

Changes to Texas Medicaid Hearing Services Benefits to Accompany PACT Transition

Effective for dates of service on or after September 1, 2009, Texas Medicaid clients who are birth through 20 years of age will be eligible to receive medically necessary hearing aid devices and services through the hearing services benefit administered by TMHP. The hearing services benefits available to Texas Medicaid clients who are birth through 20 years of age will no longer be administered by Department of State Health Services (DSHS) through the Program for Amplification for the Children of Texas (PACT). Since TMHP currently administers the benefit for Texas Medicaid clients 21 years of age or older, TMHP will process all claims and authorization transactions for Texas Medicaid hearing services benefits. This article covers only the changes to Texas Medicaid benefits. The changes to the CSHCN Services Program benefits are covered in a separate article.

Benefit: Hearing Services and Hearing Aid Devices

The Texas Medicaid hearing services benefit includes the following:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The re-assessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

The following hearing services are benefits of Texas Medicaid:

Services	Provider Type
Routine newborn hearing screening that is performed before the infant is discharged from the hospital <i>Note: The routine newborn hearing screening is included in the hospital reimbursement and is not reimbursed separately.</i>	Hospitals and birthing centers
Routine Texas Health Steps (THSteps) medical checkup hearing screening <i>Note: The routine THSteps medical checkup hearing screening is included in the reimbursement for the THSteps periodic medical checkups and is not reimbursed separately.</i>	THSteps medical providers
Audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss	Audiologists and physicians
Hearing aid devices and accessories and fitting and dispensing visits and revisits	Hearing aid fitters and dispensers
Physician otology and otorhinolaryngology services	Physicians (specialties: otologists and otorhinolaryngologists)

Note: Texas Medicaid clients whose jobs are contingent on their possessing a hearing aid or who appear to have vocational potential and who need a hearing aid may be referred to the Texas Department of Assistive and Rehabilitative

Services (DARS) for hearing aids.

Reimbursement: Hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP Special Medical Prior Authorization (SMPA) department. The reimbursement will be determined based on either the manufacturer's suggested retail price (MSRP) less 18 percent or average wholesale price (AWP) less 10.5 percent (whichever is applicable) or based on the provider's documented invoice cost.

Required forms: Required forms, which are indicated in the specific sections of this article, are not submitted with the claim to TMHP, but the forms must be completed and maintained in the client's medical record and made available upon request by HHSC or TMHP for retrospective review.

Limitations: All services provided to Texas Medicaid clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations. In addition to services that always require prior authorization, providers may request prior authorization for medically necessary services that exceed benefit limitations. Providers will be notified of procedure codes and set limitations in a future article.

Enrollment and claims filing: To be reimbursed for both audiology services and hearing aid fitting and dispensing services, audiologists must enroll with Texas Medicaid as audiologists and also as hearing aid fitters and dispensers. Audiology services must be billed using the audiologist provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter, and hearing aid and fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter.

Providers must file all claims electronically or on the appropriate Centers for Medicare & Medicaid Services (CMS) paper claim form after providing the services. Claims must include the following information:

- The most appropriate 3- to 5-digit *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis code that represents the purpose for the service
- The most appropriate *Current Procedural Terminology (CPT)* or Healthcare Common Procedure Coding System (HCPCS) procedure code(s) that represent the service(s) provided
- The appropriate information as indicated on the provider enrollment letter (Electronic claims must also include the most appropriate attested taxonomy code.)

Important: *Effective for dates of service on or after September 1, 2009 audiologists (i.e., those providers whose enrollment letter indicates "Audiologist") must no longer use benefit code CCP when submitting electronic claims to TMHP. Claims may be rejected if submitted with benefit code CCP.*

Hearing services provided before September 1, 2009, to Texas Medicaid clients who are birth through 20 years of age must be submitted to PACT.

Refer to: The [Providers – Hearing Services for Children \(PACT Transition\) web page](#) for information about enrolling in Texas Medicaid.

As of June 1, 2009, PACT is not enrolling providers and is directing providers to enroll with Texas Medicaid. Providers must be appropriately enrolled with Texas Medicaid to be reimbursed for hearing services provided to Texas Medicaid clients.

