



Louisiana

Semi-Implantable and Fully Implantable Middle Ear Hearing Aids

Policy # 00425

Original Effective Date: 09/17/2014

Current Effective Date: 09/19/2018

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: Implantable Bone-Conduction and Bone-Anchored Hearing Aids is addressed separately in medical policy 00004.

Note: Cochlear Implant is addressed separately in medical policy 00017.

Note: Auditory Brainstem Implant is addressed separately in medical policy 00475.

Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers semi-implantable and fully implantable middle ear hearing aids to be **investigational**.*

Background/Overview

HEARING LOSS

Hearing loss is described as conductive, sensorineural, or mixed, and can be unilateral or bilateral. Normal hearing is the detection of sound at or below 20 decibels (dB). The American Speech Language- Hearing Association, has defined the degree of hearing loss based on pure-tone average detection thresholds as mild (20-40 dB), moderate (40-60 dB), severe (60-80 dB), and profound (≥ 80 dB).

Treatment

Sound amplification through the use of an air-conduction hearing aid can provide benefit to patients with sensorineural, conductive, or mixed hearing loss. Contralateral routing of the signal is a system in which a microphone on the affected side transmits a signal to an air-conduction hearing aid on the normal or less affected side.

Patients with moderate-to-severe sensorineural hearing loss are typically fitted with external acoustic hearing aids. Conductive hearing loss may be treated with acoustic or bone-conduction hearing aids when surgical or medical interventions are unable to correct hearing loss. However, these hearing aids may not be acceptable to patients, either due to issues related to anatomic fit, sound quality, or personal preference. In some cases, external acoustic hearing aids cannot be used due to external ear pathologies (e.g., otitis externa).

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Semi- and Fully Implantable Middle Ear Hearing Aids

Semi-implantable and fully implantable middle ear hearing aids are alternatives to external acoustic hearing aids. Two semi-implantable devices have Food and Drug Administration (FDA) approval: the Vibrant Soundbridge and the Maxum System. The devices consist of 3 components: a magnet that is implanted onto the ossicles of the middle ear, a receiver, and a sound processor. The Soundbridge device is implanted subcutaneously behind the ear while the processor is worn externally on the scalp over the receiver unit and held in place by a magnet. The Maxum System device is placed in the user's ear canal while the processor rests over the external ear. In general, the sound processor receives and amplifies the sound vibrations and transforms the sound pressure into electrical signals received by the receiver unit. The receiver unit then transduces these electrical signals into electromagnetic energy and creates an alternating electromagnetic field with the magnetic component (floating mass transducer) implanted on the ossicles of the middle ear. This electromagnetic field results in attractive and repulsive forces on the magnetic implant, causing vibration of the bones of the middle ear similar to normal hearing.

One fully implantable middle ear hearing aid has FDA approval: the Esteem Implantable Hearing System. Similar to the semi-implantable devices, the fully implantable device consists of a sensor, a sound processor, and a driver connected to the ossicles. The sensor detects vibrations of the tympanic membrane and transforms the vibrations into electrical signals that are processed by the sound processor. The processor transduces these signals via piezoelectric transduction, as opposed to the electromagnetic transduction used in the semi-implantable devices. A piezoelectric transducer (the sensor) is placed at the head of the incus and converts mechanical vibrations detected from the tympanic membrane into electrical signals delivered to the stapes by another piezoelectric transducer (the driver).

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Two semi-implantable devices were approved by the FDA through the premarket approval process: the Vibrant[®] Soundbridge[™] (MED-EL Corp.) in 2000 and the Direct System[™] (Soundtec) in 2001. The Soundtec system was discontinued by the manufacturer Ototronix in 2004 due to performance issues; it was re-released in 2009 under the name Maxum[™] System. Approved FDA labeling for both states that the devices are "...intended for use in adults, 18 years of age or older, who have a moderate to severe sensorineural hearing loss and desire an alternative to an acoustic hearing aid." FDA product code: MPV.

