MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Adriena Krul-Hall

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

The bulletin will provide notification to providers of the elimination of the Hearing Aid Dealer chapter and revision of the Hearing Services chapter in the Medicaid Provider Manual.

Reason for policy (problem being addressed):

The revised Hearing Services and Devices chapter includes the incorporation of hearing aid information, reflects alignment with current U.S. Food and Drug Administration (FDA) audiological device indications, provides updates, and clarifies existing policy regarding hearing services.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

Yes - the Hearing Services and Devices chapter changes will require assistance from the Program Review Division.

Does policy have operational implications on other departments?

No.

Summary of input:

☐ controversial
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 1941-Hearing	**Date:** January 10, 2020

Comments Due: February 14, 2020
Proposed Effective Date: April 1, 2020
Direct Comments To: Adriena Krul-Hall
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Policy Subject: Revisions to the Hearing Services Chapter and Elimination of the Hearing Aid Dealers Chapter of the Medicaid Provider Manual

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild, Children's Special Health Care Services

Distribution: Practitioners, Local Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Hearing Aid Dealers, Cochlear Implant Manufacturers, Audiologists/Hearing Centers, Hospitals, Independent Diagnostic Testing Facilties

Summary: This bulletin provides notification of the elimination of the Hearing Aid Dealer chapter and revision of the Hearing Services chapter in the Medicaid Provider Manual. The revised Hearing Services and Devices chapter includes the incorporation of hearing aid information, reflects alignment with current U.S. Food and Drug Administration (FDA) audiological device indications, provides updates, and clarifies existing policy.

Purpose: To reduce Medicaid Provider Manual duplication, provide updates, and clarify existing hearing service and device policy.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues: Aware of none

State Plan Amendment Required: Yes ☐ No ☒ **If yes, date submitted:**	**Public Notice Required: Yes ☐ No ☒** **Submitted date:**

Tribal Notification: Yes ☐ No ☒ - Date:

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**

Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Comment001 **Revised 6/16**

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: Practitioners, Local Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Hearing Aid Dealers, Cochlear Implant Manufacturers, Audiologists/Hearing Centers, Hospitals, Independent Diagnostic Testing Facilities

Issued: March 1, 2020 (Proposed)

Subject: Revisions to the Hearing Services Chapter and Elimination of the Hearing Aid Dealers Chapter of the Medicaid Provider Manual

Effective: April 1, 2020 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild, Children's Special Health Care Services

This policy applies to Medicaid Fee-for-Service (FFS). Medicaid Health Plans (MHP) and Integrated Care Organizations (ICO) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in an MHP or ICO, the provider must check with the beneficiary's health plan for coverage parameters and prior authorization requirements.

This bulletin provides notification of the elimination of the Hearing Aid Dealers chapter and revision of the Hearing Services chapter in the Medicaid Provider Manual. The new Hearing Services and Devices chapter includes the incorporation of hearing services and hearing aid dealer information, reflects alignment with current U.S. Food and Drug Administration (FDA) audiological device indications, and clarifies or updates existing policy. The bulletin is effective for services provided on and after April 1, 2020.

Key updates include:

- Revised audiological criteria for digital hearing aids, contralateral routing devices, and cochlear implants.
- Removal of the prior authorization (PA) requirement for Contralateral Routing Devices (CROS/BICROS) included on the Michigan Department of Health and Human Services (MDHHS) Volume Purchase Contract.
- Removal of the PA requirement for Michigan Department of Health and Human Services (MDHHS) Volume Purchase Contract hearing aids prescribed for beneficiaries with unilateral hearing loss.

- Removal of the PA requirement for unilateral implantable and non-implantable bone anchored hearing devices (BAHDs).

- Revised standards of coverage for alternative listening devices.

- Addition of Independent Diagnostic Testing Facilities (IDTFs) as an allowable provider type to perform audiological diagnostic testing services.

- Revised PA documentation requirements for non-contracted hearing aids.

- Clarification of hearing aid checks and programming coverage.

Additional Changes

Providers should note the following additional changes in the Hearing Services chapter:

Updated Auditory Rehabilitation Standards of Coverage

Auditory rehabilitation is covered when medically necessary for beneficiaries who have received an implanted hearing device, hearing aid, or who have pre-lingual or post-lingual hearing loss. To align auditory rehabilitation with other Medicaid-covered rehabilitation services, visit maximums will be 36 visits per calendar year. PA is required for additional visits. Additionally, Speech Language Pathologists are now eligible to bill for these services using Current Procedural Terminology (CPT) codes 92630 and 92633.

Revised Cochlear Implant Mapping Visit Maximums

The programming of the cochlear implant speech processor to the specifications and needs of the beneficiary is a covered benefit. Eligible beneficiaries may now receive one initial and up to five subsequent mapping sessions per implant following surgery. PA is required for additional sessions. Existing cochlear implant users requiring reprogramming may receive up to five mapping sessions per year per implant.

Adult Bilateral Cochlear Implant Coverage

Cochlear implantation is covered with PA for all beneficiaries meeting the standards of coverage and audiological criteria. Cochlear implant coverage for beneficiaries 20 years of age and over has been expanded to include bilateral implantation. Adult beneficiaries are eligible for bilateral implantation when all the following standards of coverage are met:

- A diagnosis of bilateral moderate to profound hearing loss (Pure Tone Average [PTA] equal to or greater than 40 dB HL or level appropriate for model to be implanted, averaged over 500-4000Hz, ANSI 1989) in an unaided condition;

- Minimal hearing aid benefit documented by a score of less than or equal to 50 percent under best-aided conditions on an open-set sentence recognition testing (such as the Hearing in Noise Test [HINT] Sentences);

- A letter from the treating otolaryngologist establishing medical necessity and recommending implantation;

- Limited hearing aid benefit demonstrated with consistent use of appropriately-fitted hearing aid(s) over a minimum of a three-month period. The trial period may be waived or shortened with appropriate documentation of medical necessity;

- Evidence of a functioning auditory nerve;

- Freedom from middle ear infection or any other active disease;

- An accessible cochlear lumen structurally suited to implantation. No evidence of lesions in the auditory nerve and acoustic areas of the central nervous system demonstrated by an appropriate radiological evaluation;

- No medical or behavioral health contraindication for anesthesia or surgery;

- Cognitive ability to use auditory cues and demonstrate a conditioned response;

- Psychological development, motivation, and/or commitment of the beneficiary and family/caregiver(s) to undergo a program of prosthetic fitting, training, and long-term rehabilitation;

- Realistic expectations of the beneficiary and/or family/caregiver(s) for post-implant educational/vocational rehabilitation, as appropriate; and

- Reasonable expectation by treating providers that the cochlear implant(s) will confer awareness of speech at conversational levels.

Updated Cochlear Implant, Bone Anchored Hearing Device, and Hearing Aid Supplies and Accessories Lists

Cochlear implant and bone anchored hearing device accessories, parts, and supplies provided by a Medicaid-enrolled cochlear implant manufacturer and hearing aid supplies provided by an audiologist or hearing aid dealer are covered when the applicable standards of coverage have been met. Approved items and maximums are available on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Hearing Services/Hearing Aid Dealers. The lists have been updated to reflect currently available products and revised frequency maximums.

Medicaid Provider Manual - DRAFT

HEARING SERVICES AND DEVICES

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Medicaid Provider Manual - DRAFT

SECTION 1 – GENERAL INFORMATION

This chapter applies to audiology providers, hearing aid dealers, and cochlear implant manufacturers. Information contained in this chapter is to be used in conjunction with other chapters of this manual, including the Billing & Reimbursement chapters, as well as the related procedure code databases and fee schedules located on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

Medicaid covers audiology services and devices, including hearing tests, diagnostic services, auditory rehabilitation, hearing aids, cochlear implants, and bone anchored hearing devices, when ordered/referred by a Medicaid enrolled physician or qualified non-physician practitioner (i.e., physician assistant (PA) or advanced practice registered nurse [APRN]). Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment, or orthotics/prosthetics.

The term Medicaid throughout this chapter refers to all programs administered by MDHHS unless specifically stated otherwise. Providers should refer to the Children's Special Health Care Services chapter of this manual for information specific to Children's Special Health Care Services (CSHCS)-only beneficiaries.

1.1 PROVIDER REQUIREMENTS

1.1.A. LICENSED AUDIOLOGISTS

Licensed audiologists may enroll with Medicaid for reimbursement of audiology and hearing aid services. Out-of-state audiologists must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter for more information.)

