Cochlear™ Nucleus® Implants

Billing codes

For surgeons and implant facilities

The following codes may be reported by both the surgeon and the surgical facility (hospital/ASC).

CPT® Codes for 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
95867	Needle electromyography; cranial nerve supplied muscles, unilateral
92568	Acoustic reflex testing; threshold

Magnet removal/replacement

CPT 20670	Removal of implant; superficial, (e.g., buried wire, pin or rod)(separate procedure)
CPT 69799	Unlisted procedure, middle ear
CPT 92700	Unlisted otorhinolaryngological service or procedure
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "1" code

Revenue codes

Revenue codes are used only for hospital/ASC claims. Report code when providing device or service:

0278	Medical/Surgical Supplies and Devices-Other Implants
0361	Operating Room Services-Minor Surgery

Ambulatory Payment Classification (APC)

5166	Cochlear implant

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

Medicare guidance for ASC billing[1]:
Medicare defines cochlear implants as prosthetic devices and guides ASC billing as follows: Prosthetic Devices: Payment for implantable prosthetic devices without OPPS pass-through status is included in the ASC payment for the covered surgical procedure. ASCs may not bill separately for implantable devices without OPPS pass-through status.

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.

Options	Device: L8614, 1 line, 2 units	Option 3	Procedure: 69930, 69930-59, 2 lines, 1 unit per line
Option 1	Procedure: 69930-50, 1 line, 1 unit	Option 4	Procedure: 69930, 1 line, 2 units
Option 2	Procedure: 69930-LT, 69930-RT, 2 lines, 1 unit per line		

Modifiers

Payers have differing rules on proper use of modifiers. Consult your payers to confirm policies.
Add Modifier when a claim reports the following situations:

22	Increased procedural services	**59**	Distinct procedure unrelated to primary procedure *(e.g. otolaryngologic exam under general anesthesia unrelated to cochlear implant implantation procedure)*
50	Bilateral procedure in the same operative session		
51	Multiple procedure codes on the same claim	**76**	Repeat procedure or service by another physician or other qualified health care professional
52	Reported CPT code is not fully performed or partially reduced		

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This material is intended for health professionals. If you are a consumer, please seek advice from your health professional about treatments for hearing loss. Outcomes may vary, and your health professional will advise you about the factors which could affect your outcome. Always read the instructions for use. Not all products are available in all countries. Please contact your local Cochlear representative for product information.

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