Part B Insider (Multispecialty) Coding Alert

Cochlear Implants: Avoid Noncovered Codes For Speech Devices, Swallowing Tests

Try billing 31575 instead of 92613, 92615 or 92617

The 2003 CPT added new codes for cochlear implants, augmentative or alternative speech devices and swallowing tests (92601-92617). With so many options, it's easy to get confused.

Medicare will no longer cover 92510 (Aural rehabilitation following cochlear implant) because it overlaps with 92601-92604 (Diagnostic analysis of cochlear implant ...).

The addition of 92601-92604 will help physicians differentiate between rehab following cochlear implant and the diagnostic analysis and programming of the implants, says **Steven White** with the American Speech-Language-Hearing Association. When a patient receives a cochlear implant, the physician must program it, White says. Then, as the patient learns to use it and becomes more acclimated to listening while using it, the physician must adjust the implant.

The first two codes, 92601-92602, are only for children under the age of 7. For adults, you should use 92603 for programming and **CPT 92604 for** reprogramming.

To document the need for this programming and reprogramming, the chart should note the patient's hearing levels and ability to understand speech before receiving the implant, and then the levels with the implant.

The addition of 92605-92609 will help coders distinguish between non-speech-generating devices (which Medicare doesn't cover) and speech-generating devices (which are covered). Use 92605-92606 to code for these noncovered devices, White says. Codes 92610-92617 replaced G codes that the Centers for Medicare & Medicaid Services had created for swallowing tests, White says. With the old version, there were no codes purely for physician interpretation and report of swallowing tests, but the new codes add three: 92613, 92615 and 92617. Unfortunately, Medicare won't pay for these codes, White says.

So if you can't bill 92612 instead of 92613, you may be able to bill for a diagnostic laryngoscopy (31575) instead of the noncovered 92613. To receive payment for 31575, you should be sure to document that the patient had symptoms that might be consistent with cancer. You should also document that the 31575 was "incident-to" the performance of the test, White adds.