Services performed by licensed audiologists must be provided at the service/practice address identified on the Medicaid provider enrollment application or may be provided to nursing facility residents at a Medicaid-enrolled nursing facility.

1.1.B. COCHLEAR IMPLANT MANUFACTURERS

Cochlear implant manufacturers may enroll with Medicaid for reimbursement of cochlear and bone anchored hearing devices, parts, accessories, and repairs. Manufacturers must be licensed in the state in which they conduct business if that state requires licensure.

1.1.C. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORF) and Outpatient Rehabilitation Agencies (Rehab Agencies) may enroll with Medicaid for reimbursement of audiology services provided by qualified professionals. All CORFs and Rehab Agencies must provide proof of Medicare certification when enrolling in Medicaid.

Services must be provided at the service/practice address identified on the provider enrollment application or may be provided to nursing facility residents at a Medicaid-enrolled nursing facility.

1.1.D. Hearing Aid Dealers

Hearing aid dealers licensed in the state of Michigan and conforming to the standards of practice described in the current Michigan Occupational Code (Act 299 of 1980, Article 13) may enroll with Medicaid for reimbursement of hearing aid devices and services. This provider type must enroll as a Facility/Agency/Organization with a Type 2 Billing NPI.

1.1.E. Hearing Centers

Freestanding hearing centers may enroll with Medicaid for reimbursement of audiology services. The freestanding hearing center must not be part of, or owned by, a hospital, CORF, Rehab Agency, or university graduate education program.

1.1.F. Independent Diagnostic Testing Facilities

Medicare certified Independent Diagnostic Testing Facilities (IDTF) may enroll with Medicaid for reimbursement of audiology related diagnostic testing services. The IDTF must be an independent facility not associated with a physician's office or hospital.

1.1.G. Outpatient Hospital

Audiology services may be provided to beneficiaries in the outpatient hospital.

1.1.H. Physicians and Clinics

A physician, Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department that provides hearing services may enroll with Medicaid for reimbursement.

1.1.I. University Affiliated Audiology Graduate Education Programs

University affiliated audiology graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) or doctor of audiology programs accredited by the American Academy of Audiology (AAA) Accreditation Commission for Audiology Education (ACAE) may enroll with Medicaid for reimbursement of audiology services provided by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF, or Rehab Agency. All university programs must provide proof of their current ASHA-CAA or AAA-ACAE when enrolling in Medicaid.

1.1.J. Speech-Language Pathologists

Speech-Language Pathologists (SLP) may enroll with Medicaid for reimbursement of audiological rehabilitation and speech-language therapy services. SLPs must possess a current license and be authorized by ASHA to use Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) credentials.

1.2 Healthcare Common Procedure Coding System Codes, Parameters and Modifiers

Providers should refer to the current edition of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) manuals published by the American Medical Association (AMA) for the appropriate procedure code to use when billing Medicaid. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code. All NOC codes require prior authorization (PA).

For specifics regarding the HCPCS and CPT codes used to denote covered services, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for more information. (Refer to the Directory Appendix for website information.)

The "LT" or "RT" modifier must be reported for all earmolds, devices (including monaural hearing aids, Bone Anchored Hearing Devices [BAHDs], and cochlear implants) and monaural dispensing services to designate either the left or right side of the body. When the same service is provided for both the left and right ears on the same date of service (DOS), the service should be reported on two separate claim lines with the appropriate modifier on each line.

1.3 Documentation in Beneficiary File

Hearing services providers must maintain all applicable documentation in the beneficiary's file for seven years. For audit purposes, the patient's medical record must substantiate the medical necessity of the item or service supplied.

1.4 CSHCS Requirements

The following information is regarding beneficiaries who are enrolled in CSHCS only. These requirements do not apply to services provided to Medicaid-only or dual Medicaid/CSHCS beneficiaries.

Once a beneficiary is enrolled in the CSHCS program for a condition that requires audiology services, a pediatric subspecialist is authorized by CSHCS to serve the beneficiary. CSHCS does not cover audiology services that are unrelated to the beneficiary's qualifying diagnosis. Prescriptions for hearing devices and supplies must be signed by the authorized subspecialist.

The pediatric subspecialist coordinates hearing treatment and services relating to the beneficiary's CSHCS qualifying diagnosis. However, a diagnostic evaluation by an audiologist does not require a referral by the pediatric subspecialist. Before billing for audiology services, the enrolled provider(s) must verify that they have been authorized to provide services to the beneficiary. (Refer to the Children's Special Health Care Services Chapter for further CSHCS information.)

1.5 COPAYMENTS

A copayment for a hearing aid may be required for beneficiaries age 21 years and older. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

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

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements.

1.6 PRACTITIONER SIGNATURES

In all documentation requiring a signature, the signature must be handwritten by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of "signature on file" will not be accepted. An electronic signature must specifically identify and authenticate the individual practitioner. This applies to signatures for ordering, referring, and treating practitioners.

1.7 REIMBURSEMENT

Reimbursement is based on the provider's enrollment type. Reimbursement methodologies include the MDHHS Outpatient Prospective Payment System (OPPS) and Medicaid fee screens. (Refer to the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System [CHAMPS] or the MDHHS Hearing Services and Hearing Aid Dealers Fee Schedules on the MDHHS website.) For NOC codes or covered codes without established fee screens, the authorized reimbursement amount is indicated on the approved PA request.

The date of delivery of the hearing aid must be reported as the DOS. When there is a loss of eligibility or a change in eligibility status between the time a hearing aid is ordered and delivered, the DOS should be reported as the order date rather than the delivery date.

1.8 OTHER INSURANCE

If the beneficiary has another insurance plan (e.g., Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s) including, but not limited to, prescription, PA, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

SECTION 2 – COVERAGE OVERVIEW

2.1 SERVICE PROVIDERS

Audiology services may be provided by Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers in the following settings:

- Hospital
- Hearing Center
- Comprehensive Outpatient Rehabilitation Facility
- Outpatient Rehabilitation Agency
- CAA or AAA Accredited University Affiliated Audiology Graduate Education Program
- Licensed Audiologist Office/Clinic
- Physician's Office/Clinic including, but not limited to, a Federally Qualified Health Center, Rural Health Clinic, Tribal Health Centers or Local Health Department.
- Independent Diagnostic Testing Facility

Audiology services and hearing aid evaluations may be performed by the following Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers:

- Licensed Audiologist
- Supervised Limited License Audiologist completing his/her post graduate clinical experience or having completed all requirements but has not obtained a full license
- Audiology Student completing his/her clinical experience under the direct supervision of (i.e., in the presence of) a licensed audiologist

Hearing aid selection, fitting, and conformity evaluations may be performed by the following Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers:

- Licensed Audiologist
- Supervised Limited License Audiologist completing his/her post graduate clinical experience or having completed all requirements but has not obtained a full license
- Audiology Student completing his/her clinical experience under the direct supervision of (i.e., in the presence of) a licensed audiologist
- Hearing Aid Dealer

Newborn hearing screening tests may be performed by following the Medicaid-enrolled, properly credentialed/licensed providers:

- Hospital
- Hearing Center

2.2 Diagnostic and Amplification Services

The following diagnostic and amplification services may be provided to all eligible beneficiaries:

- Air and/or bone conduction audiogram
- Basic hearing evaluation (includes pure-tone audiometry, speech audiometry and report)
- Diagnostic audiologic evaluations
- Earmold fabrication
- Electroacoustic analysis of hearing aid
- Aided performance assessment with the beneficiary's hearing aid
- Hearing aid evaluation and selection
- Hearing aid orientation/training or hearing therapy

Standards of practice must conform to those published in the current version of ASHA's Preferred Practice Patterns for the Profession of Audiology or AAA's Standards of Practice for Audiology. Audiologic test equipment and hearing aid test equipment used must conform to current, applicable American National Standards Institute (ANSI) criteria.

2.3 Newborn Hearing Services

All Medicaid-covered newborns must be screened using the auditory brainstem response (ABR) method and/or the evoked otoacoustic emissions (EOAE) method. Audiology newborn hearing screening tests must be performed by staff trained in the screening of infant hearing via the ABR or EOAE method. Medicaid requires appropriate interaction with parents/guardians and the medical team, and the proper reporting of hearing results with the MDHHS monitoring program.

If the birthing facility is not equipped for ABR or EOAE, the child's APRN, physician, or PA must refer the newborn for screening prior to one month of age.