In 2010, the Esteem[®] Implantable Hearing System (Envoy Medical, St. Paul, MN), a fully implantable middle ear hearing aid, was approved by FDA through the premarket approval process. FDA-approved labeling for the Esteem hearing implant indicates it is "intended to alleviate hearing loss ... in adults 18 years of age or older with stable bilateral sensorineural hearing loss." FDA product code: OAF.

Another fully implantable middle ear hearing aid, the Carina[®] Fully Implantable Hearing Device, is in development (Otologics, now Cochlear), but does not have FDA approval. Phase 1 and 2 trials have been conducted in the United States under investigational device exemptions.

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Centers for Medicare and Medicaid Services (CMS)

No national coverage determination has been published. The Medicare Benefit Policy Manual references hearing aids and auditory implants, stating that hearing aids are excluded from coverage. However, devices producing the “perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve are payable by Medicare as prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss, or surgery.” The benefit manual does not specifically refer to semi- or fully implantable hearing aids as prosthetic devices.

Rationale/Source

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Externally worn acoustic hearing aids are widely accepted devices for patients with hearing loss. Therefore this review of semi-implantable and fully implantable hearing aids focuses on comparisons of various audiologic outcome measures between an externally worn hearing aid and a semi- or fully implantable hearing aid in the same patient. Studies of semi- and fully implantable middle ear hearing aids have frequently reported a patient preference for an implantable device compared with an externally worn device. However, it must be determined to what extent patient preference is based on convenience compared with improved hearing. Only minimal safety concerns are related to external hearing aids. In contrast, an implantable hearing aid requires a surgical procedure. Potential risks cited for semi-implantable middle ear hearing aids include a decrease in residual hearing in the implanted ear, infection in the ear and adjacent structures, and risks associated with general anesthesia. Major ear surgery may also result in numbness, swelling, or discomfort around the ear, the possibility of facial palsy, neck pain, and disturbance of balance and taste. Therefore, equivalency or improvement in audiologic outcomes associated with an implantable hearing aid must be balanced against the potential risks inherent in a surgical procedure.

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SEMI-IMPLANTABLE MIDDLE EAR HEARING AIDS

Trials Supporting Regulatory Approval of Semi-Implantable Hearing Aids for Sensorineural Hearing Loss

The U.S. FDA approvals of the Soundbridge and Soundtec (now marketed as the Maxum System) devices were based in part on clinical trials of 53 and 108 patients, respectively, who had a moderate-to-severe sensorineural hearing loss and who were dissatisfied with their existing external acoustic hearing aids. Results of these trials are available in the FDA Summaries of Safety and Effectiveness. The results of the Soundbridge and Soundtec trials have also been reported in the peer-reviewed published literature. The principal outcome measures were audiologic before (with the hearing aid in use) and after the implant. The following audiologic outcomes were reported: functional gain, speech recognition, patient assessments, and safety. Each is discussed below.

Functional Gain

Functional gain is defined as the difference in sound-field thresholds (measured in dB) and is an indicator of functional benefit from an amplification device. For the Soundbridge device, the improvement in functional gain was 14.1 dB; for the Soundtec device, it was 7.9 dB. Both gains were considered modest improvements. The clinical significance of the improvements is difficult to determine. For example, this level of improvement may be more clinically significant in patients with moderate hearing loss, for whom a 14-dB improvement in threshold might move them into the normal range for the spoken voice.

Speech Recognition

Speech recognition is assessed using the Speech Perception in Noise test and the Northwestern University-6 test, which consists of a 50-item word list. For the Soundbridge device, no significant difference in word recognition was found in quiet or noisy conditions between the implant and the acoustic hearing aid. For the Soundtec device, a statistically significant improvement was noted in Northwestern University-6 and Speech Perception in Noise test results at 52 weeks compared with an optimally fitted hearing aid. However, only 12 patients had completed the 52-week follow-up.

