Department: Utilization Management	**Policy and Procedure No:** MCD-OH-CLI-H1346	
Policy and Procedure Title: Hearing Aides Medical Necessity		
Process Cycle: Annually	**Responsible Departments:** Clinical	
Approved By: Mark Rastetter MD	**Effective Date:** 2/1/2023	**Revised:**

POLICY AND PROCEDURE:

Policy:
Humana Healthy Horizons™ of Ohio will use established criteria guidelines to make medical necessity decisions on case-by-case basis, based on the information provided on the member's health status.

Procedure:
For Hearing Aides services, Humana Healthy Horizons in Ohio uses OAC Rule 5160-10-11.

A) Definition. "Basic hearing test" is an evaluation of an individual's ability to hear that includes the following components:

(1) Testing of air-conducted stimuli at thresholds of five hundred hertz (Hz), one thousand Hz, two thousand Hz, and four thousand Hz;
(2) Assessment of air-conducted speech awareness or speech reception threshold.
(3) Establishment of most comfortable and most uncomfortable listening levels;
(4) Pure-tone bone conduction audiometry (unless the individual's age or capability precludes such testing); and
(5) For an individual younger than twenty-one years of age, the following components:
(a) Tympanometry.
(b) Acoustic reflex battery; and
(c) Otoacoustic emissions testing.

(B) Coverage.

(1) The default certificate of medical necessity (CMN) form is the ODM 01915, "Certificate of Medical Necessity: Hearing Aids" (rev. 7/2018).
(2) A completed CMN, signed and dated not more than ninety days before the requested dispensing date, must be accompanied by a hearing evaluation report, compiled not more than six months before the requested dispensing date, made up of the following components:
(a) A detailed description of the hearing test, signed by the physician specializing in otology or otolaryngology, audiologist, or licensed hearing aid fitter who administered iit;
(b) A copy of the hearing test results; and
(c) A written summation of the hearing test results, prepared and signed by a physician specializing in otology or otolaryngology or by an audiologist.
(3) Separate payment may be made for the hearing test itself. All hearing tests must be administered by authorized individuals working within their scope of practice and must be conducted in an appropriate sound environment in accordance with nationally accepted standards. Hearing tests should be performed on both ears; a detailed explanation must be included in a PA request if bilateral testing cannot be done.

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(4) The need for a hearing aid is demonstrated when the results of a basic hearing test performed on one ear indicate the following minimum best pure-tone average hearing loss:
(a) Thirty-one decibels (dB); or
(b) In an individual younger than twenty-one years of age, twenty-six dB.
(5) To assess the performance and acceptability of the hearing aid, the provider must attempt to schedule a follow-up visit with the individual within thirty days after delivery. No claim for payment should be submitted during this period. The provider must keep on file, for at least four years, either a confirmation of the follow-up visit signed by the individual or an explanation of why the visit was not conducted. If as a result of the follow-up visit the hearing aid is deemed unacceptable by either the provider or the individual, then payment is limited to the cost of the earmold insert and batteries. In such an instance, if payment has already been made for the hearing aid, then the provider must arrange for adjustment of the claim.
(6) The following warranty periods apply:
(a) For a covered hearing aid, it is the greater of the manufacturer's warranty period or one year from the date of delivery; and
(b) For an earmold insert, it is ninety days.
(7) A warranty comprehensively covers the following services:
(a) Repair, including labor and parts (except earmold inserts and batteries);
(b) Replacement necessitated by damage or loss; and
(c) Two adjustments per year for changes in hearing sensitivity or growth of the ear canal (after which additional adjustments made during the year will be treated as repairs).
(8) A programmable hearing aid, such as a hearing aid employing contralateral routing of signal (CROS) or binaural contralateral routing of signal (BiCROS), may be indicated if an individual has a documented need for such technology in noisy or otherwise adverse hearing environments.
(9) Separate payment may be made for the taking of an impression for an earmold insert (other than an insert dispensed with a hearing aid). Such payment is limited neither by the place of service nor by the individual's living arrangement.
(10) Regardless of how a hearing aid was purchased, payment may be made for necessary repair only if the following conditions are satisfied:
(a) The medical necessity of the hearing aid has been established;
(b) The repair is not covered by warranty or insurance; and
(c) The repair is not associated with routine maintenance or cleaning of the hearing aid.

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(C) Requirements, constraints, and limitations.

(1) The provider must keep on file a copy of the manufacturer's original cost estimate, a copy of the manufacturer's final invoice detailing discounts and shipping costs, and (if applicable) an explanation of any differences between the figures.
(2) No payment will be made for the following hearing aids:
(a) A hearing aid designed to be worn inside the ear canal.
(b) A disposable hearing aid; and
(c) A hearing aid that has been previously used by another individual.
(3) No payment (including payment of a deductible amount) will be made for replacement if either of the following conditions is satisfied:
(a) The hearing aid is covered by warranty or insurance; or
(b) Repair or reconditioning would be more cost-effective.
(4) Concurrent requests or claims for two separate hearing aids will be treated as a single request or claim for a binaural hearing aid.
(5) Payment for a hearing aid includes the following items:
(a) A cleaning kit;
(b) An initial earmold insert (applicable to behind-the-ear hearing aids); and
(c) One month's supply of batteries.
(6) Payment for hearing aid dispensing includes the following services:
(a) The taking of initial earmold impressions.
(b) Assistance with selection of the hearing aid;
(c) Up to three hours of counseling.
(d) All visits (including travel) necessary for the dispensing and fitting of the hearing aid (regardless of place of service); and
(e) All service calls and follow-up visits during the warranty period.