Equipment must be available to audiologists providing a comprehensive diagnostic evaluation to infants less than six months of age. Infant evaluation services include, but are not limited to:

- Tone Burst ABR or Auditory Steady State Response (ASSR) Test
- Click ABR
- Bone Conduction ABR
- High Frequency Acoustic Immittance Measures
- Otoacoustic Emissions

Equipment must be available to audiologists providing hearing aid evaluation, selection, and follow-up services to infants less than six months of age. Infant hearing aid services include, but are not limited to:

- Infant Predictive Method (e.g., Desired Sensation Level)
- Real-Ear to Coupler Difference

Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

2.4 Hearing Aid Services and Supplies

Medicaid covers hearing aid devices, repairs, earmolds, batteries, supplies, and accessories provided by a licensed hearing aid dealer or audiologist. Batteries may also be provided by a medical supplier.

Hearing aids are only a benefit when:

- The recommended hearing aid meets United States Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements;
- Medical documentation indicates that the conductive hearing loss is not transient in nature due to a treatable medical middle ear effusion or that surgery is not planned within the next year;
- The beneficiary has not received a Medicaid covered hearing aid(s) within the last five years;
- A manufacturer's warranty of 24 months covering parts and labor and a 12-month warranty covering loss or damage are included. These warranties apply to all hearing aids, including those not covered under the MDHHS volume purchase contract.

MDHHS participates in a volume purchase contract agreement for hearing aid devices. Providers must purchase hearing aids directly from the manufacturers that are part of the MDHHS volume purchase contract whenever possible. The Hearing Aid Contract Vendor listing is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Providers should refer to the Hearing Aids section of this chapter for complete information on hearing aid services and devices.

2.5 Assistive Listening Devices

An Assistive Listening Device (ALD) is a benefit when the patient management of a personal hearing aid is considered unrealistic or the frequency specific audiometric data cannot be obtained in each ear. The ALD is provided for situations involving one-on-one conversation and is not designed primarily for recreational or educational use. An ALD is covered when Medicaid has not covered any hearing aid(s) or ALD dispensed to the beneficiary within the last three years. Providers should refer to the Other Hearing Devices section, Assistive Listening Devices subsection of this chapter for additional information.

2.6 Speech Services

Evaluation and treatment of speech, language, cognition, voice, and auditory processing is covered when performed by a SLP. Refer to the Therapy Services Chapter for information and requirements related to speech therapy services.

2.7 Auditory Rehabilitation

Auditory rehabilitation is covered when medically necessary for beneficiaries who have received an implanted hearing device, hearing aid, or who have pre-lingual or post-lingual hearing loss. Auditory rehabilitation services are designed to optimize the benefit provided by the hearing device and improve the communication relationships affected by the beneficiary's loss of hearing. Aural rehabilitation focuses on auditory signal utilization, speech perception, and communication and listening skills development.

Auditory rehabilitation can be provided by a licensed audiologist or SLP who has training and expertise in the procedures. Evaluations for auditory rehabilitation may be provided up to two times per year, and a maximum of 36 visits per year of aural rehabilitation are allowed. SLPs should refer to the Therapy Services Chapter for documentation requirements. If additional visits are needed, PA is required.

2.8 Cochlear Implants

Cochlear implantation and associated mapping/calibration are covered and reimbursable under Medicaid and CSHCS programs for eligible beneficiaries using FDA approved implants. Cochlear implants are covered with PA for beneficiaries with pre- or post-lingual deafness who meet the implantation criteria. Providers should refer to the Other Hearing Devices Section, Cochlear Implants subsection of this chapter for complete information.

2.9 Bone Anchored Hearing Devices

Medicaid covers FDA approved implantable and non-implantable Bone Anchored Hearing Devices (BAHDs) as an assistive hearing instrument for those who can benefit when there is no other suitable aid. Beneficiaries must have a unilateral or bilateral conductive or mixed hearing loss, or a unilateral sensorineural hearing loss. Providers should refer to the Other Hearing Devices Section, Bone Anchored Hearing Devices subsection of this chapter for additional information.

SECTION 3 – PRIOR AUTHORIZATION

PA is required for certain services before the services are rendered. To determine which services require PA, refer to the Prior Authorization Requirements subsections throughout this chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

PA is required for the following situations:

- Services or devices for which the beneficiary does not meet the Medicaid Standards of Coverage as outlined in this policy
- Any hearing aids that are not covered under the MDHHS volume purchase contract
- ALDs
- Cochlear implant devices or processors (unilateral or bilateral)
- BAHDs or processors (bilateral only)
- Services and items that exceed quantity limits, frequency limits, or established fee screens
- Use of a NOC code

3.1 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 MDHHS website for a copy of the form.) Medical documentation (e.g., medical clearance, audiogram, and hearing aid recommendation from audiologist) must accompany the MSA-1653-B.

Providers requesting PA for items without an established fee screen must also include a copy of the manufacturer's invoice that lists the acquisition cost for the item. Manufacturer quotes or dealer list prices are not accepted as documentation of the cost. Modified manufacturer invoices will not be accepted. If the manufacturer's invoice is not included with the initial PA request, the MDHHS determination letter will indicate an approved fee of $0.01 for PA purposes; the reimbursement fee will be updated once the actual invoice is submitted to MDHHS for pricing.

The information on the MSA-1653-B 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 device requested (if applicable), and the appropriate HCPCS procedure codes with applicable modifiers must be provided on the form. The MSA-1653-B and all documentation must include the beneficiary's name and **mihealth** card identification (ID number), provider name, address, and National Provider Identification (NPI) number.

A sample of the MSA-1653-B with additional instructions is available in the Forms Appendix of this manual.

For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-1653-B must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a PA request in CHAMPS or by

contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)

PA requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-1653-B must be attached to each electronic prior authorization request.

A copy of the PA determination letter must be retained in the beneficiary's medical record.

3.2 Retroactive Prior Authorization

Hearing services or devices provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and a subsequent eligibility determination was made retroactive to the DOS. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive PA will be denied.

3.3 Beneficiary Eligibility

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. Approval of a PA request does not guarantee beneficiary eligibility or payment. To assure payment, it is recommended providers verify the beneficiary's eligibility on the DOS. Providers should refer to the Beneficiary Eligibility Chapter of this manual for additional information.

3.4 Reimbursement Amounts

Many items have established fee screens that are published in the MDHHS Hearing Services or Hearing Aid Dealers Fee Schedules. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized MSA-1653-B.

3.5 Billing Authorized Services

After PA is issued, the information (e.g., PA number, HCPCS/CPT code, modifier, and quantity) that was approved must match the information submitted on the claim form. (Refer to the Billing & Reimbursement chapters of this manual for complete billing instructions.)

SECTION 4 – HEARING AIDS

4.1 DEFINITIONS

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

Hearing Aid	A hearing aid is a wearable instrument or device designed to deliver amplified sound in order to compensate for a hearing loss. Models include body worn, behind the ear, in the ear, in the canal, and bone conduction. The hearing aid usually consists of a microphone, an amplifier, and a receiver.
Contralateral Routing System Hearing Aid	A hearing aid with a microphone worn on an unaidable ear with a receiver or additional microphone worn on the better ear.
Digital Hearing Aid	A hearing aid that uses digitized sound processing (DSP) to convert sound waves into digital signals.

4.2 COVERED SERVICES AND ITEMS

Medicaid covers the following services and items when medically necessary and provided by a licensed hearing aid dealer, hearing center, or audiologist.

- Hearing aids and delivery
- Hearing aid repairs and modifications
- Replacement earmolds
- Hearing aid supplies and accessories
- Replacement of hearing aid batteries
- Assistive listening devices

Disposable hearing aid batteries may also be provided by a medical supplier.

4.3 NONCOVERED SERVICES AND ITEMS

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

- Hearing aids that do not meet FDA and FTC 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

- Devices (i.e., hearing aids and non-surgical BAHDs) ordered for eligible beneficiaries but delivered more than 30 days after a beneficiary became ineligible for Medicaid
- Services rendered or devices dispensed before PA is approved
- Services or devices required to be provided by another public agency or program (e.g., school-based services, etc.)

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

4.4 Hearing Aid Contract

MDHHS participates in a volume purchase contract agreement for hearing aids. Providers must purchase hearing aids directly from the manufacturers that are part of the MDHHS volume purchase contract whenever possible. The Hearing Aid Contract Vendor listing is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Providers must bill and are reimbursed the contract price for the hearing aid which cannot be further reduced or altered.

