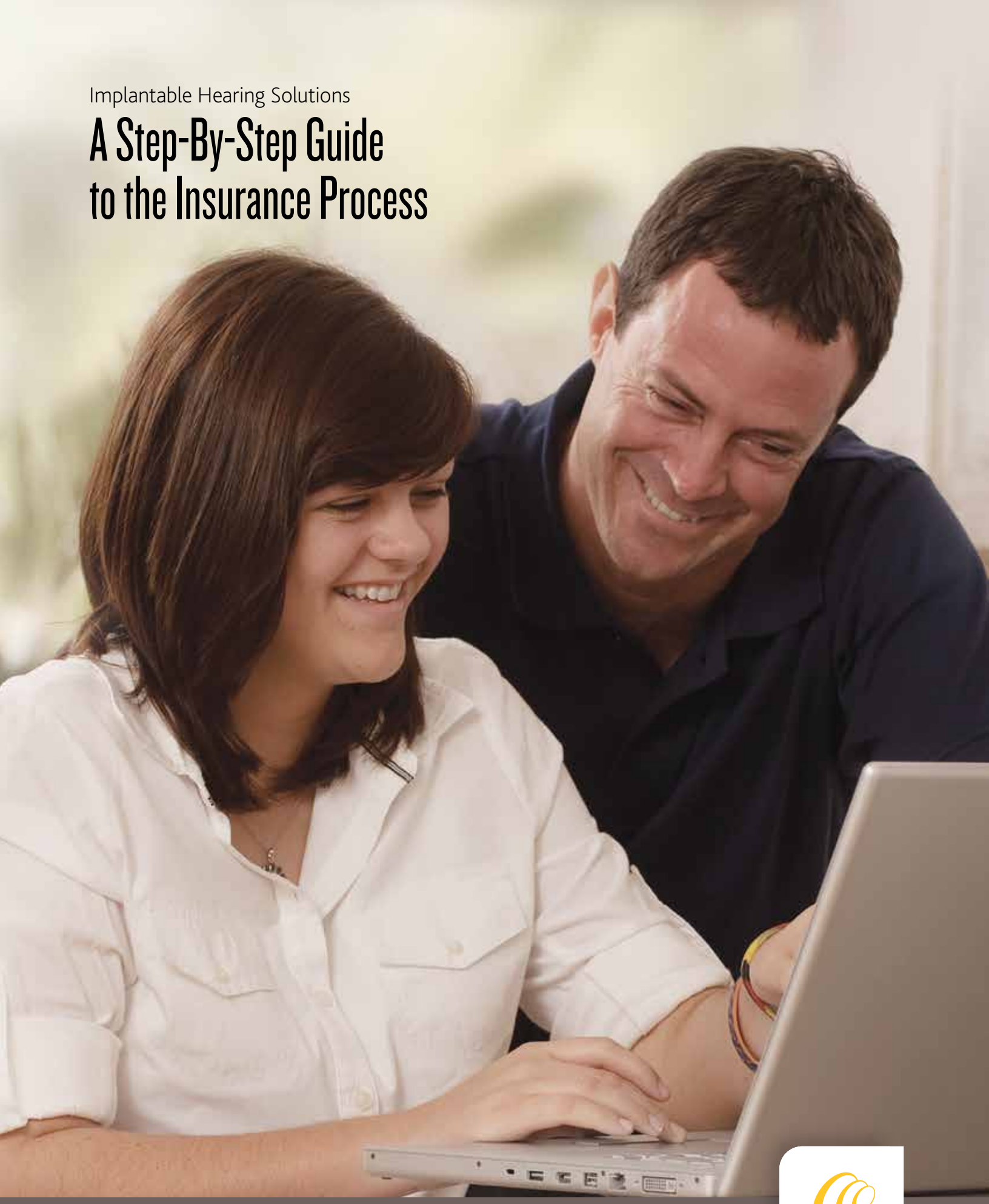
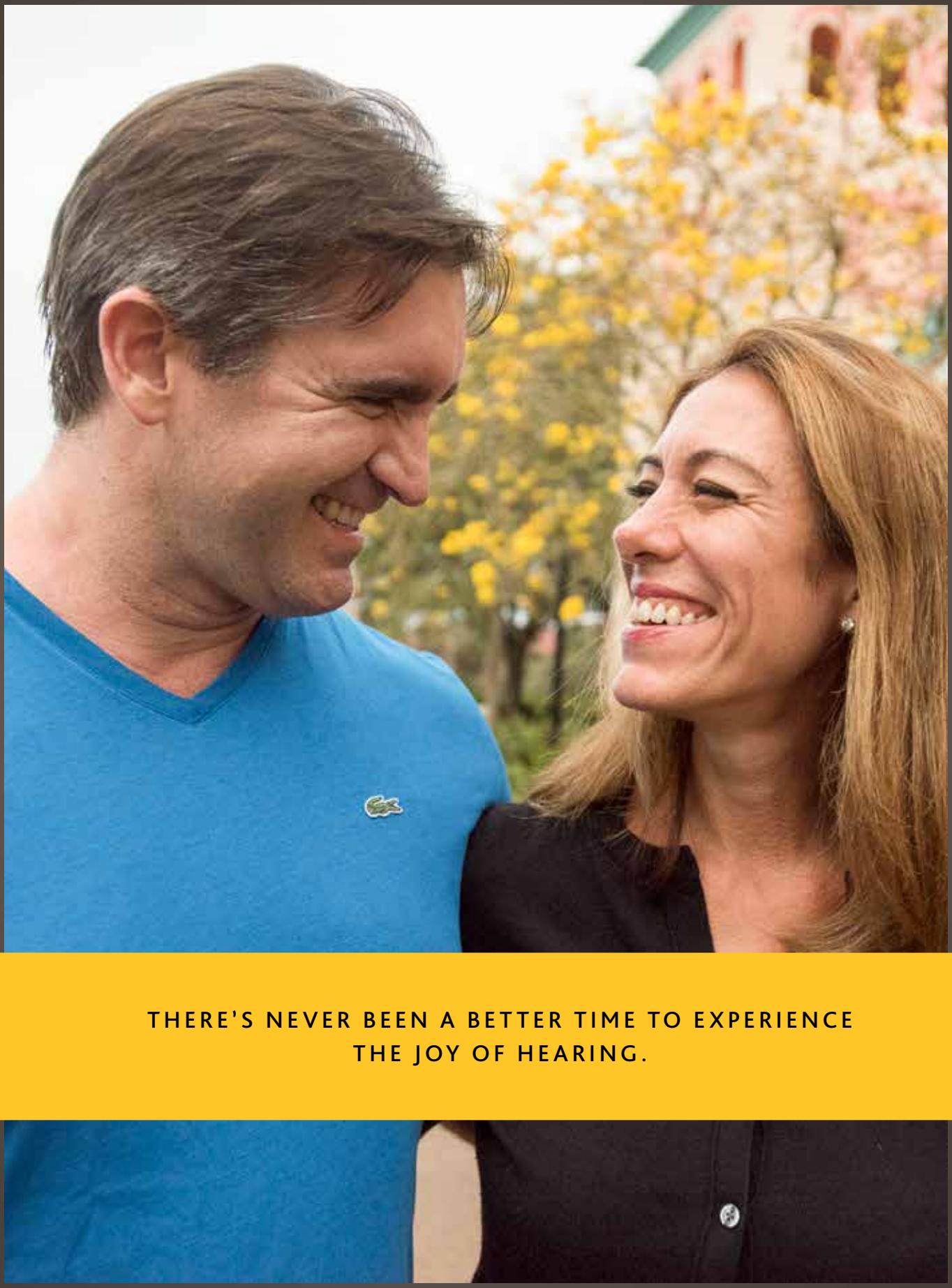
Implantable Hearing Solutions

