CIGNA MEDICAL COVERAGE POLICY

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

Effective Date 9/15/2010
Next Review Date 9/15/2011
Coverage Policy Number 0180

Subject **Aural Rehabilitation**

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Cochlear and Auditory Brainstem Implants
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INSTRUCTIONS FOR USE

*Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant'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 participant'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 participant'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 group 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.*

Coverage Policy

Aural rehabilitation is considered a form of speech therapy. Coverage for outpatient speech therapy is subject to the terms, conditions and limitations of the Short-Term Rehabilitative Therapy benefit as described in the applicable benefit plan's schedule of copayments.

Outpatient speech therapy/aural rehabilitation is the most medically appropriate setting for these services unless the individual independently meets coverage criteria for a different level of care.

Many benefit plans have exclusion language that impacts coverage of speech therapy, including any or all of the following:

- **Many benefit plans include a maximum allowable speech therapy benefit for duration of treatment or number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met.**
- **Specific coverage exclusions for behavioral training/treatment or services that are considered educational and/or training in nature.**

- **Some benefit plans specifically exclude maintenance or preventive treatment, consisting of routine, long-term or non-medically necessary care provided to prevent recurrences or to maintain the individual's current status.**

- **Under many benefit plans formerly administered by Great-West Healthcare, aural rehabilitation is only covered for hearing impairment following acute injuries, diseases or conditions when the therapy services are expected to result in significant clinical improvement within two months.**

If coverage is available for aural rehabilitation, the following conditions of coverage apply.

CIGNA covers an aural rehabilitation evaluation as medically necessary for the assessment of a hearing impairment.

CIGNA covers aural rehabilitation as medically necessary for the treatment of a hearing impairment when ALL of the following criteria are met:

- The hearing impairment is the result of trauma, tumor or disease, or following implantation of a cochlear or auditory brainstem device.
- An evaluation has been completed by a certified speech-language pathologist or licensed audiologist that includes standardized speech and/or hearing tests.
- The treatment being recommended has the support of the treating physician.
- The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist or audiologist.
- The therapy plan includes specific tests and measures that will be used to document significant progress.
- Meaningful improvement is expected from the therapy.
- The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance level on discharge.

CIGNA HealthCare does not cover aural rehabilitation for presbycusis because it is considered experimental, investigational or unproven.

CIGNA does not cover aural rehabilitation in ANY of the following situations as it is excluded from many benefit plans and considered not medically necessary when used for these purposes:

- computer-based learning programs used for aural rehabilitation
- school aural rehabilitation programs
- group aural rehabilitation (because it is not one-on-one, individualized to the specific person's needs)
- maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist or audiologist and that can be reinforced by the individual or caregiver
- aural rehabilitation that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., audiologic therapy)
- vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- therapy or treatment intended to improve or maintain general physical condition
- long-term rehabilitative services when significant therapeutic improvement is not expected

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General Background

Aural rehabilitation refers to services and procedures for facilitating adequate receptive and expressive communication in individuals with hearing impairments (American Speech-Language-Hearing Association [ASHA], 1984). It is also referred to as auditory or audiologic rehabilitation. Aural rehabilitation is frequently used as an integral component in the overall management of individuals with hearing loss. Aural rehabilitation is often an interdisciplinary endeavor involving physicians, audiologists and speech-language pathologists. For school-

age children, therapy may also be coordinated with the school system. In general, services may be initiated as soon as a patient has been identified as having a hearing impairment, following the fitting of a hearing device or after implantation of a cochlear device. Services involved in the provision of aural rehabilitation include:

- identification and evaluation of sensory capabilities, including extent of impairment and fitting of auditory aids
- interpretation of audiologic findings, plus counseling and referral
- development and provision of an intervention program for communicative disorders to facilitate expressive and receptive communication
- re-evaluation of the patient's status
- evaluation and modification of the intervention program

Although aural rehabilitation programs are accepted and widely used in the management of hearing-impaired individuals, the role of aural rehabilitation in the overall treatment and its impact on health outcomes has not been clearly delineated, other than in those with cochlear device implants.

Aural rehabilitation should be structured, systematic, individualized and goal-directed (i.e., both long- and short-term goals). For patients who acquire a hearing loss post-lingually, treatment would be considered rehabilitative and restorative in nature. Although the term "rehabilitation" is commonly used in association with services provided to pre-lingually hearing-impaired patients, treatment would more accurately be described as "habilitative" in nature, as it does not involve restoring a lost function.