4.5 Medical Clearance

A medical clearance is a statement signed by the physician, PA, or APRN indicating that:

- A medical evaluation was performed within six months prior to the beneficiary obtaining a hearing aid; and
- There are no contraindications to the use of a hearing aid.

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

For Medicaid beneficiaries age 18 years or older, the medical clearance may be completed by a Medicaid enrolled primary care provider, otolaryngologist, or other appropriate specialty physician.

The medical clearance must include the beneficiary's name, birth date, address, Medicaid ID number, the services provided, the DOS, the provider's name and provider NPI number.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The hearing aid prescription must be related to the CSHCS qualifying diagnosis.
- The otolaryngologist signing the medical clearance must be a CSHCS enrolled provider.

4.6 Evaluation and Selection

Audiologists may perform hearing aid evaluations and selections with medical concurrence from the primary care provider, otolaryngologist, or other appropriate specialty physician. After the appropriate audiologic procedures have been completed and it is determined that the beneficiary requires a hearing aid, a recommendation for the hearing aid must be completed and signed by the audiologist. The recommendation, as well as a copy of the physician's medical clearance, is given to the beneficiary along with a list of Medicaid-enrolled hearing aid dealers in the area. Beneficiaries must be given freedom of

choice of any Medicaid-enrolled hearing aid dealer when obtaining their hearing aid, even when the licensed audiologist is also enrolled with Medicaid to dispense hearing aids.

4.7 Measurable Benefits/Conformity Check

Any delivered hearing aid is expected to demonstrate measurable benefit, established either at the time of fitting or follow-up. Benefit may be established by one, or a combination of, commonly used procedures, 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 members or guardian, or attending staff.

Benefit may be demonstrated in cases of severe to profound hearing loss by at least one of the following measures:

- Improved functional or insertion gain in the speech frequencies.
- Increased awareness of speech and/or environmental sounds.
- Improved word recognition performance at average or slightly raised conversational levels with or without visual cues.
- Beneficiary's or family member's subjective report of speech benefit in everyday listening situations.

Hearing aid dealers must instruct beneficiaries to return to the evaluating audiologist for the conformity evaluation to allow for the return of the device, if necessary, within 90 days of the hearing aid dispensing date. When a delivered hearing aid does not provide benefit, as defined above, providers are expected to return it to the manufacturer within 90 days for modifications, remake, exchange, or credit as recommended by the evaluating audiologist. 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 90-day trial period and replaced with a less costly aid must be returned to Medicaid via a claim replacement.

Hearing aid conformity evaluations for beneficiaries with an existing hearing aid may be provided up to two times per year if necessary.

4.8 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. With the exception of adjustments required within the manufacturer's warranty period, the dispensing fee covers all services and products listed below for a period of 90 days. Reimbursement for the hearing aid dispensing fee includes, but is not limited to:

- Hearing aid delivery
- 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 90-day supply of batteries per aid (or charger for rechargeable models)
- A 90-day trial/adjustment period with exchange/return privilege. Hearing aids that do not prove satisfactory to a user are to be returned to the manufacturer within 90 days from the date the hearing aid is provided to the beneficiary at no cost to MDHHS, the hearing aid dealer, hearing center, or the licensed audiologist.

Providers may not receive a dispensing fee for hearing aids returned during the 90-day trial period. Any dispensing fees paid to providers for hearing aids subsequently returned during the 90-day trial period must be returned to MDHHS via a claim replacement. If the hearing aid is returned, MDHHS will reimburse for hearing aid fitting/checking services provided during the 90-day trial period.

4.9 Mandatory Manufacturer's Warranty

Medicaid requires that all hearing aids include a manufacturer's equipment warranty that includes parts and labor for all repairs and modifications for a 24-month period, and loss and/or damaged replacements for a 12-month period. This warranty must be provided at no cost to the beneficiary or to Medicaid. Manufacturers may not charge for packing, shipping, invoicing, postage, insurance, or handling while the hearing aid is under warranty.

Repairs required after the hearing aid repair warranty has expired are reimbursed based on the contracted rate and will have a new warranty period specified per the contract. The manufacturer is also responsible for all shipping costs on non-warranty equipment repairs.

4.10 Hearing Aid Checks and Programming

Hearing aid checks performed by a hearing aid dealer or audiologist are billable services only after the hearing aid trial period. Hearing aid check services may include, but are not limited to, device inspection and cleaning, resetting volume, reprogramming, listening checks, and other electro acoustic testing. Hearing aid checks may be billed up to a maximum of two times per year, without PA.

4.11 Replacement

Medicaid covers one (monaural) or two (binaural) hearing aids once every five years. PA is required when a hearing aid is needed more frequently.

If a hearing aid is lost or damaged beyond repair within five years of the dispensing date and the 12-month loss and damage warranty has expired, Medicaid will pay for the replacement of the aid **one** time. Beneficiaries aged 21 years and under may be eligible for additional replacements. PA is required.

Medicaid will not replace a hearing aid when lost or damaged beyond repair as a result of misuse or abuse by the beneficiary or caregiver. If loss or damage to a hearing aid is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the MSA-1653-B. All liable insurance coverage should be sought before requesting replacement by Medicaid.

4.12 DIGITAL HEARING AIDS

4.12.A. STANDARDS OF COVERAGE – UNILATERAL HEARING LOSS

Age Under 21 Years	A digital **monaural** hearing aid is covered for beneficiaries with unilateral hearing loss documented by **one** of the following: ▪ An audiogram showing hearing loss of 25 dB HL or greater using the four-frequency average of 500, 1000, 2000 and 4000 Hz in the ear to be aided with normal hearing in the better ear; or ▪ Results of a complete diagnostic audiological evaluation (e.g. ABR, EOAE, sound field testing, pure tone audiometry, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
Age 21 Years or Over	A digital **monaural** hearing aid is covered when **all** the following apply: ▪ Unilateral hearing loss documented by an audiogram showing a hearing loss of 30 dB HL or greater using the four-frequency average of 500, 1000, 2000 and 4000 Hz in the ear to be aided with normal hearing in the better ear; ▪ A Hearing Handicap Inventory for Adults, Hearing Handicap Inventory for the Elderly, Abbreviated Profile of Hearing Aid Benefit, or similar inventory indicates a need for amplification; and ▪ Hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.B. STANDARDS OF COVERAGE – BILATERAL HEARING LOSS

Age Under 21 Years	A digital **monaural or binaural** hearing aid is covered for beneficiaries with bilateral hearing loss documented by **one** of the following: ▪ An audiogram showing a 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. ABR, EOAE, sound field testing, pure tone audiometry, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
Age 21 Years or Over	A digital **monaural or binaural** hearing aid is covered when **all** the following apply: ▪ 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 ▪ Hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.C. Prior Authorization Requirements

PA is not required for either monaural or binaural digital hearing aids included in the MDHHS volume purchase contract if all other hearing aid requirements are met and restrictions, i.e., frequency of replacement, are not exceeded.

PA is required for the following:

- Any hearing aid not included in the MDHHS volume purchase contract
- Replacement aids within five years

All Ages	For beneficiaries of all ages, the following documentation must be submitted with the MSA-1653-B: ▪ Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the specific standards of coverage have been met (i.e., audiogram and amplification inventory). ▪ A medical clearance signed and dated by the primary care or specialty provider within six months prior to prescribing the hearing aid. ▪ Recommended manufacturer, model, and style of hearing aid. ▪ For hearing aids not covered under the MDHHS volume purchase contract, documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges. ▪ If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system.
Age 21 Years or Over	In addition to the above documentation, providers must submit the following for beneficiaries 21 years or older: ▪ Documentation demonstrating hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.D. Documentation

Applicable documentation to be maintained in the beneficiary record includes:

- Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the specific standards of coverage have been met (i.e., audiogram and amplification inventory);
- A medical clearance signed and dated by the primary care provider or otolaryngologist within six months prior to prescribing the hearing aid;
- Recommendation of the make, model, and type of hearing aid;
- For hearing aids not covered under the MDHHS volume purchase contract, a copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and handling charges; and

- If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system including, but not limited to, letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.

4.12.E. Payment Rules

Most items have established fee screens that are published in the MDHHS Hearing Aid Dealers Fee Schedule or MDHHS volume purchase contract. For codes without established fee screens, the approved reimbursement amount is indicated on the approved PA request.

