

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

13A, *Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair*

10A, *Outpatient Specialized Therapies*

1.0 Description of the Procedure, Product, or Service

A cochlear implant is an electronic medical device designed to restore some ability to perceive sounds and understand speech by individuals with severe to profound hearing loss. A cochlear implant bypasses damaged hair cells in the cochlea and stimulates the remaining nerve fibers directly through the application of electrical current. Cochlear implants have external parts and internal (surgically implanted) parts that work together to allow the user to perceive sound.

An auditory brainstem implant (ABI) is a modification of the cochlear implant in which the stimulating electrode is placed directly into the brain.

After surgery, these two devices require activation, fitting of essential external components, programming, and rehabilitation for proper function and benefit.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- 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.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.

2.2 Special Provisions

2.2.1 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.

b. 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/>

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

3.2.2 Cochlear Implant

- a. Medicaid shall cover cochlear implants and aural rehabilitation for Medicaid beneficiaries ages 12 months of age and older when ALL of the following requirements are met and are documented in the health record:
 1. The device must be used according to the U.S. Food and Drug Administration (FDA) labeled indications.
 2. There are no contraindications for the surgery.
 3. The personal physician or otolaryngologist documents that the beneficiary has realistic expectations of the performance of the device and is able to participate in a program of aural rehabilitation.
 4. The beneficiary has a confirmed diagnosis of severe to profound (greater than or equal to 70 dB HL) sensorineural hearing loss in the ear to be implanted;

Note: An exception to the degree of hearing loss provision of severe to profound sensorineural hearing loss (greater than or equal to 70 dB HL) is the confirmed and documented case of auditory neuropathy spectrum disorder wherein hearing thresholds may be better than this level but word recognition is poor.

5. The beneficiary is free of middle ear infection, has an accessible cochlear lumen that is structurally sound for implantation, and is free of lesions in the auditory nerve and acoustic areas of the central nervous system.

- b. the beneficiary age 12 months to 20 years has limited benefit from at least a three-consecutive month trial of appropriately fitted hearing aids. When radiological evidence of cochlear ossification on computerized tomography (CT) scan or obstruction exists, the trial requirement may be waived; and

Note: Limited benefit from amplification is defined by test scores of less than or equal to 40 percent correct in the ear to be implanted using an age-appropriate test of speech recognition.

- c. The beneficiary age 21 years of age and older has an appropriate hearing aid evaluation completed with an appropriate hearing aid fitting trialed by a licensed audiologist.

3.2.3 Auditory Brainstem Implants

Medicaid shall cover Auditory Brainstem Implants (ABIs) for Medicaid beneficiaries 12 years through 20 years of age when ALL the following criteria are met:

- a. The beneficiary has been diagnosed with neurofibromatosis type 2;
- b. The beneficiary:
 - 1. is undergoing bilateral removal of tumors of the auditory nerves, and the beneficiary is expected to become completely deaf as a result of the surgery; **or**
 - 2. has had bilateral auditory nerve tumors removed and is now bilaterally deaf.
- c. the FDA approved device must comply with the FDA indications for use; and
- d. there are no contraindications for the surgery.

3.2.4 Upgrades and Maintenance

Medicaid shall cover the replacement of an existing traditional cochlear implant as medically necessary when ANY of the following criteria is met:

- a. The currently used component is no longer functional and cannot be repaired and there is no evidence to suggest that the device has been abused or neglected;
- b. The currently used component renders the implanted beneficiary unable to adequately or safely perform age-appropriate activities of daily living; or
- c. The current technology has been made obsolete by the manufacturer.

For information on requirements and limitations for external components, refer to Clinical Coverage Policy 13A, *Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair* on Medicaid's website at <https://medicaid.ncdhhs.gov/media/12340/download?attachment>.

3.2.5 Contralateral Cochlear Implant

Medicaid shall consider coverage of contralateral cochlear implant after the successful placement of the original implant on a case-by-case basis for Medicaid beneficiaries ages 12 months of age and older with documentation of medical necessity.

Medicaid shall cover contralateral cochlear implants, after the implantation of the **first side** device, when ALL the following are met:

- a. demonstrated successful usage of the device;
- b. active participation in an appropriate auditory-based intervention program;
- c. active participation in an appropriate educational program;
- d. radiographic evidence that contralateral cochlea and nerves are present;
- e. demonstration by the beneficiary or family of the ability to care for the equipment needs of two devices;
- f. no evidence of severe physical, psychomotor, or cognitive delays; AND
- g. when at least ONE of the following applies:
 1. continued usage of a hearing aid has been unsuccessful, if residual hearing is present;
 2. the first side device is non-functional for medical or surgical reasons and replacement surgery is not an option;
 3. the first side is suspected of having a device failure but still provides some beneficial auditory input; **or**
 4. the beneficiary develops significant delayed-onset visual impairment.

3.2.6 Simultaneous Bilateral Cochlear Implants

Medicaid shall cover simultaneous bilateral cochlear implants **ONLY** when there is:

- a. clear evidence of ongoing bilateral cochlear ossification or fibrosis from previous meningitis or cochlear inflammation **or**
- b. significant bilateral visual impairment present or expected to develop, such as in Usher's syndrome.

3.2.7 Diagnostic Analysis and Programming

After the postoperative period, Medicaid shall cover activation, evaluation, and programming of:

- a. cochlear implants as separate procedures for Medicaid beneficiaries 12 months of age and older; and
- b. auditory brainstem implants as separate procedures for Medicaid beneficiaries ages 12 years through 20 years of age.

Note: Refer to **Subsection 3.2.4.** for upgrades and maintenance. Refer to **Subsection 5.1.7** for additional information on diagnostic analysis and programming.

