POLICY AND PROCEDURE MANUAL

Policy Title: Replacement Cochlear Implant & Speech Processors	**Policy Number: A.04**
Primary Department: Medical Management **Affiliated Department(s): N/A**	**NCQA Standard: N/A** **URAC Standard: N/A**
Last Revision Date: 05/2018 **Revision Dates: 07/2014; 04/2015; 05/2016; 04/2017; 05/2018** **Effective Date: 10/24/2014**	**Next Review Date: 06/2019** **Review Dates: 10/24/2014; 06/26/2015; 06/24/2016; 06/28/2017; 06/27/2018**
Applicable Lines of Business: ☐MeridianCare ☒MeridianHealth ☐MeridianComplete ☒MeridianChoice	
Applicable States: ☐All ☒MI ☒IL ☐OH ☐_____ ☐_____	
Applicable Programs: ☒All ☐Other _____	
Policy is to be published: Internally Only ☐ Internally & Externally ☒	

NOTE: Cochlear implant initial requests will be reviewed with InterQual. See below for replacement processors, equipment or CI calibration

Definitions:

Cochlear implant	The cochlear implant is composed of three parts, which include external components and two internal surgically implanted components. Externally, a microphone, speech processor, and transmitter coil with cables are worn or carried by the individual to capture, analyze, and code sound. The speech processor converts sound into electrical stimuli. Internal components include an antenna and electrodes. The antenna electromagnetically captures the stimuli transmitted by the speech processor and directs this information to internal electrodes. The electrodes provide direct electrical stimulation to the auditory nerve, bypassing the transducer cells which are absent or nonfunctional. Because the cochlear implant does not magnify sound, none of its components are considered a hearing aid. The purpose of implanting the device is to provide awareness and identification of sounds and to facilitate communication for persons who are moderately to profoundly hearing impaired.
Degree of hearing loss	The degree of hearing loss is defined as : Mild: 26 to 40 decibels (dB) hearing loss, Moderate: 41 to 55 dB hearing loss, Moderately Severe: 56 to 70 dB hearing loss, Severe: 71 to 90 dB hearing loss, Profound: 91 dB or more hearing loss (ASHA, Type, Degree and Configuration of Hearing Loss).

Policy: Cochlear implants (unilateral or bilateral) are a covered benefit for specific indications listed below when preauthorized. A cochlear implant is a device for individuals with severe to profound hearing loss who only receive limited benefit from amplification with hearing aids. A cochlear implant provides direct electrical stimulation to the auditory nerve, bypassing the usual transducer cells that are absent or nonfunctional in deaf cochlea.
A cochlear implant in **one** ear is recommended as a possible option for everyone with severe to profound deafness if they do not get enough benefit from hearing aids after trying them for 3 months.

Cochlear implants in both ears are recommended for children or adults who are blind or have other disabilities which mean that they depend upon hearing sounds for spatial awareness AND who have severe to profound deafness only if they do not get enough benefit from hearing aids after trying them for 3 months and the implants are placed during the same operation.
In all cases, if more than one type of cochlear implant is suitable, the most cost effective option should be used.

The Centers for Medicare and Medicaid Services (2005) has determined that the evidence is adequate to conclude that cochlear implantation is reasonable and necessary for the treatment of bilateral pre- or post-linguistic, sensorineural, **moderate-to-profound** hearing loss in individuals who demonstrate limited benefit from amplification. Limited benefit from amplification is defined by test scores of 40 % correct or less in the best-aided listening condition on tape recorded tests of open-set sentence cognition.

Procedure:
Criteria for Coverage:

a.

Replacement of Speech Processors
Replacement of the speech processor with a new same generation or new upgraded speech processor requires prior authorization.
Documentation from the licensed audiologist and/or otolaryngologist to substantiate the need for the processor replacement must be submitted with the Prior Authorization request and include:

1. Recent audiogram within previous 60 days. Audiogram must show hearing loss that is not correctible
2. Clinic note from audiologist and/or otolaryngologist within previous 60 days
3. Some processors may be deemed "obsolete", this means the device may unable to be repaired or replacement parts ordered. However, the documentation submitted still must show device is not able to be routinely serviced and therefore non-functional. These processors often provide good hearing outcomes a MHP representative may request for processor to be evaluated by an independent repair technician.

Replacement Cochlear Implant
Replacement of the internal cochlear implant device for a previously-approved procedure is covered in cases when the cochlear implant team indicates function of the internal device has failed and is no longer under warranty. A letter from the manufacturer corroborating the internal device failure is required. An upgrade from single to multi-channel electrodes or the newer processor is considered not medically necessary.

If an existing implant is functioning, an upgrade or replacement of electrodes to another processor should **not** be made.

