

Hearing Services

Policy Number: BIP074.L
Effective Date: August 1, 2023

[➔ Instructions for Use](#)

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Federal/State Mandated Regulations

Oklahoma

Oklahoma Statutes §36-6060.7. Insurance Plans to Include Audiological Services

<https://www.oscn.net/applications/oscn/deliverdocument.asp?id=104387&hits=>

- A. 1. Any health benefit plan that is offered, issued, or renewed on or after the effective date of this act shall provide coverage for audiological services and hearing aids for children up to eighteen (18) years of age.
2. Such coverage:
 - a. Shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and
 - b. May limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months; provided, however, coverage may provide for up to four additional ear molds per year for children up to two (2) years of age.
- B. Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the practice and privileges of the provider.
- C. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

Oregon

Effective January 1, 2019

Bilateral Cochlear Implants

Section 1 ORS 743A.140

<https://www.oregonlaws.org/ors/743A.140>

Section 1 ORS 743A.140 is amended to read:

- (1) A health benefit plan, as defined in ORS 743B.005, shall reimburse the cost of:
 - (a) Bilateral cochlear implants if medically appropriate for the treatment of hearing loss; and
 - (b) Programming and reprogramming cochlear implants.
- (2) For purposes of ORS 746.230, (Unfair claim settlement practices) a reasonable investigation of a claim for bilateral cochlear implants must include a request to the treating surgeon for a written recommendation based on peer-reviewed medical literature and for the medical findings that support the recommendation.

- (3) A health benefit plan shall reimburse the cost of repair and replacement parts for a cochlear implant if the repair or parts are not covered by a warranty and are necessary for the device to be functional for the user.
- (4) The provisions of this section are exempt from ORS 743A.001. (Automatic repeal of certain statutes on individual and group health insurance).

Hearing Aids and Hearing Assistive Technology Systems

Section 2 ORS 743A.141

ORS 743A.141 is amended to read:

<https://www.oregonlaws.org/ors/743A.141>

- (1) As used in this section :
 - (a) "Hearing aid" means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.
 - (b) "Hearing assistive technology systems" means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.
- (2) A health benefit plan, as defined in ORS 743B.005, shall provide payment, coverage or reimbursement for:
 - (a) One hearing aid per hearing impaired ear if:
 - (A) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and
 - (B) Medically necessary for the treatment of hearing loss in an enrollee in the plan who is:
 - (i) 18 years of age or younger; or
 - (ii) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.
 - (b) Ear molds and replacement ear molds:
 - (A) Up to four times per plan year for enrollees who are younger than eight years of age; and
 - (B) At least once per year for enrollees who are:
 - (i) Eight to 18 years of age; or
 - (ii) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.
 - (c) One box of replacement batteries per year for each hearing aid.
 - (d) Necessary diagnostic and treatment services at least twice per year for enrollees who are younger than four years of age and at least once per year for enrollees who are four years of age or older, including:
 - (A) Hearing tests appropriate for an enrollee's age or developmental need;
 - (B) Hearing aid checks; and
 - (C) Aided testing.
 - (e) Bone conduction sound processors, if necessary for appropriate amplification of the hearing loss.
 - (f) Hearing assistive technology systems for an enrollee who is younger than 19 years of age, if necessary for appropriate amplification of the hearing loss.
- (3) An insurer may not impose any financial or contractual penalty upon an audiologist if an enrollee elects to purchase a hearing aid or other device priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid or other device.
- (4) A health benefit plan shall provide the benefits described in subsection (2)(a), (e) and (f) of this section:
 - (a) Every 36 months; or
 - (b) For hearing aids, more frequently than every 36 months if modifications to an existing hearing aid will not meet the needs of an enrollee who is:
 - (A) Under 19 years of age; or
 - (B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.
- (5) An insurer must contract with pediatric audiologists in sufficient numbers and geographic locations in this state to comply with ORS 743B.202 and 743B.505.
- (6) Insurance producers shall ensure that enrollees have access to navigators or other assisters to facilitate the diagnosis of hearing loss and needed amplification and ensure that technologies are available to treat hearing loss in enrollees who are 19 years of age or younger. Upon receiving a claim for reimbursement for the diagnosis of hearing loss, an insurer shall provide notice of the coverage limits to the enrollee or to the parent or legal guardian of the enrollee. With respect to enrollees with hearing loss who are younger than 19 years of age, an insurer shall provide educational materials to the parent or legal guardian of the enrollee and shall have a process in place to ensure that appropriate technologies are available.

