Prior Authorization Review Panel
MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review. Policies submitted without this form will not be considered for review.

Plan: Aetna Better Health

<table>
<thead>
<tr>
<th>Policy Number: 0034</th>
<th>Submission Date: 04/01/2019</th>
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</table>

Policy Name: Aural Rehabilitation

Type of Submission – Check all that apply:

- [ ] New Policy
- [x] Revised Policy*
- [ ] Annual Review – No Revisions

*All revisions to the policy must be highlighted using track changes throughout the document. Please provide any clarifying information for the policy below:

CPB 0034 Aural Rehabilitation

This CPB has been revised to state that aural rehabilitation is considered experimental and investigation for the treatment of tinnitus.

Name of Authorized Individual (Please type or print):

Dr. Bernard Lewin, M.D.

Signature of Authorized Individual:
Aural Rehabilitation

Number: 0034

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Aetna considers aural rehabilitation medically necessary as speech therapy for members with hearing impairments and after placement of a cochlear implant.

Aetna considers aural rehabilitation experimental and investigation for individuals with hearing loss and without a cochlear implant and for the treatment of tinnitus because of insufficient evidence of this approach.

See also CPB 0013 - Cochlear Implants and Auditory Brainstem Implants (0013.html)

Background

An aural rehabilitation program generally starts as soon as a patient is identified as having a hearing impairment, or after placement of a cochlear implant. The patient is taught to speak, to adjust to a hearing aid or cochlear implant, and to look to a speaker's mouth and face to better comprehend what is being said. The parent or other caregiver is taught to treat the patient normally, to talk to the patient, and

Definitions

Additional Information

Policy History

Last Review: 03/18/2019
Effective: 07/21/1995
Next Review: 01/09/2020

Review History

Definitions

Additional Information
interact with him/her as though there were no impairment. The rehabilitation
program following implantation of a cochlear implant usually consists of 6 to 10
sessions that last approximately 2.5 hours each.

Hearing Loss and Without a Cochlear Implant

Michaud and Duchesne (2017) stated that few systematic reviews have been
conducted regarding aural rehabilitation for adults with hearing loss, with none
specifically targeting the older adult population. These researchers stated that with
prevalence rates of hearing loss being highest in older adults, examining the effects
of aural rehabilitation on this population is needed. They evaluated the effects of
aural rehabilitation on quality of life (QOL) in an older adult population presenting
with hearing loss. Studies with adults presenting with hearing loss, greater than or
equal to 50 years of age, with or without hearing aids, receiving interventions such
as auditory training, speech-reading, communication strategies training, speech
tracking, counseling, or a combination of approaches, and measuring outcomes
related to QOL, in an individual or group format, with or without significant others
and with no limitations as to year of publication were selected for analysis. These
investigators performed searches in 6 databases, as well as results from hand-
searching, gray literature, and cross-referencing of articles, and retrieved 386
articles. Of the 145 assessed as full-text articles for eligibility, 8 studies met
inclusion criteria. A component-based risk of bias assessment, as recommended
by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses
(PRISMA) statement was adopted. No effect sizes were found in group
interventions measuring outcomes related to QOL, such as mental and emotional
functions, environmental factors, participation restrictions, and activity limitations.
An intervention effect regarding participation was found for a self-administered
home training program, but an effect size was unavailable. Small-to-medium effect
sizes were found in 1 of 2 individual communication training programs, for which
outcomes related to QOL, such as emotional functions, activities, participation, and
environmental factors were measured. The results of the component-based risk of
bias assessment indicated that the quality of reporting was poor, thus
compromising the internal validity of included primary studies. The authors
concluded that these findings indicated that the combined body of evidence in
support of aural rehabilitation for older adults with hearing loss was insufficient to
draw any firm conclusions; they identified a need for more rigorous research to
guide clinical decision-making.
Moberly and colleagues (2018) stated that for experienced adult cochlear implant (CI) users who have reached a plateau in performance, a clinician-guided aural rehabilitation (CGAR) approach can improve speech recognition and hearing-related QOL. These researchers proposed that CGAR could improve speech recognition and hearing-related QOL in experienced CI users. A total of 12 adult CI users were enrolled in an 8-week CGAR program guided by a speech-language pathologist and audiologist; 9 patients completed the program along with pre-AR and immediate post-AR testing of speech recognition (AzBio sentences in quiet and in multi-talker babble, consonant-nucleus-consonant words in quiet), QOL (Nijmegen Cochlear Implant Questionnaire, Hearing Handicap Inventory for Adults/Elderly, and Speech, Spatial and Qualities of Hearing Scale), and neurocognitive functioning (working memory capacity, information-processing speed, inhibitory control, speed of lexical/phonological access, and nonverbal reasoning). Pilot data for these 9 patients were presented. From pre-CGAR to post-CGAR, group mean improvements in word recognition were found. Improvements were also demonstrated on some composite and sub-scale measures of QOL. Patients who demonstrated improvements in word recognition were those who performed most poorly at baseline. The authors concluded that CGAR represents a potentially effective approach to improving speech recognition and QOL for experienced CI users. These investigators also discussed limitations and considerations in implementing and studying aural rehabilitation approaches.

