



Early Steps Procedural Guidelines for Services to Children with Hearing Impairment (SHINE)

I. Background

Research evidence supports the findings that children with hearing impairment that receive early, appropriate intervention services can learn language at a typical rate. Children learn language through interaction and exposure to language being used in their everyday activities, routines, and places. The barrier to normal language development for a child with hearing loss is due to reduced access to communication. This barrier can be addressed by appropriate early intervention that assists parents and caregivers in interacting with the child and arranging the environment in a manner that allows the child to access communication. Only persons that have received specialized training to address specific competencies are appropriate service providers to meet the specialized needs of this population. The purpose of this policy is to define how SHINE providers and hearing specialists should be involved in providing Early Steps services to infants and toddlers with hearing loss.

II. Serving Hearing Impaired Newborns Effectively (SHINE) Component of Early Steps Services

In section 6.11 of the Early Intervention Program Plan and Operations Guide SHINE services are defined as “Services that address the assessment, parent education and support, information and provision of initial services and ongoing service coordination of children with hearing loss.” Information and supporting materials about SHINE that are mentioned within this document can be found at www.cms-kids.com/SHINE/index.htm.

A. Philosophies

There are three foundation philosophies of the Serving Hearing Impaired Newborns Effectively component of Early Steps programs: (1) Parents of children who have just been diagnosed with hearing impairment require emotional support and information about hearing loss. Because these children have an established condition there is no justification for delaying support and information to the family until after the multidisciplinary assessment; (2) Parents need to receive unbiased information about features of communication that combine into different communication options so that they may select the communication choices that best fits their lifestyle, their goals for the child, and adjust their communication use to match the child's emerging learning style and needs; and (3) Based on research, if parents and caregivers are actively involved in appropriate early intervention services, it is possible for the child to develop language at a rate typical of their peers with normal hearing, thus preventing developmental delays from occurring. Only by regular assessment of communication skills can a child's progress be monitored.

B. Goals

There are six goals of the SHINE component. Objectives under each of the first four goals can be found on the Example Plan of Care and are illustrated in the SHINE Case Examples

1. The family/caregivers will increase their knowledge of hearing impairment and the potential effects of limited communication access on child development
2. The family/caregivers will increase their knowledge of auditory skill development and amplification use
3. The family/caregivers will increase their knowledge of and comfort with techniques and strategies to provide communication access to the child with hearing loss
4. The family/caregivers will increase their knowledge of different communication features and options available to provide their child with full communication access in all typical daily situations.
5. The SHINE provider and the family will **monitor** the child's development of communication skills to determine his or her communication style and progress over time and the IFSP team will update the Communication Plan as needed
6. The SHINE provider as a part of the IFSP team will assist families in matching communication methods and Hearing Specialist expertise to the learning style and strengths of the child and family as he or she develops over time

C. SHINE Timeline and Activities

1. Audiologists as the identified health professional to diagnose hearing loss must refer a child to the Local Early Steps within two working days of confirmation of the hearing loss (CFR 303.321d). Referrals to Early Steps can also be made by any health professional or concerned individual.
2. Per the operating procedures of the Local Early Steps, the referral information is provided to the service coordinator (preferably a designated SHINE service coordinator) who then makes an initial contact. During this initial contact, the service coordinator will inform the parent that the SHINE provider will be in contact with them to describe information specific to helping a child with hearing loss. The SHINE provider can accompany the service coordinator during first contact activities to describe SHINE services or the SHINE provider can meet with the parents following first contact by the service coordinator.
3. As with any other child referred to Early Steps, the service coordinator will make a first contact meeting to determine the family/caregiver priorities, goals, and objectives and to explain the IFSP and the Early Steps services, Procedural Safeguards, and Conflict Resolution.
4. An interim Individual Family Support Plan (IFSP) will be completed by the SHINE provider or by the service coordinator, specifying the parent information outcomes in the SHINE goals_[p1-2]. The interim IFSP will consist of completion of Forms A, B, E, F, and H. The date of the interim IFSP is not to be considered the initial IFSP date. The IFSP date of record is the date following the multidisciplinary assessment during which the IFSP team met and the IFSP was completed in its entirety.
5. SHINE initial services will begin following the completion of the interim IFSP. The implementation of SHINE services has been illustrated for children with different degrees of hearing loss in Case Examples
6. It is intended that initial SHINE services be provided to the family until they have made a decision about the communication option and service provider they desire, and have worked with the SHINE provider to complete the

Communication Plan. The Communication Plan is a document detailing the parents' desire for use of communication features, amplification use, interaction with other families of children with hearing impairment, use of effective communication practices in everyday routines and activities, and the professionals providing support and services to address the communication needs of the child with hearing loss. The Communication Plan and subsequent updates of the Communication Plan should be included in the child's Early Steps file.

