Audiology Services

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This document provides the general guidelines used by the Oklahoma Health Care Authority's Audiology Consultant for review of requests for Audiology services. This document also provides guidance for requests for a variety of amplification devices such as conventional and digital hearing aids as well as other DME devices such as FM systems and cochlear implants. Additional information regarding Audiology services and devices approved by the Oklahoma Health Care Authority can be obtained by contacting the Medical Authorization Unit (MAU) at 1-800-522-0114 to request a return call from the Audiology Consultant.

According to current Rules of the Oklahoma Health Care Authority the following information applies to the minimum required Audiology services that are covered and the minimum required qualifications of individuals who can request and provide Audiology services.

317:30-3-65.9 Hearing services

[Issued 06-25-06]

(a) At a minimum, hearing services include hearing evaluation once every 12 months, hearing aid evaluation if indicated and purchase of a hearing aid when prescribed by a state licensed audiologist who:

(1) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(2) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(3) has completed the academic program and is acquiring supervised work experience necessary for the certificate; and

(4) holds a contract with OHCA to perform such an evaluation and obtains prior authorization for the evaluation.

(b) Interperiodic hearing examinations are allowed at intervals outside the periodicity schedule when a hearing condition is suspected (refer to OAC 317:30-5-676 for amount, duration and scope). The following schedule outlines the services required in the EPSDT/OHCA child Health screening program for hearing services adopted by the OHCA.

(1) **Birth**: Physiologic screen utilizing automated brainstem response testing or transient-evoked otoacoustic emissions testing.

(2) **Two to five months**: Subjective screens; question if passed physiologic newborn hearing screen months in both ears in addition to caregiver concerns regarding hearing sensitivity.

(3) **Six to twelve months**: Infants with JCIH risk factors are screened with physiologic or behavioral months measures including either visual reinforcement audiometry, auditory brainstem response testing or otoacoustic emissions testing. Infants without risk factors are screened subjectively with auditory behavior development checklist.

(4) **18 months**: Subjective screen; to include brief questionnaire regarding appropriate speech and language development.

5) **24 months**: Children with JCIH risk factors screened with physiologic or behavioral measures including visual reinforcement audiometry, otoacoustic emissions, or acoustic immittance/reflex testing. Subjective screen for all others to include concerns of caregivers and brief questionnaire regarding speech and language development.

(6) **Three years**: Behavioral or physiologic screen including either conditioned play audiometry, acoustic immittance testing (including reflexes), pneumatic otoscopy, or otoacoustic emissions.

(7) **Four years**: Behavioral or physiologic screen including either conditioned play audiometry, acoustic immittance testing (including reflexes), or otoacoustic emissions.

(8) **Five to six years**: Behavioral screen if not completed in school including conventional behavioral pure tone screening.

(9) **Eight, ten and 12 years**: Behavioral screen if not completed in school including conventional behavioral pure tone screening.

(10) **15 and 18 years**: Subjective screening to include concerns regarding school and home communicative performance.

Audiology Services- General Considerations for Prior Authorization

Medicaid recipients must be under 21 years of age in order to be eligible for Audiology services or DME devices and accessories.

The following information provides the general outline and procedures that contracted audiologists should follow when requesting Audiology services or DME devices that require a Prior Authorization (PA) from the Health Care Authority.

1. The audiologist should submit the following required paperwork to the Oklahoma Health Care Authority:

   a) A completed **HCA-12A** Prior Authorization form that is signed by the child's physician, designated primary care provider or medical professional authorized by the Oklahoma Health Care Authority

   b) An audiogram, ABR or ASSR test documenting degree and type of hearing loss for each ear. The audiogram, ABR or ASSR should have been completed within six months of the date of request. The audiogram must be ear specific. Unaided sound field test results are not considered to be sufficient documentation for a hearing aid request. If an ABR is being used for fitting of amplification, then the waveforms must be submitted for review. In addition to the click waveform, tone burst information at 500, 2000 and 4000 Hz must also be submitted for each ear. When possible, the audiologist should submit all other relevant diagnostic testing such as OAE information or acoustic immittance information. If the request for PA for a DME device is for a child with unilateral or bilateral conductive hearing loss, documentation that loss will likely be persistent (persist for greater than six months) is needed

   c) Audiologic report / statement clearly stating the specific recommendation for amplification system or DME device/accessory being requested

   d) The electro acoustic specifications for the specific DME device that is being requested

