Clinical Policy: Bone-Anchored Hearing Aid

Reference Number: TX.CP.MP.522
Last Review Date: 07/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Sensorineural hearing loss or nerve deafness is a type of hearing loss that results when delicate portions of the inner ear known as hair cells have been damaged and fail to perform their normal function of converting sound waves into electrical current which then stimulates the auditory nerve to transmit impulses to the brain, where they are recognized as sound.

Bone-Anchored Hearing Aids (BAHA) are an alternative to conventional hearing aids when physical conditions or medical complications preclude hearing aids or cochlear implants from achieving functional improvement in hearing. Sound quality of BAHAs is superior to, and pain or discomfort is largely diminished compared to traditional air conduction hearing aids.

This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP.

Policy/Criteria
It is the policy of Superior HealthPlan that BAHAs are medically necessary for the following indications:

BAHAs

I. BAHAs are **medically necessary** for members with the following indications:
   A. *Implantable device* for age ≥ 5 years; or *head band device* for age < 5 years or for members medically unable to have an implant;
   B. Unilateral or bilateral conductive hearing loss; or unilateral or bilateral mixed conductive and sensorineural hearing loss; or unilateral sensorineural hearing loss;
   C. Member has pure tone average bone conduction threshold (measured at 0.5, 1, 2, and 3kHz) ≤ 70 dB HL and an unaided speech discrimination score ≥ 60%;
   D. One of the following indications:
      1. Congenital or surgically induced malformations of the ear canal such that it does not exist or cannot accommodate a standard air-conduction hearing aid, or
      2. Chronic infection of the middle or outer ear that is exacerbated by a standard air-conduction hearing aid, or
      3. Allergic reactions to standard air-conduction hearing aids, or
      4. Single-sided deafness occurred after removal of an acoustic neuroma, from trauma, or from a viral or vascular insult. *or*
      5. Tumors of the external canal and/or tympanic cavity, *or*
      6. Air-conduction hearing aid ineffective due to large conductive hearing loss (inadequate gain, uncomfortable occlusion, and feedback effects).

II. BAHAs for any other indication are considered **not medically necessary** because effectiveness has not been established.
III. Bilateral BAHA is not a benefit of Texas Medicaid.

IV. Batteries Replacement
Replacement batteries for the BAHA (procedure code V5266) do not require prior authorization.

V. **Repair of a sound processor replacement** will be considered for prior authorization with documentation of medical necessity for the requested repair. Documentation should include the following:
   A. Processor used for a minimum of 12 months before replacement of the unit will be considered
   B. Evidence of the purchase, such as the invoice or receipt.

   Note: Procedure code L8499 with modifier RB may be reimbursed for sound processor repair. Repair or replacement of a sound processor is not a benefit during the manufacturer's warranty period.

Background

- *Definitions:***Bone-Anchored Hearing Aide (BAHA)** - BAHA is an implantable hearing device used to treat hearing loss by directly stimulating the inner ear through the bone. It is used to improve hearing in patients with chronic ear infections, congenital external auditory canal atresia or one-sided deafness who cannot benefit from regular hearing aids.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
L8613	Ossicular Implant
L8690	Auditory osseointegrated device, includes all internal and external components
L8691	Auditory osseointegrated device, external sound processor, replacement

HCPCS Codes	Description
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment
L8693	Auditory osseointegrated device abutment, any length, replacement only
L8499	Unlisted procedure for miscellaneous prosthetic services

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
H60.00-H62.8X9	Diseases of external ear
H61.001- H61.039	Chondritis and perichondritis of external ear
H61.111-H61.119	Acquired deformity of pinna
H65.20- H65.23	Chronic serous otitis media
H65.30- H65.33	Chronic mucoid otitis media
H65.411- H65.499	Other chronic non-suppurative otitis media
H71.00- H71.93	Cholesteatoma of middle ear
H800.00- H80.93	Otosclerosis
H90.11-H90.8	Conductive and sensorineural hearing loss
H91.01- H91.93	Other and unspecified hearing loss
Q16.0- Q16.9	Congenital malformation of ear causing impairment of hearing
H90.3	Sensorineural hearing loss, bilateral
H90.41	Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.42	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.5	Unspecified sensorineural hearing loss
Q85.00	Neurofibromatosis, unspecified
Q85.02	Neurofibromatosis, type 2