7. A provider with competencies in providing services for children with hearing impairment is known as a hearing specialist. A specialist in hearing impairment will be included on the assessment team for a child with a diagnosed permanent hearing loss so that this condition can be fully taken into consideration in the planning process for services to be provided to the family and child. This individual can be the SHINE provider who will be an ongoing member of the IFSP team. This individual can also be the hearing specialist service provider if the family has already decided on a communication option and a preferred service provider prior to the assessment appointment. The selection of a hearing specialist will not be made until the Communication Plan has been completed by the family and the SHINE provider.
8. If the child's only area of disability is hearing impairment, the SHINE provider or hearing specialist should act in the role of the primary service provider unless extenuating circumstances exist that are taken into consideration by the IFSP team. If the child has multiple disabilities including hearing impairment the SHINE provider will meet with the family during the period in which the interim IFSP is active. Once the multidisciplinary evaluation is completed the IFSP team will determine if the SHINE provider has the expertise to act as the primary service provider or if this person or a hearing specialist should provide consultative services as a member of the IFSP team.
9. The child will receive a multidisciplinary assessment within 45 calendar days of referral to the Early Steps program. This procedural guidelines document recommends certain assessment tools to be used with this population. Refer to [this](#) for a summary of assessment and monitoring procedures and timelines. The SHINE provider or the hearing specialist should administer the Language Development Scale (LDS) as part of this assessment. The LDS is currently available to SHINE providers or hearing specialists by contacting the Early Steps coordinator for hearing and vision services. If the child is older than 8 months (chronologically or developmentally) the age-appropriate SHINE Vocabulary Checklist should be administered as a baseline measure to which ongoing assessment would be compared. Finally, the Auditory Skills Checklist should be completed as a final part of the assessment of functional auditory and communication skills. As always, the needs of the individual child will guide assessment decisions, therefore there may be occasions when not all portions of this assessment battery are completed. At the time of the multidisciplinary assessment Form D of the **IFSP** will be completed and Form B, E, F, and G will be completed again to reflect all information and services that are appropriate to address following information gathering during the assessment process. Examples of functional outcomes and strategies have been developed that are appropriate for children with hearing loss.
10. In addition to outcomes related to prevention of delays due to hearing loss, the IFSP should address audiology services and amplification as appropriate. As the payer of last resort, the Early Steps program may be responsible for

- reimbursement of the child's hearing aid(s). See the Section III of this document for more information on amplification reimbursement.
11. The completed Plan of Care will be forwarded to the service coordinator. At the completion of every SHINE session, the SHINE provider should complete Daily Progress Notes documenting the date and activities that reflect the goals and objectives on the IFSP/Plan of Care. An example of a SHINE services daily progress notes record sheet has been developed.
 12. SHINE initial services will be discontinued when the **first four goals** have been discussed with the family and/or caregivers and they have made a decision regarding which communication features will be used in communication with the child and who the hearing specialist service provider(s) will be. This information will be contained within a Communication Plan that will be completed by the parent and the SHINE provider at the culmination of SHINE initial services. Completed Communication Plans will be included in the child's Early Steps record.
 13. At a minimum of every 6 months the SHINE service provider will obtain completed information defined in the Communication Development Monitoring Procedures from the family. Best practice would be for monitoring with the age appropriate SHINE Vocabulary Checklist, the Language Development Scale, and the Auditory Skills Checklist to occur at least quarterly and for informal assessment by service providers to occur as an integrated part of regular consideration of the child's needs. Communication Development Monitoring Procedures are comprised of specific parent interview and child observation instruments that assess a child's current communication performance. This information will be discussed with the IFSP team, including the parents/caregivers, and the Communication Plan will be reviewed and updated as appropriate. If the child with hearing impairment has not made approximately 6 months of progress in 6 months of early intervention it is recommended that communication development monitoring occur again in 3 months. Training on SHINE service provision, including completion of the SHINE Vocabulary Checklist Procedures and other assessment instruments for children with hearing impairment is available from the Coordinator for Hearing and Vision Services at the Early Steps State Office.
 14. Within 30 days of completion, a copy of all pages of the appropriate results pages from the Communication Development Monitoring Procedures manual will be mailed or faxed to: Karen Anderson, Early Steps State Office, confidential fax number 850-245-4295. This information is submitted for the purpose of tracking child outcomes statewide and locally so that the state SHINE component can be evaluated and targeted technical assistance can be provided. Only checklists completed every 6 months need to be submitted. If checklists are completed more frequently, only two need to be submitted per year, as close to 6-month intervals as possible. At the current time, data entry for analysis of aggregate data will not be the responsibility of the Local Early Steps offices.