4. Once the required paperwork has been received Audiology Consultant for review. If the request is approved, the DME analyst will issue an approval for Prior Authorization using the following procedures:

    a) Prior Authorization will be issued using the HCPC codes submitted

    b) If there is an allowable in the system, no price is shown on the Prior Authorization

    c) The price for devices in which there is no allowable in the system is based on the actual invoice cost or estimated invoice cost (or price quote) plus a percentage as determined by the Medicaid pricing schedule. See Provider Letter 2009-21 dated June 10, 2009 that references category pricing for hearing loss types

    a) Hearing aids are approved as one unit, whether they are monaural or binaural

Important Information:

- When submitting a request for a hearing aid repair, the serial number and original invoice showing warranty expiration will need to be submitted with the request. If the original invoice is not available, documentation from the manufacturer showing the warranty expiration date is needed. Please provide the serial # of the device and identify the ear location as well. OHCA will not pay for repairs of "Back-up" hearing aids
- If the Audiology Consultant requires additional information before making a decision, the consultant will pend the request for additional documentation and indicate what is needed in the external text on the PA. Providers have 14 calendar days to submit the requested documentation. If nothing is received during this time, the request will auto-deny
- Batteries—Members are allowed 75 units of batteries without a PA and 75 units of batteries with a PA per calendar year (150 units total). When providers are submitting a PA for units above the 75 allowed without a PA, it should be notated on the paperwork submitted that the request is for units above the allowed amount without a PA
- Earmolds—Members under the age of 2 are allowed 8 units of earmolds per 365 days without a PA. Members 2 and older are allowed 4 units of earmolds per 365 days without a PA. Additional units may be requested with a PA. Request should indicate that the units being requested are above the allowed amount without a PA
- Earmold Impressions—Earmold Impressions will only be approved when the request of custom hearing aids is submitted. Earmold Impressions will not be approved when made for earmolds
- Custom Earplugs—Custom Earplugs are not covered by OHCA

Audiogram and other Diagnostic Tests Results – Minimum Requirements for Prior Authorization for DME devices

- When possible, a behavioral pure tone audiogram should be completed on all children prior to the request a PA for DME devices
- Audiograms or other diagnostic test results such as ABRs or ASSRs should be completed with six months of the time of PA request
- The audiogram should include thresholds for both the right and left ear for air conduction and bone conduction and, when necessary, masked thresholds should be provided
- When possible, word recognition results should be included on the submitted audiogram. Except in cases of infants, young children, and children in which word recognition cannot be performed, amplification is generally not approved in cases in which no measurable word discrimination is present unless supporting documentation regarding benefit is provided
- Audiograms should also include, when possible, acoustic immittance or other physiologic findings that support the degree and nature of the child's hearing loss
- ABR test results should include tone burst findings for the right and left ear as well as masked bone conduction results when appropriate (Tone burst ABR test results should include, at a bare minimum, 500 Hz, 2000 Hz and 42000 Hz.")
- Test results documenting sensorineural loss in at least one ear of 20 dB HL or more hearing loss at three or more frequencies from 500 through 4000 Hz, or (25) dB HL or more hearing loss a two or more frequencies from 1000 through 4000 Hz
- In cases of DME requests for the treatment of auditory neuropathy spectrum disorder (auditory dys-synchrony), diagnostic test results must present a clear picture supporting this diagnosis
- Amplification is generally not approved in cases of transient or fluctuating slight to mild conductive hearing loss unless documentation is submitted supporting that observed conductive loss is expected to persistent indefinitely and that medical intervention will be not be undertaken to address the conductive loss within six months of the time of the request

Behind-the-Ear Hearing Instruments
(V5257-monaural; V5261-binaural)

Behind-the-ear (BTE) hearing instruments are the most common type of hearing aid device approved by the Oklahoma Health Care Authority and are generally considered the most appropriate amplification device for school-aged children and younger. Due to the superior ability of BTE instruments to couple with assistive listening devices in the educational environment and given multiple considerations such as durability, safety and growth factors, BTE are generally recognized as most appropriate hearing instrument for most school-aged children. When requesting a BTE device, the Audiology service provider should consider the following:

- BTE instruments should demonstrate direct audio input capability or compatibility with assistive listening device technology (i.e. FM System)
- BTE instruments should demonstrate frequency response, gain and output fitting flexibility to account for subtle changes in hearing sensitivity or as additional information regarding a child's hearing sensitivity is obtained
- BTE instruments with fully digital signal processing should always be considered
- For children who have a severe to profound hearing loss and are being considered for cochlear implantation, loaner hearing aids should be fit until cochlear implant candidacy can be determined. If the family decides not to pursue cochlear implantation, or the child receives adequate benefit from the hearing aids during the trial period, permanent hearing aids can be requested

Custom Hearing aids (CIC, ITC and ITE)
(V5254-monaural CIC; V5258-binaural CIC; V5255-monaural ITC; V5259-binaural ITC; V5256-monaural ITE; V5260-binaural ITE)