(D) Claim payment.
(1) Payment for an analog hearing aid is the lesser of two figures:
(a) The Medicaid maximum amount listed in the appendix to rule 5160-10-01 of the Administrative Code; or
(b) The provider's acquisition cost, which is the sum of the manufacturer's final invoice price and shipping less any discounts received.
(2) Payment for a digital hearing aid is the lesser of two figures:
(a) A percentage of the Medicaid maximum amount listed in the appendix to rule 5160-10-01 of the Administrative Code, determined by the age of the individual:
(i) For an individual younger than twenty-one years of age, one hundred per cent; or
(ii) For an individual twenty-one years of age or older, fifty per cent; or
(b) The provider's usual and customary charge.
(3) Payment for repair of a hearing aid is the submitted charge, which must represent one of the following amounts:
(a) If the provider performed the repair, the provider's usual and customary total charge; or
(b) If the provider subcontracted the repair, one hundred twenty-five per cent of the amount shown on the invoice sent to the provider.

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CPT® Code(s)	Description
	NA
CPT® Category III Code(s)	**Description**
	NA
HCPCS Code(s)	**Description**
V5130	Binaural, in the ear
V5140	Binaural, behind the ear
V5150	Binaural, glasses

1) The Plan covers all benefits and services required in OAC chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.
2) When applying coverage policies and medical necessity criteria, the Plan will consider individual member needs and an assessment of the local delivery system.
3) The Plan uses the following hierarchy of guidelines to review for medical necessity:
    a) Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
    b) Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines)
    c) Humana Healthy Horizons in Ohio clinical policies
    d) In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes:
        i. Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations.
        ii. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
        iii. Medical association publications
        iv. Government-funded or independent entities that assess and report on clinical care
        v. decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;

vi. Published expert opinions;
vii. Opinion of health professionals in the area of specialty involved;
viii. Opinion of attending provider

e) Dental: DentaQuest coverage guidelines and policies
Dental Coverage - Humana Healthy Horizons in Ohio | Humana
f) Vision: EyeMed coverage guidelines and policies
Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana

Only practitioners with the appropriate clinical expertise can make the decision to deny or reduce the amount, duration or scope of the services being requested.

Humana Healthy Horizons™ in Ohio requires prior authorization on all "Miscellaneous", "Unlisted", "Not Otherwise Specified" codes. Medical necessity documentation and rationale must be submitted with the prior authorization request. The medical director adheres to the above process to align criteria based on the information provided on the member's health status.

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, from 7 a.m. to 8 p.m.

Providers may submit a request for medical necessity request by calling 877-856-5707 (TTY:711), Monday – Friday, from 7 a.m. to 8 p.m. EST or emailing the request to OHMCDUM@humana.com.

RESOURCES:

- Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. Retrieved December 22 ,2022, from Rule 5160-10-11 - Ohio Administrative Code | Ohio Laws
- Ohio Administrative Code Rule 5160-10-11

CONTRACT LANGUAGE:

5. Coverage Requirements

a. Medical Necessity Criteria

i. Pursuant to OAC rule 5160-26-03, the MCO's coverage requirements and decisions must be based on the coverage and medical necessity criteria published in OAC Chapter 5160 and practice guidelines as specified in OAC rule 5160-26-05.1.
ii. The MCO must have objective, written criteria based on sound clinical evidence to make medical necessity and utilization decisions. The MCO must involve appropriate providers in the development, adoption, and review of medical necessity criteria. The MCO's written criteria must meet NCQA standards and must specify procedures for appropriately applying the criteria.

iii. The MCO must use ODM-developed medical necessity criteria where it exists. In the absence of ODM-developed medical necessity criteria, the MCO must use clinically-accepted, evidence-informed medical necessity criteria (e.g., InterQual®, MCG®, and ASAM) as approved by ODM.
iv. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically-accepted, evidence-informed medical necessity criteria, the MCO's adaptation or development of medical necessity criteria must be based upon evaluated, peer reviewed medical literature published in the United States.
    1. Peer reviewed medical literature must include investigations that have been reproduced by non-affiliated authoritative sources.
    2. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.
v. When applying coverage policies and medical necessity criteria, the MCO must consider individual member needs and an assessment of the local delivery system.

DEFINITIONS:

Adverse Benefit Determination – As defined in OAC rule 5160-26-08.4, a Managed Care Organization's (MCO's):

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
b. Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO;
c. Denial, in whole or part, of payment for a service (a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” is not an adverse benefit determination);
d. Failure to provide services in a timely manner as specified in OAC rule 5160-26-03.1;
e. Failure to act within the resolution timeframes specified in this rule; or
f. Denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable.

American Society of Addiction Medicine (ASAM) – a professional medical society representing over 7,000 physicians, clinicians, and associated professionals in the field of addiction medicine.

ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addition and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.

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MCG® – Formerly known as Milliman Care Guidelines, are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.

Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:

a. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
b. Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.
c. Conditions of medical necessity are met if all the following apply:
    i. It meets generally accepted standards of medical practice;
    ii. It clinically appropriate in its type, frequency, extent, duration, and delivery setting;
    iii. It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
    iv. It is the lowest cost alternative that effectively addresses and treats the medical problem;
    v. Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
    vi. It is not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.
d. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.
e. The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

VERSION CONTROL

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Version Review Approval History				
Department:	**Purpose of Review**	**Reviewed and Approved By:**	**Date:**	**Additional Comments:**
Clinical	Policy Development	Dr. Mark Rastetter	12//23/2022	

DISCLAIMER:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained by CMU to ensure no modifications have been made.

NON-COMPLIANCE:

Failing to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to non-compliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet of Hi! (Workday & Apps/Associate Support Center).