorization Requirements

PA is **not** required for hearing aid repairs and/or modifications if:

- The payments for the repair/modification are less than $80.
- No more than two separate repairs/modifications are billed in 365 days.

PA **is** required for hearing aid repairs and/or modifications if:

- The requested payment amount is over $80.
- Separate repairs/modifications are billed over two times in 365 days.

Repairs that are expected to exceed either the maximum payment limit of $80 or two episodes in 365 days require PA. Documentation must be submitted with the MSA-1653-B PA request providing a written estimate of what the repair and/or modifications will be. The estimate should include the materials, labor and shipping costs.

2.9.D. Payment Rules

Medicaid's payment for hearing aid repairs/modifications includes no more than the actual cost plus $20. Actual cost consists of acquisition cost of materials used for the repair plus related labor costs and actual shipping costs.

2.10 Alternative Listening Devices

An Alternative Listening Device (ALD) is defined as a special purpose electro-acoustic device designed to enhance receptive communication (e.g., Pocket Talker).

2.10.A. STANDARDS OF COVERAGE

ALDs are a benefit for beneficiaries **age 21 or over** under the following conditions:

- No hearing aid has been dispensed to the beneficiary within three years.
- No ALD has been dispensed to the beneficiary within three years.
- The beneficiary is residing in a nursing facility.
- Patient management of a personal hearing aid is considered unrealistic and/or frequency-specific audiometric data cannot be obtained in each ear.
- The ALD is provided for situations involving one-on-one conversation.
- The ALD is not designed primarily for television or telephone amplification, theater or classroom use.

2.10.B. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes:

- A letter from the audiologist delineating why a personal hearing aid is inappropriate and the recommended type of ALD.
- An audiogram, signed and dated by the audiologist within six months prior to dispensing the device or documentation showing that frequency-specific audiometric data could not be obtained in each ear.
- Copy of the manufacturer's invoice showing the ALD model, serial number, invoice price, applicable discounts and shipping charges.

2.10.C. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all alternative listening devices. The following documentation must be submitted with the PA request:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- A letter from the audiologist delineating why a personal hearing aid is inappropriate and the recommended type of ALD.
- An audiogram signed and dated by the audiologist within six months prior to dispensing the device or documentation showing that frequency-specific audiometric data could not be obtained in each ear within six months prior to dispensing the device.

2.10.D. PAYMENT RULES

Medicaid's payment for an ALD includes the provider's acquisition cost plus $20. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and

includes actual shipping costs. Medicaid does not reimburse providers for a separate dispensing fee for ALDs.

SECTION 3 – SPECIAL SERVICES PRIOR APPROVAL-REQUEST/AUTHORIZATION FORM (MSA-1653-B)

The following instructions for the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B) are self-explanatory. Special instructions are noted, when necessary. It is mandatory to complete boxes 12 through 39. For complete information on required modifiers, documentation, and appropriate quantity amounts, please refer to the following documents:

- The Standards of Coverage, Limitations and Payment Rules Section of this chapter
- Billing and Reimbursement Chapter
- Hearing Aid Dealers Database on the MDCH website

Boxes 1. Through 10. – MDCH use only.

Box 11. – MDCH Prior Authorization Number

AL SERVICES
REQUEST/AUTHORIZATION
nent of Community Health

CONSULTANT USE ONLY
2. 3. 4. 5. 6. 7. 8. 9. 10.

11. Prior Authorization No.

NOTE: APPROVAL REFERS TO SERVICE AND DOES NOT GUARANTEE RECIPIENT ELIGIBILITY.

12. Provide

13. Type | 14. ID Number | 15. Provider Use Only

Boxes 12 Through 14., 16. & 17. – Provider Name, Type, Provider ID Number, Address and Phone Number

Box 15. – Provider Use Only

16. Provide

18. Recipient's Name *(Last, First, Middle Initial)* | 19. Sex | 20. ID Number | 21. Birth Date | 22. County

Boxes 18. Through 23.- Beneficiary Name, Sex, ID Number, DOB, County of Residence, and Address

23. Recipient's

24. Does Patient Reside in a Nursing Care Facility ☐ YES ☐ NO

25. Referring P | 26. Type | 27. ID Number | 28. Phone Number

29. Referring Physician's Address *(Number, Street, City, State, Zip)*

30. Line No.	31. DESCRIPTION OF SERVICE (Include brand name and model number where applicable)	32. Procedure Code	33. Qua	34	35
01					
02					
03					
04					
05					

Box 24 – Check Yes if beneficiary is in NF or No if the beneficiary is not in an NF. Provide NF Address and Phone Number in Box 37

Boxes 25. Through 29. – Referring provider name, Type, Medicaid ID Number, Phone Number and Address

Box 31.-Enter a complete description, including manufacturer, model and style of hearing aid requested.

Box 32.-Enter the HCPCS procedure code.

Box 35.-Enter the applicable HCPCS modifier

36. Primary Diagnosis Description and Prescription (Quote Physician Order)

37. Remarks and/or Documentation of Medical Necessity

Box 36. –Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description).

Box 37. –Any additional remarks regarding the request should be listed in this box such as NF Name , Address, and Phone Number, verbal authorization date, retroactive date of service if being requested, etc.

38. Indicate Any Other Services Provided To This Recipient During the Past Year

39. PROVIDER CERTIFICATION: The patient named above (parent if minor or authorized representative) understands the necessity to request prior approval for the services indicated in Item 31. I understand the services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of nd that any false claims, statements or documents or concealment of a material fact may be prosecuted

Box 40. If amended, a change has been made on the form.

Date

CONSULTANT USE ONLY

40.	41.	42.
APPROVED AS:	DISAPPROVED ☐	
PRESENTED ☐	NO ACTION ☐	
AMENDED ☐	INSUFF. DATA ☐	

Box 42 –The MDCH Consultant signature.

Consultant Signature | Date

MSA-1653-B

Box 41. –If No Action, returned because beneficiary is in an HMO, service does not require PA, etc. If Insuff. Data, returned for more information.