D. Responsibilities of the SHINE Service Provider

1. All SHINE service providers should have an educational background in speech-language pathology, teaching deaf/hard of hearing, audiology, and/or should have completed SKI*HI training and taken additional coursework specific to the developmental needs of young children with hearing impairment (full competencies and coursework specifications for hearing specialists are pending). It is necessary for persons fulfilling the SHINE provider role to agree with the philosophy of unbiased presentation of communication features and options.

- The SHINE provider must be able to provide training to the family including, but not limited to:
- a. Providing the Family Resource Guide
 - b. Describing the effects of hearing loss on development
 - c. Describing the early communication strategies
 - d. Assisting caregivers in understanding hearing loss using the Early Listening Function_test, simulations, and/or other materials
 - e. Assisting the caregivers in the use and monitoring of their child's hearing aids
 - f. Presenting communication options in an unbiased manner, including loan of SHINE Resource Basket materials
 - g. Connecting the parents to other parents of children with hearing loss
 - h. Discussing the expertise of the pool of hearing specialists available to the team and assisting the family in choosing which provider(s) to include on the team for assessment and/or to provide ongoing services
 - j. Participating as a member of the child's IFSP team, including performing assessments, monitoring and being an active member in attending IFSP team meetings to discuss child and family needs and progress
 - i. Completing the Communication Plan in conjunction with the IFSP team when the parent has decided on which communication features to begin to learn
 - j. Administering the Communication Development Monitoring Procedures (summary) at least twice per year consisting of gathering demographic and hearing related information, and completing the age appropriate SHINE Vocabulary Checklist, the SKI*HI Language Development Scale (LDS), the Auditory Skills Checklist, and the Parent Interview Report Form.
2. The SHINE service provider must have completed a training session to orient them to the SHINE component and their responsibilities that are unique to this service component. This training session is available from the Coordinator for Hearing and Vision Services at the Early Steps State Office.
 3. In the discussions of the team during the development of the IFSP the SHINE provider should include consideration of the need to authorize for hearing aids, hearing aid fitting, earmolds, hearing aid follow up checks, and hearing aid insurance as appropriate, specifying Part C as the payer of last resort.
 4. The SHINE provider is responsible for being aware of all children with hearing impairment in the service area designated by the Director of the Local Early Steps. Furthermore, the SHINE provider is responsible for assuring that a Communication Plan is established and updated every 6 months as needed, and that the SHINE Communication Development Monitoring is completed at a minimum of 6-month intervals.
 5. The SHINE provider should advocate for prompt fitting of amplification (loaner or personal hearing aids) within 30 days of recommendation for hearing aid fitting by the audiologist. He or she should work with the family to ensure that hearing aid follow-up visits occur as appropriate to the schedule based on the child's age (refer to the Section III of this document) and that hearing reevaluation is conducted a minimum of every 6 months. The SHINE provider and the child's service coordinator should work with the Children's Hearing Help Fund Hearing Aid Loan Bank for Infants and Toddlers and the child's audiologist to obtain loaner hearing aids when appropriate and to assist in the return of the loaner hearing aids to the Hearing Aid Loan Bank when necessary

