Clinical Policy: Cochlear Implants and Bone-Anchored Hearing Aid

Reference Number: TX.CP.MP.522 Coding Implications
Last Review Date: 07/20 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. A cochlear implant, an electronic device surgically placed under the skin, bypasses the hair cells and directly transmits sounds through multiple electrodes, which stimulate the auditory nerve. Once the auditory nerve is activated, signals are sent to the brain. The brain learns to recognize these signals and the person experiences this as "hearing."

The cochlear implant has 4 basic components: a microphone worn externally behind the ear which picks up sounds; an external speech processor, which converts sounds to electrical signals; a transmitter and receiver/stimulator which forward the signals; and implanted electrodes, which stimulate the fibers of the auditory nerve.

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 cochlear implants and BAHAs are medically necessary for the following indications:

Cochlear Implants

I. Cochlear implantation for members ≥12 months of age are considered **medically necessary** when criteria are met using specific Procedure InterQual subset.

II. **Replacement** of a cochlear implant and/or its external components (external speech processor, controller, etc.) are considered **medically necessary** when any one of the following is present:
   A. The existing device is no longer functional and cannot be repaired; or
   B. A change in the member's condition makes the existing unit inadequate for the hearing-related activities of daily living and improvement is expected with a replacement unit.

III. **Replacement** or upgrade of an existing, properly functioning cochlear implant and/or its external components (external speech processor, controller, etc.) is considered **not medically necessary** when requested for convenience or to upgrade to a newer technology.

IV. **Replacement batteries** and related items for the cochlear implant device include non-rechargeable batteries, rechargeable batteries, and recharger units as follows:

Procedure Code	Prior Authorization	Limitation
L8621 (Zink air non-rechargeable)	Not required	Maximum of 50 per month
L8622 (Alkaline non-rechargeable)	Not required	Maximum of 31 per month
L8623 (Lithium ion rechargeable)	Not required	2 batteries per calendar year
L8624 (Lithium ion rechargeable)	Not required	2 batteries per calendar year
L7368 (Battery recharger unit for lithium ion rechargeable batteries)	Not required	1 replacement unit every 5 rolling years

Replacement batteries for members with bilateral cochlear implants and two sound processors may be reimbursed when billed with the applicable battery procedure code and the appropriate LT or RT modifier.

Additional batteries and lithium ion battery recharger units beyond these limitations may be reimbursed with prior authorization.

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.

III. BAHAs for any other indication are considered **not medically necessary** because effectiveness has not been established. Bilateral BAHA procedures are not benefits of the Plan.

IV. Batteries Replacement

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

V. CPT codes

Procedure codes L8691, L8692, and L8693 will be denied as part of another service when billed by any provider with the same date of service as procedure code L8690. Procedure code L8692 for the BAHA device and components may be reimbursed once per day with prior authorization.

VI. ***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.

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:

- **Cochlear Implant** - A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multichannel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

- **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.

CPT® Codes	Description
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69949	Unlisted procedure, inner ear

HCPCS Codes	Description
L8613	Ossicular Implant
L8690	Auditory osseointegrated device, includes all internal and external components
L8691	Auditory osseointegrated device, external sound processor, replacement
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
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L6819	Cochlear implant, external speech processor and controller, integrated system, replacement
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each
L8624	Lithium ion battery for use with cochlear implant device speech-processor, ear level replacement, each
L8627	Cochlear implant, external speech processor, component, replacement
L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement

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
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
Z96.21	Cochlear implant status

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
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

Reviews, Revisions, and Approvals	Date	Approval Date
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

References

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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.