**Procedures**

**Scheduling**

Scheduling can occur via an online portal or email, text or phone. All communication systems must meet the Security and Privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Audiology practices should obtain the following information during the scheduling process:

* Triage questions to determine if medical necessity likely met and to assist in scheduling the appropriate appointment type and length. These questions should, at a minimum, include questions related to hearing loss, tinnitus, and the eight warning signs of ear disease, as determined by the Food and Drug Administration (FDA) guidelines and requirements.
* Questions related to mobility and communication, such as whether or not an interpreter is required.
* Patient demographic and insurance information, including but not limited to the guarantor and the name and date of birth of the insured.

Audiology practices should inform patients of their:

* Insurance network participation status.
* Any Medicare order, insurance referral or prior authorization requirements.
* Financial responsibilities such as co-payment, co-insurance, unmet deductibles and costs of non-covered services.
* Practice financial policies such as payment due at the time of visit and forms of payment accepted.
* The resources available on the practices’ website (policies, forms, etc.).
* Instructions for the day of the testing.

Staff should schedule the appointment and recommend that all new patients come in 15-30 minutes before their appointment to complete the intake process.

**Patient Intake and Registration**

Patient intake and registration can occur via a paper form or electronic device. All intake information submitted via a paper form should be inputted into an electronic office management system and all forms should be scanned into that same system.

All office management and communication systems must meet the Security and Privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA).

The following information should be obtained from the patient at initial intake and registration:

* Copy of the patient’s insurance card(s).
* If child of divorced parents, in foster care or under guardianship, copies of legal documents indicating who can have access to the patient’s medical records, make medical decisions, authorize medical care and treatment, and accept financial responsibility for medical care and treatment.
* Copy of power of attorney, if applicable.
* Patient demographic information.
* Name of guarantor, if different from the patient.
* Name and date of birth of the insured.
* Names and basic contact information of ordering or referring physician or qualified practitioner.
* Name of primary care physician or qualified practitioner.
* Name and address of school, if child.
* Information related to how the patient came to schedule an appointment with the practice (marketing tracking information).
* Comprehensive case history, including but not limited to:
	+ Chief complaint.
	+ Hearing loss and hearing aid use history.
	+ FDA warning signs of ear disease.
	+ Tinnitus.
	+ Current medications.
	+ Allergies.
	+ Family history.
	+ Social history, including occupational and recreational noise exposure, and tobacco, alcohol and drug usage.
	+ Falls risk.
	+ Co-morbidities.
	+ Review of systems.
* Authorization to release protected health information to specific entities.
* Hearing handicap inventory.
* Acknowledgment of practices’ financial and office policies.
* Acknowledgement of receipt of HIPAA Notice of Privacy Practices
* HIPAA marketing authorization.

**Otoscopy**

The audiologist will use either a handheld or video otoscope or operating microscope to view , the patient’s right and left external auditory canal and tympanic membrane.

The audiologist will document what they visualize and any resulting medical decision making in the medical record.

**Cerumen Management**

Otoscopy should be conducted and documented prior to any cerumen removal.

As allowed by and in accordance with state audiology licensure laws, audiologists will attempt to remove either incidental or impacted cerumen from one or both ear canals as long as, following case history, cerumen removal is not contraindicated (i.e. surgically altered ear, exotoses, hematologic disorder, blood thinner use, etc.).

Infection control guidelines and policies should be followed during and following cerumen removal.

Cerumen will be removed using irrigation, lavage, or other instrumentation. The type and degree of cerumen evident, the instrumentation used, and the otoscopic findings following cerumen removal should be documented in the medical record.

**Hearing Screening**

Hearing screenings should be conducted in quiet, preferably sound treated environment or in accordance with applicable state or federal requirements or regulations.

Otoscopy should be conducted and documented, on the screening form, prior to any hearing screening.

Hearing screenings should be conducted under headphones or insert earphones. These “pass/fail” screenings should be conducted at 20dBHL at the octave frequencies between 500 and 4000Hz, at a minimum.

Individuals who fail a hearing screening should be referred for a comprehensive audiologic evaluation and this referral should be documented.

**Audiometric Testing**

*Adult*

Audiometric testing should be conducted in a sound treated test environment, preferably an audiometric test booth, and in accordance with applicable state and/or federal regulations.

