Clinical Policy: Bone-Anchored Hearing Aid

Reference Number: CP.MP.93
Effective Date: 12/13
Last Review Date: 12/17

Coding Implications
Revision Log

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

Description

Bone-anchored hearing aids (BAHAs) are an alternative to conventional hearing aids when physical or medical complications prevent adequate functional improvement in hearing. Sound quality of BAHAs is superior to, and pain/discomfort is largely diminished, when compared to traditional air-conduction hearing aids.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that BAHAs are **medically necessary** for members with all of 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. Pure tone average bone conduction threshold (measured at 0.5, 1, 2, and 3kHz) ≤ 70 dBHL (decibels hearing level) and an unaided speech discrimination score not worse than 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,
    2. Chronic infection or dermatitis of the middle or outer ear that is exacerbated by a standard air-conduction hearing aid,
    3. Allergic reactions to standard air-conduction hearing aids,
    4. Single-sided deafness occurred after removal of an acoustic neuroma, from trauma, or from a viral or vascular insult,
    5. Tumors of the external canal and/or tympanic cavity.

II. BAHAs for any other indication are considered **not medically necessary** because effectiveness has not been established.

Background

Hearing loss affects up to 20 percent of the population in the United States (Lin, Niparko, and Ferrucci, 2011). According to Blanchfield, et al., as many as 738,000 people in the U.S. experience severe to profound hearing loss, with 8% of these under age 18 (2001). Although the reliability and effectiveness of hearing aids have improved over time, there are still limitations to conventional air-conduction hearing aids.

Physical and medical complications such as chronic ear infections and canal deformities can make it difficult to impossible for some to wear hearing aids. Poorly fitting ear molds can lead to bothersome feedback and inadequate functional gain. Implantable hearing devices can

improve reliability and functional gain over the standard air-conduction hearing aids when some of these issues exist.

Bone-anchored hearing aids are indicated for people with conductive hearing loss, mixed hearing loss, or unilateral profound sensorineural hearing loss to achieve improved auditory acuity by transmitting the sound directly through the bone into the inner ear. There are three devices currently available for use and the appropriate device is selected based upon the patient's hearing level.

A BAHA consists of a titanium implant surgically inserted into the skull attached to an abutment of which a small portion protrudes through the skin and forms a snap attachment point for a removable bone conduction hearing aid or processor. Children are typically about six years of age before an implantable BAHA is feasible because 3 to 4 mm of bone is needed to ensure osseointegration. The processor is adjusted to the patient's level of hearing, much like in a traditional hearing aid fitting. When complications occur, the majority of them are related to skin issues around the implant. Proper skin care and hygiene at the surgical and abutment sites are essential to maintain good skin integrity.

Coding Implications

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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

HCPCS Codes	Description
L8613	Ossicular Implant
L8690	Auditory osseointegrated device, includes all internal and external components
L8691	Auditory osseointegrated device, external sound processor, replacement
L8693	Auditory osseointegrated device abutment, any length, replacement only

ICD-10-CM Diagnosis Codes

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

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, specialist reviewed	11/13	12/13
Added the indication for soft headbands for children <6 yrs and those unable to have an implant	11/14	12/14
Reworded policy/criteria for clarity Updated template	12/15	1215
Updated template, added dermatitis to criteria I.D.2, added criteria I.D.5: "tumors of the external canal and/or tympanic cavity". Updated hearing loss statistics in background.	11/16	12/16
References reviewed and updated.	11/17	12/17

References

1. Blanchfield, B. B., 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.
2. 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.
3. Monfared A. Bone-anchored hearing aids. Medscape. Feb 02, 2016. http://emedicine.medscape.com/article/1989565-overview
4. Hagr A. BAHA: Bone-anchored hearing aid. Int J Health Sci (Qassim), 2007 July; 1(2): 265-276.
5. Hol MK, et al. The BAHA Softband. A new treatment for young children with bilateral congenital aural atresia. Int J Pediatr Otorhinolaryngol, 2005 Jul;69(7):973-80.

6. Lin FR, Niparko JK, Ferrucci L. Hearing loss prevalence in the United States. Arch Intern Med. 2011 Nov 14; 171(20): 1851–1852. doi: 10.1001/archinternmed.2011.506
7. Shohet JA. Implantable hearing devices. Medscape, July 14, 2017. http://emedicine.medscape.com/article/860444-overview#showall
8. Smith RJH, Gooi A. Hearing impairment in children: Treatment. In: UpToDate, Isaacson GC (Ed), UpToDate, Waltham, MA, 2015. Accessed 11/30/17.
9. Weber PC. Hearing amplification in adults. In: UpToDate, Deschler DG (Ed), UpToDate, Waltham, MA, 2015. Accessed 11/30/17.

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.

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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.