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Reimbursement guide for cochlear implant and auditory osseointegrated devices

Frequently asked questions

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General

Q: Are audiologists required to enroll with Medicare?

A: The federal Social Security Act requires audiologists and speech language pathologists (SLPs) to enroll in and bill Medicare when they provide any covered services to a Medicare beneficiary. There are two categories of participation within Medicare:

- Participating provider (who must accept assignment)
- Non-participating provider (who does not accept assignment)

Please see below for additional resources and/or reach out to your professional organizations should you have additional questions.

ASHA Wire Article on Medicare
ASHA Medicare FAQ

Q: Does Medicare require an order to perform diagnostic services related to either cochlear implants (CI) or auditory osseointegrated implants (AOIs)?

A: Yes, in most instances, a physician referral is required. There are exceptions for select non-acute hearing conditions once per patient per 12-month period with the use of the AB modifier. (See next Question).

Audiology tests are covered as "other diagnostic tests" under section 1861(s)(3) or 1861(s)(2)(C) of the Act in the physician's office or hospital outpatient settings, respectively, when a physician or Non-Physician Practitioner (NPP) orders such testing for the purpose of obtaining information necessary for the physician's diagnostic medical evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem.

Hearing and balance assessment services are generally covered as "other diagnostic tests" under section 1861(s)(3) of the Social Security Act. Hearing and balance assessment services furnished to an outpatient of a hospital are covered as "diagnostic services" under section 1861(s)(2)(C).

As defined in the Social Security Act, section 1861(ll)(3), the term "audiology services" specifically means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

Audiological diagnostic testing refers to tests of the audiological and vestibular systems, e.g., hearing, balance, auditory processing, tinnitus and diagnostic programming of certain prosthetic devices, performed by qualified audiologists.

Audiological diagnostic tests are not covered under the benefit for services incident to a physician's service (described in Pub. 100-02, chapter 15, section 60), because they have their own benefit as "other diagnostic tests".

ASHA Medicare Frequently Asked Questions: Audiology
AAA: CMS Releases Updated Guidance on AB Modifier
CMS: Audiology Services

Q: When can I use the AB modifier to see Medicare patients without a referral?

A: Starting January 1, 2023, audiologists can provide select hearing assessment services to Medicare Part B (outpatient) beneficiaries without a physician order under specific circumstances.

ASHA Medicare Hearing Assessments Provided by Audiologists Without a Physician Order

AAA CMS Releases Updated Guidance on AB Modifier

CMS Audiology Services

Q: Does the audiology clinic need a referral for every single follow up programming appointment for Medicare patients? Or is it just a yearly referral?

A: The physician must state the intent for the diagnostic test to be performed in the medical record. Best practice would be to obtain an order/ referral stating for each prospective visit as a standard of care for a recipient. Per the Medicare Benefit Policy Manual Chapter 15: Medicare Benefit Policy Manual "Audiology diagnostic tests before and periodically after implantation of auditory prosthetic devices are covered audiological diagnostic tests when ordered by physicians or NPPs. Orders and documentation should indicate what test was ordered, the reason for the test, and that the test was furnished to the patient by a qualified individual. Reevaluation is appropriate at a schedule dictated by the ordering physician when the information provided by the diagnostic test is required; for example, to determine changes in hearing, to evaluate the appropriate medical or surgical treatment or to evaluate the results of treatment."

ASHA Medicare Frequently Asked Questions: Audiology

AAA Physician Referrals

CMS Audiology Services

Cochlear implants

Q: What is Medicare's medical necessity criteria for coverage of cochlear implants?

A: Medicare has published a National Coverage Determination (NCD) for Cochlear Implant coverage criteria.

Cochlear Implant NCD 50.3

Q: What ICD-10-CM code(s) does Medicare allow for coverage of cochlear implant surgery and post-operative management services?

A: As documented in the CMS Manual System Transmittal 1244:

ICD-10 CM	ICD-10 CM Description For all patients (in a clinical trial or not in a clinical trial)
H90.3	Sensorineural hearing loss, bilateral
Z45.321	Examination for adjustment and management of cochlear device
Z00.6*	Encounter for examination for normal comparison & control in a clinical research program

*For FI only and only patients in a clinical trial. A second DX should also be reported.

Q: How does Medicare define best-aided condition for cochlear implant candidacy evaluations?

