Medical Necessity Guidelines: Cochlear Implants

Effective: April 1, 2023

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

Applies to:

Commercial Products
☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409
CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 857-304-6404
☐ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 857-304-6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products
☐ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0965
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0965

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

Overview
Cochlear implants are a device used for the treatment of severe-to-profound hearing loss in individuals 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 cochlear.

Clinical Guideline Coverage Criteria
Cochlear implantation of a U.S. Food and Drug Administration (FDA) approved cochlear implant device may be medically necessary in patients aged nine (9) months and older when all of the following criteria are met:

1. Patient has been diagnosed with one of the following:
   a. Bilateral moderate-to-profound sensorineural hearing loss as defined by behavioral audiometric recorded word/sentence testing score (e.g., consonant-nucleus-consonant CNC) of less than or equal to 60% in the best aided binaural condition or Auditory Brainstem Response (ABR) hearing thresholds greater than or equal to 70 dB (decibels) hearing level at frequencies 1000, 2000, and 4000 Hz (Hertz) who have shown limited or no benefit from hearing aids OR
   b. Unilateral Hearing Loss (UHL) as defined by an absence of usable hearing in one ear (recorded word/sentence testing score less than or equal to 40% or ABR thresholds greater than or equal to 70 dB at frequencies 1000, 2000, and 4000 Hz); and Normal to near-normal hearing in the contralateral ear or hearing loss that is treatable by hearing aid. This includes Single Sided Deafness (SSD).

2. Inner ear anatomy is expected to support cochlear implantation
3. None of the following contraindications are present:
   a. Absent cochlea or known absent cochlear nerve such as post trauma or post-surgical, etc.
   b. Major cochlear ossification defined as obliteration of both scala tympani and scala vestibuli in two or more turns of the cochlear
   c. Otologic conditions in which surgery is contraindicated, such as
      i. Active middle ear or mastoid infection
      ii. Tympanic membrane perforation
      iii. Any other contraindication
   d. Evidence of retro cochlear pathology including but not limited to:
      i. Brainstem lesions involving cochlear nucleus
      ii. Severe central auditory processing disorder

### Codes

The following code(s) are associated with this service:

<table>
<thead>
<tr>
<th>CPT/HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>69930</td>
<td>Cochlear device implantation, with or without mastoidectomy</td>
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<tr>
<td>L8614</td>
<td>Cochlear implant, includes all internal and external components</td>
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<tr>
<td>L8619</td>
<td>Cochlear implant, external speech processor and controller, integrated system, replacement</td>
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### References:


### Approval And Revision History

October 19, 2022: Reviewed by the Medical Policy Approval Committee (MPAC).

Subsequent endorsement date(s) and changes made:
- February 15, 2023: Reviewed by MPAC. Updated criterion 1.b. Normal to near-normal hearing in the contralateral ear or to include language “hearing loss that is treatable by hearing aid.” Language to be effective April 1, 2023.

### Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven
effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.