Given a number of important considerations (e.g., ear canal growth, educational needs, coupling to FM systems, safety concerns, etc.) in-the-ear (ITE) instruments, half-shell instruments, in-the-canal (ITC), and completely-in-the-canal (CIC) hearing aids are generally not considered medically necessary and are generally not approved for children under age nine (9). However, under certain conditions, custom instruments may be appropriate for children under age nine (e.g., cases of microtia, mal-formation of pinna, etc.). If medically and audiologically appropriate, custom amplification or similar instruments may be considered pending submission of appropriate supporting documentation. If custom amplification is deemed medically necessary for a child under age nine, the Audiology Service provider should submit documentation indicating the method by which remakes/recasing of the hearing instrument to account for growth factors will be handled.

For children nine years of age and older, custom amplification may be approved if considered audiologically appropriate and pending consideration of child's future educational and psychosocial needs.

Bone Conduction Hearing Aids
(L8691)

Bone conduction hearing aids may be approved with supporting documentation for children who:

- Demonstrate persistent unilateral or bilateral conductive hearing loss that can not be addressed by conventional amplification methods
- Demonstrate stenosis or atresia of the outer ear canal or other malformations of the ear such that conventional amplification is not ideal or effective
- Demonstrate chronic conditions of the outer ear, ear canal, or middle ear system that preclude the effective use of conventional amplification
- Bone conduction hearing aids are generally not approved in cases of unilateral sensorineural hearing loss (single-sided deafness - SSD) until age five or older and documentation demonstrating benefit can be provided

Surgically Implantable Bone Anchored Hearing Aids (BAHAs)

These may be approved with supporting documentation for children who:

- Are five years of age or older
- Demonstrate persistent unilateral or bilateral conductive hearing loss that can not be addressed by conventional amplification methods
- Demonstrate stenosis or atresia of the outer ear canal or other malformations of the ear such that conventional amplification is not ideal or effective
- Demonstrate chronic conditions of the ear canal or middle ear system that preclude the effective use of conventional amplification
- Do not demonstrate cognitive or physical challenges that preclude safe and effective management of the BAHA
- Do not demonstrate medical contraindications
- Please note: A surgically implantable bone conduction aid or BAHA device is generally not approved in cases of unilateral sensorineural hearing loss (single-sided deafness - SSD) until a trial period with a conventional bone conduction instrument has been completed and subsequent documentation of benefit has been provided. Documentation regarding the inability to benefit from a more traditional form of amplification (BTE, Cross, FM, etc.) must also be submitted. Recorded word recognition/ sentence testing must be presented in several different listening conditions:
    - ◊ Without the use of the bone anchored hearing aid:
        - ♦ Speech material presented to the good ear; speech weighted noise (background babble) presented to the ear to be implanted
        - ♦ Speech material presented to the ear to be implanted; speech weighted noise (background babble) presented to the good ear
    - ◊ With the bone anchored hearing aid (headband or softband):
        - ♦ Speech material presented to the good ear; speech weighted noise (background babble) presented to the ear to be implanted
        - ♦ Speech material presented to the ear to be implanted; speech weighted noise (background babble) presented to the good ear

Body-Worn Hearing Aids (V5030-monaural; V5100-binaural)

Although uncommon, body-worn hearing aids may be appropriate for some children with significant unilateral or bilateral hearing loss. These devices may be approved with appropriate supporting documentation.

CROS, Bi-CROS and Multi-CROS Hearing Instruments
(V5170-CROS ITE; V5180-CROS BTE; V5210-Bi-CROS ITE; V5220-Bi-CROS BTE)

Behind-the-ear and in-the-ear CROS, Bi-CROS and multi-CROS instruments may be approved with appropriate supporting documentation. These instruments are generally approved for school-aged children five years of age and older.

FM Systems

Audiology service providers may receive Prior Authorization for FM systems, pending submission of the following supporting documentation:

- **OHCA does not provide FM systems for use in school**
- A behavioral pure tone or sound field audiogram or results of ABR or ASSR documenting the degree and nature of hearing loss for each ear that has been completed within six months of the request
- Diagnostic test results documenting sensorineural loss in at least one ear of (20) dBHL or more hearing loss at three or more frequencies from 500 through 4000 Hz, or (25) dBHL or more hearing loss at two or more frequencies from 1000 through 4000 Hz
- **Aided** word recognition testing using recorded materials (i.e. PBK 50, LNT, MLNT, W22, NU6) presented at normal conversational levels in quiet **and** with a +10 to +15 SNR. Documentation of fair to excellent (60%-100%) word recognition in quiet, with noted decrement in performance in noise must be documented. For children too young to perform open set word recognition testing, an **aided** picture pointing test (i.e. NU-CHIPS) can be performed in quiet and in noise (+10 to +15 SNR). Since FM systems support speech understanding in noise, they will not be considered for patients who cannot perform word recognition testing in quiet
- Audiologic report from audiologist that specifically recommends use of the FM system for the home environment or for use outside the educational setting
- Make and model of appropriate FM systems and compatibility with child's current hearing instruments

