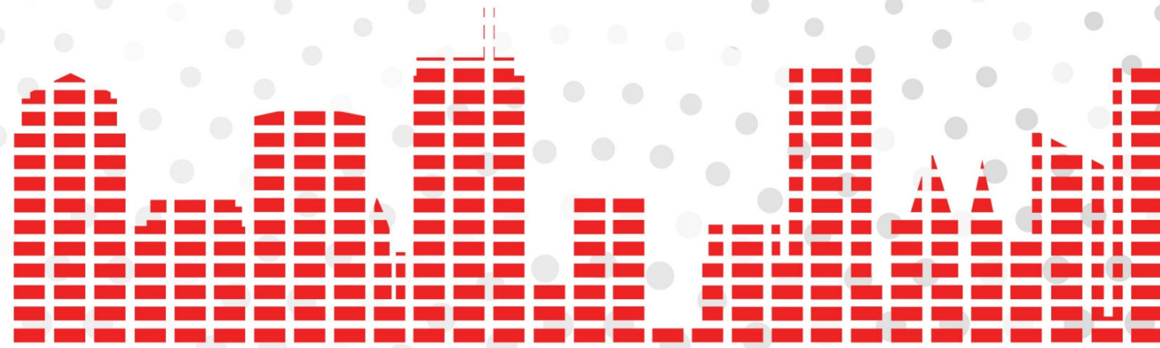


AuDACITY

Bolder than Ever

Billing and Coding

Debbie Abel, AuD
Manager, Coding and Contracting Services
Audigy

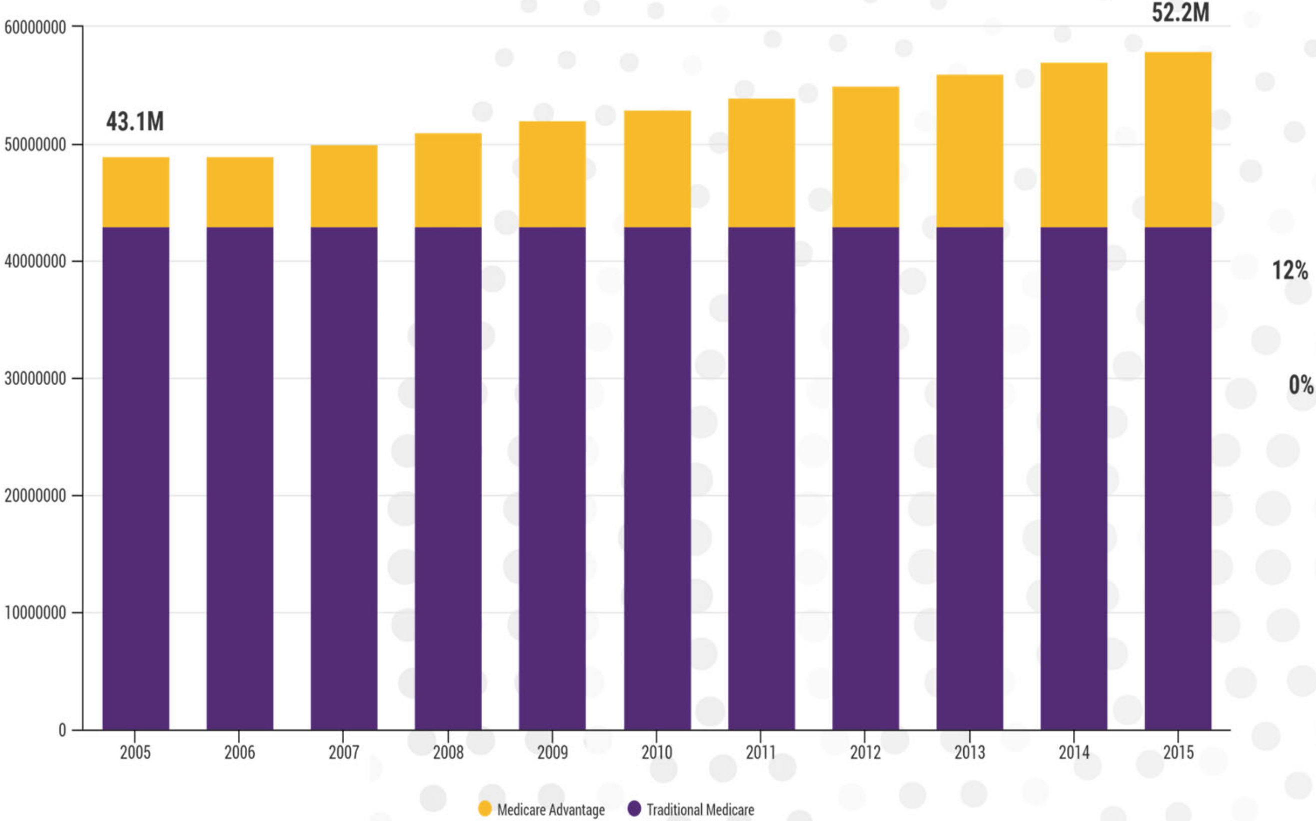
Agenda

- Identify the effects of taking third party payers and how to incorporate them in your practice, if you choose

