Semi-Implantable and Fully Implantable Middle Ear Hearing Aids

Policy # 00425
Original Effective Date: 09/17/2014
Current Effective Date: 09/21/2016

 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.

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
Moderate-to-severe sensorineural hearing loss is often treated with external acoustic hearing aids, while conductive hearing loss may be treated with acoustic or bone conduction hearing aids when surgical or medical interventions are unable to correct hearing loss. Semi-implantable and fully implantable middle ear hearing aids detect sound and transduce signals directly to the ossicles in the middle ear, and have been use as an alternative to external acoustic hearing aids.

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 (ASLHA) has defined the degree of hearing loss based on pure-tone average (PTA) detection thresholds as mild (20-40 dB), moderate (40-60 dB), severe (60-80 dB), and profound (≥80 dB).

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 signal (CROS) 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. However, these hearing aids may not be acceptable to patients, either due to issues related to anatomic fit, sound quality, or personal preference. Conductive hearing loss may be treated with acoustic or bone conduction hearing aids when surgical or medical interventions are unable to correct hearing loss. Semi-implantable and fully implantable middle ear hearing aids have been developed as an alternative to external acoustic hearing aids.

Semi-implantable and fully implantable middle ear hearing aids have been developed as an alternative to external acoustic hearing aids. Two semi-implantable devices have Food and Drug Administration (FDA) approval: the Vibrant™ Soundbridge™ (MED-EL Corp.) and the Maxum™ System (Ototronix). The devices consist of 3 components: a magnetic component 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.
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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 that are 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 (Envoy Medical). 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 that are 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 U.S. Food and Drug Administration (FDA) through the premarket approval process: the Vibrant Soundbridge in August 2000 and the Soundtec Direct System™ in September 2001. The Soundtec was discontinued by the manufacturer Ototronix in 2004 due to performance issues; it was re-released in 2009 under the name Maxum System. The FDA labeling approved for both devices 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 March 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, was in development (Otologics, Boulder, CO), but does not have FDA approval.

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 which produce 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
This policy was created and has been updated regularly with searches of the MEDLINE database. The most recent literature review covers the period through December 17, 2015.

Externally worn acoustic hearing aids are widely accepted devices for patients with hearing loss. Therefore this policy of semi-implantable and fully implantable hearing aids focuses on various audioligic measures achieved with an externally worn hearing aid compared with a semi- or fully implantable hearing aid in the same patient. Another outcome that has been studied is 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, which is not an element of medical necessity, compared with preference based on improved hearing. Only minimal safety concerns are related to external hearing aids. In contrast, an implantable hearing aid requires a surgical procedure for implantation. Potential risks cited for semi-implantable middle ear hearing aids include decrease in residual hearing in the implanted ear, infection in the ear and adjacent structures, and general anesthesia. Major ear surgery may also result in numbness, swelling, or discomfort around the ear, the possibility of facial paresis, neck pain, and disturbance of balance and taste. Therefore, equivalency or improvement in audioligic outcomes associated with an implantable hearing aid must be balanced against the potential risks inherent in a surgical procedure.

Semi-Implantable Hearing Aids

Clinical trials for FDA-Approval of Semi-Implantable Middle Ear Hearing Aids

The FDA approval of the Soundbridge and Soundtec devices was based in part on clinical trials of 53 and 108 respective patients who had moderate to severe sensorineural hearing loss and who were dissatisfied with their existing external acoustic hearing aid. 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 the audioligic outcomes before (with the hearing aid in use) and after the implant. The following audioligic outcomes were reported:

Functional Gain

Functional gain is defined as the difference in sound field threshold (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, while for the Soundtec device, it was 7.9 dB; both are considered a modest improvement. The clinical significance of this improvement 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 Speech Perception in Noise (SPIN) test and the Northwestern University-6 test (NU-6), 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 acoustic hearing aid. For the Soundtec device, a statistically significant improvement was noted in results of the NU-6 and SPIN test at 52 weeks compared with an optimally fitted hearing aid. However, only 12 patients had completed the 52-week follow-up.
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**Patient Assessments**