4.13 Contralateral Routing Systems

4.13.A. Standards of Coverage

All Ages	A contralateral routing hearing aid is covered when **one** of the following applies: ▪ An audiogram indicates profound hearing loss in the poorer ear (unaidable) as demonstrated by greater than 90 dB HL and indicates thresholds less than or equal to 30 dB HL in the better ear using the four-frequency average of 500, 1000, 2000, and 4000 Hz; or ▪ An audiogram indicates profound hearing loss in the poorer ear (unaidable) as demonstrated by greater than 90 dB HL and indicates a hearing loss greater than 25 dB HL in the better ear using the four-frequency average of 500, 1000, 2000, and 4000 Hz.
Age 21 Years or Over	In addition to the above, beneficiaries age 21 years or over must have **all** the following: ▪ A Hearing Handicap Inventory for Adults, Hearing Handicap Inventory for the Elderly, Abbreviated Profile of Hearing Aid Benefit, or similar inventory that indicates a need for amplification; and ▪ A hearing loss that interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.13.B. Prior Authorization Requirements

PA is not required for monaural or binaural contralateral routing hearing aids included in the MDHHS volume purchase contract if all other hearing aid requirements are met and restrictions (i.e., frequency of replacement) are not exceeded.

PA is required for the following:

- Any hearing aid not included in the MDHHS volume purchase contract.
- Replacement aids within five years.

All Ages	When PA is needed, the following documentation must be submitted with the MSA-1653-B: ▪ Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the contralateral routing system's standards of coverage have been met (e.g., audiogram and amplification inventory); ▪ A medical clearance signed and dated by the physician within six months prior to prescribing the hearing aid; ▪ Hearing aid recommended manufacturer, model, and style; ▪ For hearing aids not covered under the MDHHS volume purchase contract, documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges; and ▪ If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system including, but not limited to, letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.
Age 21 Years or Over	In addition to the above, providers must submit the following documentation for beneficiaries age 21 years or over: ▪ Documentation demonstrating hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.13.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record for a contralateral routing hearing aid includes:

- Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the contralateral routing system's standards of coverage have been met (i.e., audiogram and amplification inventory);
- A medical clearance signed and dated by the physician within six months prior to prescribing the hearing aid;
- Recommendation of the make, model, and type of hearing aid;
- For hearing aids not covered under the MDHHS volume purchase contract, a copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and handling charges; and
- If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system, including letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.

4.13.D. PAYMENT RULES

Each of the HCPCS codes for contralateral routing systems covers both the transmitter and the receiver/hearing aid. Monaural codes should be used when providing one contralateral routing device to a beneficiary who already wears a Contralateral Routing of

Signals (CROS) compatible hearing aid in the better ear. Providers should choose the procedure code that corresponds to the appropriate model being fit on the poorer ear. Binaural codes should be used when providing one hearing aid and one contralateral routing device. No other hearing aid device procedure code may be billed in addition to the specific contralateral routing systems code used.

Most devices have established fee screens that are published in the MDHHS Hearing Aid Dealers Fee Schedule or indicated on the MDHHS volume purchase contract. For codes without established fee screens, the approved reimbursement amount is indicated on the approved PA request.

4.14 Non-Contract Hearing Aids

Hearing aid providers must provide hearing aids available through the MDHHS volume purchase contract whenever possible. If the provider prescribes a non-contract hearing aid, the hearing aid provider must obtain PA.

In addition to the required documents listed under the PA section of the hearing aid type, a letter of medical necessity must be submitted with the MSA-1653-B. The letter must identify the specific medical reason(s) why a contracted hearing aid will not meet the beneficiary's needs.

4.14.A. Payment Rules

Payment for a non-contract hearing aid may not exceed Medicaid's maximum allowable amount unless the documentation submitted with the MSA-1653-B supports the need for the more advanced technology found with a non-contract hearing aid. When documentation of the need for a non-contract hearing aid is provided, the payment is the acquisition cost for the non-contract hearing aid. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

Medicaid requires all non-contract hearing aids to include a manufacturer's equipment warranty that covers parts and labor for all repairs and modifications for a 24-month period, and loss and/or damaged replacements for a 12-month period. The warranty is included in the hearing aid's acquisition cost and should not be charged separately.

SECTION 5 – HEARING AID SUPPLIES, ACCESSORIES, AND REPAIRS

5.1 STANDARDS OF COVERAGE

Hearing aid supplies and accessories are a covered benefit when medically necessary. A list of approved supplies, accessories, and maximums is available on the Hearing Aid Supplies and Accessories list located on the MDHHS website. (Refer to the Directory Appendix for website information.)

5.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for hearing aid supplies and accessories if:

- Any single item is billed with requested payment amounts over the maximum fee as identified on the MDHHS Hearing Aid Dealers Fee Schedule.
- The sum of all payments for supplies/accessories billed within the past year is over the maximum fee as identified on the MDHHS Hearing Aid Dealers Fee Schedule.
- An item exceeds the frequency standards of coverage.

A list of supplies/accessories provided within the past year and a copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges must be submitted with the MSA-1653-B.

5.3 DOCUMENTATION

Applicable documentation to be maintained by the provider includes:

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

5.4 PAYMENT RULES

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.5 DISPOSABLE HEARING AID BATTERIES

5.5.A. STANDARDS OF COVERAGE

Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 36 batteries per hearing aid per DOS when dispensed by a hearing aid dealer, audiologist, hearing center, or medical supplier. A maximum of 72 batteries per aid per year is covered.

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 and medical suppliers may not bill for replacement of disposable batteries for cochlear implant devices.

5.5.B. Prior Authorization Requirements

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

5.5.C. Payment Rules

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.6 Replacement Earmolds

Beneficiaries who use hearing aids that require custom earmolds are eligible for replacement earmolds after the 90-day dispensing period. PA is not required when the earmold standards of coverage are met.

5.6.A. Standards of Coverage

Age 3 Years or Under	Up to four times per 12 months
Age 3 to 21 Years	Up to two times per 12 months
Age 21 Years or Over	Once every 12 months

5.6.B. Prior Authorization Requirements

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

5.6.C. Payment Rules

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.7 Hearing Aid Repairs and Modifications

5.7.A. Standards of Coverage

Providers may bill for repairs and modifications only to the most recently dispensed out-of-warranty hearing aid. Repairs required after the hearing aid repair warranty has expired are reimbursed based on the contracted rate and will have a new warranty period specified per the contract. MDHHS volume purchase contract vendors must continue to honor the repair pricing of the contract under which the hearing aid was sold for the life of the hearing aid. The vendor is responsible for all shipping costs related to warranty and non-warranty equipment repairs. When a warranty covered hearing aid requires a repair by the manufacturer, MDHHS will not reimburse the hearing aid dealer/audiologist for hearing aid fitting/checking services.

Repairs are not covered for back-up aids or devices.

The replacement of a hearing aid will be considered when the cost of the equipment repair is greater than the replacement. When submitting a PA request for the replacement, the provider must provide a statement regarding the cost to repair the aid/device versus replacement.

5.7.B. Prior Authorization Requirements

PA **is** required for repairs and modifications to out-of-warranty hearing aids if any of the following apply:

- The requested payment amount is over the maximum payment limit as published on the MDHHS Hearing Aid Dealers Fee Schedule. (Refer to the Directory Appendix for website information.)
- More than two separate repairs or modifications have been billed within the previous year.
- The hearing aid was not purchased under the MDHHS volume purchase contract.

Documentation must be submitted with the MSA-1653-B. If the manufacturer's invoice is not included with the initial PA request, the MDHHS determination letter will indicate an approved fee of $0.01 for PA purposes; the reimbursement fee will be updated once the actual invoice is submitted to MDHHS for pricing. A repair processing fee of $19.20 per aid may be added to the repair cost for hearing aids that are not covered under any warranty.

The repair or modification of a hearing aid not purchased by Medicaid may be covered only when all the following apply:

- The beneficiary's hearing level, as supported by an audiogram, meets Medicaid coverage criteria; and
- The aid itself meets Medicaid coverage criteria.

The MSA-1653-B for this type of repair or modification must include the date of purchase, warranty expiration date, and the current audiogram.

5.7.C. 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.

5.7.D. Payment Rules

Medicaid's payment for hearing aid repairs or modifications includes no more than the actual repair cost plus a $19.20 processing fee per aid. Actual repair cost consists of acquisition cost of materials used for the repair, related labor costs, and shipping costs. The $19.20 processing fee may only be added to repairs that are not covered under a

warranty. The maximum payment limit is published on the MDHHS Hearing Aid Dealers Fee Schedule.

Non-warranty repair pricing for hearing aids purchased under the MDHHS volume purchase contract are fixed rates established by the contract under which the hearing aid was sold. These rates apply for the life of the hearing aid.