**Aural Rehabilitation for Tinnitus**

Searchfield and associates (2018) stated that tinnitus is a common otoneurological complaint often accompanying hearing loss. In this perspective on rehabilitation, these investigators described a framework for sound therapy and aural rehabilitation of tinnitus based on the ecological model of tinnitus. A thematic network analysis-based approach was used to relate aural rehabilitation methods to the ecological model of tinnitus and the client-oriented scale of improvement in tinnitus. Aural rehabilitation methods were mapped to concepts of context, presence of sound, and reaction to sound. A global theme was: adaptation to sound. The framework was the result of an iterative and cumulative research program exploring tinnitus as the outcome of the relationship between individual psycho-acoustics and psycho-social factors including context of perception. The authors concluded that the intent of this framework was to help guide audiologists managing tinnitus. The framework has been useful in the authors’ clinic as illustrated by a case study. They stated that the benefits of this approach relative to...
standard care needs to be independently ascertained.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td></td>
<td>CPT codes covered if selection criteria are met:</td>
</tr>
<tr>
<td>92626</td>
<td>Evaluation of auditory rehabilitation status; first hour</td>
</tr>
<tr>
<td>92627</td>
<td>each additional 15 minutes</td>
</tr>
<tr>
<td>92630</td>
<td>Auditory rehabilitation; pre-lingual hearing loss</td>
</tr>
<tr>
<td>92633</td>
<td>post-lingual hearingloss</td>
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<tr>
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<tr>
<td></td>
<td>Other CPT codes related to the CPB:</td>
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<tr>
<td>69930</td>
<td>Cochlear device implantation, with or without mastoidectomy</td>
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<tr>
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<tr>
<td></td>
<td>Other HCPCS codes related to the CPB:</td>
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<tr>
<td>L8614 - L8624</td>
<td>Cochlear device/system/supplies</td>
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<tr>
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<tr>
<td></td>
<td>ICD-10 codes covered if selection criteria are met:</td>
</tr>
<tr>
<td>H74.01 - H74.93</td>
<td>Other disorders of middle ear mastoid</td>
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<tr>
<td>H80.00 - H80.93</td>
<td>Otosclerosis</td>
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<tr>
<td>H81.01 - H81.09</td>
<td>Meniere's disease</td>
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<tr>
<td>H90.0 - H90.8</td>
<td>Conductive and sensorineural hearing loss</td>
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<tr>
<td>H93.011 - H93.099, H93.211 - H93.93</td>
<td>Other disorders of ear, not elsewhere classified</td>
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<tr>
<td>Z96.21</td>
<td>Cochlear implant status</td>
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<tr>
<td></td>
<td>ICD-10 codes not covered for indications listed in the CPB:</td>
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The above policy is based on the following references:


Amendment to
Aetna Clinical Policy Bulletin Number: CPB 0034 Aural Rehabilitation

For the Pennsylvania Medical Assistance plan:

Aetna Better Health of Pennsylvania considers aural rehabilitation medically necessary as speech therapy for members with hearing impairment/loss after placement of a cochlear implant.

Aural rehabilitation therapy is considered experimental and investigational for individuals with hearing impairment/loss without a cochlear implant because of insufficient evidence of the effectiveness of this approach.