Patient self-evaluation was performed in a variety of ways. The Profile of Hearing Aid Performance (PHAP) consists of 7 subscales that measure several dimensions of hearing aid effectiveness, such as ease of communications, reverberation, distortion of sound, etc. The Hearing Device Satisfaction Scale (HDSS) was developed by Symphonix, the manufacturer. This scale evaluated hearing aid and Soundbridge use and the general satisfaction level. The number of subjects who reported improvement was significant across all 7 subscales of the PHAP. The largest improvements in the Soundbridge compared with the acoustic hearing aid were reported for reverberation, reduced cues, and background noise. Based on the HDSS, 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, perception of speech quality, occlusion, and tinnitus. At 20 weeks postimplant, improvements in all of the parameters were clinically significant. For example, 89% of patients preferred the implantable hearing aid to the acoustic hearing aid, 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 improvement in functional gain and speech perception is uncertain, although there appears to be a clear patient preference for the implantable devices.

**Safety**

Minimal safety issues appeared associated with either device. In 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 Middle Ear Hearing Aids**

In 2013, Butler et al published results of a systematic review of comparative studies evaluating partially- and fully-implantable middle ear hearing devices for sensorineural hearing loss. The review included 14 studies, none of which were randomized controlled trials, 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 that reported on the primary outcome of functional hearing gain, 1 found that middle ear implants were significantly better than hearing aids, 1 found that hearing aids were significantly better than implants, and 6 studies found that middle ear implants were better than hearing aids, but without a clinically significant difference. The authors conclude that middle ear implants appear to be 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). 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...
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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 and 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 and 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 had a malfunction that led to explantation.

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 lags 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 the 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 the lower speech frequencies was similar to that reported in the FDA summary of safety and effectiveness, while the 27 dB gain at the higher frequencies was higher than 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 move inside the ear, resulting in a refinement of the surgical procedure to better stabilize the magnet.

Semi-Implantable Middle Ear 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 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.

In 2015, Ernst et al published results of a systematic review of studies reporting on the Vibrant Soundbridge for conductive or mixed hearing loss. The authors 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) compared
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The Vibrant Soundbridge with no intervention were identified, including 16 cohort before-after studies, 2 concurrent cohort studies, and 1 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 (total N=43 individuals) compared the Vibrant Soundbridge and 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 in terms of whether the Vibrant Soundbridge was associated with greater improvements in speech recognition.

Since publication of the Ernst systematic review, Frenzel et al, using a single-subject repeated-measures design, reported outcomes on the Vibrant Soundbridge among 19 patients ages 5 to 17 with conductive or mixed hearing loss in a prospective study. 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, 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.

In the largest series identified, Colletti et al reported longer term outcomes for a case series of 50 patients ages 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 hearing outcomes with the Vibrant Soundbridge, using various coupling methods. These studies generally report improvements in hearing measures and good patient satisfaction relative to external hearing aids.
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One study, by Skarzynski et al, 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 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 address the Vibrant Soundbridge device. For the use of semi-implantable middle ear hearing aids in patients with sensorineural hearing loss, the body of evidence suggests 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 alternative coupling methods for the Vibrant Soundbridge for patients with conductive or mixed hearing loss also report improved hearing thresholds and word recognition. Although the devices appear to have a good safety profile in the short term, 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
Clinical Trials for FDA Approval of a Fully Implantable Hearing Aid
FDA approval of the Esteem device was based on a prospective, nonrandomized, multicenter clinical trial of 60 patients with moderate to severe sensorineural hearing loss designed to assess the safety and efficacy of the Esteem Hearing System. Patients served as both control and test subject 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 study, patients experienced an improvement of 11.4 dB in mean speech reception threshold at 10 months’ postimplantation when 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 than preimplant scores using hearing aids.

