Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 45—Hearing Aid Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 45—Hearing Aid Program

13 CSR 70-45.010 Hearing Aid Program

PURPOSE: This rule is to establish the regulatory basis for the administration of the Hearing Aid Program, including the method of purchasing hearing aids; designation of professional persons who may perform the medical ear examination and testing; and the method of reimbursement for the aids and related services. More specific details of the conditions for provider participation, criteria and methodology of provider reimbursement, recipient eligibility and amount, duration and scope of services covered are included in the provider program manual.

(1) Administration. The Hearing Aid Program shall be administered by the Department of Social Services, Division of Medical Services. The services and items covered and not covered, the program limitations and the maximum allowable fees for all covered services shall be determined by the Department of Social Services, Division of Medical Services.

(2) Eligibility. Any person who is eligible for Title XIX benefits as determined by the Division of Family Services and who is found to be in need in accordance with the procedures listed in section (5) is eligible for a hearing aid.

(3) Prior Authorization of Hearing Aids. Effective for service dates November 1, 1989 and thereafter, all hearing aids and related services will require prior authorization with the exception of audiological testing, post-fitting evaluations, post-fitting adjustments, repairs to hearing aids no longer under warranty and special tests for ruling out retrocochlear involvement.

(4) Audiological Requirements. An audiological examination must be performed by an audiologist, hearing aid dealer/fitter or physician (MD or DO) prior to the submission of a Prior Authorization Request form. This testing, when administered for the purpose of prescribing a hearing aid, will be reimbursed by the Medicaid program. Audiological testing performed in relation to a medical or surgical diagnosis or treatment for hearing deficits or related medical problems for purposes other than determining the need for a hearing aid is a noncovered service and is not reimbursable by the Medicaid Hearing Aid Program. The audiological tests for a hearing aid must include, at a minimum, air conduction thresholds, bone conduction thresholds (with masking when necessary), speech reception thresholds and speech discrimination scores. The results obtained from these basic audiological tests must be clear and internally consistent, and must demonstrate that a hearing aid is needed, that it will benefit the recipient and will support the recommendation of which ear is to be fitted. Testing must be provided in accordance with sound professional practice and the standards under which the provider is licensed.

(5) Hearing Loss (HL) Requirement. A recipient's pure-tone average (PTA) must be thirty decibels (30dB) HL or greater in the better ear to qualify for a hearing aid. The PTA is the average air-conduction threshold for five hundred (500), one thousand (1000) and two thousand (2000) Hertz (Hz) measured with an earphone. A recipient's speech discrimination must be at least forty percent (40%) without visual cues in the ear to be aided to qualify for a hearing aid. The speech discrimination is measured with an earphone using a CID W-22 word list or equivalent. The speech discrimination test materials that are used must be specified.

(6) Medical Ear Examination Requirements. The recipient must receive a medical ear examination for pathology or disease by a physician licensed as an MD or DO. The medical ear examination must be performed within six (6) months prior to the date a hearing aid is dispensed.

(7) Obtaining and Fitting the Aid. Only after receipt of an approved Prior Authorization Request form should the provider proceed with the fitting and dispensing of the hearing aid.

(8) Post-fitting Evaluation. A post-fitting evaluation will be performed no sooner than fourteen (14) days or later than thirty (30) days after the hearing aid is dispensed. If the hearing aid is not providing adequate and substantial correction of the loss, reimbursement will not be made for the hearing aid.

(9) Reimbursement for Hearing Aids and Related Services. Payment will be made for each unit of service or item provided in accordance with the fee schedule determined by the Division of Medical Services. Providers must bill their costs for the hearing aids. Reimbursement will not exceed the lesser of the maximum allowed amount determined by the Division of Medical Services or the provider's billed charge.

(10) Services/Items Provided in a Nursing Home. A request for audiological testing and a hearing aid must originate with the recipient and must proceed with the recipient's full knowledge and consent. All hearing aids and related services performed or provided in a nursing home, boarding home, domiciliary home or institution require prior authorization as specified in section (3), with the exception that audiological testing performed in these places of service also requires prior authorization.

(11) Binaural Hearing Aids. Binaural hearing aids may be covered by Medicaid if medically necessary and if prescribed by an otolaryngologist, otologist or otorhinolaryngologist.

(12) Exception to Audiometric Criteria. If, despite speech discrimination less than forty percent (40%) or PTA threshold less than 30dB HL, there are special circumstances that would justify the need and benefit of a hearing aid, prior authorization may be granted.

(13) Replacement Hearing Aids. Prior authorization may be granted for a second hearing aid within four (4) years if the first hearing aid was lost, destroyed or ceased to function effectively and cannot be repaired.