Audiologists and speech-language pathologists certified by the American Speech-Language-Hearing Association [ASHA], 2004a) are qualified to provide aural rehabilitation components. The audiologist may be responsible for:

- the fitting, dispensing and management of a hearing device
- provision of counseling about hearing loss and processes to enhance communication
- skills training regarding environmental modifications which will facilitate the development of receptive and expressive communication

The speech-language pathologist is typically responsible for evaluating receptive and expressive communication skills and providing services to improve them, as well as for providing training and treatment in communication strategies (e.g., assertive listening tactics), speech-perception training (e.g., speech-reading, auditory training and auditory-visual-speech-perception training), speech and voice production, and comprehension of oral, written and signed language.

Initially, aural rehabilitation records should be provided to substantiate the need for this therapy. Records should include clinical narrative notes from the attending physician or referring provider, with a description of expressive and/or receptive speech impairments and reports of standardized speech and hearing tests, if applicable. An evaluation and treatment plan, including assessment of level of function, measurable long- and short-term goals, progress toward achieving goals, anticipated timeframe for achieving goals, and anticipated frequency and duration of therapy, should also be obtained. For continued treatment, it is necessary to obtain follow-up evaluations, auditory therapy notes, documentation of progress toward goals, and treatment plan revisions.

Both group therapy and computer-based training are often used in aural rehabilitation; however, these methods are not individualized to specific patient needs. The primary focus of many aural rehabilitation components and interventions may be training (e.g., speech-reading training, vocational training). This training can occur in group or individual sessions. Computer-assisted programs used in aural rehabilitation include, but are not limited to:

- Computer-Assisted speech Perception Testing and training at the Sentence Level (CASPERSent)
- Computer Assisted Tracking Simulation and Computer Assisted Speech Training (CATS)
- Sound and WAY Beyond™ (Cochlear Americas, Centennial, CO)
- Listening & Communication Enhancement (LACE)™ (Neurotone, Inc., Redwood City, CA)

Group-based therapy, computer-based training and school-based programs are considered training in nature and are not considered medically appropriate, as they do not involve the formal interaction of one-to-one supervision with a speech-language pathologist or audiologist.

Hearing Loss
Hearing loss, one of the most common sensory disorders, is the consequence of sensorineural and/or conductive malfunctions of the ear. The impairment may be congenital or caused postnatally by trauma or disease. Hearing loss may be pre-lingual (i.e., occurring prior to speech and language acquisition) or post-lingual (i.e., occurring after the acquisition of speech and language).

In conductive hearing loss, an obstruction to air conduction prevents the proper transmission of sound waves through the external auditory canal and/or the middle ear. The auricle (pinna), external acoustic canal, tympanic membrane, or bones of the middle ear may be dysfunctional. Conductive hearing loss can be congenital or caused by trauma, severe otitis media, otosclerosis, neoplasms, or atresia of the ear canal. Conductive hearing loss is marked by an almost equal loss of all frequencies. Some conductive hearing loss can be treated surgically with tympanoplasty or stapedectomy. Many individuals can also benefit from hearing aids and assistive listening devices.

Sensorineural hearing loss, which is more common than conductive hearing loss, occurs when the sensory receptors of the inner ear are dysfunctional. Sensorineural deafness is a lack of sound perception caused by a defect in the cochlea and/or the auditory division of the vestibulocochlear nerve. This type of hearing loss is typically irreversible. It tends to be unevenly distributed, with greater loss at higher frequencies. Sensorineural deafness may be congenital or result from intense noise, trauma, viral infections, ototoxic drugs (e.g., Cisplatin, salicylates, loop diuretics), fractures of the temporal bone, meningitis, Ménière's disease, cochlear otosclerosis, aging (i.e., presbycusis), or congenital malformation of the inner ear. Genetic predispositions, either alone or in combination with environmental factors, may be responsible as well. Many patients with sensorineural hearing loss can be habilitated or rehabilitated with the use of hearing aids. Patients with profound bilateral sensorineural hearing loss (e.g., at least 90 dB) who derive no benefit from conventional hearing aids may be appropriate candidates for cochlear device implantation. The implant bypasses the damaged structures of the cochlea and stimulates the function of the auditory nerve. Auditory brainstem implants are similar to the multichannel cochlear implants. Brainstem implants are used in patients with neurofibromatosis type 2 who have lost integrity of auditory nerves following vestibular schwannoma removal.