A Step-By-Step Guide to the Insurance Process



Hear now. And always

Cochlear®



THERE'S NEVER BEEN A BETTER TIME TO EXPERIENCE THE JOY OF HEARING.

Jack B. – Nucleus recipient

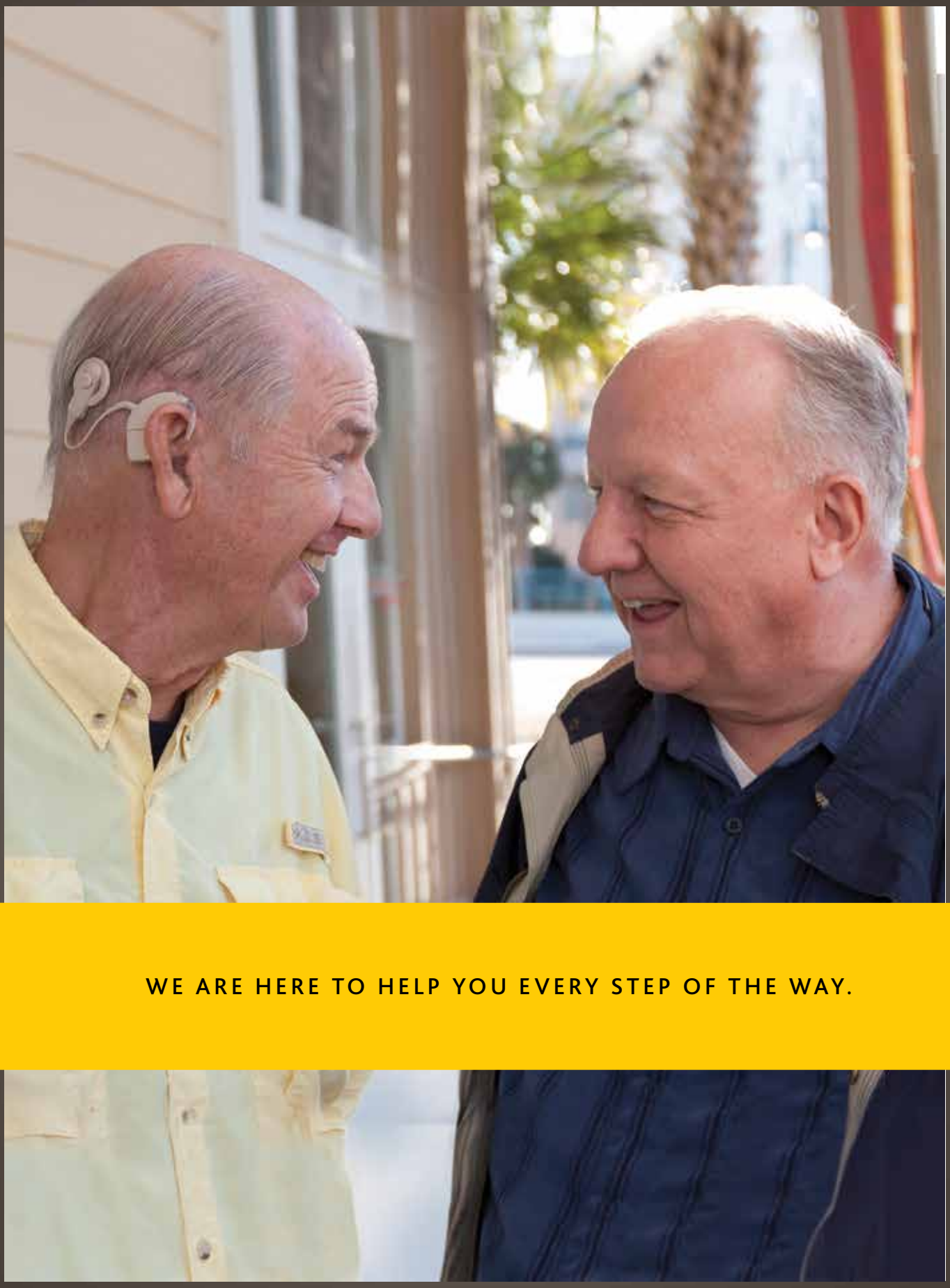
Your journey to better hearing is worth every step.