Otoscopy should be conducted and documented, in the medical record, prior to any audiometric testing.

Audiometric testing should be conducted in the soundfield or under headphones or insert earphones or via a bone conductor.

Audiometric testing should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Pure-tone, air conduction testing should be performed, binaurally, at octave frequencies between 250 and 8000Hz. Interoctave assessment should occur when there is a greater than 10dBHL difference between the results at two, consecutive octave frequencies. Masking should be utilized when required.

High frequency, air conduction testing should be performed, binaurally, at octave frequencies between 10000 and 20000Hz. Interoctave assessment should occur when there is a greater than 10dBHL difference between the results at two, consecutive octave frequencies.

Pure-tone, bone conduction testing should be performed, binaurally, at octave frequencies between 250 and 4000Hz. Interoctave assessment should occur when there is a greater than 10dBHL difference between the results at two, consecutive octave frequencies. Bone conduction testing should be performed to confirm the type and degree of conductive hearing loss present. Masking should be utilized when required.

Speech awareness/reception threshold testing should be completed, as needed, to validate the pure-tone audiometric results and should be assessed using recorded test materials or monitored live voice. Masking should be utilized when required.

Speech recognition testing should be completed, at most comfortable loudness levels and/or PBmax and should be assessed using recorded test materials. Masking should be utilized when required.

Most comfortable and uncomfortable loudness levels should be established, binaurally, using speech and/or tonal stimuli.

All audiometric test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

Individuals who report or exhibit, in testing, active drainage within previous 90 days, a history of sudden or rapidly progressive hearing loss, unilateral hearing loss, conductive hearing loss or air-bone gap, impacted cerumen or foreign body in the ear canal, pain or discomfort, visibly congenital or traumatic deformity of the ear, acute or chronic dizziness or tinnitus should be referred to an otolaryngologist/otologist for an otologic evaluation prior to pursuing audiologic management and/or treatment. Follow-up, audiometric assessment should be completed following medical or surgical intervention by the otolaryngologist/otologist.

*Pediatric*

Audiometric testing should be conducted in a sound treated test environment, preferably an audiometric test booth, and in accordance with applicable state and/or federal regulations.

Otoscopy should be conducted and documented, in the medical record, prior to any audiometric testing.

Audiometric testing should be conducted in the soundfield or under headphones or insert earphones or via a bone conductor.

Audiometric testing should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Pure-tone, air conduction testing should be performed, binaurally, at octave frequencies between 250 and 8000Hz using visual reinforcement audiometry, conditioned play audiometry, or conventional test techniques. Interoctave assessment should occur when there is a greater than 10dBHL difference between the results at two, consecutive octave frequencies. Masking should be utilized when required.

High frequency, air conduction testing should be performed, binaurally, at octave frequencies between 10000 and 20000Hz using visual reinforcement audiometry, conditioned play audiometry, or conventional test techniques. Interoctave assessment should occur when there is a greater than 10dBHL difference between the results at two, consecutive octave frequencies.

Pure-tone, bone conduction testing should be performed, binaurally, at octave frequencies between 250 and 4000Hz using visual reinforcement audiometry, conditioned play audiometry, or conventional test techniques. Interoctave assessment should occur when there is a greater than 10dBHL difference between the results at two, consecutive octave frequencies. Bone conduction testing should be performed to confirm the type and degree of conductive hearing loss present. Masking should be utilized when required.

Speech awareness/reception threshold testing should be completed, as needed, using a spondee board, visual reinforcement audiometry, conditioned play audiometry or conventional test techniques, to validate the pure-tone audiometric results. Masking should be utilized when required.

Speech recognition testing should be completed, at most comfortable loudness levels and/or PBmax using a picture speech recognition test tool or conventional test techniques. Masking should be utilized when required.

Most comfortable and uncomfortable loudness levels should be established, binaurally, using speech and/or tonal stimuli.

All audiometric test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

Individuals who report or exhibit, in testing, active drainage within previous 90 days, a history of sudden or rapidly progressive hearing loss, unilateral hearing loss, conductive hearing loss or air-bone gap, impacted cerumen or foreign body in the ear canal, pain or discomfort, visibly congenital or traumatic deformity of the ear, acute or chronic dizziness or tinnitus should be referred to an otolaryngologist/otologist for an otologic evaluation prior to pursuing audiologic management and/or treatment. Follow-up, audiometric assessment should be completed following medical or surgical intervention by the otolaryngologist/otologist.