SECTION 6 – OTHER HEARING DEVICES

6.1 ASSISTIVE LISTENING DEVICES

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

6.1.A. STANDARDS OF COVERAGE

All Ages	ALDs are a benefit for beneficiaries when all the following conditions are met: ▪ Patient management of a personal hearing aid is considered unrealistic and/or frequency specific audiometric data cannot be obtained in each ear; ▪ The beneficiary has not received a Medicaid covered ALD within the last three years; ▪ The ALD is provided for situations involving one-on-one conversation.

6.1.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all ALDs.

All Ages	The following documentation must be submitted with the MSA-1653-B: ▪ A manufacturer's invoice showing the item acquisition cost; ▪ 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.

6.1.C. DOCUMENTATION

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

- A letter from the audiologist demonstrating 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; and
- A copy of the manufacturer's invoice showing the ALD model, serial number, invoice price, applicable discounts, and shipping charges.

6.1.D. Payment Rules

Medicaid's payment for an ALD includes the provider's acquisition cost plus a percentage over cost. 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.

6.2 Cochlear Implants

Cochlear implants are devices that replace the function of the cochlear structures and provide electrical energy to auditory nerve fibers. They require a surgically placed internal device and external hardware. The surgery must be performed by a licensed medical doctor (MD) or doctor of osteopathy (DO) who specializes in otolaryngology and has training and expertise in the surgical procedure.

Cochlear implantation may be an option to improve communication skills for persons with severe to profound hearing loss who receive limited or no benefit from hearing aids.

6.2.A. Standards of Coverage

Unilateral and bilateral cochlear implantation is covered with PA for beneficiaries meeting the standards of coverage and audiological criteria. Implants must be FDA approved and used according to FDA labeled indications. Cochlear implants are covered for pre- or post-lingual deafness.

Hearing aids, hearing aid services, and accessories may be covered after the beneficiary has received a unilateral cochlear implant with PA. Documentation must be submitted to support improvement in speech perception abilities using a hearing aid in the opposite ear. Documentation of hearing aid audibility measures (i.e., speech mapping) on prescriptive hearing aid measurements may be submitted for beneficiaries who are unable to participate in speech perception testing.

All Ages	In addition to meeting the cochlear implant audiological criteria, **all** the following requirements must be met for unilateral and bilateral implantation: ▪ A letter from the treating otolaryngologist establishing medical necessity and recommending implantation. ▪ Limited benefit demonstrated with consistent use of appropriately fitted hearing aid(s) over a minimum of a three-month period. The trial period may be waived or shortened with appropriate documentation of medical necessity. ▪ Evidence of a functioning auditory nerve. ▪ An accessible cochlear lumen structurally suited to implantation. No evidence of lesions in the auditory nerve and acoustic areas of the central nervous system. This may be demonstrated by an appropriate radiological evaluation. ▪ Freedom from middle ear infection or any other active disease. ▪ No medical or behavioral health contraindications for anesthesia or surgery. ▪ Cognitive ability to use auditory cues and demonstrate a conditioned response.

	▪ Psychological development, motivation of the candidate, and/or commitment of the beneficiary and family/caregiver(s) to undergo a program of prosthetic fitting, training, and long-term rehabilitation. ▪ Realistic expectations of candidate and/or family/caregiver(s) for post-implant educational/vocational rehabilitation, as appropriate. ▪ Reasonable anticipation by treating providers that the cochlear implant(s) will confer awareness of speech at conversational levels. ▪ Documented intervention or school placement, as appropriate. Documentation may include the Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) involving individuals with specialization in the education of children who are deaf or hard of hearing.

6.2.A.1. AUDIOLOGICAL CRITERIA

Under 24 Months	▪ Diagnosis of bilateral severe to profound sensorineural hearing loss (Pure Tone Average [PTA]) equal to or greater than 70 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz (ANSI 1989) in an unaided condition. Electrophysiological assessment must corroborate behavioral testing. ▪ Lack of auditory skills development and minimal hearing aid benefit documented by results or outcomes of parent questionnaire (such as the Infant Toddler-Meaningful Auditory Integration Scale [IT-MAIS]).
Age 24 Months through 17 Years	▪ Diagnosis of bilateral severe to profound sensorineural hearing loss (PTA equal to or greater than 70 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz, ANSI 1989) in an unaided condition. ▪ Lack of auditory skills development and minimal hearing aid benefit documented by word recognition scores less than or equal to 50 percent on open set tests such as the Multisyllabic Lexical Neighborhood Test, Lexical Neighborhood Test, or other appropriate developmental tests in the best aided condition.
Age 18 Years and Older	▪ Diagnosis of bilateral moderate to profound sensorineural hearing loss (PTA equal to or greater than 40 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz, ANSI 1989) in an unaided condition. ▪ Minimal hearing aid benefit documented by a score of less than or equal to 50 percent under best-aided conditions on an open-set sentence recognition testing (such as the Hearing in Noise Test [HINT] Sentences) in the best aided condition.

6.2.B. PRIOR AUTHORIZATION

Unilateral and bilateral cochlear implantation require PA. All audiological evaluations must be signed and dated by the audiologist and performed within one year of the date of the PA request unless otherwise specified.

All Ages	The following documentation must be submitted with the MSA-1653-B: ▪ Documentation of complete audiology evaluation that defines the type and degree of hearing loss in each ear and applicable assessment results (e.g., speech recognition test scores and/or parent questionnaire) confirming the audiological criteria standards of coverage (as defined above) applicable to the beneficiary have been met. ▪ A letter from the treating otolaryngologist, with evaluation supporting medical necessity and treatment recommendations. ▪ Documentation of appropriately fitted hearing aids (for the trial period) verified through prescriptive measurements (e.g., aided audiograms). ▪ Documentation of minimal or no benefit from appropriate amplification (e.g., hearing aids) following an adequate period of auditory training (minimally three months) using the best ear responses. The trial period may be waived or shortened with appropriately submitted medical documentation. ▪ Documentation of an accessible cochlear lumen structurally suited to implantation (e.g., no evidence of lesions in the auditory nerve and acoustic areas of the central nervous system). This must be demonstrated by an appropriate radiological evaluation. ▪ Identification of the cochlear manufacturer of the internal device, with the model of the external processor. ▪ Identification of the anticipated side to be implanted (unilateral only).
Age 12 Months Through 17 Years	In addition to the documentation for beneficiaries of all ages, the following must also be submitted for beneficiaries aged 12 months through 17 years: ▪ Speech and language evaluation report; and ▪ Documented intervention or school placement, as appropriate. Documentation includes the IFSP or IEP involving individuals with specialization in the education of children who are deaf or hard of hearing.

6.2.C. DOCUMENTATION

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

- Complete audiology evaluation that defines the type and degree of hearing loss in each ear and applicable assessment results (e.g., speech recognition test scores and/or parent questionnaire) confirming the audiological criteria standards of coverage applicable to the beneficiary have been met.
- A letter from the treating otolaryngologist, with evaluation supporting medical necessity and treatment recommendations.
- Documentation of appropriately fitted hearing aids verified through prescriptive measurements (e.g., aided audiograms).
- Aided speech perception test battery results.

- Documentation of minimal or no benefit from appropriate amplification (i.e., hearing aids) following an adequate period of auditory training (minimally three months) using the best ear responses. The trial period may be waived or shortened with medical documentation.
- Documentation of an accessible cochlear lumen structurally suited to implantation. No evidence of lesions in the auditory nerve and acoustic areas of the central nervous system. This must be demonstrated by an appropriate radiological evaluation.
- Identification of the cochlear manufacturer of the internal device and model of the external processor.
- Identification of the anticipated side to be implanted (unilateral only).

6.2.D. Programming / Mapping

Cochlear implant mapping is the programming of the speech processor to the specifications and needs of its user following cochlear implant surgery. Mapping is used to analyze sound and convert the speech information into electrical impulses to the implanted electrodes. An initial post-operative session may be billed once per beneficiary per implant. Subsequent programming/mapping sessions may be billed up to five per year per implant. If additional sessions are needed, PA is required.

6.2.E. Repairs, Accessories, and Replacement Parts Standards of Coverage

Replacement of the internal cochlear implant device is covered with PA in cases when the audiologist or physician (e.g., otolaryngologist) indicates the function of the internal device has failed and is no longer under warranty. A letter from the manufacturer corroborating the internal device failure is required.