We understand that getting a hearing implant is a life-changing event for you and your family. We know the insurance approval process for any surgery can be confusing and overwhelming. We are here to help you every step of the way.

You should be aware of your health plan coverage and the process of requesting and obtaining insurance approval for a hearing implant.

We have information that can help you find the answers you need to move forward in your treatment process.

The information provided in this document is provided as guidelines only to address the unique nature of implantable hearing solutions technology and is not intended as legal advice. There is no guarantee that following these guidelines will result in any form of coverage or reimbursement from any insurance company or federal health care program payer. The information presented herein is subject to change at any time. This information cannot and does not contemplate all situations that a health care professional may encounter. To be sure that you have the most current and applicable information available for your unique circumstances, please consult your own experts and seek your own legal advice regarding your reimbursement needs and the proper implementation of these guidelines..



WE ARE HERE TO HELP YOU EVERY STEP OF THE WAY.

Bob & Jim – Nucleus recipients

Health Plan Benefits – What You Should Know

HEALTH PLAN – DID YOU KNOW?

- Your health plan policy is a contract between you and the insurance company.
- This contract details the specifics of what is covered and what is not covered under your health plan (*insurance plan*).
- Your health plan is required by law to follow the terms of this policy.
- Most health plans have a glossary of important terms within your plan documents.

WHAT ARE YOUR RIGHTS?

- Your health plan must provide you a dispute process for any unfavorable decisions or denials.
- Your health plan must provide access to the health plan policy (*benefit handbook or summary of benefits*).
- Your health plan must provide you with a list of in-network doctors and facilities. This allows you to have the option to use your in-network benefit.

UNDERSTAND YOUR HEALTH PLAN COVERAGE

- Review documentation provided to you by your health plan (*i.e., request a copy of your benefit handbook or summary of benefits*).
- Find out which services are covered and which are not.
- Be aware of the processes involved in requesting and obtaining coverage.

You should contact your health plan to determine coverage as well as your estimated out-of-pocket expenses before surgery. You will need to determine coverage for the following:

- Hearing evaluation and test cost
- Implant system costs (*hearing implant and sound processor*)
- Implant procedure (*hospital, doctor, surgery and anesthesia*)
- Battery costs (*rechargeable, disposable*)
- Follow-up care

HOW YOUR HEALTH PLAN SHOULD WORK FOR YOU.

1. Your doctor recommends a hearing implant for your hearing loss.
2. You or your doctor submit a written request to obtain and verify pre-determination* and/or pre-certification* of benefits based on your health plan policy for the procedure and device.
3. Your health plan notifies you and your doctor in writing if the procedure and device is covered or is not covered.
4. You and your doctor move forward if your health plan approves the request. Your plan's deductible, coinsurance and/or co-payment will apply.

*See page 9 for the definition of predetermination and pre-certification.

RECONNECT TO A WORLD OF SOUND.

Leah A. – Nucleus recipient

Questions to Ask Your Health Plan

You will want to reach out to your insurance provider by calling the number listed on the back of your insurance member ID card. They may ask you for the billing codes or CPT codes which are at the bottom of this page.

Representative name: _____ **Date:**_____

1. Am I covered for surgery for a hearing implant?

_____

2. Am I covered for the hearing implant system?

_____

3. Do I have an out-of-pocket maximum? If so, how much have I satisfied at this time?

_____

4. What is my benefit for the surgery and device?

_____

5. Can you provide me with an estimate of out-of-pocket costs including any coinsurance, co-payment, or deductible costs for all providers related to the hearing implant surgery? (*Ask if there are any exclusions or restrictions for hearing related services or devices that would affect or limit coverage.*)

_____

_____

6. Is my physician and/or hospital in-network or out-of-network?

_____

7. Do I need preauthorization before surgery? How long does the preauthorization process typically take? (*You will want to ask if authorization is also needed for post-operative mapping services.*)

_____

8. Is a referral required? (*A referral is a written order from your doctor to see a specialist or to get special medical services.*)

_____

9. Do I have a co-payment or coinsurance? It is important to ask if co-payments or coinsurances are applicable to each service or provider (*hospital, surgery, implant system*). See list on page 5.