6. The SHINE provider should obtain communication development monitoring information from families of children with hearing loss at least twice per year, preferably with contributions from the hearing specialist that is providing ongoing services to the child and family. The implications of these findings should be discussed in depth with the family/caregivers. The SHINE provider is an active part of the IFSP team discussions about child progress and the need for changes in service when necessary. These discussions should occur in the context of an IFSP team meeting. It is appropriate for the Communication Plan to be updated by the IFSP team in collaboration with the SHINE provider as appropriate after communication monitoring activities.
7. It is suggested that a list of family members of children with hearing loss who consent to have their names released to parents of newly diagnosed children with hearing loss should be developed and maintained for each Early Steps area. It is suggested that developing this list be a collaborative effort of the SHINE service provider(s), the Family Resource Specialists, the Coordinator of Hearing and Vision services at the Early Steps State Office, any organized local parent organizations, and relevant community professionals. Effort should be made to include children with different degrees of hearing loss and who use a variety of communication features and options on this list.
8. It is suggested that in conjunction with the Early Steps State office, the Local Early Steps should maintain and update a list of service providers who have expertise in serving young children with hearing loss and their families. It is suggested that the SHINE provider(s) assist the Coordinator of Hearing and Vision services at the Early Steps State Office in updating the statewide list of service providers for children with hearing impairment. In order to be considered Hearing Specialists, these professionals must have fulfilled the competencies specified for this role (pending).
9. The SHINE providers are expected to avail themselves of opportunities to increase their knowledge regarding hearing impairment, amplification usage, and the needs of families of children with hearing loss. A minimum of participation at one educational offering relevant to SHINE/hearing impairment is recommended per year (e.g. Florida Symposium on Early Childhood Hearing Loss; Department of Education Weekends with the Experts, other targeted training activities generated by determination of technical assistance needs).
10. The SHINE provider is responsible for loaning SHINE Resource Basket materials to parents/caregivers based on their interests and for reclaiming these materials before the family exits from SHINE services. Resource Basket materials are the property of the Local Early Steps and will not be replaced by CMS/Early Steps in the case of loss or damage. If multiple SHINE service providers are in a single Early Steps area they will need to resolve how to best share the SHINE Resource Basket materials.

E. Responsibilities of the SHINE Service Coordinator

The Early Steps service delivery system will require greater team involvement by the service coordinator. Thus, in highly populous areas or large geographic areas it will not be practical for all children with hearing impairment to be served by a single service coordinator. Regardless, the Local Early Steps should strive to maintain a designated SHINE service coordinator to the maximum extent possible. This may require that a number of service coordinators in an Early Steps region receive basic orientation to issues related to hearing impairment and that children with hearing loss be served by selected Early Steps teams. Due to the low incidence of hearing impairment, training of a small portion of service

coordinators is recommended. SHINE service coordinator responsibilities would relieve the SHINE service provider of some of the administrative, advocating, and coordination activities above, specifically numbers 3, 4, 5, 7, and 8. Additional duties of the SHINE provider could be assumed by the SHINE service coordinator depending on the training and experience of the service coordinator. When appropriate, the SHINE service provider can act in the role of service coordinator to provide targeted case management to the family.

F. Implementation of SHINE and Hearing Services within the Early Steps Service Delivery System

Below are some examples of how SHINE and hearing specialty services can be included on Early Steps teams. These examples are also displayed on the schematic of SHINE in Early Steps teams. In all cases the SHINE provider would be a continuing active member of the child's IFSP team. It must be noted that it is necessary to maintain parent choice of hearing specialists, as very few persons with a background in hearing impairment will be able to instruct parents competently in all communication options. In addition, communication options can be combined as caregivers explore the methods that work best for their child and family. Thus, it is possible that more than one hearing specialist (in addition to the SHINE service provider) may provide services to the family at one time, especially as families are striving to make adjustments necessary to meet their child's emerging communication needs.

1. **Hearing Specialty Team (SHINE Team):** The SHINE service coordinator would be assigned to this team and the SHINE provider would provide initial SHINE services and would act as the hearing specialist or in conjunction with identified hearing specialists that were experienced in one or more communication options. The hearing specialty team would be assigned whenever a child with hearing impairment was referred for services. Parents would be provided information on all communication options by the SHINE provider. If the hearing specialist did not have sufficient skills in the parent's area of interest then additional hearing specialist services would be accessed in consultation with the SHINE provider.

EXAMPLE 1: If parents desire services from an Auditory Verbal Therapist they could receive these services directly^[p2] or the Auditory Verbal Therapist could consult with the SHINE provider or a hearing specialist on the team for carryover during daily activities in the home (consultation would be paid for by Early Steps) by participating in joint sessions and regular consultation and collaboration.