A: Medicare does not define best-aided conditions. Providers are encouraged to use clinical discretion and decision-making to define best-aided conditions and apply consistently across all evaluations. For more information, providers may want to reference material from the Institute for Cochlear Implant Training (ICIT). The Minimum Speech Test Battery (MSTB-3) Test Suite shares an updated and streamlined test battery for pre-operative determination of candidacy and post-operative assessment of cochlear implant performance in adults.

ICIT MSTB-3 Suite

Q: How does Medicare define moderate to profound hearing loss?

A: Medicare does not specify this level of detail for degree of hearing loss. Providers are encouraged to use clinical discretion and decision-making to establish their practice protocol and apply it consistently across all evaluation protocols. As a reference point, please review ASHA's guidance:

Degree of Hearing Loss

Q: Are cochlear implant programming services separately payable to an audiologist under Medicare Part B when the recipient is receiving home health services under a Medicare benefit?

A: No, under the Home Health Prospective Payment Systems, , CPT codes 92601-92604 are subject to consolidated billing under a Medicare home health benefit. If an audiologist reports these codes while the recipient is also receiving home health services, the audiological services will likely be denied with remark code CO-97 (the benefit for this service is included in the allowance for another service and cannot be separately reported). Additional information may be accessed under the Home Health Prospective Payment System, including a master code list subject to consolidated billing. Providers may confirm eligibility and dates of home health service benefit periods utilizing the Interactive Voice Response (IVR) eligibility services under their specific Medicare Administrative Contractors (MAC).

Home Health Prospective Payment Systems:
Coding and Billing Information | CMS

Home Health Consolidated Billing Master Code List

Additional information can be found on ASHA's website

Q: What can I report under CPT code 92626: Evaluation of auditory rehabilitation status?

A: Professional societies have published articles with guidance on this specific service. Please reference these for more information.

AAA: Specialty Series: Cochlear Implants

ASHA: Dos and Don'ts for Revised Implant-Related Auditory Function Evaluation CPT Codes

Q: What is the recommended coding guidance to indicate programming services were performed on two separate processors/sides on the same date of service?

A: Coding guidance varies according to how hearing is defined; more specifically, if cochlear implant programming services are considered as inherently bilateral or unilateral/single device codes.

- The Medicare fee schedule lists codes CPT 92601-92604 with a bilateral indicator of "0" translated as a bilateral increase does not apply because: The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. Since Medicare assigns a bilateral indicator code of "0", additional fees will not be paid for services performed on a second processor/side.
- AAA recommends the -22 and LT/RT modifiers with documentation to differentiate unilateral from bilateral programming services.
  AAA Billing & Coding for Audiology Services
- Some payers may accept two-line items of the same code with –RT or –LT ear modifiers to designate which side was programmed. Other payers may consider a binaural programming session as a same-day repeat procedure. In this case, a separate bill with the same date of service would be completed. The second cochlear implant programming code would be billed with a repeat procedure modifier added (-76: Repeat procedure by same provider; or -77: Repeat procedure by another provider).
  ASHA: Billing and Coding for Pediatric Audiology Services

NOTE: It is important to bill consistently across all payers and/or check with the payer for specific guidance.

Q: What codes have reimbursement restrictions when billed together?

A: The National Correct Coding Initiative (NCCI, or more commonly, CCI) is an automated edit system to control specific Current Procedural Terminology (CPT®) code pairs that can be reported by an individual provider on the same day for the same patient. Medicare, Medicaid, and many commercial health plans apply NCCI methodologies to claims processing.

ASHA CCI Edit Tables for Audiology Services

National Correct Coding Initiative (CCI) Edits for Audiology Procedures - American Academy of Audiology

CMS: Medicare National Correct Coding Initiative (NCCI) Edits

Q: Can I bill CPT 92626 and CPT 92601-92604 together on the same day?*

A: The National Correct Coding Initiative (NCCI) is an automated edit system to control specific Current Procedural Terminology (CPT®) code pairs that can be reported by an individual provider on the same day for the same patient. The NCCI tables lists code pairs and outlines whether a restriction may be bypassed with a modifier, such as the -59 modifier (distinct procedural service).

Modifier 59 is used to identify procedures/services, other than E/M services, which are not normally reported together, but may be appropriate under specific circumstances. Documentation must support services which are not ordinarily encountered or performed on the same day by the same individual.