Patient Assessments

Patient self-evaluation was performed in a variety of ways. The Profile of Hearing Aid Performance measure consists of 7 subscales that assess several dimensions of hearing aid effectiveness, such as ease of communications, reverberation, and distortion of sounds. The Hearing Device Satisfaction Scale was developed by Symphonix, the manufacturer. This scale evaluates hearing aid and Soundbridge use and general satisfaction level. The number of subjects who reported improvements was significant across all 7 Profile of Hearing Aid Performance subscales. The largest improvements in the Soundbridge compared with the acoustic hearing aid were reported for the reverberation, reduced cues, and background noise subscales. Based on Hearing Device Satisfaction Scale scores, 94% reported improved overall sound quality for the Soundbridge. For the Soundtec device, patient satisfaction was based on the Hough Ear Institute Profile. This profile assesses patient preference, acoustic feedback, the perception of speech quality, occlusion, and tinnitus. At 20 weeks postimplant, improvements in all parameters were clinically significant. For example, 89% of patients preferred the implantable hearing aid to the acoustic hearing aid,

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although this result is not surprising because only patients who were dissatisfied with their previous acoustic hearing participated in the trial. A total of 67% of patients reported feedback with their previous acoustic hearing aid, while only 9% reported feedback with the implanted device. The clinical significance of the improvements in functional gain and speech perception is uncertain, although there appeared to be a clear patient preference for the implantable devices.⁵

Safety

Minimal safety issues were associated with either device. For the Soundbridge device, the most common complication was a fullness sensation in 18, which did not resolve in 13. Altered taste sensation was reported in 7 and transient pain in 13. Two patients reported a reduction in residual hearing. In the Soundtec device, the most common complication included device noise, ear pain, ear irritation, and processor failure. These complications resolved in almost all patients; no patient requested removal of the device. However, risks can only be adequately evaluated in broader populations over time.

Additional Studies for Semi-Implantable Hearing Aids for Sensorineural Hearing Loss

Systematic Reviews

Ernst et al (2016) reported on a systematic review of the Vibrant Soundbridge for the treatment of mixed or conductive hearing loss. Thirty-four studies (total N=294 patients) were selected: 19 studies (n=294 patients) reporting on Vibrant Soundbridge outcomes; 13 studies (n=666 patients) reporting on bone-conduction hearing implants; and 4 studies (n=43 patients) reporting on middle ear surgery plus hearing aid outcomes. No studies directly compared methods. The functional gains with the Vibrant Soundbridge at 3 months ranged from 12.5 to 43.4 dB hearing loss, averaging 29.6 dB. Significant improvements in speech recognition occurred, although methods of measuring speech differed across studies.

Bruchhage et al (2017) reported on a systematic review of the Vibrant Soundbridge for the treatment of sensorineural hearing loss. Reviewers included comparative and noncomparative studies with 5 or more patients published through 2012, which resulted in 24 studies reported in 22 articles, a conference proceeding, and an FDA report, with a total of 679 subjects (range, 5-125 subjects) in the articles and 1100 in the conference proceeding. In total, 14 studies had level 4, and 9 studies had level 3 evidence. Regarding adverse events, reviewers concluded: "Adverse events occurring with VSB [Vibrant Soundbridge] implantation were in general low, presenting mainly aural fullness (27%) or taste disturbances (9%)." Studies varied in the audiologic outcomes, but all reported functional gains and improvements in speech perception in noise and quiet.

Butler et al (2013) published results of a systematic review of comparative studies evaluating partially and fully implantable middle ear hearing devices for sensorineural hearing loss. Reviewers included 14 studies, none of which was an RCT, 13 of which evaluated a semi-implantable device (most often the Vibrant Soundbridge), with 1 study evaluating the Envoy fully implantable system. Outcomes reported across studies were heterogeneous. Among the 9 studies reporting on the primary outcome (functional hearing gain), one found that middle ear implants were statistically significantly better than hearing aids, one found that hearing aids were statistically significantly better than implants, and six found that middle ear implants

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were better than hearing aids, but without a clinically significant difference. Reviewers concluded that middle ear implants were at least as effective as hearing aids in improving hearing outcomes.

