Foundations of Cochlear Implants: Billing and Coding for a Successful Clinic

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All products should be used according to their labeling. In all cases, services billed must be medically necessary, actually performed, and appropriately documented in the medical record.

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Objectives

- Highlight Health Insurance Basics
  - Health Insurers
  - Health Insurance Terminology
- Present Basic Coding Concepts
  - Review Commonly Billed CPT Codes
    - Preoperative and Postoperative Services Associated with Cochlear Implants
    - CPT Code Modifiers
    - Correct Coding Initiative Edits
- Provide Overview of Cochlear Implant Coverage
- Review Denials and Appeals
- Present Resources and Services

Health Insurance Basics
## Health Insurers

### Public Health Plans
- Programs funded by federal or state governments
  - Medicare
  - Medicaid

### Private Health Plans
- Commercial insurance companies
- Bought individually or extended through an employer sponsored plan

### Medicare
- Federal insurance program
  - Health insurance for persons age 65 or older, blind or disabled, or persons with End Stage Renal Disease
  - Administered locally to providers and beneficiaries through 12 Medicare Administrative Contractors (MACs)
  - MACs function as Part A and Part B payers - paying claims, enrolling healthcare providers, establishing healthcare policies called local coverage determinations (LCD)
  - National coverage determinations developed at the national level supersede LCDs
  - Medicare managed care plans (Medicare Advantage Plans) are a large market ~2034 plans covering ~17.6 million
Health Insurers

- Medicaid – joint federal-state health insurance program
  - Provides coverage to eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities
  - Administered by states, according to federal requirements
  - If other insurance exists, it's always the payer of last resort. If individual also has Medicare for example, Medicaid never pays first
  - Trending towards state agencies arranging for delivery of Medicaid health benefits through contractual arrangements with managed care entities (similar to Medicare Advantage Plans) ~55 million enrolled

Health Insurers

- Commercial/Private Insurance
  - Over 2,000 health insurance carriers in the U.S. and almost 1,000 HMOs
  - Each plan has its own coinsurance, deductibles, and out-of-pocket maximums based on the plan in which the patient is enrolled
  - Most commercial plans cover cochlear implants and bone conduction implants
Medical necessity is usually defined in benefit contracts and definitions vary from insurer to insurer. Definition often includes the following:

- The service or benefit will, or is reasonably expected to:
  - Prevent the onset of an illness condition, or disability
  - Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition or disability
  - Assist the individual to achieve or maintain maximum functional capacity in performing daily activities

- Other health insurers may include in their definitions “exercising prudent clinical judgement”, “…for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms”

Medical necessity definition from a national health insurer:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Not primarily for the convenience of the patient, treating physician or other healthcare provider, and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results

A health insurer may deny a request for a service/procedure if it determines that the service/procedure doesn’t meet its definition of medical necessity
Health Insurance Terminology

- **Letter of Medical Necessity (LOMN or LMN)**
  - An essential part of a request for services. It provides the opportunity to summarize the candidate’s medical necessity for the proposed treatment
  - Included in the letter:
    - Type, cause, duration and severity of hearing loss
    - Any other pertinent medical or development info
    - Summary of previous treatments (including prior hearing aid use)
    - Explanation of why proposed treatment is medically necessary
  - Helpful hints
    - Do not refer to the implant as bone-anchored hearing aid
    - Include applicable CPT and HCPCS codes
    - Be concise but complete

Health Insurance Terminology

- **Summary of Benefits & Coverage or Summary Plan**
  - Document provided to individuals by insurer
  - Allows one to compare health insurers’ varied plans and to understand the coverage one has
  - Summarizes key features, such as covered benefits, cost-sharing provisions and coverage limitations and exceptions
  - Information in the Summary Plan may be helpful if the insurer denies a particular service/procedure
  - A member’s benefit plan document always supersedes the information in a medical coverage policy
    - A service could be determined to be medically necessary, but is an exclusion according to the member’s Summary Plan, Summary of Benefits and Coverage, or Schedule of Benefits
**Health Insurance Terminology**

- **Precertification/Preauthorization**
  - Determine if health insurer finds a service to be medically necessary
  - Lack of precertification/preauthorization could result in non-payment; however, having it is no guarantee of payment