- Identify the codes pertinent to audiologists and Medicare regulations

- Identify how to incorporate Over-The-Counter devices in your practice

GEORGE
CLOONEY
MARK
WAHLBERG
THE
PERFECT STORM


Total Medicare
Enrollment
Medicare Advantage Growth
60000000
50000000
40000000
30000000
20000000
10000000
0
43.1M
52.2M
12%
0%
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Medicare Advantage
Traditional Medicare

The "WOW" factor: Baby Boomer Growth

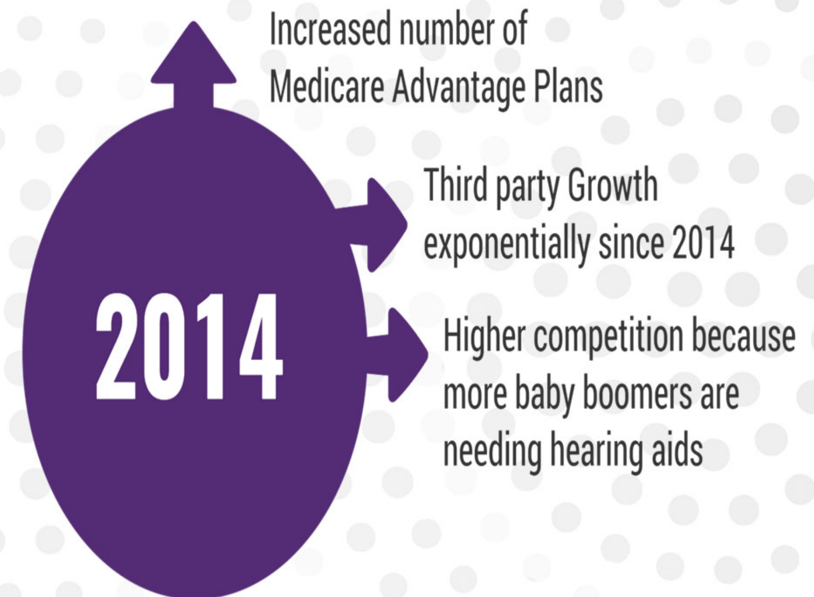
77Million

THIRD PARTY PAYERS AND THE POTENTIAL EFFECT ON YOUR PRACTICE

Since 2014, invasion of third party payers due to a rise in Medicare Advantages plans and baby boomers reaching Medicare age

These Part C plans are directing payers to provide discounted and reduced reimbursement for services