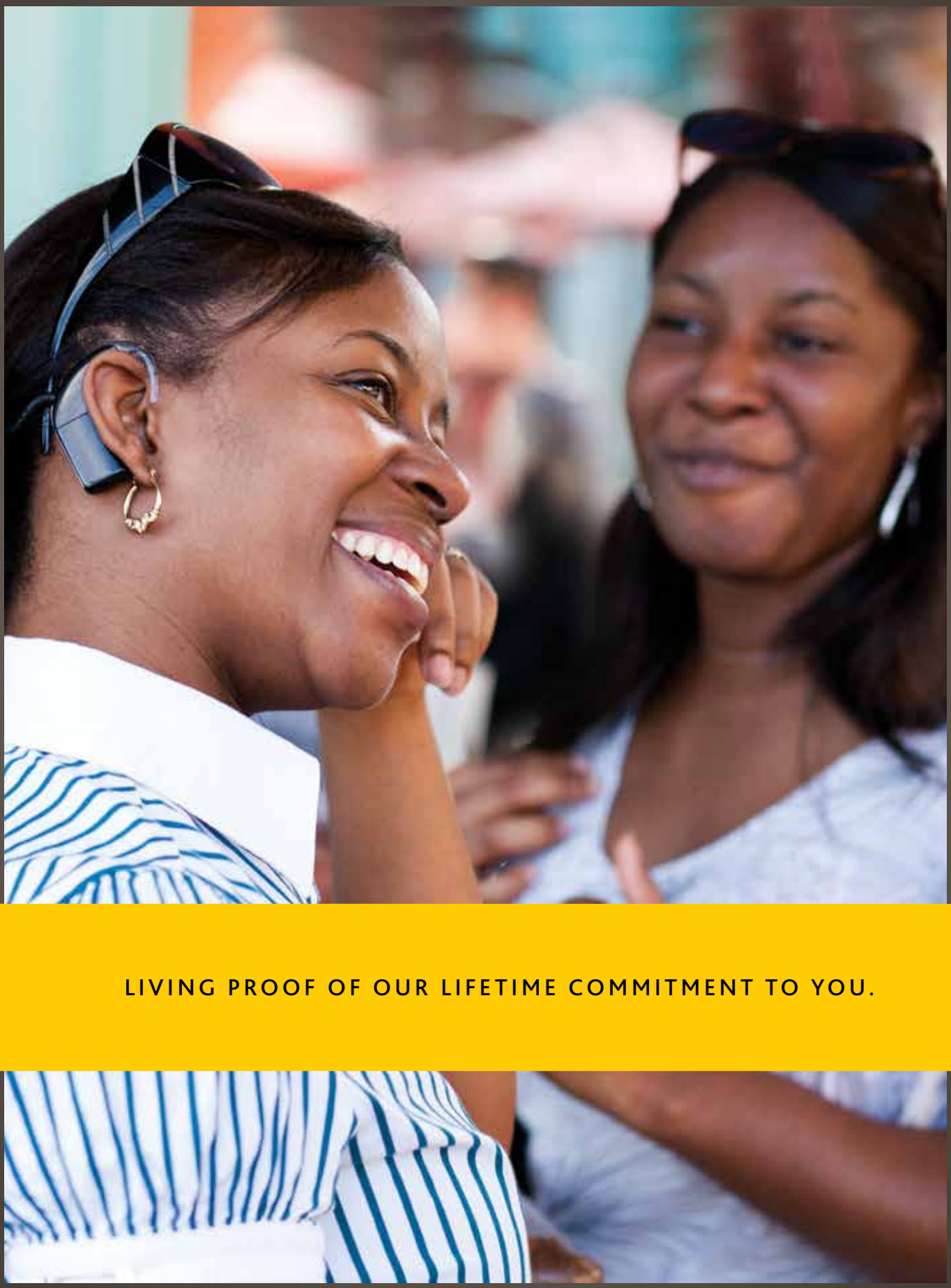
_____

_____

SURGERY BILLING CODES

Cochlear Implant	
CPT Code:	**Description**
69930	Cochlear Device Implantation (*surgery*)
L8614	Cochlear Implant System
Baha	
CPT Code:	**Description**
69714	Implantation, Osseointegrated implant, temporal bone, with percutaneous attachment to the external speech processor/cochlear stimulator, without mastoidectomy
69715	Implantation, Osseointegrated implant, temporal bone, with percutaneous attachment to the external speech processor/cochlear stimulator, with mastoidectomy
L8690	Auditory Osseointegrated Device; includes all internal and external components

Ask your insurance provider if your health savings account (HSA) or flexible spending account (FSA) can provide you with financial support for your hearing implant system.



LIVING PROOF OF OUR LIFETIME COMMITMENT TO YOU.

Nicole L.– Nucleus recipient

All you need to know about Predetermination, Pre-Authorization and Pre-Certification

Predetermination is a process that allows your physician to submit a treatment plan to your health plan before surgery. The health plan reviews the treatment plan, your insurance benefit plan and medical policy to determine if:

- The treatment is covered
- Your plan's maximum benefits or limitations

It is strongly recommended that a predetermination of benefits for a hearing implant system is submitted to the health plan before surgery, except for Medicare beneficiaries. Your provider will assist you in this process. If you are a candidate for a Baha® Implant System, please refer to the Baha implant insurance information on page 11 to understand how this authorization may impact your benefit.

Predetermination is an optional process offered by many health plans. Pre-authorization/pre-certification is mandatory for most health plans.

WHAT IS THE DIFFERENCE BETWEEN PRE-CERTIFICATION AND PRE-AUTHORIZATION?

Pre-certification confirms eligibility and collects information before inpatient admissions and select ambulatory procedures and services. It is comprised of two components:

- Notification - process of documenting coverage requests.
- Coverage Determination – review of plan documents and submitted clinical information to determine whether the health plan's clinical guidelines and criteria are met for coverage.

The pre-certification process:

- Encourages the health plan to communicate with your doctor and/or you in advance of the procedure, service or supply.
- Enables the health plan to identify patients who may require continued disease management.

Pre-authorization is the process used to confirm whether a proposed service or procedure is:

- Medically necessary
- Covered for the proposed care
- Covered for the proposed length of stay (*if applicable*)
- Scheduled for review

Most health plans require doctors to:

- Seek advanced approval for most outpatient surgeries
- Obtain approval within a specific timeframe
- Verify coverage and benefits of the proposed treatment plan
- Provide applicable coding and medical necessity for services/procedures requested

Insurance Coverage for Cochlear Implants

The cost of a cochlear implant system may be covered by your insurance plan. Every health insurance plan is different. We know that the insurance approval process can be confusing. Here are guidelines to help you through the process.