**Immittance Testing**

Otoscopy should be conducted and documented, in the medical record, prior to any immittance testing.

Immittance testing should be conducted using screening and/or diagnostic immittance test equipment.

Immittance testing should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Tympanometry should be performed, binaurally, when medically reasonable and necessary. Audiologists should select the appropriate probe tip that allows them to maintain a pneumatic seal. At a minimum, static admittance, peak ear pressure, and equivalent ear canal volume should be established and documented.

Acoustic reflex thresholds should be performed, binaurally, when medically reasonable and necessary. Audiologists should select the appropriate probe tip that allows them to maintain a pneumatic seal. Acoustic reflex thresholds should be established in the ipsilateral and contralateral test conditions at 500, 1000, 2000, and 4000 Hz.

Acoustic reflex decay should be performed, binaurally, when medically reasonable and necessary. Audiologists should select the appropriate probe tip that allows them to maintain a pneumatic seal. Acoustic reflex decay should be established at 500 and 1000 Hz.

All immittance test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Otoacoustic Emissions Testing**

Otoscopy should be conducted and documented, in the medical record, prior to any otoacoustic emissions testing.

Otoacoustic emissions testing should be conducted in a quiet room or test booth and using screening and/or diagnostic otoacoustic emissions test equipment.

Otoacoustic emissions testing should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Transient and/or distortion product otoacoustic emissions should be established, binaurally, using a screening protocol (pass or refer screening paradigm), limited diagnostic protocol (three to eleven distinct frequencies per ear) or comprehensive diagnostic protocol (twelve or more distinct frequencies per ear).

All otoacoustic test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Evoked Potential Testing**

Otoscopy should be conducted and documented, in the medical record, prior to any evoked potential testing.

Evoked potential testing should be conducted in a quiet room or test booth and using screening and/or diagnostic evoked potential test equipment.

Evoked potential testing should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Auditory brainstem response testing can be established using insert earphones or a bone conductor. Testing of infants, toddlers or the developmentally impaired my require sedation under the supervision of a physician or qualified non-physician practitioner.

An auditory brainstem response should be established, binaurally, using tone burst and/or click stimuli and using a screening (pass or refer screening paradigm), a threshold protocol (used to establish sound pressure level required to elicit a response) or otoneurologic (typically done at 70dBSPL to establish morphology and latencies of the auditory brainstem response).

Other evoked potential testing could include, but is not limited to:

* Electrocochleography
* Neurotelemetry
* Electroneurography
* Auditory Steady State Response
* Middle/late latency Response

All evoked potential test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Cochlear Implant Candidacy Determination Testing**

Otoscopy should be conducted and documented, in the medical record, prior to any cochlear implant candidacy determination testing.

Cochlear implant candidacy determination testing should be conducted in a test booth under headphones, insert earphones and/or in the soundfield. All speech testing, both in quiet and in noise, should be established using recorded test materials.

Cochlear implant candidacy determination testing should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Cochlear implant candidacy determination testing could include, but is not limited to:

* Comprehensive case history including review of systems.
* Binaural, audiometric testing, including pure-tone, air conduction testing, pure-tone, bone conduction testing, speech reception/awareness thresholds, speech recognition testing (PBmax), and most comfortable and uncomfortable loudness levels.
* Binaural, limited, diagnostic otoacoustic emissions testing.
* Binaural, otoneurologic auditory brainstem response testing at 70dBSPL.
* Speech in noise testing in the best, binaural, aided condition using the patient’s amplification and/or demonstration, audiologically appropriate hearing aids.
* Hearing handicap inventory.

An individual is considered to be a cochlear implant candidate if the individual meets the intent of use requirements documented by the Food and Drug Administration (FDA) and they have no physical or psychologic contraindications to the surgical procedure. Cochlear implant candidates should be referred to an implanting surgeon for otologic and medical evaluation.

All cochlear implant candidacy determination test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Auditory Osseointegrated Device Candidacy Determination Testing**

Otoscopy should be conducted and documented, in the medical record, prior to any auditory osseointegrated device candidacy determination testing.