- Electro acoustic specifications/device specifications for requested FM system
- FM systems are generally not approved for slight conductive hearing loss that is fluctuating in nature. Documentation of mild to moderate degree of loss that is persistent in nature is needed for consideration of FM systems in children with conductive hearing loss
- FM systems may be approved, with supporting documentation, in cases of children over age five that demonstrate normal peripheral hearing sensitivity, if diagnostic test results support the presence of a significant auditory processing disorder (i.e. two or more standard deviation's below normal for at least one or more standardized tests for auditory processing disorder other than speech in noise testing)
- FM systems will not be approved for children with normal hearing sensitivity that demonstrates difficulty understanding speech in the presence of noise unless a diagnosis of auditory processing disorder has been given

Replacement Policy for Hearing Instruments

The Health Care authority will generally approve the replacement of amplification or new amplification after three years from the time of the original request. Exceptions to this policy include:

- Loss of a hearing instrument or DME device that is not covered by a loss/damage policy. Verification of the lost serial number and lack of warranty coverage must be provided. All prior authorization requests submitted for replacement of lost hearing instruments should also include signed documentation from the member's parent/caregiver or member (if over 18), stating that the device(s) has been lost, approximate date of loss, and that every effort has been made to recover the device(s)
- Significant shift in hearing sensitivity or audiologic status rendering current DME device no longer audiologically appropriate

Hearing Aid Fitting Fee Policy (V5011-monaural or binaural)

The Health Care Authority will approve a hearing aid fitting fee when the hearing aid(s) is (are) dispensed. The hearing aid fitting is only approved for the purchase of new hearing aids. It will not be approved for the fitting of a replacement for a lost hearing aid. The only exception to this rule pertains to hearing aids that are requested due to a significant shift in hearing sensitivity. The audiologist must submit the following documentation:

- A print out of the real ear verification. A close approximation of the target gain must be obtained at all frequencies that can benefit from amplification. The DSL method should be used for children

Hearing Aid Accessories (V5299)

A variety of hearing aid accessories that support the functionality and performance of hearing aids and other amplification devices are approved if medical necessity is provided to support the requested accessory.

Cochlear Implants

Unilateral cochlear implants may be approved for children 6 months of age and older who exhibit severe to profound bilateral sensorineural hearing loss, or auditory neuropathy spectrum disorder (ANSD). Bilateral cochlear implants are approved for infants or children pending additional documentation demonstrating medical necessity. The following information must be submitted by the audiologist for all Prior Authorization requests for a unilateral cochlear implant.

- Unaided behavioral audiogram completed within six months prior to the time of request
- If an unaided behavioral audiogram can not be obtained, tone burst ABR or ASSR test results documenting ear specific results demonstrating degree and nature of loss. ABR responses must be provided in cases of ANSD
- Aided behavioral audiogram documenting aided performance with child's amplification system. Loaner hearing aids may need to be fit to determine candidacy (see BTE hearing aid section on page 8).
- The Real Ear Verification print out should be provided to document an appropriate fit of the hearing aids
- Audiologic report documenting the following: (1) completion of a trial period with appropriate amplification – specific amplification device and length of use should be identified, (2) speech audiometry results documenting performance less than would expected from a cochlear implant, (3) specific recommendation from audiologist regarding CI request and verifying audiologic candidacy
- Report from referring physician documenting medical appropriateness
- CT or MRI findings

For very young children for whom speech audiometry measures can not be reasonably obtained, the audiologist should additionally submit:

- Report documenting failure to develop basic auditory skills. This is typically obtained from their speech language pathologist

For bilateral cochlear implant requests, the audiologist should additionally submit:

- A recent audiogram of the ear to be implanted
- Documented benefit from the first cochlear implant. This should include the audiogram indicating cochlear implant thresholds, speech recognition thresholds, word recognition scores (single word or sentence testing)
- For children who are too young to, or who cannot complete speech testing, further documentation from their speech pathologist will be needed to show improvement in their auditory skill development and speech and language progress

317:30-5-676 (Coverage by category)

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children:** Coverage for children is as follows:

(C) **Hearing aids:** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults: There is no coverage for adults**

(3) **Individuals eligible for Part B of Medicare:** Services provided to Medicare eligible recipients are filed directly with the fiscal agent