- (7) The payment, coverage or reimbursement required under this section may be subject to provisions of the health benefit plan that apply to other durable medical equipment benefits covered by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior authorization.
- (8) This section is exempt from ORS 743A.001. (This section is exempt from ORS743A.001 (Automatic repeal of certain statutes on individual and group health insurance).

Section 3

The amendments to ORS 743A.140 and 743A.141 by sections 1 and 2 of this 2018 Act apply to health benefit plans for which the Department of Consumer and Business Services has not approved rates as of the effective date of this 2018 Act.

Oregon ORS Title 36 Public Health and Safety 433.321 Hearing Screening Tests for Newborns

<https://www.oregonlaws.org/ors/433.321>

- (1) In all Oregon hospitals and birthing centers where more than 200 live births occur per year, each newborn child must receive a newborn hearing screening test. A hospital or birthing center shall attempt to conduct the test required under this subsection prior to the discharge of the child from the facility.
- (2) All Oregon hospitals and birthing centers where fewer than 200 live births occur per year shall provide the parent or guardian of a newborn child with the appropriate information furnished by the Oregon Health Authority concerning the importance of newborn hearing screening tests.
- (3) All Oregon hospitals and birthing centers conducting newborn hearing screening tests within 10 days of the test shall:
 - (a) Notify the parent or guardian and the health care provider of the newborn child of the test results;
 - (b) Provide the parent or guardian with names and contact information for diagnostic facilities that conduct newborn hearing screening tests in the community; and with materials developed pursuant to ORS [433.298 \(Oregon Health Authority to compile information about congenital cytomegalovirus\)](#); and
 - (c) Report to the authority the results of the test for the newborn child and information identifying the newborn child
- (4) A diagnostic facility conducting newborn hearing tests within 10 days of conducting a newborn hearing screening test, shall report to the authority the results of the test for the newborn child and information identifying the newborn child. If a diagnostic facility conducting newborn hearing screening tests detects hearing loss in a newborn child, the diagnostic facility shall provide to the parent or guardian materials developed pursuant to ORS [433.298 \(Oregon Health Authority to compile information about congenital cytomegalovirus\)](#) section 2 of this 2017 Act.
- (5) Each public and private educational institution that provides early intervention services as defined in ORS 343.035 shall disclose to the authority information identifying the children referred to the educational institution with diagnosed hearing loss and the enrollment status of the children. The institution may disclose to the authority additional information regarding children with hearing loss who are receiving early intervention services if the educational institution has obtained consent to disclose the information.
- (6) The authority, in collaboration with the Child Development and Rehabilitation Center of the Oregon Health and Science University shall, on an annual basis, provide to all Oregon hospitals and birthing centers the following information:
 - (a) A description of the responsibilities created by this section;
 - (b) A list of appropriate screening devices and descriptions of training protocols to ensure that staff members are adequately trained in the use of hearing screening equipment;
 - (c) A list of diagnostic facilities that conduct newborn hearing screening tests;
 - (d) Using evidence-based best practice standards, a recommended schedule for conducting newborn hearing screening tests, and for referring parents and guardians to health care providers for the purpose of diagnosing whether the newborn child has congenital cytomegalovirus, within 21 days of the newborn child's date of birth
 - (e) A list of public and private educational institutions that provide early intervention services and a description of the geographic area served by each institution; and
 - (f) Other information related to newborn hearing screening tests that the authority deems appropriate.
- (7) A hospital or birthing center described in subsection (1) of this section is exempt from providing newborn hearing screening tests if the parent or guardian of the newborn child objects to the testing procedure on the grounds that the procedure conflicts with the religious tenets and practices of the parent or guardian. The parent or guardian must sign a statement that the newborn child is being reared in accordance with those religious tenets and practices.
- (8) A newborn child may not be refused the procedure described in subsection (1) of this section because of an inability of the parent or guardian to pay for the procedure.

Texas

Texas Insurance Code §1367 Coverage of Children, Subchapter C. Hearing Test

Section 1367.101 Applicability of Subchapter

<https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1367.htm>

- (a) This subchapter applies only to a health benefit plan that:
- (1) Provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
 - (A) An insurance company;
 - (B) A group hospital service corporation operating under Chapter 842;
 - (C) A fraternal benefit society operating under Chapter 885;
 - (D) A stipulated premium company operating under Chapter 884;
 - (E) A health maintenance organization operating under Chapter 843; or
 - (F) A multiple employer welfare arrangement subject to regulation under Chapter 846;
 - (2) Is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or
 - (3) Provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.
- (b) This subchapter applies to a health benefit plan described by Subsection (a) that provides coverage to a resident of this state, regardless of whether the plan issuer is located in or outside this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Section 1367.102 Exception