Online Provider Lookup (OPL): Providers are encouraged to complete a Provider Information Change (PIC) Form to designate themselves in the OPL as providers who are experienced with the pediatric population and who will offer auditory services to Texas Medicaid clients who are birth through 20 years of age. The [PIC Form](#) is available for download on this website.

Providers who choose the designation will be found when clients, parents, and guardians search the OPL. Providers are not required to make this designation in order to submit claims. PACT providers who are already enrolled with Texas Medicaid and hearing services providers who are newly enrolled and who indicate they will provide hearing services to Texas Medicaid clients who are birth through 20 years of age will automatically be assigned the designation in the OPL, so they do not need to complete the PIC form.

Hearing Screenings

Routine Newborn Hearing Screening

Form
<ul style="list-style-type: none">To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.No other forms are required.
Limitation
One per lifetime
Claims Filing
For more information about the newborn hearing screening, providers may refer to the 2009 <i>Texas Medicaid Provider Procedures Manual</i> section 23.3.1.1, "Newborn hearing Screening," on page 23-2; section 43.1.7.5, "Newborn Examination," on page 43-8; and section 43.1.7.6, "Medical Checkup, First 6 Days of Life," on page 43-9.
Authorization
Not required

Health Safety Code, Chapter 37, mandates that a birthing facility (hospital or birthing center) offer the parents of a newborn a hearing screening for the newborn so that hearing loss can be identified before the newborn is discharged from the facility. Procedures for newborn hearing screening provided during the birth admission are considered part of the newborn delivery payment to the facility and are not reimbursed as separate procedures.

For infants born outside of a hospital or birthing facility (i.e., not admitted), the hearing screening must be performed during the initial THSteps periodic medical checkup. Providers who are not enrolled as THSteps providers must refer the infant to an enrolled THSteps provider for these services.

Routine Hearing Screening Performed As Part of THSteps Medical Checkups

Form
<ul style="list-style-type: none">To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.No other forms are required.
Limitation
According to the "THSteps Medical Checkups Periodicity Schedule for Infants, Children, and Adolescents (Birth through 20 years of age)"
Claims Filing
For more information about THSteps medical checkups, providers may refer to the 2009 <i>Texas Medicaid Provider Procedures Manual</i> Section 43, "Texas Health Steps (THSteps)," on page 43-1.
Authorization
Not required

A hearing screening must be performed as part of each THSteps periodic visit. The hearing screening is included in the reimbursement for the THSteps periodic medical checkups and is not reimbursed separately.

Hearing Screenings Requested Outside of a Routine Newborn or THSteps Medical Checkup

Form
None
Limitation
As medically necessary
Claims Filing
For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.
Authorization
Not required

Hearing screening provided by an audiologist, physician, or APN at the request of a client or parent or guardian or at the provider's discretion is a benefit for Texas Medicaid clients of all ages when rendered by a provider who is enrolled with Texas Medicaid and licensed to perform these services.

Abnormal Hearing Screening Results

Form
Physician's Examination Report

If the screening has abnormal results, the referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record. A new Physician's Examination Report must be completed

whenever there is a change in the client's hearing or a new hearing aid is needed. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

The client must be referred to a Texas Medicaid provider who is a licensed audiologist or physician who provides audiology services. Clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

In addition to being referred to an appropriate provider for further testing, clients with suspected hearing loss who are 35 months of age or younger must be referred to Early Childhood Intervention (ECI) within 2 working days of the abnormal hearing screening.

For more information about ECI, providers may refer to the 2009 *Texas Medicaid Provider Procedures Manual* section 13, "Targeted Case Management for Early Childhood Intervention (ECI)," on page 13-1, and section 43.4.6, "Early Childhood Intervention (ECI) (CCP)," on page 43-50.

Audiology and Audiometry Evaluation and Diagnostic Services

Physicians must recommend hearing evaluations based on examination of the client.

Only physicians or licensed audiologists will be reimbursed for hearing evaluations. Hearing aid fitters and dispensers are not reimbursed for hearing evaluations.

Diagnostic Hearing Services

Form

Hearing Evaluation, Fitting, and Dispensing Report (Form 3503): The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the physician or audiologist conducting the diagnostic testing. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

Claims Filing

For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.

