



State of California—Health and Human Services Agency
Department of Health Care Services



Edmond G. Brown Jr
Governor

December 9, 2011

N.L.:10-1211
Index: Benefits
Supplements: NL 03-0411
Supersede: NL 09-1208

TO: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS)
ADMINISTRATORS, MEDICAL CONSULTANTS AND STATE
CHILDREN'S MEDICAL SERVICES AND REGIONAL OFFICE STAFF

SUBJECT: COCHLEAR IMPLANT UPDATED CANDIDACY CRITERIA AND
AUTHORIZATION PROCEDURE

I. PURPOSE

The purpose of this Numbered Letter is to delegate the authority to authorize certain cochlear implant evaluation requests to the County CCS and Regional Offices, and to update policy regarding cochlear implant surgery.

II. BACKGROUND

The N.L. 09-1208 requires that all requests for cochlear implant evaluations and surgeries are reviewed by the State Audiology Consultant prior to authorization by the County, and further delineates candidacy criteria for the evaluations and surgery. Assessment of this process has revealed that requests for evaluations originating from the CCS-approved Communication Disorder Centers that are also CCS-approved Cochlear Implant Centers (CICs) met current criteria, were within the national standards of practice, and were approved and authorized 100 percent of the time. It has been determined that evaluation requests submitted from the Communication Disorder Centers that are also CCS-approved CICs do not require medical or specialty review, and will be considered a routine authorization.

Due to rapid advances in cochlear implant technology and research, it is critical that the CCS program maintains comprehensive policies that allow the current standard of care to be practiced by the CCS-approved CICs. The institutions that have received CCS-approval have not only met specific program standards, but are considered to be among the top clinical and research facilities in the nation, with high implantation success rates and quality services. The current CCS-approved CICs include:

- 7.36.1: University of California Davis Medical Center
- 7.36.2: Ronald Reagan University of California Los Angeles Medical Center
- 7.36.3: Children's Hospital, Oakland
- 7.36.4: Rady Children's Hospital, San Diego
- 7.36.5: House Ear Institute, Los Angeles
- 7.36.07: Stanford Cochlear Implant Center, Palo Alto
- 7.36.08: University of California Irvine Medical Center
- 7.36.09: University of California San Francisco Medical Center (limited to current patients and in-county patients)
- 7.36.10: Lucile Salter Packard Children's Hospital, Palo Alto

The following policy will allow for children to receive the appropriate standard of care, as mandated in Title 22, Section 51340 of the California Code of Regulations (CCR).

III. POLICY

- A. Independent County CCS Program Offices and Regional Offices shall issue authorizations for the cochlear implant evaluation to the CCS-approved CIC number when they have been referred by the Communication Disorder Center at the same facility or the Cochlear Implant Center. The Service Authorization Request (SAR) will indicate if the request is being made by the CIC. The authorization will include the SCG 05 to the CIC number and the SCG 01 to the CCS-paneled surgeon selected by the CIC, and will be issued for 180 days or through the current program eligibility period.
- B. Requests for cochlear implant evaluations submitted by non CCS-approved providers, or CCS-approved Communication Disorder Centers that are not also CICs, will continue to require review by the State Audiology Consultant. If the referring audiologist, school, or physician does not indicate a specific Cochlear Implant Center in the referral, the parents should be informed of the CIC(s) that are geographically near their home to assist them in their decision of which provider to see. If the parents do not indicate a preference, the State Audiology Consultant will choose the facility to best serve the family.

Children will be considered candidates for cochlear implant evaluations with the following criteria:

1. The presence of a bilateral, moderate – profound sensorineural hearing loss.
2. Compliance with hearing aid use and clinical recommendations for treatment, including consistent appointment attendance.

3. If older than 4 years of age, the ability of the parents and the child to communicate with oral language or sign language.
- C. Requests for cochlear implant surgeries must be reviewed by the State Audiology Consultant prior to authorization.