EXAMPLE 2: If the parent desired sign language services, a hearing specialist with this expertise could become the primary service provider or could consult in the natural environment with the family and the SHINE provider during joint sessions, with the SHINE provider or another IFSP team member in the role of primary service provider.

2. **Agency-Sponsored Teams:** Local Early Steps areas using agency sponsored teams will have a pool of persons with hearing specialty expertise identified who are available to be included when a child with hearing loss is referred in each area served by an agency-sponsored team. The SHINE provider would consult with the family multiple times between first contacts and the assessment. The SHINE provider would be involved as an IFSP team member to provide ongoing consultation to the family and other IFSP team members. The hearing specialist provider could be changed, based on the progress of the child and family as reflected by the communication monitoring process and the input of the IFSP team. It is allowable for a family to have multiple hearing specialists providing

- them instruction on different communication options as long as the primary service provider provides support and assistance to the family in implementing the varying communication strategies within daily activities and routines. An additional SHINE provider could be identified and trained as needed to be able to meet the geographic demands of SHINE services to a variety of teams. Due to the need to share SHINE Resource Basket Materials, the low incidence nature of hearing impairment and the limited role of the SHINE provider in this model, it is not necessary nor recommended that each Local Early Steps team have a SHINE provider.
3. **Independent Contractor Teaming:** This model would be most commonly used in rural areas with limited professional resources. The Independent Contractor Team will likely have only a very limited number of persons with hearing expertise available to them. Once trained, these persons could adopt the role of the SHINE provider. The SHINE provider that has been working in these areas could continue in their role as much as geographically feasible, functioning as described in the Agency-Sponsored Team model. Unbiased presentation of communication options and describing the capabilities of hearing specialists in the local area and any other areas that interest the family will be maintained.

G. Children Identified with Hearing Impairment Following the Multidisciplinary Assessment

The following are suggested procedures to guide the Local Early Steps in implementing the SHINE component for children who were identified with hearing loss during or after the multidisciplinary evaluation. Initiation of SHINE services may be necessary following receipt of collateral information that documented a hearing loss or if the Parent Interview Protocol for Hearing and Vision Skills identified a hearing concern with a subsequent audiological evaluation confirming the presence of a permanent hearing loss that meets Part C Eligibility Criteria for Significant Hearing Loss.

1. Following confirmation of the hearing loss, SHINE provider in conjunction with the service coordinator will complete an IFSP Outcome Page (Form E) documenting the need for SHINE services.
2. The service coordinator or SHINE provider will assure that IFSP team discussions occur following the confirmation of hearing loss regarding the need to authorize for hearing aids, hearing aid fitting, earmolds, hearing aid follow up checks, and hearing aid insurance as appropriate, specifying Part C as the payer of last resort.
3. All other SHINE activities will commence in the same manner as if the child were initially referred with hearing loss as an established condition. During the initial SHINE goals, the SHINE provider can consult with the family and the Primary service provider so that the implications of the hearing impairment are recognized during all Early Steps services. A hearing specialist can be identified by the SHINE provider and the family to continue to provide appropriate consultative services to the family and other team members or the SHINE provider can provide these consultative services.

III. Providing Amplification to Children with Hearing Loss

A. Purpose

Amplification instruments have undergone tremendous research and development in the last decade resulting in improved technology that is more flexible and provides much improved audibility of sounds at different intensities. These programmable and digital

hearing aids meet the needs of most infants and toddlers with hearing loss. The purpose of this document is to define policy for Early Steps Programs to reimburse for the services and devices that Medicaid reimburses, but to allow for an appropriate array of hearing instruments to meet the needs of young children with hearing loss. For additional information on hearing loss diagnosis and amplification in Florida refer to the Guidelines for Infant Hearing Screening, Referral, Audiologic Assessment, Hearing Loss Management and Early Intervention.

It is critical for amplification to be provided to a child within one month of the recommendation being made by the audiologist. If for any reason it appears as though hearing aids will not be purchased within this 30 day period it is important that the audiologist, family, and service coordinator work together to obtain loaner hearing instruments through the Children's Hearing Help Fund Hearing Aid Loan Bank for Infants and Toddlers (<http://www.childrenshearinghelpfund.com>).

B. Procedures for providing reimbursement for hearing aids

Step 1: Audiologists are required to refer a child to the local Early Steps Program upon confirmation of a hearing loss that meets the Part C eligibility requirements. The Diagnostic Hearing Evaluation Form has been developed for audiologists to fax directly to the local Early Steps Program.

