



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

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Subject Hearing Aids

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INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2011 CIGNA

Coverage Policy

Hearing aids are specifically excluded under many benefit plans. In addition, coverage for hearing aids may be governed by federal and/or state mandates. Coverage for advanced signal processing technologies (e.g., digital signal processing, directional microphones, multiple channels, and multiple memories) may vary depending on benefit plan language and schedule of copayments. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage.

If coverage for a hearing aid is available, the following conditions of coverage apply.

CIGNA covers a hearing aid as medically necessary for ANY of the following:

- conductive hearing loss unresponsive to medical or surgical interventions
- sensorineural hearing loss
- mixed hearing loss

CIGNA covers the following hearing aids, including advanced signal processing technologies (e.g., digital signal processing, directional microphones, multiple channels, multiple memories) when one of the above medical necessity criteria for the hearing aid has been met :

- **air conduction hearing aid for the treatment of mild to profound hearing loss:**
 - **behind the ear (BTE) devices**, for cases of mild to profound hearing loss

- **in the ear (ITE)** devices, for cases of mild to moderate hearing loss
 - **in the ear canal (ITC)** devices, for all but the most severe hearing loss
 - **completely in the canal (CIC)** devices, for mild to moderate hearing loss
 - **on the body hearing aid** devices, for severe/profound hearing loss
 - **contralateral routing of sound (CROS)** devices, for cases of single-sided hearing loss
- **semi-implantable middle ear hearing aid when ALL of the following criteria are met:**
 - age 18 or older
 - moderate to severe sensorineural hearing loss
 - evidence of a medical condition precluding use of an air conduction aid
 - **bone conduction hearing aid when use of a conventional device is precluded by a medical condition (this list may not be all-inclusive):**
 - microtic ears
 - small ear canals
 - conditions involving chronic middle ear drainage
 - **bone-anchored hearing aid (BAHAs) for patients with ALL of the following:**
 - pure tone average bone conduction threshold of up to 70 dBHL (decibel hearing loss)
 - speech discrimination score of better than 60%
 - any of the following conditions:
 - documentation of chronic ear infection/inflammation
 - congenital or surgically induced ear malformations of the external or middle ear canal
 - tumors of the external canal and/or tympanic activity
 - conditions that contraindicate an air conduction hearing aid

CIGNA does not cover a fully implantable middle ear hearing aid, even if benefits are available for a hearing aid, because it is considered experimental, investigational or unproven.

CIGNA covers repair and/or replacement of a medically necessary hearing aid as follows:

- Repair is covered when the currently used device is no longer functioning adequately and repair is expected to make the equipment fully functional.
- Replacement is covered when the currently used device is no longer functioning adequately and has been determined to be non-repairable.

General Background

Hearing impairment is the consequence of sensorineural and/or conductive malfunctions of the ear. Hearing loss may be congenital or secondary to trauma or disease. The three basic types of hearing loss are conductive, sensorineural and mixed. Conductive hearing loss involves the outer and middle ear and is due to mechanical or physical blockage of sound. It can result from a blockage of wax, a punctured eardrum, birth defects, ear infections, or heredity. Usually, conductive hearing loss can be corrected medically or surgically. Sensorineural or “nerve” hearing loss involves damage to the inner ear (cochlea) or the eighth cranial nerve. It can be caused by aging, prenatal or birth-related problems, viral or bacterial infections, heredity, trauma, exposure to loud noises, the use of certain drugs, fluid build-up in the middle ear, or a benign tumor in the inner ear. Only rarely can sensorineural hearing loss be medically or surgically corrected. It is the type of hearing loss that is most commonly managed with a hearing aid. Mixed hearing loss is conductive hearing loss coupled with sensorineural hearing loss.

Normal speech and conversation occurs at 40–60 dB (decibels) within a frequency range of 500–3000 Hz (Hertz). Hearing loss severity is classified as follows:

Mild 26–40 dBHL
Moderate 41–70 dBHL

Severe 71–90 dBHL
Profound ≥ 91 dBHL

Hearing aids are devices that amplify and deliver speech and other sounds at levels equivalent to that of normal speech and conversation and are used by individuals with hearing loss. Hearing aids are described by the U.S. Food and Drug Administration (FDA) as "any wearable instrument or device designed for, offered for the purpose of, or represented as aiding persons with or compensation for, impaired hearing" (FDA, 2001). A hearing aid is also called an electroacoustic device, because it takes an acoustical signal, such as speech, and converts it to an electric signal before the amplification stage. Through amplification, hearing aids increase the audibility of sounds, including speech for hearing impaired listeners. All hearing aids include a microphone, an output receiver, a battery with its connectors and some way to control the electronic circuit for converting the acoustic signal to an electronic signal before the amplification stage (Ricketts, et al., 2001).