Your health plan's coverage may vary based on:

- The terms of the coverage document in effect on the date of service
- Applicable laws/regulations
- Medical coverage policies

COMMERCIAL HEALTH PLAN COVERAGE

- Coverage of a cochlear implant system varies by plan.
- Work with your surgeon's office to determine your eligibility for coverage and benefits.
- Ask if your health plan will provide a voluntary predetermination of benefits review. If yes, ask your doctor's office to submit a predetermination packet to your health plan.
  - All health plans have their own definitions of what is medically necessary. These definitions are typically tied to a medical policy based on their own assessment criteria. The predetermination or prior authorization process is the most effective way to confirm you meet the plan's medical necessity criteria.
  - If your health plan considers cochlear implantation experimental or investigational, you should work through your doctor's office and the predetermination process which includes submitting a letter of medical necessity and supportive material. The predetermination process will educate the health plan on the scientific evidence supporting the use of the device and how it applies to your treatment plan.
- Be aware of potential financial responsibilities regardless if you are covered or not by insurance (*i.e., deductibles, co-payments, coinsurance*).
- Coverage does not guarantee payment.
- If your health plan denies coverage, you have a right to appeal the coverage decision.
  - The health plan should provide you and your surgeon information on appeal rights.
  - You should work with your surgeon to assist in the appeal process.
  - Your surgeon should prepare a letter of "medical necessity" outlining your need and value for implantation, results of medical tests, published peer-reviewed literature supporting implantation, and detailed patient history applicable to the request.

MEDICARE

- Medicare covers cochlear implant systems.
- Traditional Medicare does not offer an option for predetermination or prior authorization of coverage.
- Work with your surgeon's office to determine your eligibility for coverage and benefits.

MEDICARE ADVANTAGE PLANS

- Medicare Advantage plans must offer the same benefits defined by traditional Medicare but often cover additional services.
- Medicare Advantage plans may have policies for predetermination of benefits or pre-authorization requirements. Work with your surgeon's office in contacting your Medicare Advantage plan to determine your eligibility for coverage and benefits.

MEDICAID

- Coverage for implantation varies by state.
- Work with your surgeon's office to check on your state's Medicaid plan or Medicaid HMO to determine coverage and benefits.
- State Medicaid plans and Medicaid HMOs have processes to appeal claims on an individual basis based on medical necessity.
- Prior authorizations of implantations are generally required.

Insurance Coverage for Baha® Systems

The cost of a Baha® System may be covered by your insurance plan. Every health insurance plan is different. Here are guidelines to help you through the process.

Your health plan's coverage may vary based on:

- The terms of the coverage document in effect on the date of service
- Applicable laws/regulations
- Medical coverage policies
- Plan's designation/classification of Baha
- If the plan considers the Baha System to be a prosthetic device or if they classify the implant system as a hearing aid.

COMMERCIAL HEALTH PLAN COVERAGE

- Coverage of a Baha System varies by plan.
- Work with your surgeon's office to determine your eligibility for coverage and benefits.
- Ask if your health plan will provide a voluntary predetermination of benefits review. If yes, ask your doctor's office to submit a predetermination packet to your health plan.
  - All health plans have their own definitions of what is medically necessary. These definitions are typically tied to a medical policy based on their own assessment criteria.
  - Some health plans consider the Baha System to be a hearing aid and will limit coverage to the hearing aid benefits under the plan.
  - The predetermination or prior authorization process is the most effective way to confirm you meet the plan's medical necessity criteria and confirm your plan's specific benefit coverage for the Baha System.
- Be aware of potential financial responsibilities regardless if you are covered or not by insurance (*i.e., deductibles, co-payments, coinsurance*).
- Coverage does not guarantee payment.
- If your health plan denies coverage, you have a right to appeal the coverage decision.
  - The health plan should provide you and your surgeon information on appeal rights.
  - You should work with your surgeon to assist in the appeal process.
  - Your surgeon should prepare a letter of "medical necessity" outlining the your need and value for implantation, copies and results of medical tests, published peer-reviewed literature supporting implantation, and detailed patient history applicable to the request.