A systematic review by Kahue et al (2014) evaluated studies of 3 FDA-approved middle ear hearing aids, the Vibrant Soundbridge, the Maxum System, and the Envoy Esteem (discussed in the following section on conductive and mixed hearing loss). Studies eligible for inclusion addressed purely sensorineural hearing loss, had at least 5 implanted ears, and reported comparative data between preoperative and postoperative audiometric performance. Seventeen studies (503 ears) were included, 3 of which evaluated the Soundtec System (now Maxum System, 190 ears), 5 of which evaluated the Envoy Esteem (102 ears), and 9 of which evaluated the Vibrant Soundbridge (211 ears). The 14 studies comparing preoperative *unaided* hearing with postoperative middle ear implant–assisted hearing demonstrated improvement in hearing thresholds (weight mean, 25.2 dB improvement; range, 15.6-48.2 dB). However, for the 12 studies that compared the *best-aided* preoperative condition with the postoperative assisted performance, the functional gain was smaller (weighted mean, 8.1 dB improvement; range, -9.4 to 13 dB), and only 1 reported statistically significant improvements over optimally fitting hearing aids. Similarly, studies that compared the preoperative *unaided* condition with the postoperative middle ear implant–assisted hearing demonstrated improvements in speech recognition (weighted average, 44.8% improvement; range, 8.8%-64.0%), while speech recognition was similar for the middle ear implant–assisted condition and best-aided preoperative condition. Ten studies reported on safety outcomes, including 5 studies that focused on partially implantable middle ear implants; in those studies, 15 (11.4%) of 132 implants malfunctioned and were explanted.

Case Series

One series with long-term follow-up (mean, 7.5 years) focused on middle ear implants in patients who failed external hearing aids. Zwartenkot et al (2013) described outcomes for 33 patients with moderate-to-severe sensorineural hearing loss who had severe chronic otitis externa and were implanted with the Vibrant Soundbridge system or the Otologics MET system, a middle ear implant system not available in the United States. Compared with baseline, at long-term follow-up, subjects had statistically significant improvements in total scores on the Abbreviated Profile of Hearing Aid Benefit (63.3 at baseline vs 55.6 at follow-up, $p < 0.05$). Eighty-five percent of subjects reported wearing the device more than 4 hours a day.

Results of a 2002, phase 2 trial of the Soundtec system were published, but this publication lagged behind the data included in the FDA summary of safety and effectiveness. An additional case series of 64 Soundtec implants was published in 2005. The average functional gain varied with frequency, with the lowest functional gain in lower speech frequencies (7.9 dB) and increasing functional gain at higher frequencies, ranging up to 27 dB at the highest frequency of 6000 Hz. The functional gain of 7.9 dB at lower speech frequencies was similar to that reported in the FDA summary of safety and effectiveness, while the 27 dB gain at higher frequencies was higher than reported in the FDA summary. The cause of this marked discrepancy is not apparent. In this case series, the authors also reported that a high percentage of patients heard the magnet inside the ear, resulting in a refinement of the surgical procedure to better stabilize the magnet.

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Off-Label Use of Semi-Implantable Hearing Aids for Conductive or Mixed Hearing Loss

While the Vibrant Soundbridge received FDA approval for sensorineural hearing loss, several studies have evaluated it for off-label use in conductive or mixed hearing loss with the coupling of the device's floating mass transducer to the middle ear's round or oval window, instead of the incus, bypassing the middle ear structures.