Although hearing aids provide amplification to sound, the manner by which they process or control incoming signals may differ. Presently, hearing aids fall into three categories:

1. Analog hearing aids provide constant analysis and modification of the incoming signal.
2. Digitally programmable hearing aids use analog processing and programming of the hearing aid response characteristics into digital memory, with digital control of the analog circuit.
3. True digital devices use digital signal processing (DSP). DSP differs from traditional analog and digital/hybrid systems, in that the incoming acoustic signal is first converted to a string of digits, after which a DSP scheme (i.e., complex mathematical algorithm) is applied.

Analog hearing aids provide the most basic type of technology to supply quality amplification to a wide range of hearing losses. This type of device is designed based on particular frequency response from an audiogram. Digitally programmable devices have a microchip and may allow greater flexibility for amplification needs and capability. A computer is used to program the device for different listening situations, depending on the individual hearing loss profile, speech understanding, and range of tolerance for louder sounds. Digital signal processing devices are digitally programmable hearing aids that utilize digitalized sound processing to convert sound waves into digital signals. These devices are self-adjusting, and allow even more flexibility in programming the aid so that the sound it transmits more specifically matches the hearing loss. DSP aids function by analyzing the incoming sound. The digital aid then determines whether the sound is speech or noise and converts this information to numbers. The resultant digitized numbers are then manipulated according to algorithm instructions, reconverted to an analog form (i.e., sound waves), and delivered to the ears without producing the types of distortion often associated with analog technology hearing aids. DSP aids may be considered an advanced signal processing technology.

Hearing aids can be further categorized as air conduction hearing aids, bone conduction hearing aids and middle ear hearing aids. Air conduction devices are the treatment of choice for sensorineural hearing loss, mixed hearing loss or conductive hearing loss not responsive to medical or surgical correction. Middle ear hearing aids are only indicated for sensorineural hearing loss and until recently were available only as semi-implantable devices. In March of 2010 the FDA granted premarket approval for a fully implantable middle ear hearing aid. Bone conduction devices are primarily indicated for conductive hearing loss and mixed hearing loss.

Air Conduction Hearing Aid

Air conduction hearing aids allow sound to travel along the normal physiological route through the external ear canal and middle ear. Air conduction hearing aids are designed for placement in one of several locations:

- **Behind the ear (BTE):** This type of hearing aid fits behind the ear and carries sound to the ear through a custom ear mold. Hearing aids that are attached to eyeglasses are a type of behind-the-ear hearing aid. They are useful for mild-to-severe hearing loss.
- **In the ear (ITE):** These hearing aids are custom-made to fit in the outer ear. Wires cannot be seen because they are inside the aid. They are useful for mild to moderate hearing loss.

- **In the ear canal (ITC):** This type of hearing aid is custom-made to fit in the ear canal. There are no wires or tubes. These hearing aids are almost impossible to see. They help people with all but the worst hearing loss.
- **Completely in the canal (CIC):** This type of hearing aid fits almost entirely in the canal. Due to the small size, the numbers of output/response controls are limited. Deep placement precludes use of a directional microphone. Amount of gain is sufficient for no more than moderate hearing loss.
- **On the body:** This type of hearing aid is appropriate for severe hearing loss. A larger microphone, amplifier and battery are enclosed in a case and worn on the body. The case is connected by a wire to an ear receiver that is attached to an ear mold (FDA, 2001).
- **Contralateral routing of signal (CROS):** This type of hearing aid is designed for persons with no usable hearing in one ear and normal hearing or minimal hearing loss in the other ear. A microphone is located on the impaired side and transmitted to the good ear via an open ear mold. The microphone and receiver may be coupled by a wire that runs around the back of the neck (or through the glasses), or the signal may be transmitted wirelessly over a radio frequency.

U.S. Food and Drug Administration (FDA): Air conduction hearing aids are Class I devices regulated by the FDA. Class I devices are subject to the least regulatory control. They present minimal potential for harm to the user and are often simpler in design than Class II or Class III devices.

