



Harmony Behavioral Health, Inc.

Harmony Behavioral Health of Florida, Inc.

Harmony Health Plan of Illinois, Inc.

HealthEase of Florida, Inc.

*'Ohana Health Plan, a plan offered by
WellCare Health Insurance of Arizona, Inc.*

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare Health Plans of New Jersey, Inc.

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WellCare of Texas, Inc.

WellCare Prescription Insurance, Inc.

Pediatric Hearing Amplification

Policy Number: HS-007

Original Effective Date: 12/6/2007

**Revised Date(s): 5/22/2009; 8/20/2010;
9/1/2011**

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

BACKGROUND

Amplification with hearing instruments should be considered for a child who demonstrates a significant hearing loss, including sensorineural, conductive, or mixed hearing losses of any degree. The duration and configuration (bilateral or unilateral) will assist the audiologist in the decision to fit a child with personal hearing aids. Additional factors such as the child's health, cognitive status, and functional needs also will influence the time-line of fitting hearing aids.

For newborns and infants under the developmental age of 6 months, estimates of hearing sensitivity must be supported by electrophysiological measures including auditory brainstem response (ABR) threshold assessment. Frequency-specific air-conduction and bone-conduction ABR thresholds should be obtained. Frequency-specific ABR is necessary for accurate estimation of the degree and configuration of hearing loss. A click-ABR threshold alone is not sufficient for accurate hearing aid fitting. Acoustic immittance measures, including tympanometry and middle ear muscle reflexes, and otoacoustic emissions (OAE) are necessary to determine the type of hearing loss present.

Differential diagnosis continues to be refined and these measures should be applied to the assessment of hearing in children as they become available and interpretable. Currently researchers are suggesting that the summing potential may have value in diagnosis and that a lack of response in this measure may relate to inner hair cell function. These and other electrophysiologic measures may become a valued part of the assessment of hearing in the pediatric population. At a minimum, low and high frequency, ear specific information should be obtained in order to prescribe appropriate amplification. These data are developed over the course of evaluating the infant or child and the hearing aid fitting may begin before all data are obtained.

For older infants and young children, behavioral thresholds should be obtained using visual reinforcement audiometry (VRA), or conditioned play audiometry (CPA) test techniques appropriate for the child's developmental level. Ear-specific and frequency-specific air and bone conduction thresholds are essential for providing information needed for accurate hearing aid fitting (AAA, 2003).

POSITION STATEMENT

Pediatric (Birth to 12 years of Age) hearing amplification **is considered medically necessary** when the following criteria are met:

1. Monaural Hearing Aid:
 - a. Hearing loss in the better ear of 30 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz; **OR**,
 - b. A spondee threshold in the better ear of 30 dBHL or greater when pure tone thresholds cannot be established; **OR**,
 - c. Hearing loss in each ear is less than 30 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher;

AND,

- d. Documentation of communication need and a statement that the member is alert and oriented and able to utilize the aid appropriately; **AND**,
- e. The hearing evaluation must be conducted by a licensed audiologist certified to perform behavioral pediatric testing

2. Binaural Hearing Aid:

Same criteria for monaural hearing aid applies PLUS one or more of the following:

- a. Significant social, vocational, or educational demands; **OR**,
- b. Previous user of binaural hearing aid; **OR**,
- c. Significant visual impairment.

NOTE: The presence of chronic or recurrent middle ear conditions that can affect hearing thresholds results or the ability to wear an occluding earmold should be considered. When determining hearing aid candidacy for infants or children with borderline or minimal hearing losses, middle ear status is of particular concern in determining the likelihood of a transient condition.

NOTE: Other health concerns or conditions that may affect the ability to obtain reliable threshold information must be considered. The use of physiologic test methods (ABR, OAE) may be necessary even with older children who have additional disabilities.

CODING

CPT ®Codes - No applicable codes.

ICD-9-CM Procedure Codes - No applicable codes

Covered HCPCS Level II (DME) ® Codes

- V5030** Hearing Aid, monaural, body worn, air conduction
- V5040** Hearing Aid, monaural, body work, bone conduction
- V5050** Hearing Aid, monaural, in the ear
- V5060** Hearing Aid, monaural, behind the ear
- V5070** Glasses, air conduction
- V5080** Glasses, bone conduction
- V5120** Binaural, body
- V5130** Binaural, in the ear
- V5140** Binaural, behind the ear
- V5150** Binaural, glasses
- V5170** Hearing Aid, CROS, in the ear
- V5180** Hearing Aid, CROS, behind the ear
- V5190** Hearing Aid, CROS, glasses
- V5210** Hearing Aid, BICROS, in the ear
- V5220** Hearing Aid, BICROS, behind the ear
- V5230** Hearing Aid, BICROS, glasses

Covered ICD-9-CM Diagnosis Codes

- 389.00 - 389.08** Conductive hearing loss; conductive deafness. External Ear, Tympanic Membrane, Middle Ear, Inner Ear, Unilateral, Bilateral, Combined or Unspecified
- 389.10 - 389.18** Sensorineural hearing loss;perceptive hearing loss or deafness. Bilateral, Unilateral, Central, Asymmetrical or Unspecified
- 389.20 - 389.22** Mixed Conductive and Sensorineural hearing loss; Unilateral, Bilateral or Unspecified

*Current Procedural Terminology (CPT) 2011 American Medical Association: Chicago, IL.®©

REFERENCES

Peer Reviewed

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2. Gabbard, S.A., & Schryer, J. (2008). Considerations in early amplification: selection, fitting, validation, counseling. *Hearing Journal*, 61(11), 10, 12-17.

Government Agencies, Professional and Medical Organizations

1. American Academy of Audiology. (2003, October). Pediatric hearing amplification protocol. Retrieved from <http://www.audiology.org/resources/documentlibrary/Documents/pedamp.pdf>
2. Joint Committee on Infant Hearing. (2007). Position statement: principles and guidelines for early hearing detection and intervention programs. *Pediatrics*, 120(4), 898-921.
3. Minnesota Department of Health, Early Detection and Intervention Program. (2005, February). Recommended protocol for pediatric amplification.
4. New York State Medicaid Program. (2007, February 1). Hearing aid / audiology manual policy guidelines. Retrieved from https://www.emedny.org/ProviderManuals/HearingAid/PDFS/HearingAid_Policy_Guidelines.pdf

HISTORY AND REVISIONS

Date	Action
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
9/1/2011	<ul style="list-style-type: none">• Approved by MPC. No changes.