- **Pre-determination of Benefits**
  - Determine if individual has specific benefit coverage, e.g. hearing services, and if the health insurer’s criteria for medical necessity would be met
  - Voluntary process; typically performed as a courtesy by health insurer
  - Helps to avoid misunderstandings about financial liability

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**Health Insurance Terminology**

- **Fully-insured**
  - Employers or individual subscribers pay the premiums
  - Health insurer collects the premiums and pays healthcare claims based on the coverage of benefits outlined in the policy purchased
  - Health insurer carries financial risk of claims payment
  - Regulated under state law

- **Self-funded (usually larger employers)**
  - Employer and employee contributions fund the plan
  - Employer is at financial risk for the cost of covered medical expenses
  - Employers sponsoring self-funded plans typically hire a third-party or health insurer to administer benefits and pay claims
  - Exempt from state insurance laws and mandated benefit coverage
Health Insurance Terminology

- Fully-insured or Self-funded – what difference does it make?
  - A self-funded employer may influence decisions made on payment of medical claims and healthcare decisions related to the plan
  - This will be relevant if a requested service/procedure is denied and you want to appeal the decision. The company sponsoring the health plan can make decisions as the medical insurer.

Health Insurer Network Participation

- Participating (par) provider – entered into an agreement with an insurer
  - The insurer agrees to direct health plan members to the provider and, in exchange, the provider accepts a fee for his/her services
- Non-participating (non-par) provider - declined to enter into a contract with an insurer
Health Insurer Network Participation

- Medicare
  - Audiologists cannot opt out of Medicare altogether but can elect to be par or non-par with Medicare
  - Participating: agree to accept the amount approved by Medicare as total payment for covered services
  - Nonparticipating: choose either to accept or not accept assignment on Medicare claims on a claim-by-claim basis. If choose not to accept assignment, there are limitations to what provider may charge the beneficiary

- ASHA and ADA have on-line resources to assist audiologists in enrolling with Medicare

Health Insurer Network Participation

- Commercial/Private Insurance
  - Insurer offers incentives for members to use participating providers, e.g. lower deductibles, co-pays, and coinsurance amounts
  - Par provider status does not guarantee prompt payment or streamlined claims submissions
  - Some insurers will send payment to the member for care provided by a non-par provider
  - If interested in becoming a par provider, check insurer’s website for enrollment forms and instructions

- Medicaid
  - Enrollment forms can be found at website for each states’ health plan
Basic Coding Concepts

- Code systems are the mechanisms used by healthcare providers and facilities to document and bill for services provided

<table>
<thead>
<tr>
<th>Type of Code</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System. Used to report supplies, materials, and procedures.</td>
</tr>
<tr>
<td>ICD-10 Diagnosis</td>
<td>International Classification of Diseases, 10th Revision. Used to report patient diagnoses.</td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>International Classification of Diseases, 10th Revision. Used to report hospital inpatient procedures.</td>
</tr>
</tbody>
</table>
Basic Coding Concepts

• CPT code examples:
  • 92626 Evaluation of auditory rehab
  • 92557 Comprehensive hearing test
  • 92603 Diagnostic analysis of CI, >7 years old, with programming

• HPCPS code examples:
  • L8614 Cochlear device
  • L8690 Auditory osseointegrated device

• ICD-10 diagnosis code examples:
  • H90.0 - H90.2 Conductive hearing loss
  • H90.41 - H90.42 Sensorineural hearing loss, unilateral, with unrestricted hearing on the contralateral side
  • H90.6 - H90.8 Mixed conductive and sensorineural hearing loss

Relationship between Coding and Payment

• Reimbursement/payment is based on diagnosis codes and procedure (CPT) codes filed by healthcare providers through the claims submission process
• Appropriate coding affects current and future payment rates
  • Current: accurate coding enables healthcare providers and facilities to receive appropriate payment, reduces administrative costs, and prevents denials
  • Future: Medicare uses claims data to evaluate and recalibrate payment levels
• The integrity of coded data requires all users to consistently apply the same official coding rules, conventions, guidelines and definitions
Coding and Documentation Principles

