P.O. Box 25538
Little Rock, AR 72221

Clinical Policy: Bone-Anchored Hearing Aids (Arkansas

Reference Number: AR.CP.MP.93 Coding Implications
Date of Last Revision: 07/23 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 traditional air-conduction hearing aids, and pain/discomfort is largely diminished with BAHAs.[1]

Policy/Criteria

I. It is the policy of Ambetter from Arkansas Health and Wellness and Arkansas Total Care that bone-anchored hearing aids (BAHAs) are **medically necessary** for members/enrollees with all of the following indications:

A. *Implantable device* for age ≥ five years; or *head band device* for age < five years or medically unable to have an implant;
B. Unilateral or bilateral conductive and/or mixed hearing loss (i.e., conductive and sensorineural hearing loss) or unilateral sensorineural hearing loss (i.e., sensorineural deafness in one ear and normal hearing in the other ear);
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. For bilateral BAHA, there is a mean maximum difference <10 dB (decibels) between the right bone conduction threshold and left bone conduction threshold;
E. For unilateral deafness, the hearing ear should have a bone conduction threshold of ≤ 20dB;
F. 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. Unilateral deafness occurred after removal of an acoustic neuroma from trauma, from a viral or vascular insult, or from idiopathic causes;
   5. Tumors of the external canal and/or tympanic cavity;
   6. Air-conduction hearing aid ineffective due to large conductive hearing loss (inadequate gain, uncomfortable occlusion, and feedback effects).

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II. It is the policy of Ambetter from Arkansas Health and Wellness and Arkansas Total Care that ***replacement*** of bone-anchored hearing aids (BAHAs) and/or external components (external sound processor) is considered **medically necessary** when any one of the following is present:

A. The existing device(s) is no longer functional and cannot be repaired;
B. A change in condition makes the existing unit(s) inadequate for the hearing-related activities of daily living, and improvement is expected with replacement unit(s);
C. The current sound processor is at least five years old for members without a craniofacial anomaly diagnosis and every two years for member with a craniofacial anomaly diagnosis.

III. It is the policy of Ambetter from Arkansas Health and Wellness and Arkansas Total Care that ***replacement or upgrade*** of an existing, properly functioning bone-anchored hearing aid (BAHA) and/or its external components (external sound processor) is considered **not medically necessary** when requested only for convenience or to simply upgrade to a newer technology before the timeframe noted in section III.

Background

There are an estimated 48 million adults and 1.7 million school-aged children in the United States with some type of hearing loss. Hearing loss can be classified as sensorineural (inner ear), conductive (external and middle ear), or mixed, and may be present in one or both ears.[9]

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.

Compared to bone conduction hearing aids held against the skull with a headband, implantable bone conduction hearing aids have advantages such as better tolerability and improved sound quality.[7] The bone-anchored hearing aid (BAHA) is the most widely used implantable bone-anchored prosthetic hearing aid device.[7] BAHAs are indicated for people with conductive hearing loss, mixed hearing loss, or single sided profound sensorineural hearing loss to achieve improved auditory acuity by transmitting the sound directly through the bone into the inner ear. 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.[7] The BAHA is implanted unilaterally or bilaterally, and children are usually around six years old before an implantable BAHA is feasible due to the need for three to four mm of bone to ensure osseointegration.[6] The processor is adjusted to the patient's level of hearing, much like in a traditional hearing aid fitting. When

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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

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 2022, 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, skull; with percutaneous attachment to external speech processor
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex
69717	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor
69719	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex
69726	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor
69727	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex
69728	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex

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CPT®* Codes	Description
69729	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex
69730	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex

HCPCS Code	Description
L8690	Auditory osseointegrated device, includes all internal and external components
L8691	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each
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
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed for compliance with AR §23-79-15(2021)	7/28/2021	08/21
Annual review. Reworded I.B. with no clinical significance. Revised I.E from "threshold of 20dB" to "threshold of ≤ 20dB." In I.F.4., added idiopathic causes to the list of causes of unilateral deafness. Revised description of HCPCS L8691 and added L8694. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Replaced "member" with "member/enrollee/enrollee." References reviewed, updated and reformatted. Reviewed by specialist.	09/21	10/21

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Annual Review with no changes	8/2022	8/2022
Annual review. Removed Criteria II. stating "BAHAs for any other indication are considered not medically necessary." Updated background with no clinical significance. Added new CPT codes 69728, 69729, and 69730 and removed ICD-10 codes from policy. References reviewed and updated. Reviewed by external specialist.	7/23	7/23

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 member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees 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 member/enrollees, 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 member/enrollees, 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.

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