Cochlear Americas

IMPLANT BILLING CODES

COCHLEAR™ NUCLEUS® SYSTEM

Audiologist/Professional Services

The codes in this section may be reported by audiologists and other licensed clinicians for services related to pre- and post-operative analysis and rehabilitation of Cochlear implant patients. This list is not intended to be comprehensive of all services that may be offered to Cochlear implant patients.

Use these CPT® Codes when performing the following procedures:

92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92550	Tympanometry and reflex threshold measurements
92551	Screening test, pure tone, air only
92552	Pure tone audiometry threshold evaluation via air only
92553	Pure tone audiometry threshold evaluation via air and bone
92555	Speech audiometry reception threshold evaluation *(typically used for children age 6-30 months)*
92556	Speech audiometry threshold evaluation with speech recognition test *(typically used for children age 2 ½ - 6 years)*
92557	Comprehensive audiometry threshold evaluation and speech recognition *(92553 & 92556 combined)*
92567	Tympanometry *(impedance testing)*
92568	Acoustic reflex testing; threshold
92570	Acoustic immittance testing, includes tympanometry *(impedance testing)*, acoustic reflex threshold testing, and acoustic reflex decay testing
92579	Visual reinforcement audiometry *(VRA)*
92582	Conditioning play audiometry *(threshold evaluation in children)*
92583	Select picture audiometry threshold evaluation
92585	Auditory evoked potentials for evoked response audiometry and/or testing of central nervous system; comprehensive *(e.g. NRT)*
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited *(e.g. NRT)*
92700	Unlisted otorhinolaryngological service or procedure
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician *(for participation by non-physician health care professional, bill 99368)*

For complete code descriptions, please consult a current CPT manual.

Post-Operative Clinic Services

Use these CPT Codes when performing the following procedures:

92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming

Post-Operative Clinic Services (cont.)

Use these CPT Codes when performing the following procedures:

92604	Diagnostic analysis of cochlear implant, age 7 years or older; with subsequent reprogramming
92626	Evaluation of auditory rehabilitation status; first hour *(can be used pre-op & post-op)*
92627	Evaluation of auditory rehabilitation status; each additional 15 minutes
92630	Auditory rehabilitation; pre-lingual hearing loss
92633	Auditory rehabilitation; post-lingual hearing loss

Medicare Billing Notes

Medicare has a number of rules dictating how certain codes may be billed. Some rules include:

92507 & 92508	May only be provided by an SLP. Medicare will not pay audiologists for these codes
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92626 & 92627	Are payable when billed by an audiologist or an SLP
92601-92604	May not be billed by SLPs, but can be billed by physicians and non-physician practitioners who may personally provide the services that are within their scope of practice *(such as audiologists)*
92630 & 92633	Are not payable by Medicare for any providers

Medicare instructs providers to bill 92507 instead. Medicare's National Correct Coding Initiative limits certain codes from being billed together, including several audiology codes. Some of these limits are avoidable through use of modifiers while others are strict limitations that cannot be overridden. Check with your payer or a Cochlear Americas reimbursement specialist for assistance clarifying these restrictions.

Intraoperative Neurophysiology

Add on Codes: Continuous intraoperative neurophysiology monitoring;

95940	In the operating room, one on one monitoring, each 15 minutes
95941	From outside the operating room, remote or nearby, or for monitoring of more than one case while in the operating room, per hour.
G0453	Outside operating room, per patient, the operating room *(remote or nearby),* per patient *(attention directed exclusively to one patient)* each 15 minutes. Per cms guidelines must be billed subsequent to physician services.

List these codes in addition to primary study procedure code. (i.e. 92585)

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Billing Tips and FAQs

1). **Deletion of 95920.** New code billable by Medicare HCPCS code G0453 (Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)). This code may be billed only for undivided attention by the monitoring physician to a single beneficiary. Multiple units may be billed to account for cumulative time spent. Medicare will not pay for CPT code 95941.