Authorization

Hearing screening and testing services do not require prior authorization. Documentation of medical necessity must be maintained by the provider in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

Physician Diagnostic Hearing Services

Form

Providers must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.
No other forms are required.

Claims Filing

For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.

Authorization

Not required

Noncovered Services

Texas Medicaid does not reimburse for hearing screening completed for day care, Head Start, or school. Separate procedure codes should not be billed for these services.

Hearing Aid Devices and Accessories

TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from manufacturers and vendors of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.

Texas Medicaid reimburses hearing aid fitters and dispensers for the following services:

Service*	Limitation
Hearing aid devices	1 per ear every 5 years (monaural codes = bill quantity of 1) (binaural codes = bill quantity of 1)
Hearing aid assessment	As medically necessary
Hearing aid accessories**	Prior authorization required
Fitting and dispensing visit	1 per hearing aid procedure code
Ear impression Ear mold	1 each per hearing aid device (monaural codes = bill quantity of 1) (binaural codes = bill quantity of 2)
Revisit (as necessary)	2 per calendar year when billed by any provider
Batteries (replacement only)	As medically necessary when a hearing aid device has been previously reimbursed Note: <i>If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed upon appeal with a statement documenting medical necessity.</i>
Additional hearing aids within a 5-year period	Prior authorization required
Hearing aid repair or modification	1 per year after the 1-year warranty period has lapsed

* For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.

** Hearing aid accessories including but not limited to chin straps, clips, boots, and headbands for clients who are birth through 20 years of age.

Hearing Aid Devices

Form

- To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.
- No other forms are required.

Limitation

One hearing aid procedure code (i.e., 1 monaural procedure code with modifier LT, 1 monaural procedure code with modifier RT, or 1 binaural procedure code) may be reimbursed once every 5 years from the dispensing month without prior authorization. Exceptions are considered on a case-by-case basis through the prior authorization process.

Note: *Hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) setting.*

Claims Filing

Providers may refer to the Texas Medicaid fee schedules for procedure codes that may be reimbursed.

Authorization

Prior authorization is not required for hearing aids that are within benefit limitations. Prior authorization is required for additional medically necessary hearing aid devices within a 5-year period. For details about submitting prior authorization requests, providers may refer to the “Prior Authorization” section of this article.

Important: *For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet criteria as outlined in this article, the SMPA department will refer the request to the TMHP CCP department for consideration under the Comprehensive Care Program (CCP). The provider is not required to complete additional forms or request referral to CCP.*

Reimbursement

The reimbursement for the monaural and binaural procedure codes includes the required hearing aid package as follows:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted)
- Manufacturer’s postage and handling charges
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

Claims filing: For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.

Monaural hearing aid procedure codes must be billed with modifier LT (left ear) or modifier RT (right ear) to indicate which ear is fitted with the hearing aid device.

Binaural procedure codes must be billed with a quantity of 1. The reimbursement for one binaural procedure code includes the set of hearing aid devices (i.e., 2 devices).

For clients who are birth through 20 years of age, providers may request prior authorization for hearing aids that are medically necessary but are not currently benefits of Texas Medicaid.

Medical necessity: Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following documentation of medical necessity must be maintained in the client's medical record:

- Hearing loss in the better ear of 35 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz.
- A spondee threshold in the better ear of 35 dBHL or greater when pure tone thresholds cannot be established.
- Hearing loss in each ear is less than 35 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher.
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance.

Clients meet the criteria for binaural aids if they meet the conditions for a monaural hearing aid and have at least a 35-dBHL hearing loss in both ears.

Providers must also include the model number, serial number, and warranty dates of the purchased hearing aid device in the client's medical record.

For more information about coding place of service for "other locations," providers may refer to the 2009 *Texas Medicaid Provider Procedures Manual* section 5.3.1.1, "Place of Service (POS) Coding," on page 5-18.

Replacement of hearing aid devices: Replacement devices must be prior authorized. Replacement is considered for prior authorization when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the prior authorization request. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.

