POLICY AND PROCEDURE

DEPARTMENT: Utilization Management	**DOCUMENT NAME: Bilateral Cochlear Implants**
PAGE: 1 of 2	**REPLACES DOCUMENT:**
APPROVED DATE: 12/14	**RETIRED:**
EFFECTIVE DATE: 12/22/14	**REVIEWED/REVISED: 12/2015; 12/2016; 10/2017**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER: WA.UM.28**

SCOPE
Coordinated Care Health Plan Utilization Review.

PURPOSE:
This policy is to be used as a guideline for determining the medical necessity of Bilateral Cochlear Implants, as well as aligning Coordinated Care with the Health Technology Assessment (HTA) guidelines per the HCA.

Bilateral Cochlear Implants are a covered benefit through Coordinated Care Health Plan for individuals age 20 and younger. For individuals age 21 and older Bilateral Cochlear Implants should be requested as an Exception to Rule.

POLICY / CRITERIA: It is the policy of Coordinated Care, in accordance with the Health Care Authority's High Technology Assessment, that bilateral cochlear implants are **medically necessary** when the HTA clinical criteria are met.

It is the policy of Coordinated Care that ***replacement*** of a cochlear implant and/or its external components (external speech processor, controller, etc.) are considered **medically necessary** when any one of the following is present:

- The manufacturer's warranty has expired.
- The part needs to be replaced due to normal wear and tear and is not related to misuse or abuse of the item.
- The existing device is no longer functional and cannot be repaired; or
- A change in the member's condition makes the existing unit inadequate for the hearing-related activities of daily living and improvement is expected with a replacement unit.

It is the policy of Coordinated Care that ***replacement or upgrade*** of an existing, properly functioning cochlear implant and/or its external components (external speech processor, controller, etc.) is considered **not medically necessary** when requested for convenience or to upgrade to a newer technology.

Procedure

1. The nurse reviewer will conduct a first level review utilizing the clinical criteria found in the HTA Clinical Committee Final Findings and Decision, found in the following link: http://www.hca.wa.gov/hta/Pages/cochlear.aspx

2. The HTA Clinical Committee Final Findings and Decision policy will be copied and entered into the Review Summary section of TruCare; the clinical documentation system.

Revision Log	Date
Annual review. No changes in HTA criteria, no changes in policy	12/1/2015
Annual review. No changes to HTA criteria, no changes in policy. ~~Annual review. No changes to HTA criteria. Clarifying language added for age limitations.~~	12/2016~~10/2017~~
Annual review. No changes to HTA criteria. Clarifying language added for age limitations.	10/2017

Coding Implications

The following codes are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any code(s) does not guarantee coverage.

CPT® Code	Description
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715	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	with mastoidectomy
69930	Cochlear device implantation, with or without mastoidectomy