Bone Conduction Hearing Aid

For some people, the use of a conventional amplification device is precluded by medical conditions. Under such circumstances, users must consider an alternative device, such as a bone conduction aid. With this system, a bone conduction receiver is placed on the mastoid and held in position by a headband and a small wire that connects the bone oscillator to a BTE hearing aid. Bone conduction devices stimulate the cochlea in the same way as during bone conduction threshold assessments. More energy is required to stimulate the ear by bone conduction than by air conduction; consequently, this device can be used only with milder hearing losses. The frequency response of the bone conduction aid is not as good as with the more traditional systems (Ricketts, Chicchis, Bess, 2001). Bone conduction hearing aids may be appropriate when air conduction hearing aids do not fulfill the amplification needs for conductive hearing losses. Such cases include microtic ears, chronic drainage for middle ear problems and abnormally small ear canals. Due to the variability in quality of the sound and problems in maintaining proper placement, these aids are considered only when more traditional hearing aids are not acceptable.

U.S. Food and Drug Administration (FDA): Bone conduction hearing aids, including bone-anchored hearing aids, are labeled Class II devices.

Bone-Anchored Hearing Aid (BAHA)

The BAHA devices are FDA-approved, bone-anchored, bone conduction hearing aids and, according to the FDA and manufacturer, they are specifically indicated for patients over five years of age (FDA 510(k) K984162, 1999; BAHA, Entific Medical Systems, 2002–2004). The indications for the device have broadened since the initial FDA approval. The devices have been successfully used and are FDA approved for unilateral or bilateral mixed or conductive hearing loss, and for unilateral sensorineural hearing loss. According to the FDA approval for unilateral sensorineural hearing loss (FDA, 510(k) summary K021837) the BAHA device was substantially equivalent regarding intended use to air conduction hearing aids with a CROS unit.

In this percutaneous device, the hearing aid transducer is coupled to a titanium screw located in the upper mastoid region on the temporal bone; the screw protrudes through the skin. The difference between the standard bone conduction hearing aid and the bone-anchored hearing aid is direct stimulation of the bone instead of stimulation through the skin. The BAHA device transmits sound to the cochlea bypassing any conductive component that may be obstructing sound. There are several BAHA models available: the Baha Divino™, BAHA® Classic 300, BAHA® Compact, and the BAHA® Cordelle (Entific Medical Systems, Goteberg, Sweden). The BAHA Divino utilizes digital sound processing and a built-in directional microphone. This device may be utilized by patients with bone conduction thresholds of 45 dB. Patients with unilateral, profound sensorineural hearing loss of the indicated ear with normal contralateral hearing (defined as 20 dB HL air

conduction pure tone average) may also benefit from this device. The Classic and Compact are suitable for people with conductive or mixed hearing loss and a maximum bone conduction threshold of 45 dB. The Cordelle is indicated for more severe hearing loss, with an average bone threshold of approximately 70 dB. The patients recommended for this device must either be unable to use conventional air conduction hearing aids or have undergone ossicular replacement surgery because of chronic otitis media, congenital malformation of the middle/external ear, or other acquired malfunctions of the middle or external ear canals which preclude the wearing of a conventional air conduction hearing aid. Patients must be able to maintain the abutment/skin interface of the BAHA. Therefore, careful consideration must be given to the patient's psychological, physical, emotional and developmental capabilities of maintaining hygiene. For children and patients with congenital malformations, sufficient bone volume and bone quality must be present for a successful fixture implantation.

Improved patient outcomes and functioning with the use of BAHA devices have been reported in the published medical literature. Most of the published evidence consists of case series and reviews. However, the evidence supports that a majority of patients preferred the BAHA device over conventional devices and reported improved speech recognition scores and sound quality (Snik, et al., 1995; Wazen, et al., 1998; Ontario Medical Health Technology Advisory Committee (OMHTAC), 2002; House and Kutz, 2007; Linstrom, et al., 2009; Christensen, et al., 2010; House, et al., 2010).

Middle Ear Implants (MEIs)

Implantable middle ear hearing aids can be either totally implantable or partially implantable and use either a piezoelectric, electromechanical or electromechanical based vibration transducer that directly moves inner or middle ear structures. The mechanism by which these devices amplify and transmit sound varies. Implantable middle ear hearing aids differ from other conventional aids in that they convert electric signals into mechanical energy which is coupled directly to the ossicular chain. The critical component of these devices is the transducer. Piezoelectric devices function by passing an electric current through a piezo-ceramic crystal. Piezoelectric transducers are directly coupled to the ossicular chain; electromagnetic units can be placed in approximation to the ossicular chain and provide direct drive capability. Electromagnetic transducers generate a magnetic field using a coil carrying current encoded by a microphone. In contrast to other conventional aids, fully implantable devices are not visible externally and do not require removal for activities such as bathing or swimming.