Auditory osseointegrated device determination testing should be conducted in a test booth under headphones, insert earphones and/or in the soundfield. All speech testing, both in quiet and in noise, should be established using recorded test materials.

Auditory osseointegrated device determination testing should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Cochlear implant candidacy determination testing could include, but is not limited to:

* Comprehensive case history including review of systems.
* Binaural, audiometric testing, including pure-tone, air conduction testing, pure-tone, bone conduction testing, speech reception/awareness thresholds, speech recognition testing (PBmax), and most comfortable and uncomfortable loudness levels.
* Immittance testing.
* Speech in noise testing in the best, binaural, aided condition using the patient’s amplification and/or demonstration, audiologically appropriate CROS/BICROS amplification systems and an auditory osseointegrated device, body worn, with headband.
* Hearing handicap inventory.

An individual is considered to be a candidate for an auditory osseointegrated device if the individual meets the intent of use requirements documented by the Food and Drug Administration (FDA) and they have no physical or psychologic contraindications to the surgical procedure. Cochlear implant candidates should be referred to an implanting surgeon for otologic and medical evaluation.

All auditory osseointegrated device candidacy test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Tinnitus Assessment**

Otoscopy should be conducted and documented, in the medical record, prior to any tinnitus assessment testing.

Tinnitus assessments should be conducted in a quiet room or test booth under headphones, insert earphones and/or in the soundfield. All speech testing, both in quiet and in noise, should be established using recorded test materials.

Tinnitus assessments should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Tinnitus assessments could include, but are not limited to:

* Comprehensive case history including review of systems.
* Binaural, audiometric testing, including pure-tone, air conduction testing, pure-tone, bone conduction testing, speech reception/awareness thresholds, speech recognition testing in quiet and in noise, most comfortable and uncomfortable loudness levels, loudness matching, pitch matching and masking.
* High frequency audiometry
* Immittance testing.
* Otoacoustic emissions testing.
* Hearing handicap inventory (if they have a documented hearing loss)
* Tinnitus Handicap Inventory.
* Depression screening.

All tinnitus assessment results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Vestibular Assessment**

Otoscopy should be conducted and documented, in the medical record, prior to any vestibular assessment.

Vestibular assessments should be performed using a chair or table, googles, foam, a rotational chair, posturography platform, for specific vestibular test equipment or software.

Vestibular assessments should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Vestibular assessments could include, but are not limited to:

* Comprehensive case history including review of systems.
* Binaural, audiometric testing, including pure-tone, air conduction testing, pure-tone, bone conduction testing.
* Tympanometry.
* Spontaneous and gaze nystagmus testing.
* Hallpike Maneuver/positional nystagmus testing.
* Optokinetic testing.
* Oscillating tracking testing.
* Saccade testing.
* Sensory organization testing.
* Vestibular evoked myogenic potentials.
* Video head pulse test.
* Head thrust test.
* Fukada test.
* Falls risk assessment.
* Rotational chair testing.
* Computerized posturography.
* Dizziness handicap inventory.

All vestibular assessment test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Auditory Processing Assessment**

Otoscopy should be conducted and documented, in the medical record, prior to any auditory processing assessment.

Auditory processing assessments should be conducted in a quiet room or test booth under headphones, insert earphones and/or in the soundfield. All speech testing, both in quiet and in noise, should be established using recorded test materials.

Auditory processing assessments should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Auditory processing assessments could include, but is not limited to:

* Comprehensive case history including review of systems.
* Binaural, audiometric testing, including pure-tone, air conduction testing, pure-tone, bone conduction testing, speech reception/awareness thresholds, speech recognition testing (PBmax), and most comfortable and uncomfortable loudness levels.
* Otoacoustic emissions testing.
* Evoked potential testing.
* Speech in noise testing.
* Synthetic sentence identification testing.
* Staggered Spondaic Word testing.
* Pitch Pattern Sequence testing.
* Filtered speech testing
* Dichotic testing.
* Hearing handicap inventory.

All auditory processing assessment test results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Hearing Loss Prevention and Protection**

Otoscopy should be conducted and documented, on the screening form, prior to any audiometric screening or testing.

Hearing loss prevention and protection programs should be established in accordance with all applicable state and federal regulations and requirements.