Additional Equipment:
Repair or replacement of spare equipment (e.g., old parts and accessories in working condition for back-up use in emergencies) is a non covered item.

Cochlear Implant Mapping/Calibration:
Cochlear implant mapping/calibration is the programming of the speech processor used to analyze sound and convert the speech information into electrical impulses to the implanted electrodes. Mapping and calibration of the cochlear device must be provided by a licensed audiologist who has training and expertise in the procedures. Other team members should include a speech and language pathologist, psychologist, and deaf educator, as determined by the beneficiary's need. A maximum of 10 mapping sessions are allowed for one year from the date of implantation of the cochlear implant.

Absolute Contraindications:

a. Deafness due to lesions of the acoustic nerve or central auditory pathways or brainstem
b. Radiographic evidence of absent cochlear development (cochlear asplasia).
c. Active infections of the external or middle ear and mastoid cavity, or tympanic membrane perforation. Chronic infections of these areas that have not been resolved with antibiotics and/ or surgery.

d. Active meningitis or encephalitis
e. Cochlear ossification that prevents electrode insertion, or
f. Experimental/ investigational for: auditory dyssynchrony, auditory neuropathy spectrum disorder, single-sided deafness, tinnitus
g. Inability or lack of willingness to participate in post-implantation aural rehabilitation.

Line of Business Applicability:
This policy applies to Michigan Medicaid, Illinois Medicaid, and Individual plans.

For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

For **Individual** members, consult the individual insurance policy. If there is a discrepancy between this policy and the individual insurance policy document, the guidelines in the individual insurance policy will govern.

State specific special instructions:

None: ☐

MI:

IL: Medicaid: M-210.4 Requests for Replacement

Replacements of covered equipment and prosthetic and orthotic items are subject to all policies that apply to an original purchase of the same item. Items should be ordered only when a participant is in need and should not be routinely replaced. Life expectancy of medical equipment is four to five years. In addition, a replacement covered under warranty will not be reimbursed by the department. Equipment that is in working order should not be replaced although it may have exceeded its life expectancy.

If the equipment being replaced requires prior approval and if the item was purchased by the department for the same patient within the past 12 months, the documentation of medical necessity for the first purchase will be deemed adequate for the replacement purchase. The request for prior approval will, however, need to include an explanation of the need for a replacement, enough clinical documentation to support medical necessity, and have a valid practitioner order and signature.

If replacement of an item is due to theft, vandalism, or fire, a police or fire department report is needed.

OH:

References:

1. National Institute for Health and Clinical Excellence (NICE). Technology Appraisal Guidance 166. Cochlear Implants for children and adults with severe to profound deafness. Published: January 2009.
2. Centers for Medicare & Medicaid (CMS). National Coverage Determination (NCD) Pub 100.3, Manual Section number 50.3 Cochlear Implantation. Implementation date: July 25, 2005.
3. Michigan Department of Health and Human Services. Medicaid Provider Manual. Hearing Services, section 2.3 (Version Date: April 1, 2017).
4. Illinois Department of Healthcare and Family Services. Chapter E-200. Handbook for Providers of Audiology Services. Issued February 2016.
5. Bond M, Mealing S, Anderson R, et al. The effectiveness and cost-effectiveness of cochlear implants for severe to profound deafness in children and adults: A systematic review and economic model. Health Technol Assess. 2009;13(44):1-330.
6. Peters JP, Ramakers GG, Smit AL, Grolman W. Cochlear implantation in children with unilateral hearing loss: A systematic review. Laryngoscope. 2016;126(3):713-721.

7. van Zon A, Peters JP, Stegeman I, et al. Cochlear implantation for patients with single-sided deafness or asymmetrical hearing loss: A systematic review of the evidence. Otol Neurotol. 2015;36(2):209-219.
8. Huang LH, Zhang YM, Zhang JP, et al. Effectiveness of cochlear implantation in children with auditory neuropathy and cochlear nerve aplasia. Zhonghua Er Bi Yan Hou Tou Jing Wai Ke Za Zhi. 2013;48(8):644-649.
9. Centers for Disease Control and Prevention (CDC). Use of vaccines to prevent meningitis in persons with cochlear implants. Fact Sheet. Atlanta, GA: CDC; updated June 19, 2015.
10. Up to Date Online "Hearing impairment in children: Treatment. " Last updated: Feb 17, 2016
11. Up to Date Online "Hearing amplification in adults. " Last updated: Sep 07, 2016

Medicare Managed Care Manual:				
Medicaid CFR:				
State Administrative Codes:				
Contract Requirements:				
Related Policies:				
Related Desk Level Procedures/Job Aids/Template Letters:				
Related Algorithms/Flowcharts /Attachments				