Fully Implantable Device: The Esteem[®] (Envoy Medical, Minneapolis, MN), a piezoelectric middle ear hearing aid device, has been approved through the FDA PMA process as a fully implantable hearing device indicated for the treatment of moderate to severe sensorineural hearing loss. The device consists of three implantable components: a sound processor (implanted in the temporal bone behind the outer ear) and a sensor and driver (implanted in the middle ear). The device uses the natural ear as a microphone; a sensor senses vibrations from the eardrum and middle ear bones and converts these mechanical vibrations into electric signals, which are then sent to the sound processor, where the signal is amplified and filtered to compensate for the individual's hearing loss. The driver converts the enhanced electrical signal back to vibrations which are then transmitted to the inner ear. The vibrations cause pressure waves in the fluid of the cochlea; the cochlea converts the waves to nerve impulses and transmits them to the brain where they are interpreted as sound. According to the manufacturer, the Esteem hearing device is intended for use by adults 18 years of age or older, with mild to severe sensorineural hearing loss, speech discrimination score of >40%, normally functioning Eustachian tube, normal middle ear anatomy and adequate space for the implant. Battery life is dependent on the number of hours used and exposure to average noise level (estimated at 4.5 to 9 years); replacement requires a surgical procedure and local anesthesia. Risks associated with the Esteem device are similar to those of mastoid operative procedures and those that result in limited or no hearing benefit and may require a second surgical procedure to correct. A second fully implantable middle ear device, not yet FDA approved and currently under investigation, is the Otologics MET (Middle Ear transducer) Carina[™] (Otologics, Boulder, CO) device.

Semi-Implantable Device: Semi-implantable devices consist of an external microphone and speech processor with a battery that is located in the external device. The FDA has approved two semi-implantable electromagnetic hearing aids: the Vibrant Soundbridge (manufactured by Symphonix Inc., of San Jose, CA) and Soundtec[®] Direct Drive Hearing System (manufactured by Soundtec, Inc., Oklahoma City, OK). In contrast to the standard hearing aids that use air pressure to transport sound to the middle ear, electromagnetic hearing aids use the periodic attraction and repulsion of two magnetic fields, one from an electromagnet and the other from a static magnet, as a means of vibrating ossicles and transmitting sound to the inner ear. Electromagnetic hearing aids are an alternative for adults who have moderate to severe sensorineural hearing loss. Both

systems operate by similar mechanisms, with slight differences in design (FDA, 2002a; FDA, 2002b). Each device is approved for adults age 18 or older who have moderate to severe sensorineural hearing loss and desire an alternative to an acoustic hearing aid. It is recommended that the individual have some prior experience with a well-fitting acoustic hearing aid prior to receiving a semi-implantable hearing aid. Electromagnetic hearing aids are contraindicated for subjects who have conductive hearing loss, retrocochlear or central auditory disorders, active middle ear infection, tympanic membrane perforations associated with recurrent middle ear infections, disabling tinnitus, or prior surgery of the middle ear. The manufacturers have issued a warning regarding avoidance of strong magnetic fields, including magnetic resonance imaging (MRI), electrosurgical instrumentation, diathermy, electroconvulsive therapy, positron emission tomography (PET) scans, transcranial ultrasounds, and linear acceleration techniques (FDA, 2002a; FDA 2002b).

U.S. Food and Drug Administration (FDA): Middle ear implants are regulated as Class III devices by the FDA. Class III is the most stringent regulatory category for devices and requires premarket approval to ensure safety and effectiveness.

