



Cochlear Implants

What the 2006 IDEA Part B Final Regulations Say

Cochlear implants (CIs) are addressed under three different sections of the 2006 IDEA Part B Final Regulations:

- §300.5. Assistive technology device;
- §300.34. Related services (b)(1),(2)(i),(iii); and
- §300.113. Routine checking of hearing aids and external components of surgically implanted medical devices.

Throughout the pertinent sections, the regulations clarify the intent of IDEA 2004 on covered related services and reiterate the exclusion of a surgically implanted medical device as an assistive device. A cochlear implant is not an assistive device. The U.S. Department of Education (ED) refutes in the Analysis of Comments and Changes section of the regulations the analogy between a CI and a hearing aid, which might, under some conditions, be considered an assistive device.

In the Analysis of Comments and Changes section of the regulations, ED acknowledges the need for clarification on CIs under §300.34 – Related services. The regulation now specifically state that mapping is not a related service, and also clarifies that *optimization* does refer to *mapping* a CI. Therefore, optimization services are not a covered service. Further, the language makes clear that a child with a CI or other surgically implanted medical device is entitled to those related services (e.g., speech and language services, audiology services) that are required for the child to benefit from special education, as determined by the child's individualized education program (IEP) team.

ED states that “the expertise of a licensed physician or an individual with specialized technical expertise beyond what is typically available from school personnel” is required to maintain and monitor the surgically implanted device. It further states that a public agency is responsible for the routine checking of the external components of a surgically implanted device in much the same manner as a public agency is responsible for the proper functioning of hearing aids. As part of its discussion, ED wrote the following:

“In many ways, there is no substantive difference between serving a child with a cochlear implant in a school setting and serving a child with a hearing aid. The externally worn speech processor connected with the surgically implanted device is similar to a hearing aid in that it must be turned on and properly functioning in order for the child to benefit from his or her education. Parents of children with cochlear implants and parents of children with hearing aids both frequently bring

to school extra batteries, cords, and other parts for the hearing aid or externally worn speech processor connected with the surgically implanted devices, especially for younger children. The child may also need to be positioned so that he or she can directly see the teacher at all times, or may need an FM amplification system such as an audio loop.”

This discussion regarding services for a child with a CI is again reiterated under §300.113 – Routine checking of hearing aids and external components of surgically implanted medical devices. The language “external components of surgically implanted medical devices” is new. This section (renumbered from the previous regulations) continues to read that “each public agency must ensure that hearing aids worn in school” and added “that the external components of surgically implanted medical devices are properly functioning.” Again, this section states that the public agency is not responsible for post-surgical maintenance, programming, or replacement of surgically implanted medical devices.

Implications for ASHA Members

The regulations are clear that children with CIs deserve the same array of related services as a child with a hearing aid as determined by the IEP team. The fact that a child has a CI does not disallow services to the child or from the addition of a hearing assistive device. A challenge for members who provide services to the child with the CI is to ensure that the external components are functioning. This requires the purchase of specialized equipment and additional training. Perhaps the greatest challenge here is what to do if the external components are not functioning properly. Back-up equipment and even batteries for these external parts are not routine accessories. Speech-language pathologists should be asked by the outside CI center to participate in determining when a child’s processor may need to be remapped (reprogrammed) based on the child’s progress in the acquisition of speech and language.

What ASHA Members Can Do

There are several steps that ASHA members can take. First, they must familiarize themselves as much as possible with the Act, the regulations, and the specific needs of children with CIs. Public agencies are just starting to understand these children’s abilities and needs. ASHA members will have a great deal of education to provide to ensure that teachers and other members of the classroom team understand the learning potential, as well as the needs of, children with hearing loss and especially the child with a CI.

In addition, ASHA members, specifically audiologists, will need to work with their public agency to design a plan for a non-functioning CI processor. This might be a hearing aid for a non-implanted ear, a back-up processor from home or the CI center, or a special budget to replace the specific CI batteries or cords. While the discussion indicated above suggests that families often provide this, oftentimes they do not. Finally, advocacy for increased audiologic support in the schools can be the best resource for these children and their peers with hearing loss.