

## **ALERT: Medicare Requires Device Coding on Hospital Outpatient Claims for Cochlear Implants**

### **Summary**

In the 2005 Hospital Outpatient Prospective Payment System (OPPS) final rule, the Centers for Medicare and Medicaid Services (CMS) announced that for services provided on or after January 1, 2005, “we will require hospitals to include device category codes on claims when such devices are used in conjunction with procedures billed and paid for under the OPPS.” CMS further stated “we continue to believe coding of devices is vital to enhancing the device-dependent APC claims data.” **Beginning April 1, 2005, the OPPS Outpatient Code Editor (OCE) will reject Medicare claims for CPT 69930 (Cochlear device implantation, with or without mastoidectomy) that lack the required HCPCS Level II device code, L8614 (Cochlear implant device/system).<sup>1</sup> The code and charge for the device used in the procedure must be reported.**

### **Background**

With the implementation of OPPS in 2001, Medicare created device category codes (“C-codes”) to provide new technology pass-through payments and to enable tracking of device utilization. Rather than create a separate C-code for cochlear implants, Medicare assigned pass-through status to the existing L8614 code.<sup>2</sup> In late 2002, Medicare announced the expiration of many codes assigned pass-through status and further commented:

“The code for cochlear implant system, L8614, is a permanent HCPCS code that will not expire. Although the cochlear implant system device category will expire for pass-through payment purposes, the code may continue to be reported after December 31, 2002. Beginning January 1, 2003 charges reported with L8614 will be considered as charges attributable to a packaged device under OPPS.<sup>3</sup>”

From January 2003 to January 2005, reporting L8614 on Medicare hospital outpatient claims has been optional. Because the device comprises such a large portion of the cost of cochlear implantation, tracking device costs is critical for Medicare to appropriately set payment rates for cochlear implantation (APC 0259 Implant cochlear device). The lack of consistent device coding on claims since 2003 has made it impossible for Medicare to effectively track device costs for the purposes of setting future hospital payment rates for these services.

In 2004 Medicare reconsidered the issue of device cost tracking and in the 2005 OPPS final rule, implemented the device coding requirement for many device dependent APC’s, including cochlear implantation, in order to improve the claims data used annually to update the OPPS payment rates.

### **Action**

**To prevent cochlear implantation claims under the OPPS from being rejected, we recommend that you work with your hospital’s coding and billing staff to review the claims process for cochlear implantation and ensure that the new device coding requirements have been implemented. Improved claims data should support more appropriate payment rates and ultimately improve beneficiary access to cochlear implants.**

If you have any questions, please contact our Reimbursement Services Department at 877-779-0229.

<sup>1</sup> Medicare Claims Processing Manual [Pub 100-4] Transmittal 403, Request 3606

<sup>2</sup> Program Memorandums A-01-41 (section 1), A-01-73 and A-02-50

<sup>3</sup> Program Memorandum A-02-129