Clinical Policy: Implantable Bone Conduction Hearing Aids (BAHA)

Reference Number: WNC.CP.111
Last Review Date: 08/23

Coding Implications
Revision Log

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

Note: 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.

Description[1]

A bone-anchored hearing aid (BAHA) is a surgically implanted osseointegrated prosthetic device that provides bone conduction hearing for recipients with moderate to severe, bilateral conductive or mixed hearing loss who cannot wear a conventional air-conduction hearing aid or cannot reasonably or satisfactorily undergo ossicular replacement surgery. A BAHA device includes the implantation of a titanium abutment to which an external speech processor is attached.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Implantable Bone Conduction Hearing Aids (BAHA) are **medically necessary** for the following indications:

A. The beneficiary shall meet at least **one** of the following conditions:
   1. One or more congenital or acquired abnormalities of the middle or external ear canal that precludes the wearing of a conventional air conduction hearing aid; **OR**
   2. One or more tumors of the external canal or tympanic cavity; OR
   3.Dermatitis of the external ear canal; **OR**
   4. Chronic external otitis or otitis media with persistent discharge **AND**

B. The beneficiary shall meet **all** of the following criteria.
   1. The beneficiary has a bone conduction pure-tone average of 40–50 decibels or fewer, with no single frequency more than 50 decibels (at 1000 and 2000 Hz).
   2. The beneficiary has speech discrimination of the indicated ear of 60% or more at elevated sound pressure levels (SPL) during speech discrimination testing using consonant–nucleus–consonant [CNC] words (conventional testing).
   3. The beneficiary (either alone or with the aid of a parent or caregiver) shall be able to perform proper hygiene of the abutment (skin interface) and maintain the hearing aid device.
   4. There shall be sufficient bone volume and bone quality to support the implantation.
   5. There shall be no active scalp disease or disorder at the proposed site for the surgery

C. Medically necessary **maintenance and upgrades** of existing internal components for next-generation devices are covered for beneficiaries ages 5 years and older when:

1. The beneficiary's response to existing components is inadequate to the point of interfering with the educational process, learning, and socialization; **or**
2. The components are no longer functional and cannot be repaired.

II. It is the policy of WellCare of North Carolina® that Implantable Bone Conduction Hearing Aids (BAHA) is **not medically necessary** for the following indications:

A. The beneficiary has a disease state that may jeopardize osseointegration
B. The beneficiary can gain sufficient benefit from conventional amplification **or**
C. The beneficiary's audiometric criteria are outside the range of specifications stated in the medical necessity criteria above.

Background[1]

WellCare of North Carolina will cover Food and Drug Administration (FDA) approved implantable bone conduction hearing aids for Medicaid beneficiaries 5 through 20 years of age, who is moderate to severe, bilateral, conductive or mixed hearing loss cannot be effectively restored by conventional air conduction hearing aids or by ossicular replacement surgery. Careful consideration shall be given to the beneficiary's psychological, physical, emotional, and developmental capabilities.

Note: For children under 5 years of age, or for beneficiaries who prefer an alternative to surgery, refer to Clinical Coverage Policy *Hearing Aid Services* at **WNC.CP.106**.

I. It is the policy of WellCare of North Carolina® that hearing loss can be classified as **Conductive, Sensorineural,** or **Mixed**.

A. **Conductive hearing loss** involves the external or middle ear and is due to mechanical or physical blockage of sound as a result of
   1. Perforation of the tympanic membrane
   2. Congenital malformations
   3. Otitis media (for example, infection, effusion, or drainage)
   4. Otitis externa
   5. Hereditary malfunctions
   6. Certain bone disorders (for instance, osteogenesis imperfecta or otosclerosis)
   7. Obstruction of the ear canal (such as by cerumen, exostoses, tumor, or temporomandibular joint prolapse)
B. **In sensorineural** (that is, inner ear or nerve) hearing loss, the auditory cranial nerve or the inner ear is damaged due to:
   1. Congenital malformations (such as nerve atresia)
   2. Viral or bacterial infections (for example, meningitis or herpes zoster)
   3. Trauma
   4. Exposure to extreme noise or extensive exposure to loud noises
   5. Exposure to certain medications
   6. Hereditary malfunctions
C. **Mixed hearing loss** is a combination of conductive hearing loss and sensorineural hearing loss.

II. It is the policy of WellCare of North Carolina® that the provider shall obtain prior approval before rendering Implantable Bone Conduction Hearing Aids (BAHA).

III. It is the policy of WellCare of North Carolina® that implantable bone conduction hearing aid devices shall be FDA approved for the population being considered.

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 2023, 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
69714	Implantation, osseointegrated implant, skull, with percutaneous attachment to external speech processor
69717	Revision or Replacement (including removal of existing device), osseointegrated implant, skull, with percutaneous attachment to external speech processor
69799	Unlisted procedure, middle ear
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue

HCPCS ®* Codes	Description
No applicable codes.	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
H90.0	Conductive hearing loss, bilateral
H90.11	Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.12	Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.2	Conductive hearing loss, unspecified

ICD-10-CM Code	Description
H91.8X1	Other specified hearing loss, right ear
H91.8X2	Other specified hearing loss, left ear
H91.8X3	Other specified hearing loss, bilateral
H91.8X9	Other specified hearing loss, unspecified ear
H91.90	Unspecified hearing loss, unspecified ear
H91.91	Unspecified hearing loss, right ear
H91.92	Unspecified hearing loss, left ear
H91.93	Unspecified hearing loss, bilateral
H90.6	Mixed conductive and sensorineural hearing loss, bilateral
H90.8	Mixed conductive and sensorineural hearing loss, unspecified

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/21	05/21
Reviewed CPT and ICD-10-CM codes.	08/21	11/21
Updated description on 69714, 69717, deleted 69715, 69718. Reviewed CPT and ICD-10-CM codes.	08/22	08/22
NCHC verbiage removed from NC Guidance Verbiage.	03/23	03/23
Annual Review. Reviewed CPT & ICD-10-CM codes.	08/23	08/23

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1A-36 Implantable Bone Conduction Hearing Aids (BAHA). Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2023. Accessed June 1, 2023.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a

condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

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.

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.