# Clinical Policy: Pediatric Hearing Amplification

Reference Number: CP.MP.192 Coding Implications
Last Review Date: 09/20 Revision Log

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

**Description**
This policy outlines the medical necessity criteria for monaural and binaural hearing aids for pediatric (birth to 12 years of age) hearing amplification.

**Policy/Criteria**

**I.** It is the policy of health plans affiliated with Centene Corporation® that monaural hearing aids for pediatric hearing amplification are **medically necessary** when all of the following are met:
- **A.** Hearing loss meets one of the following:
  1. Hearing loss in the better ear of 30 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz;
  2. A spondee threshold in the better ear of 30 dBHL or greater when pure tone thresholds cannot be established;
  3. Hearing loss in each ear is less than 30 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher;
- **B.** Documentation of communication need and a statement that the member/enrollee is alert and oriented and able to utilize the aid appropriately;
- **C.** The hearing evaluation was conducted by a licensed audiologist certified to perform behavioral pediatric testing.

**II.** It is the policy of health plans affiliated with Centene Corporation that *binaural hearing aids for pediatric hearing amplification* are **medically necessary** for the following indications:
- **A.** Hearing loss meets one of the following:
  1. Hearing loss in the better ear of 30 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz;
  2. A spondee threshold in the better ear of 30 dBHL or greater when pure tone thresholds cannot be established;
  3. Hearing loss in each ear is less than 30 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher;
- **B.** Documentation of communication need and a statement that the member/enrollee is alert and oriented and able to utilize the aid appropriately;
- **C.** The hearing evaluation was conducted by a licensed audiologist certified to perform behavioral pediatric testing;
- **D.** One or more of the following:
  1. Significant social, vocational, or educational demands;
  2. Previous user of binaural hearing aid;
  3. Significant visual impairment.

## Background

Amplification with hearing instruments should be considered for a child who demonstrates a significant hearing loss, including sensorineural, conductive, or mixed hearing losses of any degree. The duration and configuration (bilateral or unilateral) will assist the audiologist in the decision to fit a child with personal hearing aids. Additional factors such as the child's health, cognitive status, and functional needs also will influence the time-line of fitting hearing aids. For newborns and infants under the developmental age of 6 months, estimates of hearing sensitivity must be supported by electrophysiological measures including auditory brainstem response (ABR) threshold assessment. (Joint Committee on Infant Hearing, 2007). Frequency-specific air-conduction and bone-conduction ABR thresholds should be obtained. Frequency-specific ABR is necessary for accurate estimation of the degree and configuration of hearing loss. A click-ABR threshold alone is not sufficient for accurate hearing aid fitting. Acoustic emittance measures, including tympanometry and middle ear muscle reflexes, and otoacoustic emissions (OAE) are necessary to determine the type of hearing loss present.[1,2]

Differential diagnosis continues to be refined and these measures should be applied to the assessment of hearing in children as they become available and interpretable. Currently researchers are suggesting that the summating potential may have value in diagnosis and that a lack of response in this measure may relate to inner hair cell function. These and other electrophysiologic measures may become a valued part of the assessment of hearing in the pediatric population. At a minimum, low and high frequency, ear specific information should be obtained in order to prescribe appropriate amplification. These data are developed over the course of evaluating the infant or child and the hearing aid fitting may begin before all data are obtained. For older infants and young children, behavioral thresholds should be obtained using visual reinforcement audiometry (VRA), or conditioned play audiometry (CPA) test techniques appropriate for the child's developmental level. Ear-specific and frequency-specific air and bone conduction thresholds are essential for providing information needed for accurate hearing aid fitting.[1]

## 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 2019, 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 |
|---|---|
| V5030 | Hearing Aid, monaural, body worn, air conduction |
| V5040 | Hearing Aid, monaural, body work, bone conduction |
| V5050 | Hearing Aid, monaural, in the ear |
| V5060 | Hearing Aid, monaural, behind the ear |

| HCPCS ®* Codes | Description |
|---|---|
| V5120 | Binaural, body |
| V5130 | Binaural, in the ear |
| V5140 | Binaural, behind the ear |
| V5150 | Binaural, glasses |
| V5170 | Hearing Aid, CROS, in the ear |
| V5180 | Hearing Aid, CROS, behind the ear |
| V5190 | Hearing Aid, CROS, glasses |
| V5210 | Hearing Aid, BICROS, in the ear |
| V5220 | Hearing Aid, BICROS, behind the ear |
| V5230 | Hearing Aid, BICROS, glasses |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**
+ Indicates a code(s) requiring an additional character

| ICD-10-CM Code | Description (Inpatient Only) |
|---|---|
| H90.0 | Conductive hearing loss, bilateral |
| H90.11 - H90.12 | Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side |
| H90.2 | Conductive hearing loss, unspecified |
| H90.3 | Sensorineural hearing loss, bilateral |
| H90.41 H90.42 | Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side |
| H90.5 | Unspecified sensorineural hearing loss |
| H90.6 | Mixed conductive and sensorineural hearing loss, bilateral |
| H90.71 H90.72 | Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side |
| H90.8 | Mixed conductive and sensorineural hearing loss, unspecified |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Original approval date | 9/1/2011 | 9/1/2011 |
| New template design approved by MPC. | 12/1/2011 | 12/1/2011 |
| Approved by MPC. No changes. | 9/6/2012 | 9/6/2012 |
| Approved by MPC. No changes. | 9/5/2013 | 9/5/2013 |
| Approved by MPC. No changes. | 9/4/2014 | 9/4/2014 |
| Approved by MPC. No changes. | 8/6/2015 | 8/6/2015 |
| Approved by MPC. No changes. | 1/12/2017 | 1/12/2017 |
| Approved by MPC. Coding changes only. | 12/7/2017 | 12/7/2017 |
| Approved by MPC. No changes. | 11/1/2018 | 11/1/2018 |
| Approved by MPC. No changes. | 11/7/2019 | 11/7/2019 |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Transferred to CNC template from HS-07. Removed codes for hearing evaluation. References reviewed and updated. Replaced "member" with "member/enrollee" in I.B and II. B. Replaced "members/enrollees" with "members/enrollees/enrollees" in all instances. | 9/20 | 9/20 |

**References**

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2. Joint Committee on Infant Hearing. Position statement: principles and guidelines for early hearing detection and intervention programs. *Pediatrics*. 2007;120(4):898-921.
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6. Handbook for providers of audiology services: chapter E-200 policy and procedures for audiology services. https://www.illinois.gov/hfs/SiteCollectionDocuments/e200.pdf. Published February January 11, 2019. Accessed August 28, 2020.
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8. New Jersey administrative code: title 10 human services, chapter 64 hearing aid services. State of New Jersey Division of Medical Assistance and Health Services Web site. http://www.state.nj.us/humanservices/dmahs/info/resources/manuals/. Published June 2, 2014. Accessed August 28, 2020.
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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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members/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 members/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.