Published data evaluating the fully implantable Esteem middle ear device consist of a feasibility trial (n=7), case series (n=6), and a trial (n=57) that was part of the FDA PMA process, in addition to published reviews. Chen et al. (2004) published the results of a feasibility study that demonstrated the device had potential benefit for subjects with mild to severe sensorineural hearing loss. Barbara et al. (2009) evaluated the use of the Esteem 2[®] device and remarked primarily on aspects regarding the surgical procedure. The authors noted the surgical procedure was complex, the duration differed among patients, and required interruption of the ossicular chain resulting in unaidable hearing until activation of the device following surgery. Once the device was activated, hearing was restored. According to the FDA PMA application study results, the Esteem implant had a 5% revision rate prior to the four month follow-up visit due to fibrotic tissue growth/interference, and no revisions between the four and 10 month follow-up. The Esteem implant procedure had no significant effect on cochlear function stability as measured by bone conduction. Regarding effectiveness, the Esteem was statistically superior to the pre-implant hearing aid in Speech Reception Threshold and Word Recognition Scores; the type of pre-implant hearing aid varied among subjects and included BTE, ITE, ITC, CIC. In addition, Esteem outcomes were better than or equal to the pre-implant hearing aid condition in several other standard audiological measures, including Abbreviated Profile of Hearing Aid Benefit and the hearing in noise test as measured by QuickSIN. As part of the PMA process, the FDA is requiring two post approval studies. Facial paralysis developed in seven percent of the FDA PMA study participants and 42 percent developed taste disturbance. Both events resolved during the one-year study period. Although the available evidence lends support to short-term safety and clinical utility, the device is a fully implantable device requiring disruption of a normal intact ossicular chain and partial resection of the incus, data supporting long-term safety, efficacy, device durability and improvement in health outcomes is not available. Furthermore, clinical trials comparing the outcomes of fully implantable devices to other conventional aids, such as bone conduction or semi-implantable devices are lacking and the clinical advantages of this device, which requires a surgical procedure for insertion and battery replacement, have not been established.

Early published clinical studies evaluating middle ear implantable hearing aids focused on the use of the Soundtec Direct System and the Vibrant Soundbridge semi implantable devices and involved small numbers of patients (Hough, et al., 2002; Luetje et al., 2002). However, the results of those early trials indicate the devices are well tolerated and capable of improving thresholds in patients with moderate to severe sensorineural hearing loss. More recent studies in the published peer reviewed scientific literature continue to support safety and efficacy. Furthermore, there is evidence from published clinical trials that suggests when compared to acoustic hearing aids, the semi-implantable devices are relatively safe and can provide significant improvements in functional gain and speech perception.

Advanced Signal Processing Technologies

There is extensive growth in the number of new sound-producing schemes aimed at improved speech recognition, sound quality and comfort. Advanced signal processing technologies such as digital signal processing, directional microphones, multiple channels and multiple memories have been incorporated into hearing aid devices. Edwards (2007) reported that in 2005, 93% of hearing aids sold in the United States contained digital signal processing technology, and more than half of those included directional microphones. Digital signal processing is utilized in many hearing aids to improve performance. Some of the potential advantages of DSP include flexible gain processing, digital feedback reduction, digital noise reduction and digital speech enhancement (Ricketts, 2005). However, in some cases, even the most complex DSP schemes

may not be very selective to speech; they generally amplify all environmental sounds within specific frequency ranges. Directional microphones can improve signal-to-noise ratio by reducing input that is not in front of the hearing aid user (i.e., amplifies sounds originating in the front). Combining DSP with directional microphones may further enhance the signal-to-noise ratio. Multiple channels allow different programming for gain and compression, and may be useful for digital noise reduction and feedback cancellation. Multiple memories are used to store hearing aid settings designed for particular listening situations and may be controlled with a remote device or automatically. In most cases, advanced signal processing technologies are accompanied by high patient expectations. Nevertheless, despite these improvements, some individuals continue to have problems with background noise, especially the speech of other people talking in their vicinity. Data suggests that 25% of people who own hearing aids do not wear them due to this problem (Ricketts, et al., 2001).

The instrument of choice is dependent on the severity of hearing loss, the acoustic environment in which the individual functions, and whether or not that individual's hearing needs are being met. DSP instruments are very sophisticated and offer many advantages and options not available in standard technology. The evidence base comparing digital to analog hearing aids is small, of poor quality and inconsistent. Some authors have reported there are no statistically significant differences in outcomes when comparing the use of digital signal processing devices to analog devices (Taylor, et al., 2001; Moore, et al., 2001; Bille, et al., 1999). Few authors have reported some evidence for advantages of digital aids compared to analog; however, the average differences are not large. Wood and Lutman (2004) compared linear analog and advanced digital hearing aids (DSP) in 100 first-time hearing aid users with mild to moderate sensorineural hearing loss in a single-blind randomized crossover trial. The authors reported that speech recognition in noise was significantly better with digital aids at a raised level of 75dB, and that user satisfaction and preference was higher when compared to analog aids. Arlinger et al. (1998) evaluated 33 patients using a digital signal processing aid (i.e., Oticon DigiFocus), in subjects who had previous experience with modern analog aids, in a one-month clinical trial, and reported that most patients preferred the digital aid over their analog aid (n=23); six preferred their own aid, and four stated there was no difference. The choice of selecting advanced signal processing technologies (i.e., DSP, directional microphones, multiple channels, multiple memories) versus the standard analog device is a decision that needs to be made by the patient in concert with a trained health professional (physician or audiologist).