Ernst et al (2016) published results of a systematic review of studies reporting on the Vibrant Soundbridge for conductive or mixed hearing loss. Reviewers included studies that compared the Vibrant Soundbridge with no intervention, bone-conduction hearing implants (the Bonebridge implant, a fully implantable bone-conduction hearing implant that uses a bone-conduction floating mass transducer to transmit signals to the cochlea), and middle ear surgery plus hearing aids. Nineteen articles (total N=294 individuals) comparing the Vibrant Soundbridge with no intervention were identified, including 16 cohort before-after studies, 2 concurrent cohort studies, and a nonrandomized clinical trial. No improvements in bone-conduction thresholds were reported. Studies reported a variety of methods for determining air-conduction thresholds, precluding pooling of results, but hearing thresholds improved substantially in all studies. For speech recognition, a meta-analysis of results for change in score on the Italian disyllabic word lists and Freiburg Monosyllabic Word Test was conducted, with pooled mean improvements of 71.5% and 69%, respectively. No studies were identified that compared the Vibrant Soundbridge with the Bonebridge. Four studies (n=43 individuals) compared the Vibrant Soundbridge with middle ear surgery plus hearing aids. Improvements in air-conduction thresholds and functional gain were generally better with the Vibrant Soundbridge, but studies were mixed regarding whether the Vibrant Soundbridge was associated with greater improvements in speech recognition.

Since the publication of the Ernst systematic review, Frenzel et al (2015), using a single-subject repeated-measures design, reported on outcomes from a prospective study of the Vibrant Soundbridge among 19 patients ages 5 to 17 with conductive or mixed hearing loss. Younger children (age range, 5-9 years) improved monosyllable word recognition score from a mean of 28.9% preoperatively to 80% at the initial fitting ($p=0.005$) and to 95.5% at 6-month testing ($p=0.001$). Older children (age range, 10-17 years) improved on word recognition score from a mean of 18.5% preoperatively to 80.5% at the initial fitting ($p=0.001$) and to 89% at 6 months postoperative ($p=0.001$). Improvements in speech recognition threshold and signal-to-noise ratio were also reported.

Earlier series have reported within-subject comparisons of hearing outcomes before and after hearing aid amplification and patient-reported outcomes with implantable hearing devices. One study focused on implantable hearing aid outcomes in patients who failed external hearing aids. Marino et al (2013), which was included in the Ernst systematic review, reported results of round window-coupled Vibrant Soundbridge implantation in 18 subjects with conductive or mixed hearing loss who could not derive benefit from conventional hearing aids due to chronic otitis externa, blind sac closure, pain with hearing aid mold use, and severe-to-profound mixed hearing loss. Speech recognition in quiet settings with the Soundbridge device was similar to conventional hearing aids, while speech recognition in noisy settings was improved with the Soundbridge device.

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In the largest case series identified, Colletti et al (2013) reported on longer term outcomes for 50 patients (age range, 2 months to 74 years) with severe conductive or mixed hearing loss due to ossicular chain defects who underwent coupling of the Vibrant Soundbridge system to the round window. Although subjects demonstrated improvements in speech perception and pure-tone audiometry (in adults) and auditory brainstem response thresholds (in infants), the study's implications for practice are limited due to a large number of subjects with missing data (17/50).

Other series, with sample sizes ranging from 9 to 25 subjects, have reported on hearing outcomes with the Vibrant Soundbridge, using various coupling methods. These studies generally reported improvements in hearing measures and good patient satisfaction relative to external hearing aids. Among the group, Skarzynski et al (2014) reported up to 3 years of follow-up in adults who received the Vibrant Soundbridge. Over the 3 years, bone-conduction hearing thresholds were stable. There were no cases of device extrusion or significant complications; 19% of patients had tinnitus, which resolved within 2 months postoperatively.

Section Summary: Semi-Implantable Middle Ear Hearing Aids

The evidence for the use of semi-implantable middle ear hearing aids includes the clinical trials that supported FDA approval of the Vibrant Soundbridge and the Soundtec devices, along with a large number of observational series. Most available studies have addressed the Vibrant Soundbridge device. For the use of semi-implantable middle ear hearing aids in patients with sensorineural hearing loss, the body of evidence has suggested that these devices may be associated with a modest improvement in functional gain compared with external hearing aids, with similar improvements in speech recognition scores.

Case series reporting on off-label alternative coupling methods for the Vibrant Soundbridge for patients with conductive or mixed hearing loss have also reported improved hearing thresholds and word recognition.

