Clinical Policy: Cochlear Implants

Reference Number: WA.CP.MP.502
Last Review Date: 04/25
Effective Date: 09/01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for cochlear implants (unilateral and bilateral).

NOTE: See also CP.MP.14 – Cochlear Implant Replacements

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., and Coordinated Care Corporation, in accordance with the Health Care Authority's Health Technology Assessment and Health Care Authority Billing Guidelines, that cochlear implants are considered **medically necessary** when *all* of the following are met:

A. Bilateral severe to profound sensorineural hearing loss and
B. Limited or no benefit from hearing aids and
C. Cognitive ability and willingness to participate in an extensive auditory rehabilitation program and
D. Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system and
E. No other contraindication for surgery and
F. Device is used in accordance with FDA approved labeling.

Note: Implantation may be performed unilaterally or bilaterally.

Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

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
69930	Cochlear device implantation, with or without mastoidectomy.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed. Previously WA.UM.28.	07/19	10/19
Annual review. Reference updated.	04/20	05/20
Annual review. Added "Bilateral vs. Unilateral" to policy title. Reference updated.	03/21	04/21
Annual review. Reference updated.	03/22	03/22
Annual review. Reference updated. Removed L8614. Replaced "members" with "members/enrollees".	03/23	03/23
Annual review. References updated. Removed "Bilateral vs. Unilateral" from policy title. Removed use of InterQual criteria for unilateral implants as the HTA/HCA Billing Guideline covers unilateral and bilateral. Policy description edited to reflect unilateral and bilateral implants. Section I. removed "bilateral." Section I. A. age parameters updated per Billing Guideline. Section I. C. minor grammatical error corrected with no impact on criteria. Policy note added per Billing Guideline that implantation may be performed unilaterally or bilaterally. Added note referencing CP.MP.14.	03/24	3/24
Annual review. Updated logo and added "Coordinated Care Corporation". Removed age restriction to mirror HCA Billing Guideline. Updated references.	03/25	04/25

References

1. Hayes, Inc. Cochlear Implants: Bilateral versus Unilateral. Washington Health Technology Assessment. April 2013.
2. Washington State Health Care Authority. Hearing Services Billing Guide. Hearing Services Billing Guide Revision effective January 1, 2025.

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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.