(14) Hearing Aid Repairs. Medicaid will cover necessary repairs to any eligible recipient's hearing aid that is no longer under warranty. The warranty period on new aids or repairs will be for one (1) year from the date the hearing aid is dispensed. The methods of reimbursement for repairs are as follows:

(A) Out-of-shop Repairs. Necessary repairs made out-of-shop, where the aid must be sent out to the manufacturer or repair lab, will be reimbursed at twenty dollars ($20) plus the invoiced cost of the repair. The twenty dollars ($20) covers the provider's cost for postage and processing. Included also is any postage for returning the aid to the provider, any insurance fee charged and a six (6)-month warranty; and

(B) In-shop Repairs. Necessary repairs made in-shop will be reimbursed at the provider's cost for parts plus a reasonable charge for labor. The state consultant will determine the reasonable charge for labor. Repairs will be considered as in-shop repairs for—

1. Any repair made in the provider's office;

2. Any repair made in a provider-owned and/or operated repair or manufacturing lab; or

3. Any repair made by a provider who is employed by or affiliated with another provider who owns or operates a repair or manufacturing lab.

(15) Post-fitting Adjustments. A maximum of three (3) post-fitting adjustments or hearing aid repairs or any combination totaling three (3) are covered in a twelve (12)-month period. Minor adjustments and repairs such as the following must be billed as a post-fitting adjustment:

(A) Resetting or adjusting the frequency response of the aid;

(B) Modifying an earmold;

(C) Checking that the ear, earmold and tubing are not occluded with ear wax;

(D) Removing of ear wax from the earmold and tubing;

(E) Venting earmold or closing vent;

(F) Adjusting maximum power output;

(G) Reinstructing the patient in the use and care of the aid;

(H) Performing minor in-shop hearing aid repairs;

(I) Conducting hearing retests;

(J) Evaluating the electroacoustic hearing aid; or

(K) Cleaning the hearing aid.

(16) Basic Program Limitations. Benefits under the hearing aid program are limited by the following:

(A) A recipient is entitled to one (1) new hearing aid and related services (testing, earmold, fitting, dispensing and post-fitting evaluation) per four (4) years;

(B) Backup or spare hearing aids are non-covered regardless of when first hearing aid was dispensed;

(C) Any hearing aid for the purpose of binaural amplification must be prescribed by an otolaryngologist, otologist or otorhinolaryngologist;

(D) All repairs for hearing aids must include a six (6)-month warranty;

(E) Medicaid will not reimburse for repairs to a hearing aid that is five (5) years of age or older; and

(F) A new hearing aid will not be purchased within six (6) months of the repair of an old hearing aid.

Auth: sections 208.153, RSMo (1986) and 208.201, RSMo (Supp. 1988). This rule was previously filed as 13 CSR 40-81.120. Emergency rule filed June 1, 1979, effective June 11, 1979, expired Sept. 13, 1979. Original rule filed June 1, 1979, effective Sept. 14, 1979. Emergency amendment filed April 10, 1981, effective April 20, 1981, expired July 10, 1981. Amended: Filed April 10, 1981, effective July 11, 1981. Rescinded and readopted: Filed July 18, 1989, effective March 1, 1990.

MISSOURI MEDICAID PRIOR AUTHORIZATION REQUEST

Return to: GTE Data Services
P.O. Box 5700
Jefferson City, MO 65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. Authorization expires 120 days from the date of approval.

I. GENERAL INFORMATION

Recipient: 1. Last Name & Address	2. First Name	3. M.I.	4. Date of Birth	5. Medicaid Number
	6. Prognosis	7. Diagnosis Code	8. Diagnosis Description	

9. Name and Address of Facility Where Services are to be Rendered if Other than Home or Office

II. SERVICE INFORMATION

Ref. Let.	10. Type Serv.	11. Procedure Code	12. Description of Service/Item	13. Qty or units	14. Amt. to be charged	For State Office Use Only: Appr.	Denied	Amt. Allowed if Priced by Report
a.								
b.								
c.								
d.								
e.								
f.								
g.								
h.								

15. Detailed explanation of medical necessity for Equipment/Procedure/Prosthesis (Attach additional pages as necessary):

III. PROVIDER REQUESTING PRIOR AUTHORIZATION:

(Affix Label Here)

16. Provider Name: _____

17. Address: _____

18. Medicaid Provider No.: _____ DATE

19. SIGNATURE

IV. PRESCRIBING PHYSICIAN (For DME):

20 Name

21 Address

22. Phone Number

23 Date Disability Began

24. Period of Medical Need in Months

V. FOR STATE OFFICE USE ONLY:

Denial Reason(s): Referenced to lines above by letter.

I CERTIFY THAT THE INFORMATION GIVEN IN SECTIONS I AND II OF THIS FORM IS TRUE, ACCURATE, AND COMPLETE.

25. _____ (Signature of Prescribing Physician)

26. _____ (Date of Signature)

AUTHORIZATION: Service(s) Authorized to begin on or after:

_____ (Date)

REVIEWED BY:

_____ (Signature)

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