2). **Magnet removal;** Explant of the magnet may be billed using CPT code 20670, if removal and replacement take place the 22 modifier and description of the services may be necessary for payment review.

3). **Timed code tip.** A timed code is billed only if face- to -face time spent in an evaluation is at least 51% of the time designated in the codes's descriptor.

4). **CPT codes 92601-92604,** when billing this code range, if bilateral analysis, fitting, and adjustments of bilateral cochlear implants, CMS recommends that a -22 modifier (unusual procedural service) be added to the applicable code. Necessary documentation should be outlined to show what differentiates a singular cochlear implant fitting/remapping from a bilateral fitting/remapping. Some other payors may require other modifiers such as RT and LT to indicate services rendered.

5). **Deletion of 92506.** Replacement codes are 92521, 92522, 92523, and 92524.

Modifiers

Add Modifier when a claim reports the following situations:

50	Bilateral procedure in the same operative session
51	Multiple procedure codes on the same claim
52	Reported CPT code is not fully performed or partially reduced
59	Distinct procedure unrelated to primary procedure *(e.g. otolaryngologic exam under general anesthesia unrelated to Cochlear implant implantation procedure)* ***Note:*** *Payers have differing rules on proper use of modifiers. Consult your payers to confirm policies.*

Cochlear Implant Device

This code is typically only reported by the surgical facility providing the device.

Report Code when providing device:

L8614	Cochlear device, includes all internal and external components

For the latest information, visit www.Cochlear.com/US/Professionals and click on Reimbursement Support, then Coding and Billing Support or call the Cochlear Coding Support Hotline **1 800 587 6910**

Surgical Services Related To Cochlear Implant Implantation

The codes in this section may be reported by both the surgeon and the surgical facility (ASC/Hospital).

Use these CPT Codes when performing the following procedures:

69930	Cochlear implant device implantation, with or without mastoidectomy
69949	Unlisted procedure, inner ear *(removal of cochlear implant)*
69990	Use of operating microscope
92584	Electrocochleography
92585	Auditory evoked potentials for evoked response audiometry and/or testing of central nervous system; comprehensive *(e.g. NRT)*
92586	Auditory evoked potentials for evoked response audiometry and/or testing of central nervous system; limited *(e.g. NRT)*
95867	Needle electromyography; cranial nerve supplied muscles, unilateral

Note: *The American Medical Association's Current Procedural Terminology (CPT®) does not limit CPT codes to any particular specialty. However, the CPT® introductory language and AMA coding guidance is clear that in order to bill these codes (+95940, +95941, or G0453) the service must be performed by a monitoring professional who is SOLELY DEDICATED to performing the intraoperative neurophysiologic monitoring and is available to intervene at all times during the service as necessary. The monitoring professional may not provide any other clinical activities during the same period of time. In the event the monitoring is performed by the surgeon or anesthesiologist, the professional services are INCLUDED in the primary service code(s) and SHOULD NOT BE REPORTED SEPARATELY.*

Revenue Codes

Revenue codes are used only for hospital/ASC claims.

Report Code when providing device or service:

0278	Medical/surgical supplies and other implants
0361	Operating room services and minor surgery

Ambulatory Payment Classification (APC)

0259	Cochlear implant

Bilateral Billing Scenarios

If cochlear implants are implanted bilaterally in the same surgical session, the claim will need to reflect this fact. Payers have differing coverage and coding requirements for bilateral Cochlear implant implantation. For example, when billing to Medicare, hospitals can report a single code with modifier 50, but ASCs must report two separate units of the code without the bilateral modifier. The following include some options for bilateral billing. Please check with your payer for specific coverage and coding guidelines.

Add Modifier with Claim Line Item and Code	
50 *(bilateral)*	Line item 1: 69930
LT *(left side)*	Line item 1: 69930
RT *(right side)*	Line item 2: 69930
No Modifiers	Line item 1: 69930 Line item 2: 69930
No Modifiers *(bill 2 units)*	Line item 1: 69930

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