PEHP Health & Benefits

PRIOR AUTHORIZATION for Cochlear Implants, Auditory Brainstem Implants, & Bone Anchored Hearing Implants ("BAHA")

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	**DOB:**	**Age:**	**PEHP ID #:**

Section II: PROVIDER INFORMATION

Date Requested:		**Service Provider Name:**
Service Provider NPI #:	**Service Provider Tax ID #:**	**Service Provider Address:**
Contact Person:	**Phone:** ( )	**Facsimile:** ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:**	**Place of Service:** *Please check.* ☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient
Facility Name:	**Facility NPI #:**	**Facility Tax ID #:**
Facility Address:	**Facility Phone:** ( )	**Facility Facsimile:** ( )
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**	

Service (s) Requested: *Please list all requested services/codes regardless of pre-authorization requirement.*

Procedure/Service: ______________________________ CPT/HCPCS code: ______________________
Please check all that apply: ☐ Bilateral (Both) Sides ☐ Left Side ☐ Right Side ☐ Repair ☐ Replacement ☐ Second/Contralateral ☐ Upgrade

Procedure/Service: ______________________________ CPT/HCPCS code: ______________________
Please check all that apply: ☐ Bilateral (Both) Sides ☐ Left Side ☐ Right Side ☐ Repair ☐ Replacement ☐ Second/Contralateral ☐ Upgrade

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Procedure/Service: ______________________________ CPT/HCPCS code: ______________________
Please check all that apply: ☐ Bilateral (Both) Sides ☐ Left Side ☐ Right Side ☐ Repair ☐ Replacement ☐ Second/Contralateral ☐ Upgrade

A. Type of Hearing Device Being Requested:

1. ☐ Auditory Brainstem Implant (ABI)
2. ☐ Cochlear Implant without External Hearing Aid
3. ☐ Fully Implantable Middle Ear Hearing Aid (e.g., Esteem®)
4. ☐ Hybrid Cochlear Implant with External Hearing Aid (e.g., Cochlear Nucleus® Hybrid™)
5. ☐ Implantable Bone Anchored Hearing Aid (BAHA)
6. ☐ Non-Implantable Intraoral Bone Conduction Hearing Aid (e.g., SoundBite™ Hearing System)
7. ☐ Percutaneous BAHA (with Abutment or Magnetic Coupling)
8. ☐ Other (*please specify*): ______________________

(Please check device/service being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
B. ☐ **Auditory Brainstem Implant (ABI):** 1. Has the patient been diagnosed with Neurofibromatosis Type 2 (NF2)?	☐	☐	
2. Is the patient 12 years old or older?	☐	☐	
3. Will the patient be undergoing removal of bilateral tumors of the auditory nerves?	☐	☐	
3. a. Is it anticipated that the patient will become completely deaf as a result of the surgery to remove the tumors?	☐	☐	
4. Did the patient already have removal of the bilateral auditory nerve tumors and is now bilaterally deaf?	☐	☐	
C. ☐ **(Percutaneous) Bone Anchored Hearing Implants ("BAHA"):** 1. Is a *unilateral* percutaneous FDA-approved bone-anchored hearing aid (BAHA) device with abutment (e.g., Baha®, Ponto Systems, Cochlear® Baha Connect System) or magnetic coupling (e.g., Baha® Attract, Sophono® Systems) being requested because the patient has conductive or mixed hearing loss?	☐	☐	
2. Is a *bilateral* percutaneous FDA-approved bone-anchored hearing aid (BAHA) device with abutment or magnetic coupling being requested because the patient has symmetrical conductive or mixed hearing loss (i.e., difference of < 15 dB HL each side at individual frequencies or < 10 dB HL difference of pure tone average measured at frequencies of 500, 1000, 2000, and 3000 Hz between ears)?	☐	☐	

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:

(Please check service being requested.) **QUESTION (*cont'd*)**	YES	NO	COMMENTS/NOTES
3. Is use of a conventional hearing device precluded because the patient has a malformation of the external or middle ear (e.g., microtic ears, congenital atresia, small ear canals, tumor)?	☐	☐	
4. Is use of a conventional hearing device precluded because the patient has a condition that involves chronic middle ear drainage (e.g., dermatitis, severe chronic otitis media)?	☐	☐	
5. Does the patient have a pure tone average (PTA) bone conduction threshold of up to 65 dB HL (decibel hearing loss) with average measured at 500, 1000, 2000, and 3000 Hz, for the percutaneous device with abutment ?	☐	☐	
6. Does the patient have a PTA bone conduction threshold of up to 55 dB HL with average measured at 500, 1000, 2000, and 3000 Hz for the magnetic coupling device?	☐	☐	
7. Does the patient have a speech discrimination score of better than 60% in the indicated ear?	☐	☐	
8. Does the patient have any of the following conditions? ***Please check.*** ☐ Condition that is contraindicated for an air conduction hearing aid ☐ Congenital or surgically induced ear malformations of the external or middle ear canal ☐ Documentation of chronic ear infection/inflammation ☐ Tumor of the external canal and/or tympanic cavity	☐	☐	
D. ☐ **(Implantable) Bone Anchored Hearing Implants ("BAHA"):**			
1. Is an implantable BAHA being requested for conductive or mixed hearing loss?	☐	☐	
2. Is an implantable BAHA being requested for unilateral sensorineural hearing loss (single-sided deafness, i.e., deafness in one ear while the other ear has normal hearing)?	☐	☐	
3. Is an implantable BAHA being requested for bilateral pure sensorineural hearing loss?	☐	☐	
E. ☐ **Traditional Cochlear Implant without an External Hearing Aid:** ***Completion of Section E. and F. required if requesting a second/contralateral cochlear implant.*** 1. **Adults *(age 18 or older):*** Does the patient have bilateral sensorineural hearing loss with a reasonable expectation that a significant benefit will be achieved from the device?	☐	☐	*Completion of Section F. required for second implant.*
1. a. Does the patient have bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average (PTA) of 70 dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz, and 2000Hz?	☐	☐	
1. b. Did the patient have a limited or no benefit from appropriately fitting hearing aids defined as ≤ 40% correct in the best aided listening condition (i.e., non-implanted ear aided or binaurally aided) using open-set Hearing in Noise Test (HINT) sentence recognition?	☐	☐	
2. **Children *(age 12 months to 17 years, 11 months):*** Does the patient have bilateral sensorineural hearing loss with thresholds of 90 dB or greater at 1000 Hz and there a reasonable expectation that a significant benefit will be achieved from the device?	☐	☐	
2. a. ***Age five and younger:*** Did the patient have limited or no benefit from a 3-month trial of appropriately fitted binaural hearing aids defined as a lack of progress in development of simple auditory skills in conjunction with appropriate amplification and participation in intensive aural habilitation over a 3-month period?	☐	☐	
2. b. ***Over age 5 to 17 years, 11 months:*** Did the patient have limited or no benefit from a 3-month trial of appropriately fitted binaural hearing aids defined as less than 20% correct on open-set sentence discrimination (e.g., Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills?	☐	☐	
2. c. Was the child unable to undergo a 3-month trial of an appropriately fitted binaural hearing aid because the patient has a history of pneumococcal meningitis causing the hearing loss or because the patient has evidence of cochlear ossification on computerized tomography (CT) scan?	☐	☐	
F. ☐ **Second Traditional Cochlear Implant in the Contralateral (Opposite) Ear:** ***Completion of Section E. also required if requesting a second/contralateral cochlear implant.*** 1. Does the patient have an existing unilateral cochlear implant with a hearing aid in the contralateral (opposite) ear that produces limited or no benefit & there's a reasonable expectation that a significant benefit will be achieved from the device?	☐	☐	*Completion of Section E. also required.*
G. ☐ **Replacement of Traditional Cochlear Implant:** 1. Is the currently used component no longer functional, but can be repaired?	☐	☐	
1. a. If the currently used component no longer functional is there evidence to suggest that the device has been abused or neglected?	☐	☐	
2. Does the currently used component render the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living?	☐	☐	

Additional Comments:

Please fax completed form and medical records to 801-366-7449.