MEDICARE

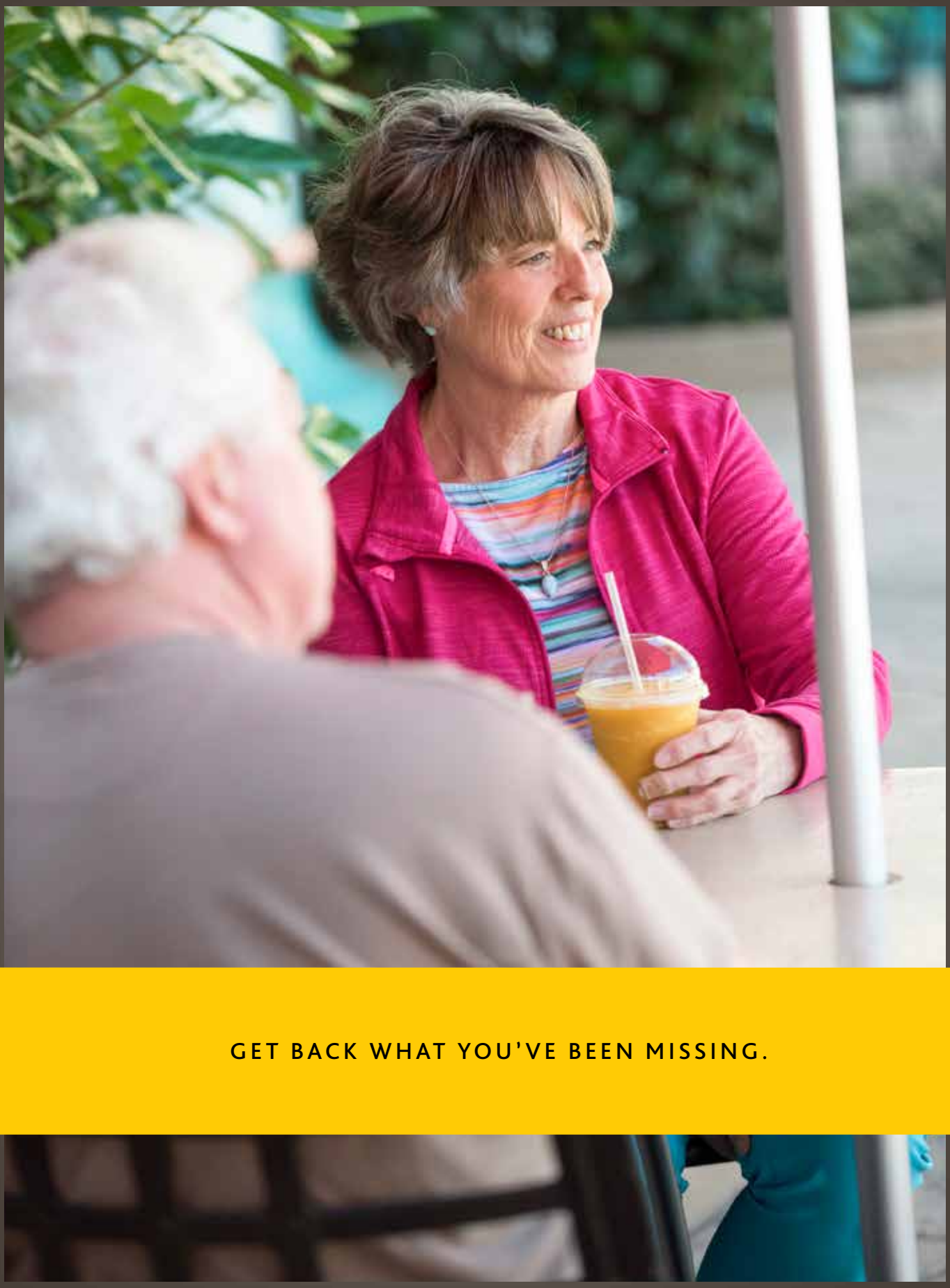
- Medicare covers Baha Systems
- Medicare refers to Baha implants as Auditory Osseointegrated Implants.
- Medicare considers auditory osseointegrated implants, like the Baha System, to be prosthetic devices.
- Traditional Medicare does not offer an option for predetermination or prior authorization of coverage.
- Work with your surgeon's office to determine your eligibility for coverage and benefits.

MEDICARE ADVANTAGE PLANS

- Medicare Advantage plans must offer the same benefits defined by traditional Medicare but often cover additional services.
- Medicare Advantage plans may have policies for predetermination of benefits or pre-authorization requirements. Work with your surgeon's office in contacting your Medicare Advantage plan to determine your eligibility for coverage and benefits.

MEDICAID

- Coverage for a Baha System varies by state.
- Work with your surgeon's office to check on your state's Medicaid plan or Medicaid HMO to determine coverage and benefits.
- State Medicaid plans and Medicaid HMOs have processes to appeal claims on an individual basis based on medical necessity.
- Prior authorizations of implantations are generally required.



GET BACK WHAT YOU'VE BEEN MISSING.

Dolly C. – Baha recipient

Managing Denials

There are a few reasons that your health plan may deny your proposed treatment, including:

- The requested procedure is specifically listed as non-covered under the terms of your health plan policy.
- The procedure may be covered but only under certain circumstances. (*i.e., You must utilize a physician that is in your health plan's network.*)
- Your physician is requesting a procedure using technology that your health plan considers to be an experimental or investigational procedure.
- Your health plan determined the procedure being requested is not medically necessary based on the diagnosis and medical documentation that was submitted.
- Your health plan misunderstands the technology and denies the implant system stating it is a hearing aid.

BENEFITS VS. MEDICAL NECESSITY

Health Policy Benefit – is a service, test, procedure or treatment that your health plan has agreed to cover as long as the medical necessity has been approved. You should understand that your Health Policy Benefit always supersedes approval for medical necessity.

- As an example, if your request was approved for medical necessity, the claim may still be denied as a Health Policy Benefit exclusion.

Medical necessity – is a review by your health plan that determines if a requested service, test, procedure or treatment is:

- In agreement with the accepted standards of medical practice.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Not primarily for the economic benefit of the health plan and purchasers or for the convenience of the patient, treating physician or other health care provider.
- If your health plan determines that the request does not meet the health plan's definition of "medical necessity" or is not appropriate, the request may be denied.

HEALTH PLAN APPEALS PROCESS

Although the appeals process will vary by health plan, you should receive a step-by-step process that allows you the opportunity to dispute denial for service. This process will be available to review in your benefits handbook or by calling the number listed on the back of your insurance card. In general, most insurance providers follow the level of appeals below.

- **Level 1** – First level appeals are usually reviewed by your health plan's Appeals Department. The medical director who was involved in the denial may be involved also.
- **Level 2** – Second level appeals are reviewed by medical directors and Appeals Department staff that were not involved in the original decision for denial.
- **Level 3** – The third level appeals are usually completed by an independent (*outside of the health plan*) reviewer who enlists the assistance of a physician who is board certified in the same specialty as the requesting physician. If an appeal is submitted at this level there can be charges to the patient for this service. In rare situations, the patient may be required to pay a nominal fee. The fee is typically $25 or less.

Managing Denials

KNOWING WHEN TO APPEAL OR NOT TO APPEAL

If the denial reason states that the health plan needs more information for the review, you may only need to gather that information and furnish it to the appropriate party who has requested it. Your physician may be able to assist you with this.

If the written denial states that a peer-to-peer review is available, be sure to give your physician this information as soon as possible. Identifying which coverage you have is very important if the health plan who denied your request may not have the final decision.