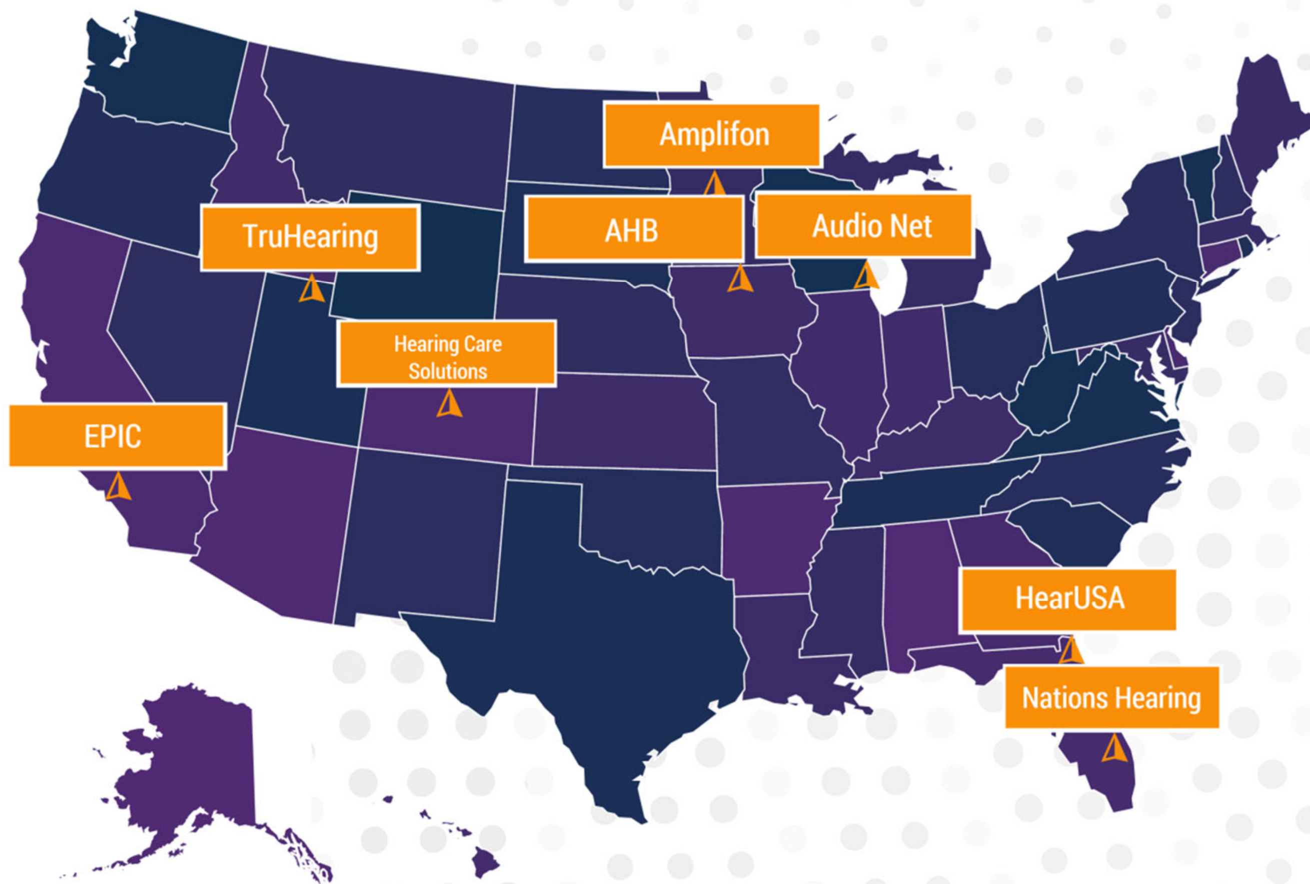
- ✓ **Medicare Advantage plans must be value added**
    - **Patients are paying for the extras and expecting options**
    - **Hearing aids may be part of that package**



Effects of Third Party Payers

- Commercial
  - Identify the top payers in your geographic area
  - Request fee schedules

- Third Party Administrators
  - Identify the Medicare Advantage plans in your area and verify if they are using a Third Party Administrator
  - Determine if this is a plan you want to work with


Amplifon
TruHearing
AHB
Audio Net
Hearing Care Solutions
EPIC
HearUSA
Nations Hearing

Peeking Behind the Curtain:

Hearing aids may lower the risk of age-related cognitive decline

Hearing aids lower levels of depression

Hearing aids improve balance and may lower risk of falls

1 Unexpected Opportunities
2 Circumvents online
3 Uses Independent channel
4 No Cost of Goods
5 $35-65/ Recheck
6 No Marketing
7 Office Time Filled

Questions to Ask Commercial Payers:

1. Hearing aid verification should be done no later than at the time of the HAE/functional needs assessment (no hearing aid should leave an office without knowing who owes what)

2. Can the patient share in the cost of an upgrade beyond their benefit? It's now a non-covered service.

3. Have the patient sign a waiver attesting to their understanding of their benefit's payment and their personal responsibilities

Offer a Service Package?

Payer	Service Package	Time
TruHearing	$250/year	After initial 3 required visits
Amplifon	Determined by provider	After 1st year
Nations Hearing	Determined by provider	After 4th visit
Epic	Determined by provider	They don't "sell" warranty after 3 years; can charge for visits after the initial 6 or provide package
AHB	Determined by provider	Plan dependent or after initial 6 months, $20/visit
HCS	Determined by provider	
AudioNet	Determined by provider	
HearUSA	Determined by provider	

Solutions?

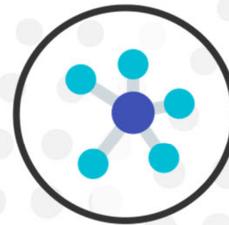
- Scheduling
- Discount programs vs. a benefit
- Establish an office policy about these plans, even if you have chosen not to accept any or all

Considerations & Best Practices

Select a day of the week to see patients

Consider utilizing support personnel for rechecks and less complex hearing aid related services

Describe to the patient their options and services



Create service plans that optimize economics

Know what the mix of payers to manage effectively

Consider & Research

- Is there availability in the practice?
- Can you sell a TPA device to one patient for $799/999 and a comparable aid for ~$2,000 to a private pay patient?
- Can you make it work economically?
- Do you know your market?