- Medicare considers audiology services as diagnostic, which requires a physician order
- The services performed from the physician order and the documentation of specifics related to each service determines what CPT code to use
- It is critical to document in the medical record all services provided
- If you are coding, you are ultimately responsible. Even if you are not coding, you are responsible for the medical record

Commonly Billed CPT Codes
Commonly Billed Codes

- May be reported by audiologists or other licensed clinicians for post-operative clinic services

<table>
<thead>
<tr>
<th>CPT</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication and/or auditory processing disorder, individual</td>
</tr>
<tr>
<td>92508</td>
<td>Treatment of speech, language, voice, communication and/or auditory processing disorder, 2+ or group</td>
</tr>
<tr>
<td>92601</td>
<td>Initial program cochlear implant &lt; 7 years</td>
</tr>
<tr>
<td>92602</td>
<td>Subsequent program cochlear implant &lt; 7 years</td>
</tr>
<tr>
<td>92603</td>
<td>Initial program cochlear implant ≥7 years</td>
</tr>
<tr>
<td>92604</td>
<td>Subsequent program cochlear implant ≥7 years</td>
</tr>
<tr>
<td>92626</td>
<td>Eval of auditory rehab status, first hour</td>
</tr>
<tr>
<td>92627</td>
<td>Eval of auditory rehab status, each add'l 15 min</td>
</tr>
<tr>
<td>92630</td>
<td>Auditory rehab; pre-lingual hearing loss</td>
</tr>
<tr>
<td>92633</td>
<td>Auditory rehab; post-lingual hearing loss</td>
</tr>
</tbody>
</table>

[1] Modifier may be applicable

- List is not intended to be comprehensive of all services that may be offered to Cochlear implant patients

Commonly Billed Codes

- Medicare has a number of rules dictating how certain codes may be billed. Some rules include:
  - CPT 92507 & 92508 May only be provided by a speech-language pathologist (SLP)
  - CPT 92626 & 92627 Payable when billed by an audiologist or an SLP
  - CPT 92601 through 92604 May not be billed by SLPs, but can be billed by physicians or non-physician practitioners (audiologists)

- Resources to aid in understanding the codes and rules include Medicare, ASHA, ADA as well as Cochlear Support Services
Commonly Billed Codes

Post-Operative Services – Baha® Fitting

- No specific CPT code precisely describes a Baha processor fitting
- Using an unlisted CPT code is common when no code exists, e.g. 92700 “unlisted otorhinolaryngological service or procedure”, although a couple of steps would need to be taken:
  - Confirm with insurer if the 92700 is a covered service, and if a paper claim is required
  - Provide on the claim a brief description of the service
- Billing the patient may be an option if the service is considered non-covered

CPT Modifiers

- Two character code used to further describe or to provide additional information about the procedure/service, for example:
  - Multiple procedures were performed
  - More than one surgeon worked on the patient
  - Added to the end of the CPT code with a hyphen, e.g. 92626-xx

- Commonly used modifiers in Audiology:
  - -22 Increased procedural service
  - -52 Reduced services
  - -59 Distinct procedure unrelated to primary procedure
  - -76 Repeat procedure by same provider

- Can affect the processing or payment of the code billed
National Correct Coding Initiative

- CMS developed CCI to promote correct coding practices and to control improper coding leading to inappropriate payment

- CCI is a collection of edits in a claims processing system that prevents some pairs of codes from being billed together for the same patient on the same date of service ("unbundling")
  - The underlying principle is that the second code defines a subset of the work of the first code

- -59 Modifier "Distinct procedure unrelated to primary procedure" is an important CCI-associated modifier