Replacement of the external speech processor with a new same generation or new upgraded speech processor is covered with PA when documentation from the licensed audiologist or physician substantiates the need for the replacement processor. Payment for the speech processor includes an initial supply of rechargeable batteries.

Cochlear repairs, accessories, replacement parts, and internal implant or external speech processor devices may be covered when dispensed by a cochlear implant manufacturer and the applicable standards of coverage have been met. Charges should reflect no more than the usual and customary (U&C) charge to the general public.

Implant or Speech Processor Repair or Replacement	Internal implants and external speech processors may be repaired or replaced when all the following apply: ▪ The device was in continuous use prior to the repair or replacement. ▪ A licensed audiologist or physician substantiates the functional need for the repair or replacement. ▪ The device is FDA-approved. ▪ The cochlear implant standards of coverage and audiological criteria have been met. ▪ Replacements only: the device is out of warranty and worn for at least four years, or the device is irreparable or lost.

	For replacement of a speech processor with an upgraded model, documentation must substantiate that the current model is obsolete or newer generation technology provides additional capacity for functional auditory-based improvement.
Accessories and Replacement Parts	Accessories and replacement parts may be covered when all the following apply: ▪ The replacement accessory or part is no longer covered by the manufacturer's warranty. ▪ A licensed audiologist or physician substantiates the need for the item. ▪ The item will be used on a cochlear device that was in continuous use prior to dispensing the item. ▪ The item will be used on an FDA-approved cochlear device.

6.2.F. Repairs, Accessories, and Replacement Parts Prior Authorization Requirements

PA **is** required for the following repairs, accessories, or replacement parts:

- External sound processors;
- Cochlear repairs, accessories, or implant parts when the sum of all charges exceeds the daily reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- Cochlear repairs, accessories, or implant parts when the sum of all charges within the past year exceeds the yearly reimbursement maximum published on the MDHHS Hearing Services Fee Schedule; and
- Items exceeding the frequency maximums published on the MDHHS Cochlear Implant Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

Some replacement parts are not subject to these reimbursement maximums. Refer to the Cochlear Implant Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

All Ages	When PA is required, the following documentation must be submitted with the MSA-1653-B: ▪ Documentation from the licensed audiologist or physician, signed and dated within the previous six months, that substantiates the need for the part(s) and/or repair; and ▪ Manufacturer's invoice itemizing the materials used to repair the device and the rationale for any related labor costs.

6.2.G. Replacement Parts and Accessories List

A list of approved cochlear implant replacement parts and accessories is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

6.2.H. Non-Covered Items

Repair or replacement of spare equipment (e.g., old parts and accessories in working condition for back-up use in emergencies) is not covered.

6.3 Bone Anchored Hearing Devices

Some beneficiaries may have physical or medical conditions that prevent them from wearing traditional hearing aids. A bone anchored hearing device (BAHD) is an alternative hearing instrument for those who can benefit when there is no other suitable aid.

6.3.A. Implantable

A BAHD or aid, also known as an auditory osseointegrated device, is an implantable bone-conduction hearing aid that allows direct bone-conduction of sound through an implant. The device has both implanted and external components. The implanted component is a small post surgically attached to the skull bone behind the ear. The external component is a speech processor connected to the implanted post. The surgically implanted components and initial external speech processor are covered as a bundled procedure at the hospital benefit level.

All device repairs and replacements, including the processor and batteries, are covered as specified on the MDHHS Hearing Services Fee Schedule.

6.3.B. Non-Implantable

BAHD sound processors can also be used without surgery when they are attached to the head by a headband device or adhesive adapter placed behind the ear. A headband system is the option for beneficiaries who meet the BAHD audiological criteria but are not appropriate surgical candidates and need hearing assistance via bone conduction.

6.3.C. Standards of Coverage

Unilateral and bilateral implantable and non-implantable BAHDs are covered for beneficiaries meeting the standards of coverage and audiological criteria. An air conduction hearing aid must also be contraindicated, failed, or not appropriate for the beneficiary's medical condition. Conditions not meeting these criteria are considered investigational/experimental and are not covered. Beneficiaries must be five years of age or older for surgically implanted BAHDs.

All Ages	▪ Has documented unilateral or bilateral conductive or mixed hearing loss or unilateral profound sensorineural hearing loss as defined under BAHD audiological criteria. ▪ Use of an FDA-approved device in accordance with its labeled indications. ▪ Has at least one of the following conditions: ➢ Congenital malformation(s) of the middle/external ear or microtia; ➢ Severe chronic otitis externa and/or chronic suppurative otitis media with chronic drainage preventing use of conventional air-conduction hearing aids; ➢ Conductive hearing loss due to ossicular disease and is not appropriate for surgical correction; ➢ Tumors of the external ear canal and/or tympanic cavity; ➢ Unilateral sensorineural hearing loss (single-sided deafness); or ➢ Condition that contraindicates an air conduction hearing aid.

6.3.C.1. AUDIOLOGICAL CRITERIA

Unilateral or Bilateral Conductive or Mixed Hearing Loss	▪ PTA bone conduction threshold less than or equal to 65 dB HL or level appropriate for model to be implanted, using the four-frequency average of 500, 1000, 2000 and 4000 Hz, in ear to be implanted; and ▪ Speech recognition scores less than or equal to 60 percent using appropriate speech recognition testing.
Unilateral Sensorineural Hearing Loss	▪ Confirmed profound hearing loss (greater than or equal to 90 dB HL using the four-frequency average of 500, 1000, 2000 and 4000 Hz) in one ear, with normal hearing on the contralateral side. Per FDA BAHD indications, normal hearing is defined as a PTA air-conduction hearing threshold of better than or equal to 20 dB HL.
Bilateral Implantation or Devices	▪ Bilateral symmetrical conductive or mixed hearing loss with a PTA bone conduction threshold less than or equal to 65 dB HL, or level appropriate for model to be implanted, in each ear using the four-frequency average of 500, 1000, 2000 and 4000 Hz; and ▪ Bone conduction threshold of less than or equal to 15 dB HL average difference between ears.

6.3.D. PRIOR AUTHORIZATION

Bilateral device implantation or dispensing requires PA.

All Ages	The following documentation, dated within six months prior to the surgical implantation or dispensing of the device, must be submitted with the MSA-1653-B: ▪ Complete audiology report (i.e., pure-tone audiogram) that defines the type and degree of hearing loss in each ear. ▪ History of hearing aid use or documentation supporting inability to use an air-conduction hearing aid. ▪ Letter from treating otolaryngologist stating medical need.

6.3.E. Documentation

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

- Complete audiology report (e.g., pure-tone audiogram) that defines the type and degree of hearing loss in each ear.
- History of hearing aid use or documentation supporting inability to use an air-conduction hearing aid.
- Letter from treating otolaryngologist stating medical need.

6.3.F. Repairs, Accessories, and Replacement Parts Standards of Coverage

Replacement of the internal implanted BAHD or external sound processor is covered in cases when the audiologist or physician (i.e., otolaryngologist) indicates the function of the device has failed and is no longer under warranty. Documentation from the licensed audiologist or physician to substantiate the need for the replacement must be submitted with the MSA-1653-B. Payment for the sound processor includes an initial supply of rechargeable batteries.

BAHD accessories, replacement parts, and repairs may be covered when dispensed by a cochlear implant manufacturer and applicable standards of coverage have been met. All charges for BAHD accessories, replacement parts, and repairs are to reflect no more than the usual and customary (U&C) charge to the general public.

Implant or Sound Processor Repair or Replacement	Implants and external sound processors may be repaired or replaced when all the following apply: ▪ The device was in continuous use prior to the repair or replacement. ▪ A licensed audiologist or physician substantiates the functional need for the repair or replacement. ▪ The device is FDA-approved. ▪ The BAHD standards of coverage and audiological criteria have been met. ▪ Replacements only: the device is out of warranty and worn for at least four years, or the device is irreparable or lost. For replacement of a sound processor with an upgraded model, documentation must substantiate that the current model is obsolete or newer generation technology provides additional capacity for functional auditory-based improvement.
Accessories and Replacement Parts	Accessories and replacement parts may be covered when all the following apply: ▪ The accessory or replacement part is no longer covered by the manufacturer's warranty. ▪ A licensed audiologist or physician substantiates the need for the item. ▪ The item will be used on a BAHD that was in continuous use prior to dispensing the item. ▪ The item will be used on an FDA-approved BAHD.

6.3.G. Repairs, Accessories, and Replacement Parts Prior Authorization Requirements

Replacement of a BAHD external sound processor is not covered more frequently than once every four years. Replacements are not covered during the warranty period.

