CPT Billing Codes

Cochlear™ Implants (Surgeons and Implant Facilities)

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 for 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

Modifiers

Add Modifier when a claim reports the following situations:

22	Increased procedural services
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

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Billing Tips and FAQs

1. **Medicare (CMS)Modifier 59 use and the changes that took effect on January 1, 2015**

   CPT Modifier 59 Changes – 2015

   XE Separate Encounter: Service That Is Distinct Because It Occurred During A Separate Encounter

   XS Separate Structure: Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

   XP Separate Practitioner: Service That Is Distinct Because It Was Performed By A Different Practitioner

   XU Unusual Non-Overlapping Svc: Use Of A Service That Is Distinct Because It Does Not Overlap usual components of the main service

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 code'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 payers may require other modifiers such as RT and LT to indicate services rendered.

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

www.Cochlear.com/US

Cochlear Americas
13059 East Peakview Avenue
Centennial, CO 80111 USA

Telephone: 1 303 790 9010
Support: 1 800 483 3123

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