Example of CCI Edits

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Can be performed on the same date of service in an office setting?</th>
<th>Can be performed on the same date of service in hospital outpatient settings?</th>
<th>If can be performed on the same date of service, what modifier should be used?</th>
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</thead>
<tbody>
<tr>
<td>CPT Procedure Code (one)</td>
<td>CPT Procedure Code (one)</td>
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<td></td>
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<tr>
<td>92540</td>
<td>92570,92541, 92542, 92544, 92545</td>
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<td>92542, 92544, 92545</td>
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<td>-59</td>
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<td>92542</td>
<td>92544, 92545</td>
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<td>-59</td>
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<tr>
<td>92544</td>
<td>92545</td>
<td>Yes</td>
<td>Yes</td>
<td>-59</td>
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<td>92550</td>
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<td>No</td>
<td></td>
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<td>Yes</td>
<td>-59</td>
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<td>92571, 92572, 92576</td>
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<td>No</td>
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<tr>
<td>92620</td>
<td>92626</td>
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<td>Yes</td>
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</tr>
<tr>
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<td>92571, 92572, 92576</td>
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<tr>
<td>92625</td>
<td>92562</td>
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<td>-59</td>
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<td>92626</td>
<td>92621</td>
<td>Yes</td>
<td>Yes</td>
<td>-59</td>
</tr>
<tr>
<td>92640</td>
<td>92507, 92508, 92550, 92552, 92553, 92555, 92556, 92557, 92558, 92561-92568, 92570-92572, 92575-92577, 92579, 92582-92588, 92596, 97755</td>
<td>Yes</td>
<td>Yes</td>
<td>-59</td>
</tr>
</tbody>
</table>

New Modifiers Introduced January 2015

- CMS developed these modifiers to describe specific subsets of the -59 modifier, a “Distinct Procedural Service”
  - XE – Separate encounter
  - XP – Separate practitioner
  - XS – Separate structure
  - XU – Unusual non-overlapping service

- CMS will issue additional guidance and education as to the appropriate use of the X-modifiers. Until then, may continue to use -59 modifier

CCI Edits for Audiology Services

- On-line resources available to provide additional information:
  - Medicare
  - American Speech-Language Hearing Association
    www.asha.org/practice/reimbursement/coding/CCI_edits_Aud/
  - American Academy of Audiology
Unlike hearing aids, Medicare covers cochlear and bone conduction implants as prosthetic devices. Many private insurers and Medicaid plans also cover the implants. Hybrid™ implants may be covered if candidate meets criteria.

### Insurer Coverage for Implantable Hearing Devices

- **Cochlear Implant**: Covered by most insurance plans, Covered, Typically covered†
- **Cochlear™ Nucleus® Hybrid™ Implant**: May be covered, May be covered*, May be covered
- **Bone Conduction Implant**: Covered by most insurance plans, Covered, Typically covered†
- **Hearing Aids**: Typically not covered, By law are not covered, Typically covered†

†Coverage for adult Medicaid recipients varies according to state specific guidelines

*May be covered for patients that meet Medicare's current coverage criteria

**The Hybrid L24 implant is approved in the US only for adults 18 and older
Cochlear Implant Coverage

- Medicare
  - National Coverage Determination (NCD) 50.3
    - Covers treatment of bilateral pre- or-post-linguistic, sensorineural, moderate-to-profound hearing loss
    - Limited benefit from amplification defined by test scores of ≤40% correct in the best-aided listening condition
    - Other criteria, such as a willingness to undergo an extended program of rehabilitation, freedom from middle ear infection
  - No prior authorization or predetermination review conducted for traditional Medicare
  - NCD diverges from the FDA labeling

Cochlear Implant Coverage

- Medicare - Hybrid™ Implant
  - May be covered if candidate meets CI criteria outlined in NCD
  - No distinction made for which CI system is covered in NCD
  - No prior authorization or predetermination review conducted for traditional Medicare
Cochlear Implant Coverage

- Medicare Advantage Plans
  - Must provide same benefits as traditional Medicare; may also provide additional benefits, such as dental or vision care
  - Process for pre-determinations of benefits or prior authorization of services will vary by plan
  - Must follow NCD criteria when determining coverage for CI

- Medicaid
  - Coverage varies:
    - Pediatrics are covered by all states
    - Adults are covered by some states
    - Prior authorizations are generally required

Cochlear Implant Coverage

- Commercial
  - Most commercial insurers cover cochlear implants for patients meeting their coverage criteria
  - Prior authorizations are generally required
  - Majority of commercial insurers offer bilateral coverage

- Hybrid™ Implant
  - Many commercial insurers cover for patients meeting their coverage criteria
  - Each insurer determines their own criteria
  - If no formal policy exists, case-by-case coverage may be secured
  - Prior authorizations are generally required
Baha® Coverage