Reviews, Revisions, and Approvals	Date	Approval Date
Updated Title to include Bone-Anchored Hearing Devices. Added medical necessity criteria for BAHA and replacement or repair for microprocessor request. Updated work process, references and signatories. Removed attachments. Deleted "Severe to profound hearing loss in children most often is caused by genetic, prenatal, perinatal or postnatal causes" under Scientific Background. Updated stats under Scientific Background.	8/14	8/14
Removed work process and imbedded in attachment section. Added policy to reference list.	02/15	02/15

Reviews, Revisions, and Approvals	Date	Approval Date
Updated BAHA Criteria to reflect Corporate's policy. Updated "Reference" list. Removed work process and sited in separate document. Added BAHA "Description" and "Background" information.	08/15	08/15
Removed work processes and background information. Grammatical edits. Removal of the verbiage regarding battery replacement that does not follow State requirements. Removed "Criteria for Coverage" table. Removed CHIP Perinate from products. Added STAR+PLUS Non-Duals to products. Inserted bilateral BAHA procedures are not benefits of the Plan. Removed prior authorization for L7368. Updated references and signatories.	08/16	08/16
Updated Procedure InterQual subset reference to 2017. Removed STAR+PLUS duplicate listing in "Products", STAR+PLUS Non-Dual added in 2016. Updated "References".	07/17	07/17
Annual Review. Updated references and signatories. Deleted revision history prior to 2014. Removed requirements for "bilateral" cochlear implants.	07/18	07/18
Updated to new template from TX.UM.10.22 (TX.CP.MP.522 nomenclature implementation 09/14/19). Updated references. Added CPT, HCPCS, and ICD 10 code charts.	07/19	07/19
Updated references. Annual Review.	07/20	07/20
Removed *Cochlear Implant* sections I, II, III, and IV. Removed definition of Cochlear Implant. Removed Cochlear Implant and device HCPCS ranges L8615-L8619, L8623-L8624, L8627-L8629 Added to BAHA Section "*One of the following indications*" numbers 5 and 6. Added ICD-10 H61.111-H61.119, removed ICD-10 Z96.21. Gramatical edits. Updated references. Annual Review.	7/21	7/21
Annual Review. Updated references. Updated coding and removed CPT code list. Removed Section III labeled *CPT Codes* as not applicable. Section II removed *Bilateral BAHA procedures are not benefits of the Plan* and added section III for *Bilateral BAHA is not a benefit of Texas Medicaid.*	7/22	7/22

References

1. CP.MP.93 Bone-Anchored Hearing Aid
2. Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook , Section 3, Implantable Hearing Devices and Related Services, June 2022 ;
3. Blanchfield BB, et. al. (2001). The severely to profoundly hearing-impaired population in the United States: Prevalence estimates and demographics. Journal of the American Academy of Audiology, 12, 183-189.
4. Christensen L, et al. Comparison of traditional bone-conduction hearing aids with the BAHA system. J Am Acad Audiol. 2010 April;21(4):267-73.

5. Cass SP. Surgical Placement of Bone-anchored hearing systems. Medscape. Oct 29, 2019. http://emedicine.medscape.com/article/1989565-overview
6. Joint Audiology Committee Clinical Practice Statements and Algorithms. Audiology clinical practice algorithms and statements. August 2000. Accessed 1/11/10 at: http://www.asha.org/docs/html/GL1999-00013.html
7. Sanford B, Weber PC. Treatment of hearing impairment in children. In: Up-to-date, Isaacson GC (Ed), Up-to-date, Waltham, MA, 2010.
8. Weber PC. Hearing amplification in adults. In: Up-to-date, Deschler DG (Ed), Up-to-date, Waltham, MA, 2010.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.