Ninety-six adverse device events occurred and were considered to be not serious. Taste disturbance was reported to be the most common side effect reported at 42% followed by tinnitus in 18% and facial paralysis/paresis in 7% of patients. Severe adverse device effects were experienced in 6 of the 57 patients implanted and included 3 revisions due to fibrous adhesions which limited implant benefit, 1 incision breakdown which required explantation, and 1 wound infection and 1 severe pain and facial weakness case, both of which resolved when treated 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.

Kraus et al reported on 1-year follow-up of the Esteem study in 2011. Results were similar to those reported to the FDA at 10 months’ follow-up. Speech reception thresholds improved 11.8±1.8 dB from a mean preimplant aided score of 41.2 dB to 29.4 dB (p≤0.001). Word recognition scores improved by a mean of
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19.8%±4.3% from preimplant aided scores. The authors reported 133 adverse events including 3 cases of facial paresis resolved with medication.

Additional Studies for a Fully Implantable Middle Ear Hearing Aid
In 2014, Pulcherio et al reported results of a systematic review of studies of 2 fully-implantable middle-ear hearing devices: FDA-approved Esteem device and the Carina device. The review included 22 studies with a total of 244 patients, 110 implanted with the Carina device and 134 with the Esteem device. No randomized controlled trials were identified, and most studies were small, with the largest series including 57 subjects and 12 series including fewer than 10 subjects. All of the studies showed improvement of sound field threshold from unaided to aided conditions with the fully implantable device, but the magnitude of the improvements varied.

A 2012 systematic review of literature on the Esteem device included 7 articles that met inclusion criteria. Complication rates 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 suggests these devices may offer a relatively safe and effective treatment option, particularly for patients who are 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, meta-analysis was not performed, and comparisons were made by structured review.

Several representative case series are described next. Barbara et al 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 found the device improved hearing when assessed during postoperative fittings. Chen et al reported on the phase 1 results of the Envoy Totally Implantable Hearing System in 7 patients followed at 2 and 4 months after activation of the device. Improvements in word recognition and communication in background noise over best-fit hearing aid usage was perceived in 5 patients. Patient outcomes in functional gain and speech reception thresholds were comparable with best-fit hearing aid usage.

Additional small case series do not provide significant additional evidence about outcome improvements associated with the Esteem device.

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

Section Summary: Fully Implantable Middle Ear Hearing Aids
The evidence for use of fully implantable middle ear hearing aids includes the clinical trial that supported FDA approval of the Esteem device, along with small observational series that report short-term results.
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These studies generally found improved hearing over unaided hearing, with modest improvements over hearing with best-fit aids.

Ongoing and Unpublished Clinical Trials
A search of ClinicalTrials.gov in January 2016 did not identify any ongoing or unpublished trials that would likely influence this review.

Summary of Evidence
The evidence for semi-implantable and fully implantable middle ear hearing aids in individuals who have hearing loss includes the single-arm interventional studies on which the devices’ FDA approvals were based, and a number of observational series. Relevant outcomes include symptoms, functional outcomes, quality of life, and treatment-related morbidity. The limited data suggest implantable middle ear hearing aids may provide marginal 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-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 few have completed more than 1 year of follow-up. Given small sample sizes and limited safety data, risks cannot be adequately evaluated and compared with the marginal improvement in hearing. Studies of patients with conductive or mixed hearing loss and aural atresia, when external acoustic hearing aids are not an option, may provide additional insights. Therefore, conclusions on the safety and effectiveness of semi-implantable hearing aids in these patients cannot be made, and further study with longer term follow-up is needed. 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.

References

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Vibrant Soundbridge or by open earing loss: preliminary
dents
Kraus EM, Shoheit JA, Catalano PJ.

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09/04/2014 Medical Policy Committee review
08/03/2015 Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
09/03/2015 Medical Policy Committee review
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

Next Scheduled Review Date: 09/20/17

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Codes added effective 10-1-16:

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

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B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

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