Step 2: If amplification recommendations have been made, the IFSP will authorize a \$500 maximum single unit wholesale amount for purchasing the hearing aids (or \$1000 for two) for a child that is not eligible for Medicaid reimbursement. The IFSP will also authorize the cost of hearing aid fitting (\$115 per hearing aid), earmolds (invoice cost indicating price per earmold, up to 3 pairs per year), and hearing aid follow up checks (see Steps 4 and 5). It is acknowledged that audiologists will determine the most appropriate amplification devices to meet the child's needs therefore, it is not necessary to convene an Assistive Technology assessment team.

Step 3: The audiologist fits the child with the hearing aid(s). The audiologist then submits an invoice that specifies the fitting fee. The fitting fee of \$115 covers (a) the earmold impression appointment, (b) the hearing aid adjustment activities (c) the fitting and hearing aid orientation appointment. The audiologist's invoice also specifies the manufacturer's wholesale price of the hearing instruments (not to exceed \$500 per analog, digital, and/or programmable hearing aid or \$1000 per pair). The audiologist's invoice will also specify the cost of the earmold(s) with a maximum reimbursement rate of \$18. If the child's insurance provides coverage for hearing aids then the insurance would pay a portion of the single unit wholesale cost and Part C would pay the remainder (i.e., if insurance pays \$300 then Part C would pay up to an additional \$200). Balance billing is allowable if the family is willing to pay for the excess wholesale cost of a more expensive hearing aid. The audiologist would still need to submit evidence of the single unit wholesale cost of the desired hearing aid. In addition, the audiologist would submit a written statement signed by the responsible family member(s) in which they have agreed to pay for the remainder of the single unit wholesale cost. This balance billing arrangement is not allowable with Medicaid reimbursement of hearing aids.

Step 4: It is recommended that the IFSP specify the need for hearing aid follow-up visits to be completed by the family. (Follow-up visits are not currently

reimbursable by Medicaid.) Part C will reimburse for these hearing follow up visits with a recommended number of visits as determined by the age of the child at hearing aid fitting and the unique needs of the family. Part C will reimburse the audiologist for each visit, not to exceed reimbursement of \$41 per visit (Early Steps taxonomy: Audiology Service Aud \$41). It is anticipated that each visit will take a minimum of 30 minutes and more typically 45-60 minutes. Hearing aid follow up visits will be conducted by a pediatric audiologist and will contain **at least two** of the following activities that are not otherwise reimbursable by health insurance:

- a) ear canal probe microphone measurements
- b) earmold impressions
- c) adjustment/programming of hearing instruments
- d) family training
- e) behavioral audiometric measurements not covered by another payer
- f) electroacoustic hearing aid analysis
- g) validation measures
- h) in-office repairs of hearing instruments (not to include delivery after manufacturer repair)

Step 5: A reasonable number of hearing aid follow up visits to be considered by an IFSP team would be as follows. The rate of \$41 per visit will be specified on the IFSP. The suggested number of visits based on the child's age is offered below for use by IFSP teams when considering a child's individual needs.

0-12 months of age	12 visits (average 1 per month)	maximum of \$492
13-35 months of age	6 visits (average 1 per 2 months)	maximum of \$246

Step 6: After the initial warranty of the hearing aid expires, the IFSP will specify payment for loss and damage insurance (\$43 per hearing aid). Loss and damage insurance will be specified on the Family Support Plans of all children with hearing aids that are out of warranty (including Medicaid eligible). Following the IFSP meeting (typically the first annual IFSP) the appropriate Midwest Hearing Industries hearing aid insurance pamphlet will be signed by the SHINE service coordinator and then sent to the audiologist for completion. It is the responsibility of the audiologist to submit the completed insurance form along with a check or purchase order to pay for the Midwest Hearing Industries insurance premium along with a letter attesting to the proper working condition of the hearing instruments. The audiologist would complete the form by specifying the child's name in care of the audiologist's name and audiologists address so that the audiologist would maintain all premium paperwork. A copy of the completed form would be submitted to Early Steps with a billing statement for reimbursement of the cost of insurance. The audiologist would process all claims, when needed, by submitting a claim form and the wholesale invoice of the replacement hearing aid to the insurance company. Midwest Hearing Industries would reimburse the audiologist for the cost of the hearing aid, up to \$500. In the event that it is necessary to replace a hearing aid, the Local Early Steps would reimburse the audiologist for two hearing aid follow up visits: one to make the earmold and another to fit the new hearing aid. These visits would be part of the maximum allowable number based on the child's age. If the hearing aid is accidentally damaged and needs repair, the audiologist will fax Midwest Hearing Industries a claim form along with the repair invoice from the manufacturer, once the aid is repaired. Normal wear and tear and general maintenance is not covered under the insurance. Part C is the payer of last resort for hearing aid repairs.