Individuals with mixed hearing loss have both conductive and sensory dysfunction. Mixed hearing loss is due to disorders that can affect the middle and inner ear simultaneously, such as otosclerosis involving the ossicles and the cochlea; head trauma; middle ear tumors; and some inner ear malformations. Trauma resulting in temporal bone fractures may be associated with conductive, sensorineural and mixed hearing loss.

Aural Rehabilitation Following Cochlear Device and Auditory Brainstem Implantation
Aural rehabilitation following implantation of these devices is considered an integral part of the overall management of implant patients. Although programs vary widely, both with regard to treating disciplines and to the duration and scope of treatment, the general consensus is that some type of post-implantation aural therapy maximizes the benefit of the device. Sound recognition and speech intelligibility are evaluated prior to and just after implantation. Hearing capabilities are assessed by an audiologist, both with and without the assistance of a hearing aid. A speech-language pathologist evaluates and categorizes the patient's pre-implantation speech and language skills. Post-cochlear implantation rehabilitation programs generally include the following components: sound awareness (e.g., recognition of novel auditory signals); visual/auditory processing, including speech-reading training (e.g., lip-reading, facial expression, gestures and body language); speech recognition; mechanical (e.g., use of the device and telephone); and voice, speech production and language therapy.

Presbycusis
Presbycusis is the general term applied to age-related hearing loss and is used to describe the sum of all the processes that affect hearing over time. Presbycusis affects both of the critical dimensions of hearing by reducing threshold sensitivity as well as the ability to understand speech. Individuals with presbycusis often do not express difficulty hearing, but are more likely to complain of problems understanding speech. Hearing aids are the primary resource for improving communication and reducing hearing handicaps in those with sensorineural presbycusis (Gates and Rees, 1997). Although communication strategies are employed in the

management of presbycusis, a comprehensive, structured aural rehabilitation program is typically not used as a treatment modality for adult-onset hearing loss that is associated with the aging process.

Professional Societies/Organizations
The American Speech-Language-Hearing Association (ASHA) preferred practice patterns for audiology state that aural rehabilitation evaluation for individuals of all ages is prompted by the identification of hearing impairment. Aural rehabilitation is indicated for individuals with hearing impairment who experience, or are at risk for, communication problems that impose activity limitations and participation restrictions. Aural rehabilitation facilitates the speech-language, cognitive, and social-emotional development and functioning of children with hearing impairment. Aural rehabilitation facilitates adjustment to and enhances benefits from the use of hearing aids, cochlear implants, and assistive technologies (ASHA, 2006).

Summary
A program of aural rehabilitation usually begins as soon as a hearing impairment is identified. Aural rehabilitation is indicated for the treatment of such impairment and is a medically necessary component of the management of cochlear device and auditory brainstem implantation. A systematic, individualized and goal-directed aural rehabilitation program has not been proven to improve health-related quality of life outcomes for individuals with presbycusis and is generally not used as a treatment modality for this indication.

Coding/Billing Information

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

Covered when medically necessary:

CPT®* Codes	Description
92626	Evaluation of auditory rehabilitation status; first hour
92627	Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)
92630	Auditory rehabilitation; pre-lingual hearing loss
92633	Auditory rehabilitation; post-lingual hearing loss

ICD-9-CM Diagnosis Codes	Description
225.1	Acoustic neuroma
387.0 – 387.9	Otosclerosis
388.11	Acoustic trauma (explosive) to the ear
388.12	Noise-induced hearing loss
388.2	Sudden hearing loss, unspecified
388.5	Disorders of the acoustic nerve
389.00 – 389.08	Conductive hearing loss
389.10 – 389.18	Sensorineural hearing loss
389.2	Mixed conductive and sensorineural hearing loss
389.7	Deaf mutism, not elsewhere classifiable
389.8	Other specified forms of hearing loss
389.9	Unspecified hearing loss
951.5	Injury to acoustic nerve/auditory nerve
	Multiple/varied codes

Experimental/Investigational/Unproven/Not Covered:

ICD-9-CM Diagnosis Codes	Description
388.01	Presbycusis

***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	9/15/2008	0180	Aural Rehabilitation