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Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Bilateral Cochlear Implants Create Programming Code Dilemma

Professional associations go to bat for audiology coders.

If your physician performs cochlear implants, you're probably familiar with the codes for when an audiologist programs and reprograms the devices about a month after the surgery.

In recent years, physicians have performed a growing number of bilateral cochlear implants. You may report 69930 (Cochlear device implantation, with or without mastoidectomy) with modifier 50 (Bilateral procedure). But what about the audiologist's initialization and programming?

That's a question that's been bugging **Charmaine Munt,** field reimbursement manager at Advanced Bionics LLC, a Sylmar, Calif., manufacturer of cochlear implants.

Munt has been hearing concerns from audiologists about coding for the programming when the procedure is bilateral. It's "a very confusing topic, which appears to be a very gray area," she says. The problem: The programming codes can't be reported as binaural.

Codes Haven't Caught Up With Practice

"Audiology codes are typically bilateral," says **Debbie Abel, AuD,** director of reimbursement for the American Academy of Audiology. But not 92601-92604 (Diagnostic analysis of cochlear implant ...), she says. On Medicare's fee schedule, the procedures have a bilateral code of 0, Abel says, which means you can't append modifier 50.

Advancement: "Bilateral cochlear implants are a relatively new development," says **Robert C. Fifer, PhD,** director of Audiology and Speech-Language Pathology at University of Miami's Mailman Center for Child Development. "They have become much more common over the last two or three years."

"At the time that the CPT codes 92601-92604 were developed and valued, no one envisioned performing bilateral cochlear implant surgery or activating both devices in the same visit," Fifer says.

Abel and Fifer agree: The best way to address the problem is to appeal to Medicare to remove the status indicator "0" for bilateral payment. The American Academy of Audiology and American Speech-Language-Hearing Association will write "a joint letter to CMS about a change in the status indicator for bilateral payment" for programming cochlear implants, Abel says.

"It may be helpful for the coder to contact that third-party payer for guidance," Abel says. If none is forthcoming, Abel recommends you code with the anatomical modifiers RT (Right side) and LT (Left side) to indicate binaural cochlear implants.

Scenario: Your physician puts two cochlear implants into a 6-year-old patient. A month later, your audiologist initializes and programs both of the child's implants. You would code 92601-RT and 92601-LT (Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming; left side).

When the young patient comes in for subsequent testing, you would report 92602-RT and 92602-LT. "The initial stimulation codes (92601, 92603) are intended to be billed on the first day of activation only," Fifer says.

Look for Room to Maneuver

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If you're dealing with a thirdparty Medicare carrier, you may find more leeway with the use of modifiers to show the audiologist has performed a service bilaterally.

Fifer suggests two modifiers to ask your payer about:

Increased services: The first suggestion would be to bill the initial stimulation code with modifier 22 (Increased procedural services) to signify extended time and effort.

If you're going to append modifier 22, you'd better do your homework. Prepare a report for the payer that shows:

• the length of time for the total procedure versus a unilateral initialization

• the need for the additional time

• exact start and end times for the session

• equipment used

• outcomes of the programming for each side

• patient's status at the end of the session an recommendations.

"The potential downside of using modifier 22 is that most third-party payers will not reimburse anything extra for this modifier," Fifer says.

Repeat procedure: An alternative would be to use modifier 76 (Repeat procedure or service by same physician) to show that the procedure was repeated in its entirety by the same provider on the same date of service, Fifer says. In this case, the physician or audiologist would bill, for example, 92603 and 92603-76.

"Again, be prepared to submit complete documentation as described above to justify the medical necessity and the activities of repeating the entire procedure again," he says.

Not for Medicare: "The contracted HMOs are allowed to set their own rules as long as they cover what Medicare covers," Fifer says. "I would not recommend using the modifiers with regular Medicare patients because of that restriction."

Coding for Unusual Scenarios

The same strategies should apply if the patient has a second implant at a later date than the first one -- different date of service, separate episode of care.

Failed device: Another reason you might report 92601 or 92603 more than once is when a cochlear implant doesn't take. You may not realize this until after the audiologist has begun programming the speech processor.

If a patient undergoes a second cochlear implantation, you may report the second round of diagnostic analysis using the same codes 92601-92604. Be prepared to back up the second use of 92601 or 92603, however.

"This would not apply for a replacement speech processor," Fifer cautions. "In that instance, the expectation would be to simply download the current map from the computer into the new processor."

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