Coding: Condensed

Coding Mantra:

- Code for the **reason** for the visit (Medicare transmittal)
- Code with **signs and/or symptoms**
  - Why the patient presented to your office
- Code by **patient complaints (medical necessity)**
  - Tinnitus?
  - Hearing loss?
  - Dizziness?
- Code by **outcome** of the procedure results
  - SNHL?
  - Tinnitus?
  - Conductive hearing loss?

Considerations:

- CPT codes (procedures/services) must be ones typically performed by audiologists
- CPT codes must support the chosen ICD (diagnoses) code(s)
- CPT codes selected must be apparent to an insurance company as to why test was performed
- Hearing aid claims will predominantly utilize the HCPCS codes

Coding Mantra (cont.)

Must code for what you did and what it indicates

THE CODE(S) YOU CHOOSE SHOULD NOT BE DRIVEN BY WHAT YOU WILL BE REIMBURSED

Thoughts:

- Case-building for differential diagnosis
- Our services provide value in the healthcare system
- We are fiscally recognized for those services
- Hearing instrument specialists can test for the sole purpose of fitting a hearing aid per state licensure
- Perform only those procedures recognized by your state licensure law
  - They determine scope of practice
  - Liability coverage is for those services in your scope

CPT Codes:

https://www.audiologist.org/_resources/documents/resources/reimbursement/Codes-CPT.pdf

CPT® Codes

CPT Code	Official CPT Description	Uses
69209	Removal of impacted cerumen using irrigation/lavage, unilateral	This is used to report removal of impacted (cannot see clinically significant portions of the tympanic membrane) cerumen using irrigation and/or lavage. Medicare will not reimburse independent audiologists for this procedure but patients may be charged privately for removal of impacted cerumen. This is a unilateral code. If the procedure is performed bilaterally you must add the -50 (bilateral procedure) modifier to the claim.
69210	Removal impacted cerumen using instrumentation, unilateral	This is used to report removal of impacted (cannot see clinically significant portions of the tympanic membrane) cerumen using instrumentation other than irrigation/lavage such as curettes and/or alligator clips; Medicare will not reimburse independent audiologists for this procedure but patients may be charged privately for removal of impacted cerumen. This is a unilateral code. If the procedure is performed bilaterally you must add the -50 (bilateral procedure) modifier to the claim.
92516	Facial nerve function studies (eg. electroneurography)	This code is used to bill for electroneurography (ENoG)
92531	Spontaneous nystagmus test, including gaze, without recording.	This code is used to perform any spontaneous or gaze testing, without recording (just visualization). Medicare does not cover this procedure.
92532	Positional nystagmus test, without recording	This code is used when you perform any form of positional testing, such as a Hallpike Maneuver, without recording (just visualization). Medicare does not cover this procedure.
92537	Caloric vestibular test with recording, bilateral, bi-thermal (i.e.one warm and one cool irrigation in each ear for a total of four irrigations)	This code is for bilateral, bi-thermal (four irrigations total) caloric testing. This code should not be billed as multiple units. If three irrigations are completed, a -52 (reduced services) modifier should be added. If more than four irrigations are completed, a -22 (increased procedural service) modifier should be added to the claim.
92538	Caloric vestibular test with recording, bilateral, mono-thermal (i.e.one irrigation in each ear for a total of two irrigations)	This code is for bilateral, mono-thermal (two irrigations total) caloric testing. This code should not be billed as multiple units. If one irrigation is completed, a -52 (reduced services) modifier should be added to the claim.
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	This bundled code is used to bill for codes 92545, 92542, 92544, and 92545 when they are performed on the same patient on the same date of service. 92537/8 are not included in this bundle and should be billed separately.
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	Spontaneous nystagmus portion of the common ENG/VNG test protocol; if billed with either 92542, 92544 and/or 92545 (two or three of the 92540 codes) add the -59 (distinct procedural service) modifier to the claim.

Cerumen Management Codes

- **69209** Removal impacted cerumen using irrigation/lavage, unilateral

OR

- **69210** Removal impacted cerumen requiring instrumentation, unilateral

- Impaction defined as "cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition" and "obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills."

- If bilateral, use -50 modifier

-AMA *CPT Assistant,* January **2016**

Cerumen Management (cont.)