3.2.8 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

- a. Medicaid shall not cover cochlear implant when contraindicated for ANY of the following conditions:
 1. Deafness due to lesions of the central auditory pathway, lesions of the eighth cranial (acoustic) nerve or brain stem;
 2. Active or chronic infections of the external or middle ear and mastoid cavity, or tympanic membrane perforation;
 3. Cochlear ossification that prevents electrode insertion; or
 4. Absence of cochlear development as demonstrated by imaging.
- b. Medicaid shall not cover bilateral cochlear implants during the same or subsequent operative session except when the criteria outlined in **Subsection 3.2.6** are met.
- c. Upgrades to existing, functioning external systems to achieve aesthetic improvement, such as substituting smaller-profile components or switching from a body-worn external sound processor to a behind-the-ear model, are not medically necessary and are not covered.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

5.1.1 Cochlear Implant

Medicaid shall not require prior approval for a routine, unilateral cochlear implant that meets the criteria in **Subsection 3.2.2**

5.1.2 Auditory Brainstem Implant

Medicaid shall require prior approval for an auditory brainstem implant. Health record documentation must be submitted with the prior approval request indicating that the beneficiary:

- a. is 12 years through 20 years of age; **and**
- b. has been diagnosed with neurofibromatosis type 2; **and**

- c. is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the beneficiary will become completely deaf as a result of the surgery; **or**
- d. has had bilateral auditory nerve tumors removed and is now bilaterally deaf.

5.1.3 Upgrades and Maintenance

Medicaid shall require prior approval for the upgrade and maintenance of internal components. Health record documentation must be submitted with the prior approval request indicating that:

- a. the beneficiary's response to the existing component(s) is inadequate to the point of interfering with the activities of daily living;
- b. the component(s) are no longer functional; **or**
- c. the device has been made obsolete by the manufacturer.

5.1.4 Contralateral Cochlear Implant

Medicaid shall require prior approval for a contralateral cochlear implant. The prior approval request must contain the following documentation:

- a. the date of the initial placement of a cochlear implant;
- b. the successful aural rehabilitation and use of the current implant; **and**
- c. the reason a contralateral implant is medically necessary, as outlined in **Subsection 3.2.5**

5.1.5 Simultaneous Bilateral Cochlear Implants

Medicaid shall require prior approval for simultaneous bilateral cochlear implants. Health record documentation must be submitted with the prior approval request indicating that the requirements of **Subsection 3.2.6** have been met.

5.1.6 Aural Rehabilitation

Prior approval is required. Refer to clinical coverage policy 10A, *Outpatient Specialized Therapies*, on Medicaid's website at <https://medicaid.ncdhhs.gov/> for additional information.

5.1.7 Diagnostic Analysis and Programming

Medicaid shall not require prior authorization for the postoperative diagnostic analysis and programming of the cochlear and auditory brainstem implants. Health record documentation must contain the date of the surgery and status of the analysis and programming procedures.

5.1.8 Replacement Parts and Repairs

Coverage requirements and limitations for replacement parts and repairs to cochlear and auditory brainstem implants are documented in clinical coverage policy 13A, *Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair*, on Medicaid's website at <https://medicaid.ncdhhs.gov/>

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

6.0 Providers 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 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).

8.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 2008

Revision Information:

Date	Section Revised	Change
7/1/08	Throughout	Initial promulgation of current coverage.
1/1/10	Header	Change clinical coverage policy references for the Cochlear and ABI Repair and Replacement policy to 13A.
7/1/10	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
3/12/12	Throughout	To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 1A-4 under Session Law 2011-145, § 10.41. (b)
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
05/01/2018	Section 1.0	Description updated
05/01/2018	Subsection 1.1	Definitions added.
05/01/2018	Subsection 3.2.2.	Age for a cochlear implant changed to 12 months of age and older for a Medicaid beneficiary. Diagnosis changed to moderate to profound sensorineural hearing loss greater than or equal to 70dB HL. Text updated in this section.
05/01/2018	Subsection 3.2.3	Age changed from 12 months to 12 years for a Medicaid beneficiary and age 6 years to age 12 years for a NCHC beneficiary.
05/01/2018	Subsection 3.2.4	Coverage was changed to cover the replacement of an existing traditional cochlear implant as medically necessary when criteria was met, regardless of age. The website address was changed.
05/01/2018	Subsection 3.2.5	Age changed for a Medicaid beneficiary from 12 months through 20 years of age to 12 months and older.
05/01/2018	Subsection 3.2.7	Age changed for a Medicaid beneficiary from 12 months through 20 years of age to 12 months and older.
05/01/2018	Subsection 4.2.1	Updated text.
05/01/2018	Attachment A: B	Deleted one ICD 10 code which was not specific and replaced with four additional ICD 10 codes that were specific.

Date	Section Revised	Change
05/01/2018	Attachment A: C	Added 1 to the title of Outpatient Specialized Therapies to make this 10A.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/04/2019	Table of Contents	Updated language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/04/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
03/15/2021	Section 1.0	Changed "moderate to profound hearing loss" to "severe to profound hearing loss" to match FDA language.
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks 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

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.

ICD-10 Code(s)
H90.A21
H90.A22
H90.3
H90.41
H90.42
Q85.02

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.

Physicians	
CPT Code(s)	
69930	92602
S2235	92603
69949	92604
92601	92640
Aural rehabilitation is billed according to clinical coverage policy 10A, <i>Outpatient Specialized Therapies</i> .	

Hospitals
Revenue Code(s)
RC 278

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

Provider(s) shall follow applicable modifier guidelines.
Simultaneous bilateral cochlear implants are billed with 69930 and modifier 50.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). The procedure codes documented in Section C are billed with one unit, except for CPT code 92640, which is billed as 1 unit = 1 hour.

F. Place of Service

Inpatient, Outpatient.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

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