Although the devices appear to have a good safety profile in the short-term, given existing alternatives, studies in larger series reporting on longer term durability, safety, and efficacy are needed to permit conclusions about the devices' risks and benefits relative to external hearing aids.

FULLY IMPLANTABLE MIDDLE EAR HEARING AID FOR SENSORINEURAL HEARING LOSS

Trials Supporting Regulatory Approval of a Fully Implantable Hearing Aid

FDA approval of the Esteem Hearing System was based on a prospective, nonrandomized, multicenter trial of 60 patients with moderate-to-severe sensorineural hearing loss designed to assess safety and efficacy. Patients served as both control and test subjects as hearing was tested before (with and without hearing assistive devices) and after Esteem implantation. Results of this trial are available in the FDA summaries of safety and effectiveness. In this trial, patients experienced an improvement of 11.4 dB in mean speech reception threshold at 10 months postimplantation compared with preimplant-aided speech reception thresholds. Overall, word recognition scores were equal to or better than preimplant-aided scores in 93% of patients. The other 7% experienced lower word recognition scores postimplant.

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Ninety-six adverse device events occurred and were not considered serious. Taste disturbance was the most common, reported at 42%, followed by tinnitus at 18% and facial paralysis/paresis at 7% of patients. Severe adverse device events were experienced by 6 of the 57 patients implanted and included 3 revisions due to fibrous adhesions that limited implant benefit, 1 incision breakdown that required explantation, and 1 wound infection and 1 case of severe pain and facial weakness, both of which resolved with medication. Overall, 70% of all adverse events resolved at 10-month follow-up. However, the serious adverse event of facial paralysis/palsy had not resolved in 2 patients by time of reporting.

Kraus et al (2011) reported on 1-year follow-up of the Esteem study. Results were similar to those reported to FDA at 10-month follow-up. Mean speech reception thresholds improved 11.8 dB from a preimplant-aided score of 41.2 to 29.4 dB ($p \leq 0.001$). Mean word recognition scores improved by 19.8% from preimplant-aided scores. The authors reported 133 adverse events, including 3 cases of facial paresis that resolved with medication.

Additional Studies of a Fully Implantable Hearing Aid for Sensorineural Hearing Loss Systematic Reviews

Pulcherio et al (2014) reported on results of a systematic review of studies of 2 fully implantable middle ear hearing devices: the FDA-approved Esteem device and the Carina device. Reviewers included 22 studies with a total of 244 patients, 134 implanted with the Esteem device and 110 with the Carina device. No RCTs were identified, and most studies were small, with the largest series including 57 subjects and 12 series including fewer than 10 subjects. All studies showed improvements in sound-field threshold from unaided to aided conditions with the fully implantable device, but the magnitudes of the improvements varied.

A systematic review of the literature by Klein et al (2012) assessing the Esteem device included 7 articles that met inclusion criteria. Complications with the Esteem device most commonly included taste disturbance. Clinically significant improvements in functional gain, speech reception, and speech recognition over the unaided condition were reported. In studies comparing the Esteem implant with conventional hearing aids, findings were mixed. Improvements in functional gain were similar to those for hearing aids; however, speech recognition and quality of life were greater with the implants. This limited evidence suggested these devices might offer a relatively safe and effective treatment option, particularly for patients medically unable to wear conventional hearing aids. However, the included studies were primarily quasi-experimental, pre/post comparisons of aided and unaided conditions. Furthermore, because of heterogeneity across studies, a meta-analysis was not performed.

Case Series

Several representative case series provide additional data. Barbara et al (2011) reported on the use of the Esteem device in 21 patients with severe bilateral sensorineural hearing loss. The authors reported mean hearing threshold levels improved overall from 70 to 48 dB. In another article reporting on 6 patients implanted with the Esteem device, Barbara et al (2009) found the device improved hearing when assessed during postoperative fittings. Chen et al (2004) reported on phase 1 results for the Envoy Totally Implantable Hearing System in 7 patients followed at 2 and 4 months after device activation. Improvements in word recognition and communication in background noise over best-fit hearing aid usage were reported

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by 5 patients. Patient outcomes in functional gain and speech reception thresholds were comparable with best-fit hearing aid usage.