Hearing loss prevention and protection programs could include, but is not limited to:

* Case history, specifically as it relates to noise exposure.
* Pure-tone, air conduction testing, including high frequency audiometry.
* Speech in quiet and in noise.
* Otoacoustic emissions testing.
* Counseling on appropriate use of recommended ear protection.

Individuals should be re-assessed in accordance with all applicable state or federal laws, whenever they notice tinnitus or a change in their ability to hear or communicate, or bin-annually.

All hearing loss prevention and protection results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Communication Needs Assessment**

Communication needs assessments should be conducted in a quiet room. All speech testing, both in quiet and in noise, should be established using recorded test materials.

Communication needs assessments should be performed when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Communication needs assessments could include, but are not limited to:

* Assess chief complaint and history of chief complaint.
* Review of diagnostic audiologic test results.
* Performance of most comfortable loudness, uncomfortable loudness, acceptable noise level and speech in noise measures.
* Unaided real ear measurement.
* Assess with patient, via case history and hearing handicap inventories, and communication partner(s) the patient’s lifestyle, their cosmetic desires, and the psychological, medical, educational, emotional, social, and/or vocational impact of chief complaint and any financial limitations.
* Assess patient’s dexterity.
* Screen patient’s cognitive and/or auditory processing status.
* Hearing handicap inventory.
* Depression screening.

All communication needs assessment results should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These results should produce a care plan.

**Hearing Aid Dispensing and Management**

*Earmold impression*

Earmold impressions should be taken for the following reasons:

* Creation of a custom earmold or monitor.
* Creation of a custom hearing aid.

Otoscopy should be conducted and documented prior to conducting any ear impressions.

Audiologists will take ear impressions if, following case history, the taking of an ear impression is not contraindicated (i.e. surgically altered ear, exotoses, hematologic disorder, blood thinner use, etc.).

Infection control guidelines and policies should be followed during and following ear impressions.

The otoscopic findings following ear impressions should be documented in the medical record.

*Hearing aid fitting and orientation*

Individuals birth to 17 years of age must have a signed medical clearance, preferably by a physician who specializes in diseases of the ear, prior to fitting amplification. This medical clearance must be provided for each hearing aid fitting.

Electroacoustic analysis should be performed prior to fitting any new, used, reconditioned, or repaired hearing aids.

During the hearing aid fitting and orientation, the audiologist needs to fit the hearing aids to the individual’s ear and orientate them on the appropriate use and care of the device.

The hearing aid fitting and orientation should include, but is not limited to:

* Instruction on identifying right versus left hearing aid(s).
* Instruction on appropriate telephone use, including telecoil.
* Instruction on insertion/removal of hearing aid(s)/earmold(s).
* Instruction on manipulation and use of volume control/switches/remote/application.
* Instruction on the proper use of telecoil.
* Instruction on how to insert/remove battery or with how to recharge batteries.
* Instruction on battery type, size, and life or with how to recharge batteries.
* Advised on the importance of the use of Dri-Aid Kit/Dry and Store, as appropriate.
* Advised on why to leave battery compartment open when not in use on battery operated hearing aids.
* Instruction on common hearing aid troubleshooting techniques.
* Advised on the proper way to store batteries for battery operated hearing aids.
* Instruction on how to clean hearing aid(s)/receiver(s)/earmold(s).
* Instruction on how to change wax filters or guards.
* Advised on proper battery disposal for battery operated hearing aids.
* Advised on where to keep aids when not worn.
* Advised on dangers of battery ingestion.
* Advised on why not to expose aids to moisture, hair spray, oil, extreme heat, spray paint, etc..
* Advised on where and how to purchase batteries for battery operated hearing aids.
* Advised on the importance of realistic expectations.
* Advised on importance of consistent hearing aid use.
* Advised on importance of family support.
* Advised on and provided with realistic expectations regarding initial sound of voice, wind, etc.
* Advised on and provided with communication strategies.
* Advised on the importance of lip-reading, speech reading and visual cues to communication and provided with resources.
* Advised on appropriate assistive listening device options.
* Advised on the process of adjusting to amplification.
* Advised on the importance of removing aid and contacting the audiologist if office if they are experiencing pain or discomfort.
* Advised on feedback (when expected and not expected).
* Advised not to wear hearing aids in noisy industrial/recreational settings.
* Instruction on long-term service and warranty options and costs.
* Advised not to attempt repairs at home.
* Advised on the importance of follow-up appointments
* Explained office repair and loaner policies.
* Advised that a lost or damaged aid cannot be returned for credit.
* Advised that they must contact our office if they are experiencing any problems during the evaluation and adjustment period.
* Advised that hearing aids may be returned for credit during the evaluation and adjustment period.
* Provided with the manufacturer user brochure as required by the Food and Drug Administration.
* Individual, guardian, and/or guarantor of a completed hearing aid purchase agreement, as required by state law.

