Administrative Code

Title 23: Medicaid
Part 218
Hearing Services

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Title 23: Division of Medicaid

Part 218: Hearing Services

Part 218 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. State-licensed audiologists and physicians must render services under their license as an audiologist or physician.

B. All providers of Medicaid services must comply with the requirements for enrollment as outlined in Part 200, Chapter 4, Rule 4.8. Physicians must satisfy the additional provider type requirements outlined in Part 203, Chapter 1, Rule 1.1. Audiologist and hearing aid dealers must satisfy the additional provider type requirements listed below:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. Copy of current license in the state in which the individual furnishes the services,

3. Verification of having met the following requirements:

   a) A master's or doctoral degree in audiology,

   b) Has received a license from a state that requires the following conditions be met for licensure:

      1) Has a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association for licensure, or

      2) Has successfully completed a minimum of three hundred fifty (350) clock-hours of supervised clinical practicum, or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctor-level audiologist; performed at least nine (9) months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

   c) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one (1) of the conditions in Part 218, Chapter 1, Rule 1.1.3(b).

4. Verification of a social security number using a social security card, driver's license if it

notes the social security number, military ID or a notarized statement signed by the provider noting the social security number, for individual providers. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 42 CFR 455, Subpart E

Rule 1.2: Cochlear Implants

A. Medicaid covers for unilateral cochlear implantation when there is documentation that demonstrates the procedure is medically necessary and would be beneficial in reducing limitations of hearing impairment.

B. The following must be documented by the surgeon and/or audiologist:

1. Severe to profound sensorineural hearing loss in both ears as defined by FDA criteria with a lack of benefit from a well-fitting aid,

2. Cognitive ability to use auditory clues, patient motivation and a willingness to undergo an extended program of rehabilitation,

3. Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system,

4. No contraindications to surgery, and

5. The device must be used in accordance with the FDA approved labeling.

C. Documentation for children twelve (12) months of age to seventeen (17) years of age must include:

1. The onset of hearing impairment must have occurred during the pre-or post-linguistic period, and

2. Bilateral severe to profound sensorineural deafness must be demonstrated by the inability to improve on age-appropriate closed set word identification tasks with amplification, or lack of progress in auditory training.

D. Documentation for adults eighteen (18) years of age and older must include:

1. The onset of hearing impairment must have occurred during the pre-linguistic, peri-linguistic, or post-linguistic period, and

2. Post-linguistic deafened adults must demonstrate current FDA guidelines on test scores on sentence recognition scores from tape-recorded tests in the beneficiary's best listening condition.

E. Medicaid covers bilateral cochlear implantation when there is documentation that demonstrates the procedure is medically necessary and would be beneficial in reducing limitations of hearing impairment. Bilateral cochlear implantation must meet all of the criteria for unilateral cochlear implantation, above, in addition to the following criteria and circumstances.

F. Medicaid covers bilateral cochlear implants under two (2) different circumstances:

1. Simultaneous bilateral cochlear implants, and

2. Subsequent contralateral cochlear implantation in patients who have already received a previous unilateral cochlear implant.

G. Simultaneous bilateral cochlear implants are covered for beneficiaries who:

1. Have significant deafness, caused by meningitis with subsequent risk for early cochlear ossification, and, in the opinion of the treating physician, are appropriate candidates for bilateral cochlear implantation for the syndrome of post-meningitis deafness prior to cochlear ossification, or

2. Pre-lingually deaf children with profound hearing loss, and who, in the opinion of the treating specialist physician, would benefit from the additional neuronal stimulation afforded by simultaneous bilateral cochlear implantation at an early age. Some patients in this category may, in the opinion of the treating specialist physician, benefit from a staged or subsequent contralateral cochlear implantation as opposed to a simultaneous implantation.

H. Subsequent contralateral cochlear implantation are covered for beneficiaries who:

1. Have bilateral profound deafness that have fallen short of communication goals despite prior placement of a unilateral cochlear implant, and in the opinion of the treating specialist physician, would substantially benefit from a subsequent contralateral cochlear implant,

2. Are prelingually deaf children with bilateral profound hearing loss who have had prior unilateral cochlear implantation and who, in the opinion of the treating specialist physician, would substantially benefit from a subsequent contralateral cochlear implant, or

3. Have bilateral auditory neuropathy to the extent such that their cochlear function is structurally normal but who have abnormal findings on auditory brainstem response testing, and, in the opinion of the treating specialist physician, would substantially benefit from a subsequent contralateral cochlear implant.

I. Medicaid does not cover for bilateral cochlear implantation, either as a simultaneous

procedure or a subsequent contralateral implantation if, in the opinion of the treating physician, audiologist, or therapist, the beneficiary has sufficient limited hearing in the lesser affected ear either could either be:

1. Sufficiently augmented by a hearing aid to augment the opposite cochlear implant, or

2. Could later benefit from a future surgical or other medical intervention to improve the hearing in the non-implanted ear.

J. Medicaid covers a subsequent contra-lateral cochlear implant procedure, the testing, services and procedures, to properly evaluate a beneficiary and address the proper post-operative care and therapy for a second cochlear implant, when the beneficiary already has a unilateral cochlear implant.

K. Medicaid does not cover the cost of the cochlear implant device through the Durable Medical Equipment program. The cost of the device is covered by the usual reimbursement methodology for either inpatient or outpatient hospital services and must be billed by the hospital. Medicaid does not cover additional benefits for the device if the surgical procedure is performed in any other outpatient settings.

L. Medicaid covers the repair and/or replacement of the cochlear implant external speech processor and other minor supplies including batteries, cords, battery charger, and headsets through the Durable Medical Equipment (DME) program. Medicaid covers these items for all beneficiaries by DME providers only. Medicaid requires prior approval for repairs or replacements of external implant parts.

M. Medicaid requires documentation by the provider of rehabilitative services supporting medical necessity and must be retained in the beneficiary's medical record.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Bone Anchored Hearing Aid

A. Medicaid covers the Bone Anchored Hearing Aid (BAHA) when both audiologic and medical criteria are met:

1. Audiologic criteria is met if all the following are present:

   a) A pure tone average bone conduction threshold of seventy (70) dB or less, and

   b) A speech discrimination score greater than sixty percent (60%).

2. Medical criteria is met if one (1) or more of the following are present:

   a) Congenital or surgically induced malformations of the external ear canal and/or middle ear, like atresia,

b) Severe chronic infections of the middle or outer ear with persistent otorrhea/discharge and documented failure with air conducted hearing aids,

c) Tumors of the external ear canal and/or tympanic cavity,

d) Otosclerosis with a contraindication to stapedectomy surgery, with the ear requiring stapedectomy is the beneficiary's only hearing ear,

e) Other anatomic or medical conditions in which an air conduction hearing aid is contraindicated, or

f) Single-sided deafness.

B. Medicaid does not cover the following:

1. BAHA for beneficiaries under five (5) years of age, or

2. BAHA for beneficiaries with bilateral sensorineural hearing loss.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121