Medical Policy
Auditory Brainstem Implant

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Policy Number: 481
BCBSA Reference Number: 7.01.83
NCD/LCD: N/A

Related Policies
• Cochlear Implant, #478
• Implantable Bone-Conduction and Bone-Anchored Hearing Aids, # 479
• Semi-Implantable and Fully Implantable Middle Ear Hearing Aid, #480

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Unilateral use of an auditory brainstem implant (using surface electrodes on the cochlear nuclei) may be MEDICALLY NECESSARY in patients with neurofibromatosis type 2, who are 12 years of age or older, and who are rendered deaf due to bilateral resection of neurofibromas of the auditory nerve.

An auditory brainstem implant is INVESTIGATIONAL for all other conditions including non-neurofibromatosis-type 2 indications.

Bilateral use of an auditory brainstem implant is INVESTIGATIONAL.

Penetrating electrode auditory brainstem implant (PABI) is INVESTIGATIONAL.

Prior Authorization Information
Inpatient
• For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
• For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.
Outpatient

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Coverage</th>
</tr>
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<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is <strong>not required</strong>.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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<td>Medicare HMO Blue℠</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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<tr>
<td>Medicare PPO Blue℠</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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**CPT Codes / HCPCS Codes / ICD Codes**

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>92640</td>
<td>Diagnostic analysis with programming of auditory brainstem implant, per hour</td>
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**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>S2235</td>
<td>Implantation of auditory brain stem implant</td>
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</table>

**ICD-10 Diagnosis Codes**

<table>
<thead>
<tr>
<th>ICD-10 diagnosis codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>Q85.02</td>
<td>Neurofibromatosis, type 2</td>
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**Description**

The auditory brainstem implant (ABI) is intended to restore some hearing in people with neurofibromatosis type 2 who are rendered deaf by bilateral removal of the characteristic neurofibromas involving the auditory nerve. The ABI consists of an externally worn speech processor that provides auditory information by electrical signal that is transferred to a receiver/stimulator implanted in the temporal bone. The receiver stimulator is, in turn, attached to an electrode array implanted on the surface of the cochlear nerve in the brainstem, thus bypassing the inner ear and auditory nerve. The electrode stimulates multiple sites on the cochlear nucleus, which is then processed normally by the brain. To place the electrode array on the surface of the cochlear nucleus, the surgeon must be able to visualize specific anatomic landmarks. Because large neurofibromas compress the brainstem and distort the underlying anatomy, it can be difficult or impossible for the surgeon to correctly place the electrode array. For this reason, patients with large, long-standing tumors may not benefit from the device.

ABIs are also being studied to determine whether they can restore hearing for other non-neurofibromatosis causes of hearing impairment in adults and children, including absence of or trauma to the cochlea or auditory nerve. It is estimated that 1.7 per 100,000 children are affected by bilateral cochlea or cochlear nerve aplasia and 2.6 per 100,000 children are affected by bilateral cochlea or cochlear nerve hypoplasia.

**Summary**

An auditory brainstem implant (ABI) is designed to restore some hearing in people with neurofibromatosis type 2 who are rendered deaf by bilateral removal of neurofibromas involving the auditory nerve. ABIs have also been studied to restore hearing for other non-neurofibromatosis indications.
For individuals who are deaf due to bilateral resection of neurofibromas of the auditory nerve who receive an ABI, the evidence includes a large, prospective case series and a technology assessment that included observational studies. Relevant outcomes are functional outcomes, quality of life, and treatment-related morbidity. The technology assessment found the highest quality evidence for improvement in hearing function, but evidence on other outcomes was lacking. The U.S. Food and Drug Administration approval of the Nucleus 24 device in 2000 was based on a prospective case series of 90 patients 12 years of age or older, of whom 60 had the implant for at least 3 months. From this group, 95% had a significant improvement in lip reading or improvement on sound-alone tests. While use of an ABI is associated with a very modest improvement in hearing, this level of improvement is considered significant for those patients who have no other treatment options. A systematic review of 16 studies found that ABI was associated with improved sound recognition and speech perception. Based on these results, ABIs are considered appropriate for the patient population age ≥12 years with NF2 and deafness following tumor removal. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are deaf due to nontumor etiologies who receive an ABI, the evidence includes case series and systematic reviews of case series. Relevant outcomes are functional outcomes, quality of life, and treatment-related morbidity. In general, ABIs have not demonstrated hearing benefits over cochlear implants for many conditions not related to neurofibromatosis type 2, and some older (now obsolete) ABI models have been associated with high rates of device failure and adverse events in this population. In addition, ABI studies have shown inferior outcomes in children with other disabilities. However, ABIs hold promise for select patients when the cochlea or cochlear nerve is absent. Evaluation is currently ongoing with the recently available Nucleus ABI541 to determine its efficacy and durability in children. Thus, further study is needed to define populations that would benefit from these devices. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

### Policy History

<table>
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<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>10/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>7/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.</td>
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<tr>
<td>5/2013</td>
<td>New references from BCBSA National medical policy.</td>
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<tr>
<td>11/2011-4/12</td>
<td>Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.</td>
</tr>
<tr>
<td>7/2010</td>
<td>Updated 7/10 based on the review of the BCBSA policy. Changes to policy statement.</td>
</tr>
<tr>
<td>1/2009</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References