For clients who are birth through 20 years of age, in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, the Special Medical Prior Authorization (SMPA) department will submit a referral to the DSHS Health Screening and Case Management unit. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Supplies and Accessories

Form

- To file claims after providing services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.
- No other forms are required.

Limitation

Providers must dispense each hearing aid reimbursed through Texas Medicaid with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. Batteries may be replaced as medically necessary without prior authorization.

Claims Filing

For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.

Supplies and accessories that are included in the hearing aid package are included in the reimbursement of the hearing aid procedure code and are not reimbursed separately.

Replacement hearing aid batteries	Replacement hearing aid batteries may be reimbursed as medically necessary without prior authorization and are limited to clients with a previously billed hearing aid. Replacement batteries for clients who did not receive the hearing aid through Texas Medicaid are considered for reimbursement on appeal with a physician’s statement documenting medical necessity.
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Children’s hearing aid accessories	For clients who are birth through 20 years of age, Texas Medicaid may also reimburse children’s hearing aid accessories, including, but not limited to, chin straps, clips, boots, and headbands with prior authorization. Providers may purchase the accessories from a vendor of their choice and submit a claim to TMHP for reimbursement.
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Authorization

Children’s hearing aid accessories must be prior authorized. For details about submitting prior authorization requests, providers may refer to the “Prior Authorization” section of this article.

Hearing Aid Warranty: Repairs and Modifications

Form

- To file claims after providing services, providers must use the appropriate electronic format or the appropriate CMS paper claim form.
- No other forms are required.

Limitation

After the warranty period has lapsed, repair or modification of a hearing aid may be reimbursed once per year if repair or modification is a better alternative than a new purchase.

Claims Filing

For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.

Authorization

Additional repairs per year may be reimbursed with prior authorization if medical necessity can be demonstrated. Requests for prior authorization must include documentation that supports the need for the requested repair.

For details about submitting prior authorization requests, providers may refer to the “Prior Authorization” section of this article.

A hearing aid dispensed through Texas Medicaid must meet the following criteria:

- Be a new and current model
- Meet the performance specifications indicated by the manufacturer
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.

During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid will not reimburse hearing aid repair during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.

Fitting and Dispensing Visits and Revisits

Forms

The forms required for the fitting and dispensing visits are as follows:

Hearing Evaluation, Fitting, and Dispensing Report (Form 3503): The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the fitter/dispenser that conducts the fitting and dispensing visit. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Client acknowledgement statement (created by the provider): At the time the hearing aid device and supplies are dispensed, the client must sign a client acknowledgement statement to verify the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need. The acknowledgement statement must include language that indicates the client is responsible for paying any hearing aid rental fees if charged. The provider must obtain the signed acknowledgment statement before dispensing the hearing aid device and supplies and must keep the signed acknowledgment statement in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

30-day trial period certification statement (created by the provider): Providers must inform clients of the trial period lasting 30 consecutive days with a written contract that was created by the provider. The contract, which must be signed by the client, must contain the beginning and ending dates of the trial period, all charges and fees associated with the trial period, an acknowledgment that the client accepts responsibility for any assessed rental fees, and the name, address, and telephone number of the State Board of Examiners for Speech-Language Pathology and Audiology. The client must receive a copy of this agreement.

After at least 30 days and the successful completion of the trial period, the provider must update the statement to indicate that the trial was successful and the client accepted the dispensed hearing aid device. The updated statement must be maintained in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Additional necessary documentation: Medical record documentation maintained in the client's medical record

Limitation

Note: Hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the SNF, ICF, or ECF setting.

Claims Filing

Providers may refer to the Texas Medicaid fee schedules for procedure codes that may be reimbursed.

Authorization

Not required

Hearing aid visits include the fitting and dispensing visit, the first revisit, and the second revisit (as needed):

Visit**	Procedure Code(s)	Limitations
Fitting and dispensing visit		Includes the fitting, dispensing, and post-fitting check of the hearing aid. The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within 5 weeks of the initial fitting. The post-fitting check is part of the dispensing procedure and is not reimbursed separately.
First and second* revisit		If additional visits are required after the post-fitting check, 2 additional revisits may be reimbursed as medically necessary. The first revisit must include a hearing aid check. The second revisit must include either a real ear measurement or aided sound field testing according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry readings from the first evaluation.