Other small case series have also reported on hearing outcomes associated with the Esteem device, which were generally on the order of that seen with best-aided hearing. More recently, Savas et al (2016) reported on comparisons between air and bone-conduction hearing thresholds with best-aided hearing and hearing with the Carina fully implantable middle ear implant in a study with 9 adults with bilateral mixed hearing loss.

In addition, a 2014 case series, published since the Pulcherio and the Klein systematic reviews, has reported high rates of facial nerve palsies (10/34 [29.4%] subjects) after implantation of the Esteem device, which persisted to the 3-month follow-up in 6 (17.6%) of 34 subjects.

Section Summary: Fully Implantable Middle Ear Hearing Aids for Sensorineural Hearing Loss

The evidence on the use of fully implantable middle ear hearing aids includes the clinical trial supporting FDA approval of the Esteem device, along with systematic reviews and observational series reporting short-term results. These studies have generally found improved hearing over unaided hearing, with modest improvements over hearing with best-fit aids.

ADVERSE EVENTS FOR SEMI- AND FULLY IMPLANTABLE AIDS

Zwartenkot et al (2016) reported on a single-center retrospective cohort study summarizing the long-term complications of active middle ear implants in 94 patients. Subjects were implanted with a total of 128 devices, including 92 Vibrant Soundbridge devices, 32 Otologics middle ear transducer devices, and 4 Otologics fully implantable ossicular devices (the Carina device). During an average follow-up of 4.4 years (range, 1-15 years), 28 patients were considered lost to follow-up, including 7 deaths, 12 explantations, and 6 missed follow-up appointments. During follow-up, 36 devices were replaced or explanted, most commonly soon after implantation, with 36% replaced within 18 months of implantation. Twenty (21%) patients had a complication during follow-up, of which 17 were considered serious.

SUMMARY OF EVIDENCE

For individuals who have hearing loss who receive semi-implantable or fully implantable middle ear hearing aids, the evidence includes the single-arm interventional studies submitted to the FDA, systematic reviews, and a number of observational series. Relevant outcomes include symptoms, functional outcomes, quality of life, and treatment-related morbidity. The data have suggested implantable middle ear hearing aids may provide some improvement in hearing compared with conventional external acoustic hearing aids in patients with sensorineural hearing loss. However, given the safety and effectiveness of external acoustic hearing aids and the increased risks inherent in a surgical procedure, the semi- and fully implantable device must be associated with clinically significant improvement in various hearing parameters compared with external hearing aids. While safety concerns appear to be minimal, only a limited number of patients have been included in the clinical trials, and with a median duration of follow-up less than 5 years. Studies of patients with conductive or mixed hearing loss and aural atresia, when external acoustic hearing aids are not an option, have also demonstrated a hearing benefit with semi-implantable middle ear hearing aids. However, these studies are few and limited to small numbers of patients. Therefore, conclusions on the

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safety and effectiveness of semi-implantable hearing aids are limited. Comparisons of semi-implantable devices with alternative hearing devices such as implantable bone-conduction and bone-anchored hearing aids would also be useful to determine device appropriateness for patients who are unable to use external air-conduction hearing aids. The evidence is insufficient to determine the effects of the technology on health outcomes.

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09/04/2014 Medical Policy Committee review
 09/17/2014 Medical Policy Implementation Committee approval. New policy.
 08/03/2015 Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
 09/03/2015 Medical Policy Committee review
 09/23/2015 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
 09/08/2016 Medical Policy Committee review
 09/21/2016 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
 01/01/2017 Coding update: Removing ICD-9 Diagnosis Codes
 09/07/2017 Medical Policy Committee review
 09/20/2017 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
 09/06/2018 Medical Policy Committee review
 09/19/2018 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
 Next Scheduled Review Date: 09/2019

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