Documentation should clearly distinguish post-operative cochlear implant (CI) auditory function status evaluation (CPT 92626/92627) from post-operative cochlear implant programming and mapping (CPT 92601–92604), when performed on the same day. In these circumstances, separately document the time and activities of the post-operative auditory function evaluation and the activities of the programming and mapping service to establish that the CPT code requirements for both procedures have been fully met.

If both procedures are performed, and the minimum time requirements are met for 92626/7, an option is to append the -59 modifier to CPT 92626/27 to indicate that the auditory function evaluation was a separate and distinct service from cochlear implant programming or reprogramming (92601–92604).

- If the evaluation of auditory function takes less than 31 minutes, the clinician cannot bill 92626 and should bill only the appropriate programming and mapping code.
- Remember, the reduced service modifier cannot be used with 92626 to reflect evaluation activities of less than 31 minutes.
- Some payers may require a more specific set of subcategory modifiers. In these cases, use of the -XU modifier instead of (not in addition to) modifier -59 may be an option.
- XU (Unusual, non-overlapping service; the use of a service that is distinct because it does not overlap usual components of the main service).

* Coding guidance is applicable to services rendered within POS 11.

CCI Edit Tables for Audiology Services

Dos and Don'ts for Revised Implant-Related Auditory Function Evaluation CPT Codes

National Correct Coding Initiative (CCI) Edits for Audiology Procedures - American Academy of Audiology

MLN17837722 - Proper Use of Modifier 59, XE,XP,XS,XU

Q: Is there a procedure/ billing code for when we run NRT?

A: Use CPT code 92584 to report neural response telemetry (NRT) when performed intraoperatively or postoperatively. (Reference: CPT Assistant, July, 2011, p. 17.)

ASHA Medicare CPT Coding Rules for Audiology Services

AAA Cochlear Implant Billing

Q: What coding options can be used for ESRT measurements?

A: Please see CODING AND REIMBURSEMENT | Specialty Series: Cochlear Implants - American Academy of Audiology and ASHA Billing & Coding for Audiology Services

- 92568 Acoustic reflex testing, threshold, or
- 92550 Tympanometry and reflex threshold measurements

Auditory Osseointegrated Implants (AOIs)

Q: What is Medicare's medical necessity criteria for coverage of auditory osseointegrated implants (AOIs)?

A: Unlike cochlear implants, there is no Medicare National Coverage Determination for AOIs. They are covered by Medicare as prosthetic devices and must be used in accordance with the FDA approved labeling.

CMS Manual System Transmittal 39

Q: Are there CPT procedure codes for the programming/fitting of AOIs?

A: Effective January 1, 2024, audiologists who program auditory osseointegrated implant (AOI) devices have two newly established Current Procedural Terminology (CPT©, American Medical Association) codes to report their services.

CPT Codes 92622 and 92623 have established service descriptors and assigned Relative Value Units (RVUs), allowing professionals a predictable pathway for reimbursement of services rendered.

CPT codes for the diagnostic analysis, programming, and verification an AOI sound processor, including non-surgical systems:

CPT Code[1]	Description
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (list separately in addition to code for primary procedure)

1 CPT codes and descriptors only are copyright 2025 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

NOTES: When reporting CPT 92623. report each 15-minute increment separately. CPT 92623 is an add-on code and must be reported in conjunction with the base service code (CPT 92622). Do not report CPT 92622/92623 in conjunction with CPT 92626/92627. Please review ASHA's coding guidelines on new codes ASHA CPT Changes for 2024.

- CPT 92622/92623 are applicable to both initial and subsequent services. They may be used for any type of AOI sound processor (i.e., both surgical and non-surgical solutions).
- These are timed codes, and providers should document either a start/stop time or total amount of time spent on the specific service. For more information on timed codes, see ASHA The Right Time for Billing Codes.
- CMS added CPT 92622/92623 to the list of audiological services for non-acute hearing conditions that may be provided without a physician/practitioner referral (identified with the AB modifier). For more information about the use of the AB modifier please visit:

  ASHA AB Modifier

  AAA New Codes and AB Modifier

- CMS requires Medicare providers to use CPT codes to report covered, professional services provided to Medicare or Medicaid beneficiaries; therefore, providers must use the new CPT codes effective as of January 1, 2024.

Q: Are the AOI fitting codes for all types of devices (i.e., surgical, nonsurgical)?

A: Yes, the code description includes "any type" of sound processor, so CPT 92622/92623 would be appropriate for surgical (percutaneous and transcutaneous) or nonsurgical AOI sound processors.