PA **is** required for the following repairs, accessories, or replacement parts:

- Bilateral external sound processors;
- BAHD repairs, accessories, or replacement parts when the sum of all charges for parts and repairs exceeds the daily reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- BAHD repairs, accessories, or replacement parts when the sum of all charges for parts and repairs within the past year exceeds the yearly reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- Items exceeding the frequency maximums indicated on the BAHD Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

Some replacement parts are not subject to these reimbursement maximums. Refer to the Bone Anchored Hearing Device Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

All Ages	The following documentation, dated within six months prior to the dispensing of the part or repair, must be submitted with the MSA-1653-B: ▪ Documentation from the licensed audiologist and/or other medical professional to substantiate the need for the part(s) and/or repair. ▪ Manufacturer's invoice itemizing the materials used to repair the device and the rationale for any related labor costs.

6.3.H. Replacement Part Maximums

A list of approved BAHD replacement parts and maximums is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

6.3.I. Non-Covered Items

Repair or replacement of spare equipment (e.g., old parts and accessories in working condition for back-up use in emergencies) is not covered.

BONE ANCHORED HEARING DEVICE REPLACEMENT PARTS AND ACCESSORIES

The following replacement parts and accessories may be considered for coverage, if necessary, at the maximum limit specified. Prior authorization is required for items exceeding these limits or if the sum of all charges for parts and repairs exceeds the daily or yearly reimbursement maximums. Refer to the Michigan Department of Health and Human Services (MDHHS) Hearing Services Fee Schedule for reimbursement maximums. Items must no longer be covered by the manufacturer's warranty to be considered for replacement.

Item	Maximum Limit
Adhesive Adaptors - (Pack)	8 per year (per aid)
Battery Charging Kit	1 per year
Battery Door – (Each or Pack)	1 per year (per aid)
Cables - Accessory and Miscellaneous	1 per year (per aid)
Earhooks-(Pack)	2 per year (per aid)
Dry Brick/Drying Capsules/Cartridges/Dessicant Pillow - (Pack)	2 per year
Dri Aid Kit	1 per year
Dry & Store Electric or UV Dryer	1 per year
Magnet	1 per 2 years (per aid)
Processor Cover	1 per year (per aid)
Softband	2 per year
Safety Line - (Pack)	2 per year (per aid)
Softwear Pads - (Pack)	2 per year (per aid)
Sound Acr/Hardband	1 per year
Snugfits/Hugfits - (Pack)	2 per year (per aid)

The following replacement parts and accessories are separate and not subject to the daily or yearly reimbursement maximums. Prior authorization is required for some items or items exceeding the below maximum limits. Refer to MDHHS Hearing Services fee schedule and the Hearing Services chapter of the Medicaid Provider Manual for complete information. Items must no longer be covered by the manufacturer's warranty to be considered for replacement.

Item	Maximum Limit
Disposable Battery-Zinc (CPT: L8621)	150 per 6 months (per aid)
Rechargeable Battery (each) (CPT: L8624)	2 per year (per aid)
Battery Charger (CPT: L8625)	1 per 2 years
Sound Processor (CPT: L8692)	1 per 4 years (per aid)
Actuator (CPT: L8694)	1 per 2 years (per aid)

COCHLEAR IMPLANT REPLACEMENT PARTS AND ACCESSORIES

The following replacement parts and accessories may be considered for coverage, if necessary, at the maximum limit specified. Prior authorization is required for items exceeding these limits or if the sum of all charges for parts and repairs exceeds the daily or yearly reimbursement maximums. Refer to MDHHS Hearing Services Fee Schedule for reimbursement maximums. Items must no longer be covered by the manufacturer's warranty to be considered for replacement.

Item	Maximum Limit
Activewear Accessory Pack	1 per year
Baby Accessory Pack	1 per year
Battery Case/Holder/Pack	1 per year (per aid)
Battery (Rechargeable) Adapter	1 per 5 years
Battery Cover	1 per year (per aid)
Carrying or Traveling Case/Pouch/Harness	1 per year
Coil Magnet	1 per 3 years (per aid)
Coil Cover	1 per year (per aid)
Clips or Lanyards	2 per year (per aid)
Cable or Cord - Accessory and Miscellaneous	1 per year (per aid)
Dry & Store Electric or UV Dryer	1 per year
Dry Brick/Drying Capsules/Cartridges/Dessicant Pillow – (Pack)	2 per year
Earhooks - (Pack)/Earhook Accessories	2 per year (per aid)
Earmold Adaptor	2 per year (per aid)
Headband/Head Adaptor	1 per year
Litewear Cable	1 per 3 years (per aid)
Litewear Fixing Aids	1 per year (per aid)
Microphone Accessories: Cover/Protector Lock	 4 per year (per aid) 1 per year (per aid)
Plug Pack	1 per year
Safety Line/Safety Cord - (Pack)	2 per year (per aid)

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COCHLEAR IMPLANT REPLACEMENT PARTS AND ACCESSORIES

Item	Maximum Limit
Signal/Listening Checker	1 per year
Soft Wear Pad - (Pack)	2 per year (per aid)
Snugfits/Hugfits	2 per year (per aid)
Waterproof Cover/Protector	1 per 2 years (per aid)
Y and USB Chargers	1 per year

The following replacement parts and accessories may be considered for coverage at the maximum limit specified. Prior authorization is required. Items must no longer be covered by the manufacturer's warranty to be considered for replacement.

Item	Maximum Limit
Remote Assistant	1 per 3 years
Remote Assistant Charging Kit	1 per year

The following replacement parts and accessories are separate and not subject to the daily or yearly reimbursement maximums. Prior authorization is required for some items or items exceeding the below maximum limits. Refer to the MDHHS Hearing Services fee schedule and the Hearing Services chapter of the Medicaid Provider Manual for complete information. Items must no longer be covered by the manufacturer's warranty to be considered for replacement.

Item	Maximum Limit (Per Aid)
Battery - Alkaline (CPT: L8622)	150 per 6 months
Battery - Zinc Air (CPT: L8621)	150 per 6 months
Battery - Lithium Ion (CPT: L8623/L8624)	2 per year
Battery Charger (CPT: L8625)	1 per 2 years
External Controller (CPT: L8628)	1 per 4 years
Sound/Speech Processor (CPT: L8627)	1 per 4 years
Speech Processor and Controller- Integrated (CPT L8619)	1 per 4 years
Microphone (CPT: L8616)	1 per year
Headpiece/Headset (CPT: L8615)	1 per 3 years
Transmitter Cable (CPT: L8618)	1 per year
Transmitter Coil (CPT: L8617)	1 per 3 years

COCHLEAR IMPLANT REPLACEMENT PARTS AND ACCESSORIES

Item	Maximum Limit (Per Aid)
Transmitting Coil and Cable - Integrated (CPT: L8629)	1 per 3 years

Hearing Aid Supplies and Accessories

The following replacement parts and accessories may be considered for coverage, if necessary, at the maximum limit specified. Prior authorization is required for items exceeding these limits or if the sum of all charges for parts and repairs exceeds the daily or yearly reimbursement maximums. Refer to MDHHS Hearing Services Fee Schedule for reimbursement maximums. Items must no longer be covered by the manufacturer's warranty to be considered for replacement.

Item	Maximum Limit
Adhesive Adaptors – (Pack)	1 per month (per aid)
Dome Earpiece - (Pack)	2 per year (per aid)
Dry Aid Kit	1 per year (per aid)
Dry Brick/Drying Capsules/Cartridges/Dessicant Pillow - (Pack)	2 per year
Earhook - (Pair)	2 per year
Earmold Blower	1 per year
Hearing Aid Battery Tester	1 per year
Moisture Guards	2 per year (per aid)
Retention and Safety cords/Huggie Aid Pack/Otoclips	2 per year (per aid)
Slim Tubes - (Pack)	2 per year (per aid)
Stethoset (under 21 years old)	1 per year
Wax Filters/Wax Guards/Cerumen Guards - (Pack)	4 per year (per aid)

The following replacement parts and accessories may be considered for coverage at the maximum limit specified. Prior authorization is required.

Item	Maximum Limit
Rechargeable Batteries	2 per year (per aid)

The following replacement parts and accessories are separate and not subject to the parts and accessories daily or yearly reimbursement maximums. Prior authorization is required when limit maximums are exceeded.

Item	Maximum Limit
Disposable Battery (CPT: V5266)	36 per day up to 72 per year (per aid)