- Medicare
  - Classifies auditory osseointegrated implants as prosthetic devices, NOT hearing aids. Medicare Benefit Policy Manual, Chapter 16, §100
  - Codified the definition of AOIs as prosthetic devices in the 2005 Final Rule
  - No prior authorization or predetermination review conducted for traditional Medicare

- Medicaid
  - Most states cover bone conduction implants for children, varies by state for adults
  - Prior authorizations are generally required

- Commercial insurers
  - Coverage varies by
    - Plan
    - Terms of the coverage document in effect at the time of service
    - Medical coverage policies
    - The plan’s designation/classification of the Baha implant system as a prosthetic device or a hearing aid
  - Prior authorizations are generally required
Denials & Appeals

Reasons for Denied Services

- The health insurer may deny services for a variety of reasons:
  - Services are deemed not medically necessary
  - Services are considered experimental or investigational for the condition
  - The effectiveness of the medical treatment hasn’t been proven
  - The candidate is ineligible for the benefit requested under the health plan
  - The implant is categorized as a hearing aid, a non-covered service
The Affordable Care Act (ACA) set national standards for internal appeal and external review processes, and ensures a privately-insured patient’s right to appeal health insurer decisions. Prior to the ACA, a patient’s right to appeal were limited and varied from state to state, and plan to plan. Not addressed by the ACA, but as a contracted par provider with a health insurer, you have a right to request a reconsideration of an insurance denial.

Appeals Process

- In general, a commercial insurer provides at least two levels of appeals.
- Timelines are typically outlined in the provider manual – e.g. file appeal within 30-days of the date denial was received.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually reviewed by insurer’s appeals or utilization department</td>
<td>Reviewed by personnel typically not involved in the original decision</td>
<td>Could involve an independent, third-party reviewer, with an appropriate level of training and/or expertise required to evaluate the necessity of the service under review</td>
</tr>
<tr>
<td>Decision is communicated by phone or letter</td>
<td>Decision at this level could be final</td>
<td></td>
</tr>
<tr>
<td>If decision not in patient’s favor, second level appeal is available</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In general, a commercial insurer provides at least two levels of appeals. Timelines are typically outlined in the provider manual – e.g. file appeal within 30-days of the date denial was received.
Appeals Process

- Appeals may need to be written and should include the following:
  - Medical records that support your statements, including audiograms
  - Reviewers, under most circumstances, do not know how to interpret the results of hearing tests. Summarize findings in simple, layman’s terms
  - A narrative on treatments that were tried yet were ineffective
  - A reference to the coverage policy and how the insurer’s standards or criteria were met
- Template letters are available from ASHA or Cochlear to help get you started
Otologic Management Services

OMS Insurance Support
OMS is available to provide support to candidates and healthcare providers seeking to obtain necessary insurance approval and to support appeals where coverage has been denied for Cochlear’s Nucleus® Cochlear Implants or Baha® Systems for medically qualified candidates.

OMS Support Services
- Pre-surgical preauthorization/predetermination specific to the implant procedure and device
- Coding information to support process of obtaining coverage for Cochlear™ and Baha® implants
- Insurance appeals, if preauthorization/predetermination is denied
- Clinical study reimbursement support
- Cochlear’s Vaccination Program administration

Coding Support Program

- Provides assistance to healthcare providers, clinics, and facilities with coding questions related to Cochlear’s cochlear implants and Baha® auditory implants

Contact Information
Phone: (800) 587-6910
Email: codingsupport@cochlear.com
Reimbursement Billing Services

- Offers direct billing services for recipients who need replacement processors, parts, or repairs and who are members of current contracted payers, e.g., Medicare, Medicaid, Kaiser, and Tricare
- Manages the process of accepting orders for upgrade or replacement processors and submitting for approval for commercially insured recipients
- Works directly with the recipient or the clinic to obtain the necessary documentation to support submissions

Contact Information
Phone (800) 633-4667
Orders: Option 2
Billing: Option 3
Email: Reimbursement@cochlear.com

Health Economics & Reimbursement Support

- Field-based resources are available to assist facilities, healthcare providers and their staff with navigating the reimbursement landscape
- Have detailed knowledge of local, regional and national payers’ reimbursement policies that impact coding, coverage and payment for hearing implants and related services
- Responsible for driving initiatives in their territories to remove barriers to patient access

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