AAA Coding Information: AOI Devices

Q: What services are included under CPT 92622/92623?

A: Codes CPT 92622/92623 describe the analysis, programming and verification of an auditory osseointegrated sound processor, any type. These services include evaluating the attachment of the processor, device feedback calibration, device programming, and verification of the processor performance. These codes should be used for subsequent reprogramming services, when performed.

American Academy of Audiology FAQ AODs - Membership required
Codify by AAPC - subscription required

Q: Is a billing modifier required if a provider is fitting a single AOI sound processor? Or when fitting bilateral sound processors?

A: CPT 92622/92623 are timed codes; therefore, the codes do not require modifiers for fitting monaurally or binaurally configurations. The provider should account for the total time spent rendering services through the chart notes/documentation.

AAA Coding Information: AOI Devices

Q: May providers report CPT 92622/92623 to fit/program a demonstration and/or loaner Baha® Softband/SoundBand™?

A: According to ASHA, the appropriate codes to report for candidacy evaluation device fittings are CPT 92626/92627.

- CPT 92626: evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour.
- CPT 92627: ..... Each additional 15 minutes (List separately in addition to code for primary procedure).

Additional guidance can be found in this article from ASHA: ASHA - Dos and Don'ts for Revised Implant-Related Auditory Function Evaluation CPT Codes

- "Do report 92626/7 for a candidacy evaluation even if the patient won't be implanted immediately, if ever. Some pediatric patients may have implantation postponed after a candidacy evaluation due to their age or skull size, such as in the case of bone-anchored implantable devices. For example, a child younger than 5 may use a head-worn soft band coupled with a bone-anchored processor following a candidacy evaluation. Follow-up evaluation would determine success with the device and candidacy for future implantation. Or, after the initial evaluation, an adult may subsequently decide to postpone implantation or may be considered a poor implant candidate based on other factors discovered in the surgical candidacy evaluation process. If the patient's condition changes or the patient later reconsiders an implanted device, another evaluation may be necessary. In both scenarios, the initial and follow-up evaluations would both be appropriately reported with 92626/7."

Q: How many units of CPT 92623 may be billed on a single date of service?

A: Medically Unlikely Edits (MUEs) are used by the Medicare Administrative Contractors (MACs), to reduce improper payments for Part B claims. An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. More information on MUEs is available on the CMS Website: CMS NCCI Medically Unlikely Edits.

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
92623	2	3 Date of Service Edit: Clinical	Nature of Service/ Procedure

Q: Can I report both CPT 92622 and 92626 if performed at the same appointment?

A: Providers should always report the code that most closely aligns with the service(s) provided.

Other coding information for consideration:

- The CPT Manual parenthetical for CPT codes 92622/92623 states these codes cannot be reported together with CPT 92626/92627.
- The current NCCI edits allow a modifier to override the edit assuming the services are separate and distinct from each other.
  - Both CPT codes are designated as timed services, and each (CPT 92622 & 92626) require a minimum threshold of 31 minutes of services to report.
    Medicare NCCI Procedure to Procedure (PTP) Edits | CMS
- Providers should check with payers for additional billing guidance on the use of modifiers with this code pair.

Q: May providers charge a dispensing/fitting fee in addition to billing CPT 92622/92623 for AOI fitting services?

A: No, it would not be appropriate to charge a dispensing/fitting fee in addition to reporting CPT 92622/92623 to insurance plans. As noted in CMS Manual System Transmittal 39, auditory osseointegrated devices are designated as prosthetic devices, which have dedicated CPT codes providers may report for the diagnostic analysis, programming, and verification services of these devices.

Dispensing fees have historically been associated with hearing aids to cover the professional services to program and fit devices. Given the AMA has created CPT codes to report these services specific to AOI devices, it would not be appropriate to duplicate charges by charging a dispensing fee in addition to billing insurance for the programming and fitting services rendered.

Cochlear resources:

1. Cochlear Reimbursement Hub: Check out the videos under “New to Implantable Technology” and other Audiologist Resources including coding sheets
2. Coding Support: codingsupport@cochlear.com
3. Connecting People with Hearing Care - Cochlear Health professionals: Cochlear site with some resources for you and your patients including the Adult CI protocol, and Programming Report Template
4. MyCochlear for Professionals: A specialized online resource for hearing healthcare professionals to support Cochlear customers

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