This subchapter does not apply to:

- (1) A plan that provides coverage:
 - (A) Only for a specified disease or for another limited benefit;
 - (B) Only for accidental death or dismemberment;
 - (C) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (D) As a supplement to a liability insurance policy;
 - (E) For credit insurance;
 - (F) Only for dental or vision care; or
 - (G) Only for indemnity for hospital confinement;
- (2) A small employer health benefit plan written under Chapter 1501;
- (3) A Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) A workers' compensation insurance policy;
- (5) Medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) A long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Section 1367.103 Coverage Required

- (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:
- (1) A screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and
 - (2) Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.
- (b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

- (c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:
- (1) employed outside this state; and
 - (2) covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Section 1367.104

Copayment or Coinsurance Requirement Permitted; Deductible Requirement or Dollar Limit Prohibited; Notice Required.

- (a) Coverage required under this subchapter:
- (1) may be subject to a copayment or coinsurance requirement; and
 - (2) may not be subject to a deductible requirement or a dollar limit.
- (b) The requirements of this section must be stated in the coverage document.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Section 1367.105 Rules

The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Texas Insurance Code 1365.003-004: Loss or Impairment of Speech or Hearing

Section 1365.003. Offer of Coverage Required

<https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1365&Phrases=1365.003&HighlightType=1&ExactPhrase=False&QueryText=1365.003>

- (a) A group health benefit plan issuer shall offer and make available under the plan coverage for the necessary care and treatment of loss or impairment of speech or hearing.
- (b) Coverage required under this section:
- (1) may not be less favorable than coverage for physical illness generally under the plan; and
 - (2) must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as coverage for physical illness generally under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Section 1365.004 Right to Reject Coverage or Select Alternative Benefits

An offer of coverage required under Section 1365.003 is subject to the right of the group contract holder to reject the coverage or to select an alternative level of benefits that is offered by or negotiated with the group health benefit plan issuer .

28 TAC Section 11.508 (a)(1)(H)(vii) Mandatory Benefit Standards: Group, Individual and Conversion Agreements

[https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508)

- (a) Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(9) or (14) of this title:
- (1) Outpatient services, including the following:
 - (H) Preventive services, including:
 - (v) Eye and ear examinations for children through age 17, to determine the need for vision and hearing correction complying with established medical guidelines;

H.B. No. 490 Chapter 1367 Subchapter F. Hearing Aids and Cochlear Implants. Section 1367.251 (01/01/2018)

Section 1. Chapter 1367, Insurance Code

Chapter 1367, Insurance Code is amended by adding Subchapter F to read as follows:

Subchapter F. Hearing Aids and Cochlear Implants, Sec. 1367.251 Applicability of Subchapter

<https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.251&HighlightType=1&ExactPhrase=False&QueryText=1367.251>

- (a) This subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided through a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:
 - 1) An insurance company;
 - 2) A group hospital service corporation operating under Chapter 842;
 - 3) A fraternal benefit society operating under Chapter 885;
 - 4) A Lloyd's plan operating under Chapter 941;
 - 5) A stipulated premium insurance company operating under Chapter 884;
 - 6) A reciprocal exchange operating under Chapter 942;
 - 7) A health maintenance organization operating under Chapter 843;
 - 8) A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
 - 9) An approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
- (b) This subchapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed within or outside this state.
- (c) This subchapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.
- (d) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this subchapter applies to health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code.
- (e) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this subchapter applies to a regional or local health care program operated under that section.
- (f) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this subchapter.
- (g) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:
 - 1) A basic coverage plan under Chapter 1551;
 - 2) A basic plan under Chapter 1575;
 - 3) A primary care coverage plan under Chapter 1579; and
 - 4) Basic coverage under Chapter 1601.

Sec. 1367.252 Exception

This subchapter does not apply to:

- 1) A plan that provides coverage:
 - A. For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - B. As a supplement to a liability insurance policy;
 - C. For credit insurance;
 - D. Only for dental or vision care;
 - E. Only for hospital expenses; or
 - F. Only for indemnity for hospital confinement;
- 2) A Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- 3) A workers' compensation insurance policy;
- 4) Medical payment insurance coverage provided under a motor vehicle insurance policy;
- 5) A long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.251; or
- 6) The state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.