Children will be considered candidates for cochlear implant surgery, unilateral or bilateral, with the following criteria:

1. Recommendation by a CCS-Approved CIC.
2. Audiometric criteria, including moderate-profound sensorineural hearing loss and limited benefit from hearing aids demonstrated by speech perception scores and/or aided thresholds.
3. Cochlea structurally suitable for implantation, normal acoustic nerve free of lesions, no middle ear fluid or infections, and no other medical contraindications to surgery, as determined by the cochlear implant surgeon.
4. Speech and language development which demonstrates communicative intent, identifiable and measurable language base, and candidacy approval by a CCS-paneled Speech Language Pathologist.
5. Behavioral and developmental characteristics that would not interfere with rehabilitation, as determined by a CIC team member.
6. Motivation and appropriate expectations by the parents and/or caregivers, through willingness to enroll in the most appropriate education program and long-term rehabilitation, as determined by a CIC team member.
7. For sequential, bilateral implantation, no functional benefit from a hearing aid on the unimplanted side and documented progress in auditory/oral language development.

IV. IMPLEMENTATION

- A. Authorizations for cochlear implant evaluations and surgeries should follow the instructions found in Numbered Letter 03-0411.
- B. Requests for cochlear implant evaluations from providers that are not a CCS-Approved CIC should be forwarded by fax to **916-440-5297**, with a face sheet indicating the name and CCS number of the beneficiary and the nurse case manager contact information. The fax should include any audiograms and audiology reports, and if available, the Cochlear Implant Evaluation Request Form (Attachment 1).

It is not necessary to include the EPSDT worksheet, or pend SARs for approval prior to forwarding the case to the State Audiology Consultant if it is not clear which provider will be offering the services.

- C. Requests for cochlear implant evaluations from providers that are CCS-approved CICs should be authorized without medical review by the nurse case manager according to instructions found in Numbered Letter 03-0411.
- D. Requests for cochlear implant surgeries should be forwarded by fax to **916-440-5297**, with a face sheet indicating the CCS number of the beneficiary, the contact information for the nurse case manager, and an indication that the request is a cochlear implant surgery. The fax should include the summative report submitted by the CIC, and, if available, the Cochlear Implant Surgery Request Form (Attachment 2). Additional reports and Individualized Education Plans (IEP)/Individualized Family Service Plans (IFSP) are not initially necessary, but should be available upon request by the State Audiology Consultant.
- E. As instructed in N.L. 03-0411, "Approved Y" SARs from the State Audiology Consultant requires authorization by the County and notification to the provider and family. "Approved-N" SARs indicate the recommendation by the State Audiology Consultant for the denial of services, and the case notes will indicate the reason for denial according to the criteria in this Numbered Letter. Language from the case note can be used in the Notice of Action, which must be issued by the County in accordance with N.L. 03-0205.

Should you have any questions regarding the authorization of cochlear implant services, please contact the State Audiology Consultants at AudConsult@dhcs.ca.gov or by fax at 916-440-5297.

Thank you for your services to California's Children.

Sincerely,

Original Signed by Robert Dimand, M.D.

Robert Dimand, M.D.
Chief Medical Officer
Children's Medical Services

Enclosures

COCHLEAR IMPLANT EVALUATION REQUEST FORM

To be completed by referring audiologist or physician

CHILD'S NAME _____ DATE OF BIRTH _____

Type and degree of hearing loss (please enclose audiogram): _____

Etiology of hearing loss (if known): _____ Age of diagnosis: _____

Please enclose:

- Reports of audiological evaluations, including most current audiogram or evoked potential report (must be within last 6 months)
- Hearing aid data and reports, to include aided audiogram if available
- Related evaluations (speech/language, speech perception, psycho/social, radiographic)