Summary

Hearing aids can be categorized as air conduction hearing aids, bone conduction hearing aids and middle ear hearing aids. Evidence in the published scientific literature supports the safety and effectiveness of these devices for a subset of individuals with hearing loss. Air conduction devices are the treatment of choice for sensorineural hearing loss, mixed hearing loss or conductive hearing loss not responsive to medical or surgical correction. Middle ear hearing aid devices are only indicated for sensorineural hearing loss. There is sufficient evidence to support safety and efficacy of semi-implantable middle ear devices; data evaluating fully implantable middle ear hearing aids and long-term clinical outcomes are lacking. Furthermore, fully implantable middle ear hearing aids require a surgical procedure for insertion and battery replacement, posing additional risk in comparison to other devices. Bone conduction hearing aids are primarily indicated for conductive hearing loss and mixed hearing loss, although some bone-anchored hearing aid (BAHA) devices may also be utilized for patients with unilateral sensorineural hearing loss. Advanced signal processing technologies such as digital signal processing devices, multiple channels or bands, and/or multiple microphones may enhance the function of the device in various listening situations.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary, if coverage for hearing aids is available under the plan:

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, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

HCPCS Codes	Description
L8690	Auditory osseointegrated device, includes all internal and external components
L8691	Auditory osseointegrated device, external sound processor, replacement
V5014	Repair/modification of a hearing aid
V5030	Hearing aid, monaural; body worn, air conduction
V5040	Hearing aid, monaural; body worn, bone conduction
V5050	Hearing aid, monaural; in the ear
V5060	Hearing aid, monaural; behind the ear
V5095	Semi-implantable middle ear hearing prosthesis
V5100	Hearing aide, bilateral, body worn
V5120	Binaural; body
V5130	Binaural body; in the ear
V5140	Binaural body; behind the ear
V5170	Hearing aid, CROS ;in the ear
V5180	Hearing aid, CROS; behind the ear
V5210	Hearing aid, bicros; in the ear
V5220	Hearing aid, bicros; behind the ear
V5242	Hearing aid, analog ,monaural, cic (completely in the ear canal)
V5243	Hearing aid, analog, monaural, itc(in the canal)
V5244	Hearing aid, digitally programmable analog, monaural, CIC
V5245	Hearing aid, digitally programmable, analog, monaural, ITC
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear)
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)
V5248	Hearing aid, analog, binaural, CIC
V5249	Hearing aid, analog, binaural, ITC
V5250	Hearing aid, digitally programmable analog, binaural, CIC
V5251	Hearing aid, digitally programmable analog, binaural, ITC
V5252	Hearing aid, digitally programmable, binaural, ITE
V5253	Hearing aid, digitally programmable, binaural, BTE
V5254	Hearing aid, digital, monaural, CIC
V5255	Hearing aid, digital, monaural, ITC
V5256	Hearing aid, digital, monaural, ITE
V5257	Hearing aid, digital, monaural, BTE
V5258	Hearing aid, digital, binaural, CIC
V5259	Hearing aid, digital, binaural, ITC
V5260	Hearing aid, digital, binaural, ITE
V5261	Hearing aid, digital, binaural, BTE
V5262	Hearing aid, disposable, any type, monaural
V5263	Hearing aid, disposable, any type, binaural
V5264	Ear mold/insert, not disposable, any type
V5265	Ear mold/insert, disposable, any type
V5266	Battery for use in hearing device

V5267	Hearing aid supplies/accessories
V5275	Ear impression, each
V5298	Hearing aid, not otherwise classified

ICD-9-CM Diagnosis Codes	Description
382.9	Unspecified otitis media
387.0 – 387.9	Otosclerosis
388.12	Noise-induced hearing loss
388.2	Unspecified sudden hearing loss
389.00 – 389.9	Hearing Loss
744.00 – 744.09	Congenital anomalies of ear causing impairment of hearing
744.23	Microtia
	Multiple/Varied

***Current Procedural Terminology (CPT®) ©2010 American Medical Association: Chicago, IL.**

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	5/15/2008	0093	Hearing Aids
Great-West Healthcare	7/28/2006	04.236.02	Bone-Anchored Hearing Aid

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