C. Procedures for providing reimbursement for personal FM systems

A personal FM system is a device that improves the ability of the child to perceive speech at a distance and in noisy conditions. It requires the parent or caregiver to wear an FM microphone transmitter during active interaction periods of the child's day. It also requires the child to wear an FM receiver. In this way speech from the caregiver is picked up and delivered through FM radio waves to the child as though the caregiver was speaking only a few inches from the child's ears. This allows the child to pick up incidental language and to be attuned to speech in his or her environment more effectively. An FM system is only effective when the caregiver consistently uses the microphone transmitter. Thus, the dynamics of the family need to be considered carefully in the discussions of the utility of an FM system. If the family is motivated to ensure that caregivers throughout the child's day will wear the microphone transmitter, then a trial period with this equipment is recommended. FM receivers can be added on to a child's hearing aids, can replace a child's hearing aids, or the hearing aids can consist of a unit that is both a hearing aid and an FM system. The hearing aid loan bank has several of the combined devices that would be appropriate to use for trial periods for children with mild through severe hearing losses. The combined FM device can be worn unilaterally and the child's hearing aid worn on the other ear. Unilateral use of FM will still allow the child to perceive the voice of the caregiver across distance and in noise, which is the objective of FM use. At the end of the trial period the service coordinator should obtain a copy of the Early Listening Function (ELF) Infant and Young Child Amplification Use Checklist, or another similar appropriate checklist, that has been completed by the parents with the assistance of the SHINE service provider or the hearing specialist. If the trial period appears to have been successful then it would be appropriate for the FM microphone transmitter and a unilateral combined FM receiver device to be reimbursed by the Local Early Steps. The combined FM device can be purchased in combination with an additional similar hearing aid for under \$1000. Other FM device types can be discussed as a part of SHINE technical assistance from the Early Steps State Office.

IV. Reimbursement for SHINE and Hearing Specialist Services

1. Persons in the role of SHINE provider or Hearing Specialist who are hearing arts professionals (e.g., speech language pathologist) will be reimbursed for hearing services that are within their scope of practice. Hearing services reflect communication techniques and strategies. Thus, a speech language pathologist would be reimbursed at the speech therapy rate by Medicaid, insurance, or Part C. Speech language pathologists who are providing SHINE or hearing specialist services should have completed SKI*HI training and/or additional coursework.
2. Persons in the role of SHINE provider or Hearing Specialist who are not hearing arts professionals (e.g., teacher of the deaf and hard of hearing) must have completed SKI*HI training and/or additional coursework. Additional competencies and coursework considerations are pending. These services (SHINE and hearing specialist) that are paid for by Part C as EI Home sessions and will be coded as "Hearing Services_[p3]".
3. Local Early Steps programs that have provider agreements with the Florida School for the Deaf and the Blind will be able to reimburse FSDB for \$25 per session provided by a SKI*HI parent advisor with whom FSDB contracts. FSDB in turn will provide these professionals with a higher rate of pay that is commensurate with their experience and education with low incidence populations. In addition, FSDB will provide ongoing coordination, training, and supervision of these providers.

4. Some Early Steps areas have local education agencies that provide services to infants and toddlers with hearing loss. Services by school employees are not subject to reimbursement. As with all other hearing specialists, SHINE providers will interact and provide services to the parent and the IFSP team to supplement services provided by teachers of the hearing impaired that are employed by local education agencies. The only exception to this case would be when the school-based employees fulfill the role of SHINE provider. Parents are able to select hearing specialists other than, and in addition to, services provided by the local education agencies.