* The second revisit is available as needed after the post-fitting check and first revisit.

** For procedure codes that may be reimbursed, providers may refer to the Texas Medicaid fee schedules.

30-Day Trial Period

Providers must allow each Texas Medicaid client a 30-consecutive-day trial period that begins with the dispensing date. This trial period gives the client time to determine whether the hearing aid device meets the client's needs. If the client is not satisfied with the purchased hearing aid, the client may return it to the provider, who must accept it. If the device is returned within 30 days of the date it was dispensed, the provider may charge the client a rental fee not to exceed \$2.00 per day. This fee is not a benefit of Texas Medicaid and will not be reimbursed. The client is responsible for paying the hearing aid rental fees if the provider chooses to charge a fee for the rental of returned hearing aid devices.

During the trial period, providers may dispense additional hearing aids as medically necessary until either the client is satisfied with the results of the hearing aid or the provider determines that the client cannot benefit from the dispensing of another hearing aid. The dispensing date of each additional hearing aid starts a new trial period.

Facility Visits and Home Visits

Home visit hearing evaluations and fittings are permitted only with the physician's written recommendation.

For clients who are birth through 20 years of age: Hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the SNF, ICF, or ECF setting.

For clients who are 21 years of age or older: Services for residents in a SNF, ICF, or ECF must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

Prior Authorization Requirements

Forms

No form (Providers may use the form of their choice to submit the required information.)

***Note:** Unless otherwise indicated, Texas Medicaid does not require prior authorization for hearing aid devices and services that are medically necessary and that are provided within the limitations outlined in this article. See below for those services that require prior authorization.*

Limitation

For services that require prior authorization, prior authorization must be obtained before the services are provided. Prior authorization may also be requested for medically necessary services required beyond benefit limitations.

Claims Filing

The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization is required only for the following devices and services:

- Additional devices and services that exceed benefit limitations as outlined in this article.

Refer to: The specific sections throughout this article for information about submitting the prior authorization requests for devices and services beyond benefit limitations.

- Replacement of hearing aids within a 5-year period.

For clients who are birth through 20 years of age, prior authorization is also required for the following services:

- Hearing aids that are medically necessary but are not currently benefits of Texas Medicaid.
- Children's hearing aid accessories including but not limited to chin straps, clips, boots, and headbands

The following table summarizes the documentation requirements for the items that require prior authorization:

Description	Prior Authorization Requirements
Hearing aids that are medically necessary for clients who are birth through 20 years of age but are not currently benefits of Texas Medicaid	The prior authorization request must include: <ul style="list-style-type: none"> • The medical necessity for the requested hearing aid device • The name of the manufacturer • The MSRP or AWP or the provider's documented invoice cost. • The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
Analog hearing aid not reimbursed for clients who are 21 years of age or older	Medical necessity documentation required.
Replacement of hearing aids within a 5-year period	Requests for prior authorization must include documentation that supports medical necessity, which may include documentation that loss or irreparable damage has occurred, a copy of the police or fire report (if applicable), and measures to be taken to prevent reoccurrence.
Children's hearing aid accessories currently available through PACT, including but not limited to chin straps, clips, boots, and headbands*	Requests for prior authorization for hearing aid supplies will be considered when the requests are submitted with documentation that shows that the client is birth through 20 years of age and that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.

Providers must submit requests for prior authorization to the SMPA department with documentation that supports medical necessity for the requested device, service, or supply. Authorizations may be submitted online, by fax, or by mail at:

Online:	www.tmhp.com
Fax:	1-512-514-4213
Mail:	Texas Medicaid & Healthcare Partnership Special Medical Prior Authorization Department 12357-B Riata Trace Parkway, Suite 150 Austin TX 78727
Request form:	None (Providers may use the form of their choice to submit the required information to the SMPA department.)

Important: For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet criteria as outlined in this article, the SMPA department will refer the request to the TMHP CCP department for consideration under CCP. The provider is not required to complete additional forms or request referral to CCP.

Refer to: The 2009 *Texas Medicaid Provider Procedures Manual* section 5, "Claims Filing," on page 5-1, for more information about the authorizations and claims filing processes.