Please answer the following questions

Y	N	Does the child wear hearing aids? Make/Model _____ Date fit _____
Y	N	Does the child cooperate during visits?
Y	N	Are the caregivers compliant with appointments/recommendations?
Y	N	Does the child exhibit communicative intent?
Y	N	Is the child receiving educational services? Type _____
Y	N	Does the child communicate with signs?
Y	N	Does the child attempt oral communication?
Y	N	Has the child been evaluated at another Cochlear Implant Center? Where? _____
Y	N	Do the caregivers use the same method of communication as the child?
Y	N	Has the method of communication been demonstrated by the parents in your office?
Y	N	Has there been a period of auditory deprivation? How long? _____
Y	N	Are the caregivers aware that cochlear implantation is a surgery?
Y	N	Are the caregivers aware that cochlear implantation is NOT a cure for hearing loss?
Y	N	Are the caregivers aware of the multiple appointments necessary before AND after cochlear implantation?
Y	N	Are the parents informed of ALL options available to hearing impaired children?
Y	N	DOES THE CHILD HAVE A BILATERAL MODERATE-PROFOUND SENSORINEURAL HEARING LOSS?
Y	N	ARE YOU RECOMMENDING AN EVALUATION FOR A COCHLEAR IMPLANT?

Audiology Provider _____ Facility _____

Telephone _____ Fax _____ E-Mail _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

How has the family and/or candidate demonstrated motivation to commit to a long-term rehabilitation program?

What are the parents/caregivers/candidate's expectations regarding cochlear implantation?

Where is the child receiving educational services and/or rehabilitation services? Please list specific names and programs.

Additional comments and clarification:

PLEASE NOTE: Recommendation for a cochlear implant evaluation does not assure that an evaluation will occur. Each Cochlear Implant Center triages the individual case according to their own cochlear implant fitting criteria. The Cochlear Implant Center will determine whether the patient is an appropriate candidate for that center's program. PLEASE INFORM YOUR PATIENT.

Signature of Audiologist

Date

To be completed by CCS office:

CCS number _____ County _____ Date of SAR _____

- ☐ Current report and/or audiogram ☐ SAR request
☐ Additional relevant reports, if available (ENT, SLP, school)

PHN _____ Phone _____ E-mail _____

COCHLEAR IMPLANT TEAM EVALUATION RESULTS and SURGICAL REQUEST FORM

To be completed by a member of the Cochlear Implant Evaluation Team

Please include relevant cochlear implant evaluation reports

CHILD'S NAME _____ DATE OF BIRTH _____

CI CENTER _____ PHONE _____

TEAM MEMBER COMPLETING FORM _____

You are requesting (Please check one): ☐ Unilateral Implant ☐ Bilateral Implants

<u>TEAM MEMBER CHECKLISTS</u>	<u>COMMENTS:</u>	<u>RECOMMEND IMPLANT?</u>
<u>MEDICAL:</u> <ul style="list-style-type: none"> ○ Diagnosis of Meningitis ○ Free from middle ear infection ○ Accessible cochlear lumen & viable cochlear nerve ○ No lesions in acoustic area of central nervous system ○ No contraindications to surgery 		YES NO
<u>AUDIOLOGICAL:</u> <ul style="list-style-type: none"> ○ Audiometric criteria, bilateral moderate-profound loss ○ Speech perception testing ○ Appropriately fitted hearing aid trial ○ Minimal periods of auditory deprivation 		YES NO
<u>SPEECH/LANGUAGE:</u> <ul style="list-style-type: none"> ○ Joint attention, communicative intent, language base ○ Speech/language evaluation ○ Parents/caregivers using appropriate communication method 		YES NO
<u>PSYCHO-SOCIAL:</u> <ul style="list-style-type: none"> ○ Appropriate expectations regarding prognosis of implant ○ Demonstrated motivation by parents or caregivers ○ History of compliance to medical evaluations and treatments ○ Behavioral and developmental indications that would not interfere with rehabilitation 		YES NO
<u>EDUCATIONAL:</u> <ul style="list-style-type: none"> ○ Willingness to enroll in most appropriate educational setting, as recommended by CI Team ○ Review of IFSP or IEP 		YES NO
<u>OVERALL RECOMMENDATION OF CI TEAM</u>		

To be completed by CCS office:

CCS number _____ County _____ Date of request _____

PHN _____ Phone _____ E-mail _____