- Verify through your employer whether you are being covered by a "Self-Funded" or "Fully Insured" policy.
- **Fully Insured policy** – an employer purchases insurance coverage from a licensed health plan and that company assumes all management of benefits and financial risks.
- **Self-Funded policy** – an employer who underwrites the financial risk and has the final determination of coverage decisions. It may be possible to discuss this denial with your Human Resources department to seek a more favorable decision.

YOU SHOULD CONSIDER APPEALING IF:

- The procedure that was requested is different from the service that was requested or the health plan defines the requested procedure differently than your physician has defined it.
- The request was denied for medical necessity and your physician has reviewed the medical policy and feels the criteria have been met.

DEVELOPING A WRITTEN REQUEST FOR APPEAL OR GRIEVANCE

Gather information from as many sources as you can. Some of the resources that may guide you are:

- Your benefits handbook from the health plan. This document should identify:
  - Timely filing requirements for appeal submissions and the name of the department or contact person
  - An address or possibly a fax number that the appeal should be submitted to

If you do not understand the information in this handbook, contact the customer service phone number on the back of your insurance card for additional assistance.

Your treating physician or the physician's staff may be able to:

- Contact the health plan and assist in the appeal process or;
- Supply you with additional clinical information supporting this request.

Use the sample appeal letters that can be found on the next two pages as a guide when creating your own.

Cochlear's Insurance Support Team is available to help you obtain necessary insurance approval and provide assistance in appealing denied coverage for Cochlear™ Nucleus® and Baha® Systems. Contact the Insurance Support Team at 800 633 4667 (*Option 4*).

COCHLEAR IMPLANT SAMPLE APPEAL LETTER

From patient to Health Plan Medical Director
Date

Medical Director or Appropriate Department
Health Plan Address
City, State, Zip Code

RE: Request for coverage decision for (INSERT patient name, policy # , date of birth, and group #).

I am writing to appeal (INSERT name of Health Plan)'s recent denial of coverage for (INSERT name of hearing implant) to restore my hearing. This denial was issued because (INSERT denial reason as stated in letter from Health Plan).

This denial is inaccurate because (INSERT information explaining why the denial reason is not accurate. Refer to Appeal Explanations provided).

I have been diagnosed with (INSERT diagnosis). My physician, (INSERT name), advised me that clinical evaluation verifies that I am a qualified candidate for this treatment option which stands alone as the only treatment for my type and degree of hearing loss.

As stated above, (INSERT physician's name) has diagnosed me with (INSERT diagnosis). (INSERT brief description of how this hearing loss affects your daily life – social situations, work, etc.)

I understand that in order to receive this hearing implant, coverage will be required for the following charges: the hearing implant components, hospital surgical fee, physician surgical fee, and anesthesia.

I look forward to your response. Please do not hesitate to contact me or (INSERT physician's name) if additional information is needed.

Sincerely,
(INSERT patient's name)
(INSERT patient's complete address)

BAHA SAMPLE APPEAL LETTER

From patient to Health Plan Medical Director
Date

Medical Director or Appropriate Department
Health Plan Address
City, State, Zip Code

RE: Request for coverage decision for (INSERT patient name, policy # , date of birth, and group #).

I am writing to appeal (INSERT name of Health Plan)'s recent denial of coverage for the Baha Implant System to restore my hearing. This denial was issued because (INSERT denial reason as stated in letter from Health Plan, such as the plan considers the Baha to be a hearing aid).

This denial is inaccurate because the Baha System is not a hearing aid and should not be confused with NON-implantable or external hearing aids. Hearing aids occlude the ear canal either by an ear mold or the hearing aid itself. Examples of hearing aid options are in-the-ear (ITE) and behind-the-ear (BTE) devices that accoustically amplify sound waves to the ear canal. There are clinical distinctions separating the Baha System from non-implanted hearing aids and bone conduction hearing aids. In contrast, the Baha System is a surgically implanted auditory device intended for patients with conductive, mixed hearing loss or single-sided deafness who cannot benefit from or utilize a hearing aid. The Baha System is a thoroughly tested system that is effective in enabling patients to hear speech and other sounds via bone conduction that is not possible with an acoustic hearing aid. If I were able to benefit adequately from hearing aids, I would not be a candidate for the Baha System.

The FDA approved the Baha System as a Class II medical implant as opposed to conventional hearing aids which are Class I devices. Coding nomenclature defines the Baha with a HCPCS code (L8690) and is reimbursed under the Ambulatory Payment Classification.

Recognizing these technological differences, the Centers for Medicaid and Medicare Services (CMS) issued a decision in October 2005 to distinctly classify the Baha Auditory Osseointegrated Implant as a prosthetic device and not a hearing aid and authorized coverage for Auditory Osseointegrated Implants. CMS classifies Auditory Osseointegrated Implants in the same category as auditory brainstem implants and cochlear implants. CMS does not provide coverage of hearing aids to their beneficiaries.

The Baha System is a prosthetic device and upon review of my current insurance handbook, (page number) through my (employer name), states that prosthetic devices are a covered benefit. The Baha System is a prosthetic device and should receive the same consideration for coverage as all other prosthetic devices as it is a reasonable and appropriate treatment to restore the function of an impaired or deceased body part.

I have been diagnosed with (INSERT diagnosis). My physician, (INSERT name), advised me that clinical evaluation verifies that I am a qualified candidate for a Baha Implant System which stands alone as the only treatment for my type and degree of hearing loss.

As stated above, (INSERT physician's name) has diagnosed me with (INSERT diagnosis). (INSERT brief description of how this hearing loss affects your daily life–social situations, work, etc.)

I understand that in order to receive this hearing implant, coverage will be required for the following charges: the Baha System components, hospital surgical fee, physician surgical fee, and anesthesia.

I look forward to your response. Please do not hesitate to contact me or (INSERT physician's name) if additional information is needed.