Sec. 1367.253 Coverage Required

- a) A health benefit plan must provide coverage for the cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger.
- b) Coverage required under this section:
 - 1) Must include:
 - A. Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;
 - B. Any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and
 - C. For a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and
 - 2) Is limited to:
 - A. One hearing aid in each ear every three years; and
 - B. One cochlear implant in each ear with internal replacement as medically or audiotologically necessary.
- c) Except as provided by Subsections (b) and (d), coverage required under this section:
 - 1) May not be less favorable than coverage for physical illness generally under the plan; and
 - 2) Must be subject to durational limits and coinsurance factors no less favorable than coverage provided for physical illness generally under the plan.
- d) Coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under the plan, including a provision relating to deductibles, coinsurance, or prior authorization.
- e) This section does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:
 - 1) This subchapter requires the plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and
 - 2) This state must make payments to defray the cost of the additional benefits mandated by this subchapter.

Washington

RCW 41.05.830 Coverage for Hearing Instruments, Definitions

<https://lawfilesexternal.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1222-S.SL.pdf>

- (1) Subject to appropriation, a health plan offered to employees and their covered dependents under this chapter issued or renewed on or after January 1, 2019, must include coverage for hearing instruments. Coverage must include a new hearing instrument every five years and services and supplies such as the initial assessment, fitting, adjustment, and auditory training.
- (2) The hearing instrument must be recommended by a licensed audiologist, hearing aid specialist, or a licensed physician or osteopathic physician who specializes in otolaryngology and dispensed by a licensed audiologist, hearing aid specialist, or a licensed physician or osteopathic physician who specializes in otolaryngology.
- (3) For the purposes of this section, "hearing instrument" and "hearing aid specialist" have the same meaning as defined in RCW 18.35.010. p. 2 ESHB 1222.SL 1 (4) This section expires December 31, 2023.

A health plan offered to public employees and their covered dependents under this chapter issued or renewed on or after January 1, 2024, is subject to section 1 of this act

RCW 48.43.016 – Utilization Management Standards and Criteria, Health Carrier Requirements, Definitions

[RCW 48.43.016: Utilization management standards and criteria—Health carrier requirements—Definitions. \(wa.gov\)](#)

- (2) (a) A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or post-service authorization for an initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care for each of the following: Chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapies. Visits for which utilization management or review is prohibited under this section are subject to quantitative treatment limits of the health plan. Notwithstanding RCW [48.43.515\(5\)](#) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.

[\[2020 c 193 § 2; 2019 c 308 § 22; 2018 c 193 § 1; 2015 c 251 § 2.\]](#)

Notes:

- Intent—2020 c 193: "The legislature intends to facilitate patient access to appropriate therapies for newly diagnosed health conditions while recognizing the necessity for health carriers to employ reasonable utilization management techniques." [[2020 c 193 § 1](#).

State Market Plan Enhancements

Oklahoma

Hearing aids and hearing devices for children up to eighteen (18) years of age: Audiological services and a standard hearing aids are covered if there is a documented hearing loss requiring a hearing aid and it is medically necessary, coverage includes:

- Standard hearing aid, per ear, every forty-eight (48) months (standard hearing aid is defined as an "In-the-ear" or "All-in-ear" device) unless another aid is medically necessary prior to the expiration of the 48 months.
- Up to four (4) additional ear molds per year for children up to two (2) years of age.
- Replacement parts and repair of hearing aid(s)

Notes:

- If the member requests a deluxe model hearing aid rather than a standard hearing aid or one deemed medically necessary, the cost of the standard hearing aid will be applied toward the cost of the deluxe model and the member will be financially responsible for the cost difference.
- Hearing loss means a hearing loss of 30 decibel hearing loss (dBHL) or greater in the frequency region important for speech recognition and comprehension in one or both ears, approximately 500 through 4,000 Hertz (Hz).

Hearing Aids and Hearing Devices (For Members 18 and Over): Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) are covered. Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a contracting physician. Covered services are provided for the hearing aid and for charges for associated fitting and testing.

Note: Hearing aids are electronic amplifying devices designated to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Oregon

Hearing aids for children includes coverage for one hearing aid per impaired ear for enrollees 18 years of age or younger, or 19 to 25 years of age and enrolled in an accredited educational institution.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine the coverage eligibility

- Hearing screening services when performed by a Network health professional to determine the need for hearing correction. Hearing screening tests are covered in accordance with the American Academy of Pediatrics (Bright Futures) recommendations
Note: Hearing screening services may include use of an office screening audiometer, tuning fork, or whispered number recognition.
- Hearing examinations to evaluate hearing loss. Examples include, but are not limited to:
 - Testing for hearing loss secondary to acute illness or injury
 - Testing for hearing loss secondary to drug therapy