*Hearing aid verification and outcomes*

Hearing aid verification and outcomes should be established either at the fitting or during the evaluation and adjustment period.

Verification should include, but is not limited to:

* Real-ear measurement.
* Speech in noise testing.
* Live speech mapping.
* Hearing aid inventories such as Hearing Handicap Inventory (HHI), Abbreviated Profile of Hearing Aid Benefit (APHAB), International Outcome Inventory – Hearing Aids (IOI-HA) Satisfaction with Amplification in Daily Living (SADL), Client Oriented Scale of Improvement (COSI), or Characteristics of Amplification Tool (COAT).

Hearing aid verification should also be completed when the hearing aid user experiences new or increased hearing or communication difficulties or annually.

*Hearing aid follow-up*

Hearing aid follow-up visits should occur at least once in the evaluation and adjustment period, when the hearing aid user experiences new or increased hearing or communication difficulties, or bi-annually.

Hearing aid follow-up visits could include, but is not limited to:

* Clean and listening check.
* Electroacoustic analysis.
* Real-ear measurement.
* Live speech mapping.
* Speech in noise testing.
* Hearing aid inventories such as Hearing Handicap Inventory (HHI), Abbreviated Profile of Hearing Aid Benefit (APHAB), International Outcome Inventory – Hearing Aids (IOI-HA) Satisfaction with Amplification in Daily Living (SADL), Client Oriented Scale of Improvement (COSI), or Characteristics of Amplification Tool (COAT).
* Counseling and auditory/aural rehabilitation.

All hearing aid dispensing, fitting and orientation, verification and outcomes, and follow-up findings should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These findings should produce a care plan.

Auditory Prosthetic Device Fitting and Management

During the auditory prosthetic device fitting and orientation, the audiologist needs to fit the processor to the individual’s ear, program the processor, and orientate them on the appropriate use and care of the device.

Auditory prosthetic device fitting and management should be provided when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

The auditory prosthetic device fitting and orientation should include, but is not limited to:

* Instruction on appropriate telephone use.
* Instruction on insertion/removal processor and magnet.
* Instruction on manipulation and use of volume control/switches/remote/application.
* Instruction on how to insert/remove battery or with how to recharge batteries.
* Instruction on battery type, size, and life or with how to recharge batteries.
* Advised on the importance of the use of Dri-Aid Kit/Dry and Store, as appropriate.
* Advised on why to leave battery compartment open when not in use on battery operated hearing aids.
* Instruction on common processor, magnet and coil troubleshooting techniques.
* Advised on the proper way to store batteries for battery operated devices.
* Instruction on how to clean processor/magnets/coil/earmold(s).
* Advised on proper battery disposal for battery operated hearing aids.
* Advised on where to keep processor and components when not worn.
* Advised on dangers of battery ingestion.
* Advised on why not to expose processor to moisture, hair spray, oil, extreme heat, spray paint, etc..
* Advised on where and how to purchase batteries for battery operated processors and replacement coils and processors.
* Advised on bimodal communication, if the individual also wear a hearing aid.
* Advised on appropriate assistive listening device options.
* Advised on the importance of realistic expectations.
* Advised on importance of consistent auditory prosthetic device use.
* Advised on importance of family support.
* Advised on and provided with realistic expectations regarding initial sound of voice, wind, etc.
* Advised on and provided with communication strategies.
* Advised on the importance of lip-reading, speech reading and visual cues to communication and provided with resources.
* Advised on the process of adjusting to implantation.
* Advised on the importance of contacting the audiologist if office if they are experiencing pain or discomfort.
* Instruction on long-term service and warranty options and costs.
* Advised not to attempt repairs at home.
* Advised on the importance of follow-up appointments
* Explained office repair and loaner policies.
* Provided with the manufacturer user brochure as required by the Food and Drug Administration.