Sincerely,
(INSERT patient's name)
(INSERT patient's complete address)

Managing Denials – Alternate Funding

Occasionally, health plans do not provide coverage for hearing implant solutions. Cochlear has compiled a list of established funding sources for Cochlear Implants and Baha Systems. Other sources of funding or small local programs may be available in your area.

When all of your options for receiving coverage through your health plan have been exhausted, consider the options below.

SOME OPTIONS TO EXPLORE INCLUDE:

- **Employer-Sponsored Health Plans:** Check to see if your employer offers other health insurance plans and if those plans provide you with coverage for your hearing implant. It may be possible to switch during your open enrollment period.
- **State Health Insurance Marketplace:** Research and explore the option of purchasing an individual plan that may provide you with hearing implant coverage.
- **Medicaid Coverage:** Coverage for hearing implants varies by state and eligibility is subject to change. Some states have expanded eligibility under the Patient Protection and Affordable Care Act. Contact your hearing implant specialist or your state Medicaid program for more details.
- **Colorado Neurologic Institute (CNI):** The CNI offers Cochlear Implant and Baha System Assistance Programs. Assistance is offered to candidates who have no other means for paying for a cochlear implant or bone conduction implant. For additional information or a program application visit: www.thecni.org.
- If seeking coverage for your child, check to see if there are any special state programs that offer assistance to children with disabilities or check to see if they qualify for state Medicaid benefits.

We recommend you to contact your audiologist to find out information regarding current federal and state programs and resources that may be available in your community.

Still have insurance questions?

Call our Insurance Support Team at **866 477 0910** or visit: **www.Cochlear.com/US/insurance**

Aural Rehabilitation

Medicare, Medicaid, Medicare Advantage and commercial health plans all have guidelines for aural rehabilitation (*cochlear implant mapping/programming).*

MEDICARE AND MEDICARE ADVANTAGE AURAL REHABILITATION COVERAGE

- Medicare covers aural rehabilitation services which includes cochlear implant mapping/programming services.
- Traditional Medicare does not offer an option for predetermination or prior authorization of coverage.
- Work with your surgeon's office to determine your eligibility for coverage and benefits.
- Medicare Advantage plans must offer the same benefits defined by Traditional Medicare but may require predetermination or prior authorization for mapping/programming services. Work with your surgeon's office to determine your eligibility for coverage and benefits.

MEDICAID AURAL REHABILITATION COVERAGE

- Coverage of aural rehabilitation varies by state.
- Work with your surgeons' office to check your state's Medicaid plan or Medicaid HMO to determine your coverage and benefits.

COMMERCIAL HEALTH PLAN AURAL REHABILITATION COVERAGE

- Typically, health plans cover aural rehabilitation services following cochlear implantation surgery.
- Work with your surgeon's office to determine your eligibility for coverage and benefits.
- Ask if your health plan will provide a voluntary predetermination of benefits or prior authorization review. If yes, work with your doctor's office to submit a predetermination or prior authorization packet to your health plan.

AURAL REHABILITATION (COCHLEAR IMPLANT MAPPING/PROGRAMMING)

Billing Code:	Description:
92601	Diagnostic analysis of Cochlear Implants, patient younger than seven years of age; with programming
92602	Subsequent reprogramming
92603	Diagnostic analysis of Cochlear Implants, age seven years or older; with programming
92604	Subsequent reprogramming

Replacements, Upgrades and Batteries

Health plans also have guidelines for when they might cover a replacement or upgrade for a sound processor (*or other parts and accessories*).

COMMERCIAL HEALTH PLAN UPGRADE AND REPLACEMENT COVERAGE

Typically, health plans cover replacement sound processors based upon the following two requirements:

- Before and after test results or information and data clearly predicting improved performance with use of the technology (*i.e., medical necessity*).
- If the current processor has been continuously used for five years, replacement with improved technology may be possible.

Your clinic may assist in the process by:

- Testing your performance with your current processor and comparing it to the performance results with the upgraded sound processor.
- Predicting improved performance based on the group average clinical data available.

MEDICARE UPGRADE AND REPLACEMENT COVERAGE

Medicare classifies Cochlear's sound processors, associated parts and accessories as prosthetics. This means they are subject to the durable medical equipment, prosthetics, orthotics and supplies ("*DMEPOS*") requirements under Medicare.

Medicare's Claim Processing Manual provides that Medicare will cover replacement of DME equipment if the equipment is lost, has irreparable damage or wear, or when required because of a change in the patient's condition.

MEDICAID UPGRADE COVERAGE

Coverage for upgrade sound processors is subject to each state's Medicaid Plan guidelines.

To find out if an upgrade or replacement is covered by your health plan you can provide the below codes to the insurance representative.

REPLACEMENT SOUND PROCESSORS

Billing Code:	Description:
HCPCS Code L8619	Cochlear Implants
HCPCS Code L8691	Baha Implants

BATTERY COVERAGE

Many health plans cover batteries. Medicare and typically Medicaid will cover disposable batteries. Medicare will cover 180 disposable batteries per ear every three months. This is subject to change. Contact your health plan to determine if disposable batteries are covered and how many are covered in the given year.

Each health plan is different and has its own criteria. It is important to check your plan regarding coverage criteria on replacement parts and upgrades.

Hear now. And always

As the global leader in implantable hearing solutions, Cochlear is dedicated to bringing the gift of sound to people with moderate to profound hearing loss. We have helped over 450,000 people of all ages live full and active lives by reconnecting them with family, friends and community.

We aim to give our recipients the best lifelong hearing experience and access to innovative future technologies. For our professional partners, we offer the industry's largest clinical, research and support networks.

That's why more people choose Cochlear than any other hearing implant company.

www.Cochlear.com/US

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