

Clinical Policy: Tinnitus Treatment

Reference Number: WA.CP.MP.510

Date of Last Review: 02/23

Effective Date: 03/01/23

[Coding Implications](#)

[Revision Log](#)

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Description

This policy describes the medical necessity guidelines for non-invasive, non-pharmacologic tinnitus treatment.

Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that cognitive behavioral therapy is considered **medically necessary** for the treatment of subjective tinnitus.
- II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that the following treatments are **not medically necessary** for tinnitus.
 - A. Sound therapies, including but not limited to:
 - i. Masking devices (sound maskers)
 - ii. Hearing aids with sound-generating features
 - iii. Altered auditory stimuli
 - iv. Auditory attention training
 - B. Repetitive transcranial magnetic stimulation
 - C. Tinnitus-specific therapies, including, but not limited to:
 - i. Tinnitus retraining therapy (TRT)
 - ii. Neuromonics tinnitus treatment (NTT)
 - iii. Tinnitus activities treatment (TAT)
 - iv. Tinnitus-masking counseling

Background

This policy is based on the Washington State Health Care Authority (HCA) Health Technology Assessment (HTA).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient
92625	Assessment of tinnitus

ICD 10 CM Codes	Description
H93.11 – H93.19	Tinnitus

Services that are not covered:

CPT® Codes	Description
90867	Therapeutic repetitive transcranial magnetic stimulation treatment; initial
90868	Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent delivery and management
90869	Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent motor threshold re-determination with delivery and management

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	02/21	03/21
Annual review. Replaced “not covered” with “not medically necessary”. References updated.	02/22	03/22
Annual review. Replaced all instances of “members” with “members/enrollees”. Added “repetitive” to transcranial magnetic stimulation in 2.B. Updated references.	02/23	02/23

References

1. Kahwait, L, Palmieri Weber R., Richardson, J, et al. (RTI International, University of North Carolina). *Tinnitus: Non-invasive, Non-pharmacologic Treatments*. Washington Health Technology Assessment. April 10, 2020.
2. Washington State Health Care Authority. *Physician-related Services/Health Care Billing Guide*. <https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20230101.pdf> Revision effective January 1, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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