*Auditory prosthetic device verification and outcomes*

Hearing aid verification and outcomes should be established either at the fitting or during the evaluation and adjustment period.

Verification should include, but is not limited to:

* Neurotelemetry
* eSRT.
* Speech in noise testing.
* Hearing aid inventories such as Hearing Handicap Inventory (HHI), Abbreviated Profile of Hearing Aid Benefit (APHAB), International Outcome Inventory – Hearing Aids (IOI-HA) Satisfaction with Amplification in Daily Living (SADL), Client Oriented Scale of Improvement (COSI), or Characteristics of Amplification Tool (COAT).

Auditory prosthetic device verification should also be completed when the user experiences new or increased hearing or communication difficulties or bi-annually.

*Auditory prosthetic device follow-up*

Auditory prosthetic device follow-up visits should occur at least every three months or when the user experiences new or increased hearing or communication difficulties.

Auditory prosthetic device follow-up visits could include, but is not limited to:

* Reprogramming of the processor.
* Speech in noise testing.
* Hearing aid inventories such as Hearing Handicap Inventory (HHI), Abbreviated Profile of Hearing Aid Benefit (APHAB), International Outcome Inventory – Hearing Aids (IOI-HA) Satisfaction with Amplification in Daily Living (SADL), Client Oriented Scale of Improvement (COSI), or Characteristics of Amplification Tool (COAT).
* Counseling and auditory/aural rehabilitation.

All auditory prosthetic device programming, dispensing, fitting and orientation, verification and outcomes, and follow-up findings should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These findings should produce a care plan.

**Tinnitus Management**

Tinnitus management should be provided to individuals who experience handicapping tinnitus.

Tinnitus management should be provided when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Tinnitus management can include but is not limited to:

* Amplification in the form of hearing aids, personal sound amplification products or assistive listening devices, as audiologically appropriate.
* Ear protection.
* Noise generating devices or tinnitus maskers.
* Tinnitus retraining therapy.
* Cognitive behavioral therapy.
* Biofeedback.
* Auditory/aural rehabilitation.
* Counseling
* Dietary supplements.
* Dietary changes.
* Referral to dentist (tempo mandibular joint syndrome), physician (medication management), psychologist (therapy), and/or acupuncturist (acupuncture).

All tinnitus management findings should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These findings should produce a care plan.

**Vestibular Management**

Vestibular management should be provided to individuals who are a falls risk or who experience dizziness, vertigo, or imbalance.

Vestibular management should be provided when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Vestibular management can include, but is not limited to:

* Canalith repositioning.
* Balance or gait training.
* Home hazards modifications.
* Counseling.
* Referral to physician (medication management) or physical therapist (balance and gait training or vestibular rehabilitation therapy).

All vestibular management findings should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These findings should produce a care plan.

**Auditory Processing Treatment**

Auditory processing treatment should be provided to individuals with a documented auditory processing disorder.

Auditory processing treatment should be provided when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Auditory processing treatment can include, but is not limited to:

* Assistive listening devices.
* Auditory/aural rehabilitation.
* Computer based training.
* Referral to physician (medication management) or speech-language pathologist (auditory training)

All auditory processing treatment findings should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These findings should produce a care plan.

**Auditory/aural rehabilitation**

Auditory/aural rehabilitation should be provided to individuals with a documented hearing loss, hearing handicap, or communication difficulty.

Auditory/aural rehabilitation should be provided when medically reasonable and necessary. Medical necessity is dictated by applicable state and/or federal regulations or payer medical policies. Medical necessity should be documented in the medical record.

Auditory/aural rehabilitation can include, but is not limited to:

* Hearing aids, personal sound amplification products, or auditory prosthetic devices.
* Assistive listening devices.
* Communication/listening strategies.
* Compensatory strategies.
* Speech-reading.
* Lipreading.
* Computer based training.
* Cognitive behavioral therapy.
* Music therapy.

All auditory/aural rehabilitation findings should be reported and interpreted in an audiologic evaluation report and documented in the medical record. These findings should produce a care plan.