V. Reimbursement for Audiology Services

1. Early Steps should not pay for diagnostic evaluations of children referred following universal newborn hearing screening (UNHS). The UNHS law (F.S. 383.145) requires that “any necessary follow up reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid...all health insurance policies and health maintenance organizations.” If a child has no payer then Early Steps shall reimburse for this evaluation as an aspect of Child Find outreach.
2. A child with an eligible delay in expressive language (phonologic disorder) or a child with hearing concerns confirmed by the Early Steps hearing screening protocol must receive an audiological evaluation. Early Steps is the payer of last resort for these audiological evaluations and reimbursement is provided at the Medicaid rate.
3. To rule out abnormal hearing, the audiologist can perform (a) Otoacoustic Emissions, Tympanometry and acoustic reflexes, OR (b) Visual Reinforcement Audiometry, Speech Awareness Threshold, Tympanometry, and acoustic reflexes OR (c) Pure Tone Air and Bone, Speech Awareness/Reception Threshold, Tympanometry, and acoustic reflexes OR (d) Conditioned Play Audiometry, Speech Reception Threshold, Tympanometry and acoustic reflexes if the child is nearing 3 years of age. The tests included in a-d will be reimbursed at the individual test fee. If additional tests are performed, then a bundled audiological evaluation rate will be reimbursed at the Medicaid rate. If a permanent hearing loss is indicated by these test procedures then a diagnostic auditory evoked response evaluation may be necessary to confirm the presence of a hearing loss.
4. All children with confirmed permanent hearing loss (not hearing loss due only to ear infection) should receive an audiological evaluation every 3 months until age 2 years, and every 6 months from age 2 to 3 years to monitor for hearing loss progression. Audiologists will need to receive prior authorization for audiological reevaluations if the child is Medicaid eligible. The IFSP will authorize these audiological reevaluations specifying Early Steps as the payer of last resort for children that have hearing loss that meets Part C eligibility criteria (Appendix H). For example, the Medicaid rate for each test included in a-d will be reimbursed or the bundled audiological evaluation rate will be reimbursed, whichever is less. The IFSP should recommend two audiological reevaluations in a 6-month period for children birth through 24 months old and one audiological reevaluation in a 6-month period for children between 25 to 36 months of age.
5. The IFSP should recommend reimbursement to the audiologist for amplification, earmolds, and hearing aid fitting fees as described in Section III. The IFSP will authorize for no more than a maximum of 2 sets of earmolds in a 6-month period and a total of 3 sets of earmolds in one year (to be reimbursed at the Medicaid rate of \$18 per earmold). The hearing aid fitting fees will be authorized once for

- the child's personal hearing aid(s). Hearing aid fitting fees are not paid in the fitting of loaner hearing instruments.
6. Hearing aid follow up appointments will be authorized on the IFSP for all children wearing hearing aids. Individual child and family needs should be taken into account by the IFSP team. Guidelines provided in this document suggest that the IFSP will consider recommending one hearing aid follow up appointment per month until the child is 12 months old, and one hearing aid follow up appointment every 2 months for children between the ages of 13 and 36 months. For example, (a) a 4-month old child would have 6 hearing aid follow up appointments recommended for a 6 month IFSP period. A child that is 10 months old would have 3 appointments recommended for months 10, 11, and 12, and 2 more appointments recommended for months 13 and 14, and 15 and 16, for a total of 5 hearing aid follow up appointments to be specified on the IFSP.
 7. A hearing aid listening kit can be obtained by the child's audiologist for use by the family of a child who is under 3 years of age and who uses amplification. The kit can be requested by the audiologist by checking the appropriate place on the Diagnostic Hearing Evaluation Form. Kits will be available at no charge until the stock is depleted. Local Early Steps should not provide reimbursement to audiologists for hearing aid listening kits as long as the supply is available from CMS Bureau or Early Interventions.
 8. The IFSP should recommend payment for hearing aid batteries only under exceptional situations of family need. The cost of batteries is less than \$15-\$20 month.
 9. The IFSP should recommend the purchase of hearing aid insurance in the time period when the hearing aid(s) become one year old and the manufacturer's warranty expires. It is preferred that the audiologist be reimbursed for obtaining hearing aid insurance, as described in Section III. If the audiologist is unable to purchase the insurance through their hospital or clinic facility, another local means of reimbursement should be determined (i.e., community partner receives reimbursement for the insurance payment while the audiologist still manages the policy).

Data Reporting

1. All children that meet the eligibility for hearing impairment criteria will be indicated as such in the Early Steps database by selecting Hearing Impairment for one of the six available eligibility codes (ECDH).