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**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:  
7, *Hearing Aid Service*  
13B, *Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair*

## **1.0 Description of the Procedure, Product, or Service**

A bone-anchored hearing aid (BAHA) is a surgically implanted osseointegrated prosthetic device that provides bone conduction hearing for recipients with moderate to severe, bilateral conductive or mixed hearing loss who cannot wear a conventional hearing aid or cannot reasonably or satisfactorily undergo ossicular replacement surgery. A BAHA device includes the implantation of a titanium abutment to which an external speech processor is attached.

(The BAHA device is Food and Drug Administration (FDA) FDA-approved. According to the FDA and the manufacturer, it is specifically indicated for patients over five years of age. If other devices become available and are approved by the FDA for the same indications for use as the BAHA device, then the North Carolina Division of Medical Assistance (DMA) will review these devices for coverage based on the criteria in this policy, specifically **Section 3.2.1**. The term “BAHA device” is used in the remainder of this policy.)

Hearing loss can be classified as conductive, sensorineural, or mixed.

### **1.1 Conductive Hearing Loss**

Conductive hearing loss involves the external or middle ear and is due to mechanical or physical blockage of sound as a result of

- a. Perforation of the tympanic membrane
- b. Congenital malformations
- c. Otitis media (for example, infection, effusion, or drainage)
- d. Otitis externa
- e. Hereditary malfunctions
- f. Certain bone disorders (for instance, osteogenesis imperfecta or otosclerosis)
- g. Obstruction of the ear canal (such as by cerumen, exostoses, tumor, or temporomandibular joint prolapse)

### **1.2 Sensorineural Hearing Loss**

In sensorineural (that is, inner ear or nerve) hearing loss, the auditory cranial nerve or the inner ear is damaged due to

- a. Congenital malformations (such as nerve atresia)
- b. Viral or bacterial infections (for example, meningitis or herpes zoster)
- c. Trauma
- d. Exposure to extreme noise or extensive exposure to loud noises
- e. Exposure to certain medications
- f. Hereditary malfunctions
- g. A tumor in the inner ear (such as acoustic neuroma)

### 1.3 Mixed Hearing Loss

Mixed hearing loss is a combination of conductive hearing loss and sensorineural hearing loss.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

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

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
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: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

### 3.0 When the Procedure, Product, or Service Is Covered

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

#### 3.1 General Criteria Covered

Medicaid and NCHC 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 both Medicaid and NCHC

Medicaid and NCHC shall cover implantable bone conduction hearing aids for beneficiaries 5 through 20 years of age and NCHC beneficiaries ages 6 through 18 years of age, whose moderate to severe, bilateral, conduction or mixed hearing loss cannot be effectively restored by conventional air conduction hearing aids or by ossicular replacement surgery. Careful consideration shall be given to the beneficiary's psychological, physical, emotional, and developmental capabilities.

**Note:** For children under 5 years of age, or for beneficiaries who prefer an alternative to surgery, refer to clinical coverage policy 7, *Hearing Aid Service* on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

The beneficiary shall meet **at least one** of the following conditions:

- a. One or more congenital or acquired abnormalities of the middle or external ear canal that precludes the wearing of a conventional air conduction hearing aid
  - b. One or more tumors of the external canal or tympanic cavity
  - c. Dermatitis of the external ear canal
  - d. Chronic external otitis or otitis media with persistent discharge
- and**

The beneficiary shall meet **all** of the following criteria.

- a. The beneficiary has a bone conduction pure-tone average of 40–50 decibels or fewer, with no single frequency more than 50 decibels (at 1000 and 2000 Hz).
- b. The beneficiary has speech discrimination of the indicated ear of 60% or more at elevated sound pressure levels (SPL) during speech discrimination testing using consonant–nucleus–consonant [CNC] words (conventional testing).
- c. The beneficiary (either alone or with the aid of a parent or caregiver) shall be able to perform proper hygiene of the abutment (skin interface) and maintain the hearing aid device.

- d. There shall be sufficient bone volume and bone quality to support the implantation.
- e. There shall be no active scalp disease or disorder at the proposed site for the surgery.

### **3.2.2 Upgrades and Maintenance**

Medically necessary maintenance and upgrades of existing internal components for next-generation devices are covered for beneficiaries ages 5 years and older when:

- a. the beneficiary's response to existing components is inadequate to the point of interfering with the educational process, learning, and socialization; or
- b. the components are no longer functional and cannot be repaired.

**Note:** Refer to clinical coverage policy 13B, *Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair* on DMA's at <http://www.ncdhhs.gov/dma/mp/>.

### **3.2.3 Medicaid Additional Criteria Covered**

None Apply.

### **3.2.4 NCHC 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 a Medicaid Beneficiary under 21 Years of Age.*

### **4.1 General Criteria Not Covered**

Medicaid and NCHC 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 both Medicaid and NCHC**

The BAHA is not covered when:

- a. the beneficiary has a disease state that may jeopardize osseointegration;
- b. the beneficiary can gain sufficient benefit from conventional amplification; or
- c. the beneficiary's audiometric criteria are outside the range of specifications stated above in **Subsection 3.2.1, Specific Criteria**.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

### **5.0 Requirements for and Limitations on Coverage**

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

#### **5.1 Prior Approval**

Medicaid and NCHC shall require prior approval for Implantable Bone Conduction Hearing Aids (BAHA). The provider shall obtain prior approval before rendering Implantable Bone Conduction Hearing Aids (BAHA).]

#### **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 3.2.1** of this policy.

##### **5.2.2 Specific**

None Apply.

#### **5.3 Additional Limitations or Requirements**

Implantable bone conduction hearing aid devices shall be FDA approved for the population being considered.

### **6.0 Provider(s) 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 or NCHC 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 a Medicaid Beneficiary 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 DMA'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:** July 1, 2010

**Revision Information:**

Date	Section Revised	Change
07/01/2010	All sections and attachment(s)	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services. Coverage for NCHC.
02/01/2013	All sections and attachment(s)	Technical changes to merge existing NCHC and new Medicaid 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.

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

### A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

### B. International Classification of Diseases, 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-CM Code(s)		
H900	H91.8X2	H90.6
H902	H91.8X3	H90.8
H90.0	H91.8X9	H906
H90.11	H91.90	H908
H90.12	H91.91	H9011
H90.2	H91.92	H9012
H91.8X1	H91.93	

### 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.

CPT Code(s)	
69714	69718
69715	69799
69717	17999

**NOTE:** When billing as a staged procedure, with the abutment being placed in a separate procedure, physicians should use the unlisted procedure codes above. The original procedure should be billed with 69799. When the second procedure is done, submit 17999 for reimbursement.

If the prior approval request has been made for a staged procedure a second request will not have to be submitted unless it has been 365 days from the date of the original prior approval.

**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.

**E. Billing Units**

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

**F. Place of Service**

Hospital inpatient, hospital outpatient, ambulatory surgical center

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>