LittleListeners
Helping young minds learn to listen

Frequently Asked Questions (FAQ)

Q: Why are good hearing skills important for a child?

Children depend on their hearing to develop speech and language skills and apply auditory meaning to letters for reading. When a hearing loss occurs, no matter the degree, there can be a significant impact on the child's education, development and self-esteem.

Q: What is the difference between hearing and listening?

Hearing is the physical ability to detect sound while listening is what the brain does with the information that is heard.

It is important to keep in mind that even a child with normal hearing will pass a basic hearing screening/evaluation, but could still have abnormal listening skills. In contrast, all children with abnormal hearing will have some sort of listening weakness as their auditory models are distorted.

Q: When should a child be tested for hearing problems or loss?

Hearing screenings should begin at birth and continue annually throughout childhood.

Universal hearing screenings have been mandated nationally since the early 2000's. However, follow-up programs after the initial screening and through at least 4 years of age are not consistent or monitored. Once a child turns 4 years of age, screenings finally become part of their routine physical exam at the pediatrician's office. It is often not initiated prior to the age of 4 due to the lack of access to appropriate equipment for children that are too young to follow directions for traditional screening ("When you hear a beep, raise your hand.") or they are intolerant to head phone placement. More sophisticated and appropriate equipment exists for younger children, but it is expensive so pediatricians often do not utilize it.

It is important to remember that normal hearing at birth does not guarantee that hearing loss won't develop in the future. The incidence of "progressive hearing loss" is widely unknown because there haven't been reliable follow-up programs for tracking normal hearing infants from birth. However, it is agreed there is a true risk for any infant and that risk increases with various risk factors or chronic middle ear infections.

Children with hearing loss should be assessed multiple times a year to monitor progress with amplification and speech/language development. This should also include routine medical examinations by an ENT (Ear, Nose and Throat) physician.

Q: What is the difference between screening and testing?

Screening is intended to identify as many hearing/listening difficulties as possible while minimizing false readings. Testing is utilized when a screening indicates the need for further assessment or the medical/case history reports indicate a hearing loss is likely to be present. Testing ultimately provides the definitive results the enable the audiologist to provide an accurate diagnosis and subsequent therapy plan.

The newborn hearing screening program is nationally mandated with very high standards. At Little Listeners, we go above and beyond the stringent national standards and screen on an even more rigid protocol to ensure we minimize the false negative results–even more than what is nationally accepted.

This protocol includes a program to monitor persistent ear infections throughout childhood that don't necessarily cause permanent hearing loss, but may set a child up for temporary periods of "auditory deprivation." These periods can interrupt overall auditory development and cause delays in various areas of education, speech/language, reading and communication.

Q: What is Auditory Processing Disorder (APD)?

Auditory Processing Disorder is when an interruption in the normal development of auditory skills occurs.

Auditory processing develops rapidly from birth to approximately 18 years of age and involves a complex series of neurological occurrences. Many times, the cause of APD is unknown, but some risk factors include chronic ear infections, family history of APD or other developmental delays (ex: motor, speech, sensory, cognitively)and hearing loss to name a few.

Q: What are the primary indicators that a child may be experiencing APD?

Sensitive to loud sounds
Short attention span
Impulsive
Easily distracted
Daydreams
Forgetful
Seeks attention
Uncooperative
Easily frustrated
Awkward or clumsy
Restless
Unmotivated
Inattentive

Appears to be confused in noisy places
Difficulty following directions
Reverses words, numbers, letters
Lacks self confidence
Inappropriate social behavior
Does not complete assignments
Disruptive or rowdy
Asks for repetition (says "huh" a lot)
Tires easily
Fakes illnesses or dislikes school
Acts hearing impaired
Shy or anxious
Academic performance below potential

Q: How can you determine if a child does have APD?

There are many psychological and speech/language tests that can show that APD may be a concern and the presence of specific characteristics are a fairly reliable indicator.

However, only a licensed audiologist–utilizing calibrated audiometric equipment and specific auditory processing tests in a sound protected environment–can fully diagnose or rule out APD.

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Q. What is the best course of action for someone diagnosed with APD?

APD can be diagnosed at any age. Regardless of the age group, it is imperative to obtain therapy to overcome and cope with APD. A successful therapy program can be facilitated by a trained speech therapist or an audiologist who specializes in APD treatment.

Success of therapy depends on the severity of the diagnosis and the age of the patient. Therapy is very successful in children through the mid-teen years, before the brain becomes rigid and less accepting of new processes. Therapy can also be successful for adults and brain injury patients. However, the focus shifts more to accommodations and strategies than activities that will actually change the neurological processes.

Q: Typically, how long is the therapy for someone diagnosed with APD?

The duration of therapy depends on the severity and age of the patient. A typical therapy regimen can be as little as a few months to several years depending on the specific needs of the patient

A customized plan is developed after the initial assessment. To create an effective therapy plan, the patient themselves should be involved in establishing obtainable goals. .

Q: What kind of results can one expect from therapy?

In some cases, full resolution can be achieved. However, expectations vary widely depending on the severity of the APD, age of the patient, other associated problems and lifestyle and motivation for improvement.

Q: What are some common misdiagnoses?

Auditory Processing Disorder (APD) can be easily misdiagnosed as:

- Attention Deficit (Hyperactivity) Disorder
- Behavioral Disorder or Learning Disabled
- Language Disorder
- Dyslexic
- Depression

Q: Does health insurance typically cover treatment/therapy for APD?

Many insurance companies recognize APD as a medically treatable disorder and will cover testing and therapy. Full coverage depends on your plan and status of your deductible.

Please use the following codes to obtain a quote from your insurance carrier regarding your coverage. The ICD-10 code (diagnosis code) most commonly used is H93.25 (Impairment of Auditory Discrimination) and the CPT Codes (procedure codes) for assessment are 92557, 92620, 92621 (x 8), 92588 and 92570. The CPT code for treatment is 92507.