- Further diagnostic testing by a Participating Audiologist, including hearing and balance assessment services, is covered when the member's primary care provider orders the testing as part of the diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem.
Note: These services are not covered when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for or the appropriate type of a hearing aid, unless member has a supplemental Hearing Aid benefit.
- Cochlear Implants when criteria are met. (Refer to the Medical Management Guideline titled [Cochlear Implants](#))
The initial placements of the cochlear implant external components that are done during the surgery are covered under the surgical benefit. However, if **replacement** external components of the cochlear implant system are needed at any point after that, then the benefit for those replacement items is under prosthetics and subject to prosthetic benefits.
Note: Cochlear Implants are covered under the medical benefit.
- Wearable hearing aids (including non-implantable bone conduction hearing aids utilizing a headband) required for the correction of a hearing impairment are covered when ordered by a physician. Coverage includes the hearing aid, fitting, assessment, and testing of the hearing aid.
Note: Replacement external Hearing Aid components are covered under DME and are subject to DME benefit limitations.

Refer to the Schedule of Benefits for any applicable copayments, deductible amounts, and annual dollar limit benefit maximum.

- Bone-anchored hearing aids (BAHA) are covered only when the member has either of the following:
 - Craniofacial anomalies in which abnormal or absent ear canals prevent the use of a wearable hearing aid, or
 - Hearing loss of sufficient severity that it cannot be corrected by a wearable hearing aid.

Benefits are limited to one bone anchored hearing aid per member who meets the above coverage criteria during the entire period of time the member is enrolled in the health plan.

Note: Coverage for bone-anchored hearing aids (BAHA) which use a headband, rather than osseointegration, are covered as “wearable hearing aids”, rather than as semi-implantable Hearing Aids. Therefore, the benefit limitation of one single bone anchored hearing aid per member’s enrollment does not apply.

- Other types of hearing aids and hearing devices are addressed in the Medical Management Guideline titled [Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable](#):
 - Semi-Implantable Electromagnetic Hearing Aids for Sensorineural Hearing Loss (SEHA)
 - Totally Implanted Middle Ear Hearing Systems
 - Partially Implantable Bone Conduction Hearing Aid With Magnetic Coupling
 - Intraoral Bone Conduction Hearing Aids (example: Soundbite)
 - Laser or light based Hearing Aids

Not Covered

- Repairs and/or replacement for a bone anchored hearing aid are not covered, other than for malfunctions. Deluxe models and upgrades that are not medically necessary are not covered.
- Hearing *aid dispensing fees, batteries, accessories, cords, assistive listening devices, and communications devices unless required by a state mandate.
- Frequency modulated (FM) systems can be used as an extension or accessory of hearing aids. FM systems are excluded from coverage unless required by a state mandate. These do not prevent, diagnose or treat a sickness or injury, and are not integral to the hearing aid itself.

Definitions

Cochlear Implant: An electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture, analyze, and code sound.

References

American Disabilities Act <http://www.ada.gov/pubs/ada.htm>

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
08/01/2023	All	<p>Covered Benefits</p> <ul style="list-style-type: none"> ● Revised list of covered services; replaced: <ul style="list-style-type: none"> ○ “Hearing screening services when performed <i>in the primary care physician's office</i>” with “hearing screening services when performed <i>by a network health professional to determine the need for hearing correction</i>” ○ “<i>Routine</i> hearing screening tests in accordance with the American Academy of Pediatrics (Bright Futures) recommendations” with “hearing screening tests <i>are covered</i> in accordance with the American Academy of Pediatrics (Bright Futures) recommendations” ● Removed language indicating coverage for hearing aids (including repair and replacement) is limited to one hearing aid per hearing impaired ear every three years <p>Definitions</p> <ul style="list-style-type: none"> ● Removed definition of: <ul style="list-style-type: none"> ○ Bone-Anchored Hearing Aids (BAHA) ○ Hearing Aids <p>Supporting Information</p> <ul style="list-style-type: none"> ● Archived previous policy version BIP074.K
	Oklahoma	<p>Not Covered</p> <ul style="list-style-type: none"> ● Added language to clarify repairs and/or replacement <i>for the implanted components of</i> a bone anchored hearing aid are not covered, other than for malfunctions
	Washington	<p>Federal/State Mandated Regulations</p> <ul style="list-style-type: none"> ● Added language pertaining to <i>Revised Code of Washington Section 41.05.830</i> ● Added reference link to <i>Revised Code of Washington Section 48.43.016</i>

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member’s EOC/SOB, the member’s EOC/SOB provision will govern.