



August 27, 2015

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**Attention CMS-1633-P**  
PO Box 8013  
Baltimore, MD 21244-1850

RE: **Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System; *Federal Register*, July 08, 2015. CMS-1633-P.**

Dear Acting CMS Administrator Slavitt:

The American Cochlear Implant Alliance (ACI Alliance) is a non-profit, 501(c)3 whose mission is to advance the gift of hearing provided by cochlear implantation and other implantable prosthetic hearing implants through research, advocacy and awareness. The membership includes clinicians who provide the intervention (e.g., ENT surgeons, audiologists, speech language pathologists), other professionals on implant teams including social workers and psychologists, teachers of deaf children, researchers, parents of children with cochlear implants, adult cochlear implant recipients, and other advocates. The organization seeks to ensure appropriate access to, and quality of, clinical care relating to cochlear implantation. An annual research-based scientific meeting is convened. Most ACI Alliance clinicians serve Medicare patients and provide cochlear implant services to patients at their clinics, the majority of which are rendered in outpatient hospital settings during the post-surgical phase of care.

We are writing regarding the accuracy and appropriateness of the current Ambulatory Payment Classifications (APCs) across the OPPS to group services that are clinically similar and have similar resource costs relative to cochlear implant post-operative care. Given that the surgery for a cochlear implant is the beginning of a process of gaining hearing acuity by utilizing electrical impulses, the *programming* of the device by a specially trained cochlear implant audiologist is critical to patients' outcomes, both following the surgery and over the long term. Sensitive programming is important for all patients, but is particularly critical for an older adult who may have been severely to profoundly deaf for many years. At present, programming

services are categorized by CPT codes 92601-92604. **We are recommending the Status Indicators for these services be changed from “Q1” to “S”, and that the codes be included in either APC5722 to improve clinical consistency or in APC 5721 to better represent cost consistency.**

One of the major concerns of the ACI Alliance is access to appropriate care by patients who could benefit from hearing restoration via cochlear implantation. When reimbursement for services does not reflect the complexity of the service or the actual cost of the service, hospitals may underinvest in clinical care and patients may experience long wait times when they attempt to schedule and receive needed clinical services. This is currently the case with cochlear implantation in many areas of the country. If the need for services is not an emergency, it is not unusual for patients in some localities to experience 3-month wait times to schedule and receive cochlear implant services. These waits are related to the fact that cochlear implant audiology services are poorly reimbursed by some insurers, and especially by Medicare; thus, outpatient centers are reluctant to expand the number of these highly specialized clinicians. Not only do cochlear implant audiologists require special training and a doctoral level entry degree, they require *ongoing* training to keep up-to-date with the number of different technologies available to patients. There are three different cochlear implant manufacturers with many variations within and between each manufacturer’s devices. Replacements of the external device are typically made every five to six years with programming processes changing for each device.

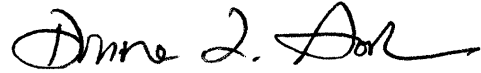
The initial cochlear implant programming provided 2 to 4 weeks following surgery as well as the follow-up reprogramming procedures are distinct, primary services that are independent of the surgery and performed by personnel with specialized education and training. Services provided to patients include auditory electrophysiology measurements and behavioral data to program and enhance the way the external device interacts with the patient’s internal implant. The clinical process for cochlear implant services is similar to other non-invasive electrophysiological diagnostic and treatment codes found in APC 5722: Level 2 Diagnostic Tests and Related Services.

An analysis of the NPRM CPT codes 92603 and 92604 Cost Statistics indicated that the majority of procedures paid in lieu of these codes were actually unrelated to the cochlear implant service and were paid to the facility based on an unrelated service provided by a different practitioner. Further, about half of the time the unrelated service provided a lower APC payment than the cochlear implant service. This is not the stated intent of CMS, which is to ensure that the higher paying APC would be paid when multiple services are provided on the same day.

In summary, we are concerned that access to care is impacted negatively when services which require clinicians with highly specialized education and call for ongoing training are either inappropriately or inaccurately assigned to an APC for payment, or not paid at times due to another unrelated service that was provided to the same patient on the same day. **For all of the above reasons, the American Cochlear Implant Alliance respectfully requests that CPT codes 92601-92604 be assigned the Status Indicator “S” and be included in either APC 5722 which is more clinically consistent with the service provided, or APC 5721 which is more consistent on a cost-basis.**

We appreciate the opportunity to comment on this proposed rule. Please do not hesitate to contact us if you have questions on these comments or wish to discuss other elements, which we may not have addressed here.

Sincerely,

A handwritten signature in black ink that reads "Donna L. Sorkin". The signature is fluid and cursive, with the first name "Donna" being the most prominent.

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