- Check with state licensure laws
  - Some state licensure laws do not allow CM to be performed by an audiologist
    - Removal restrictions may apply
- Can offer an ABN
- Any patient can pay for cerumen removal by an audiologist, if allowed by state licensure law

Modifiers

- -22 Unusual Procedural Services
  - Utilized when procedure is greater than what is typically required
    - Involves increase in provider work, time and complexity of what is typically performed
      - Many insurance carriers state that if it is less than 25% more work, should not append
      - May yield a 20-50% increase of the allowable rate
    - Example: 92557-22

Modifiers (cont.)

- -26 Professional component
  - Utilized with:
    - ENG (CPT 92537-92546, 92458)
    - ABR (CPT 92585)
    - OAE (CPT 92587, 92588)
  - Utilized:
    - When another professional performed the procedure
    - You do the interpretation and prepare the report
  - Example: 92585-26

Modifiers (cont.)

- TC Technical component
  - Utilized with:
    - ENG (CPT 92537-92546, 92548)
    - ABR (CPT 92585)
    - OAE (CPT 92587, 92588)
  - Utilized:
    - When you only performed the test
      - Bill TC
    - Another provider does the interpretation
      - They bill –26
    - This equals the same reimbursement as the global fee
    - Example: 92585-TC

Technician Services

- TC may be performed by a technician under a physician's supervision
  - May need to demonstrate tech's qualifications
  - Must be filed by a physician who provided direct supervision (must be in the facility and available)
- TC services can not be filed by an audiologist when performed by another provider, including an audiologist

Modifiers (cont.)

- -33 Preventative Service
  - Use with newborn hearing screening code(s)
    - 92558 (OAE screening)
    - 92586 (ABR screening)
  - No co-pay or deductible is to be applied

Modifiers (cont.)

- -52 Reduced services
  - Procedure is partially reduced or eliminated
    - Discontinued at provider's discretion after the procedure commenced
    - Can be used to indicate monaural vs binaural testing
    - Not recognized by all carriers
      - Medicare suggests in box 19 add "why reduction was necessary." You may need to send chart notes separately with claim.
    - Example: 92557-52

Modifiers (cont.)

- -53 Discontinued procedure
  - Procedure started, patient's well being becomes jeopardized during the procedure, provider discontinues
  - Example: Patient having ototoxicity monitoring, becomes ill during procedure
    - Reimbursed at 25% of the allowed amount
    - Example: 92557-53

Modifiers (cont.)

- -59 Distinct procedural service
  - Will need to append to CPT codes 92541, 92542, 92544 or 92545…
    - **ONLY** if performing 1-3 tests of the 4 code bundle
    - Documentation should include why you performed the tests you did

As of 1/1/15, the following are to replace -59:

- **XE**—Separate Encounter: A service that is performed under the same billing provider NPI on the same date of service, but is distinct because it is a separate encounter for the patient.
- **XS**—Separate Structure: A service that is performed under the same billing provider NPI on the same date of service, but on a different structure or organ.
- **XP**—Separate Practitioner: A service that is performed under the same billing provider NPI on the same date of service, but is distinct because it is performed by a different individual provider.
- **XU**—Unusual Non-Overlapping Service: A service that is performed under the same billing provider NPI on the same date of service, but the procedure does not overlap the usual components of the main service performed.

Medicare Modifiers

- **GY**-Item or service is statutorily excluded or does not meet the definition of any Medicare benefit
  - Often used when a secondary insurance has a hearing aid benefit
  - On the Office of the Inspector General's list for 2009
- **GA**-Waiver of liability on file
  - To be used when a denial is expected and an ABN is on file
    - No ABN, no billing the patient
- **GX-** "Notice of Liability Issued, Voluntary Under Payer Policy"
    - For services that are non-covered, statutorily excluded
- **GZ- "**Must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary."

Health Care Procedure Code System (HCPCS) Codes

- https://www.audiologist.org/_resources/documents/resources/reimbursement/Codes-HCPCS.pdf

HCPCS CODING REFERENCE CHART

HCPCS CODES	HCPCS CODE DESCRIPTIONS	COMMENTS
L7510	Repair of prosthetic device, repair or replace minor parts	This code covers replacement parts for bone anchored hearing aid that are not otherwise classified by another HCPCS code; bill Part B
L7520	Repair prosthetic device, labor component, per 15 minutes	This code covers the labor for repair of cochlear implant or bone anchored hearing aid; bill Part B
L8614	Cochlear device, includes all internal and external components	This code represents the acquisition/device cost of an initial cochlear implant, speech processor and accessory kit; billed by implanting facility
L8615	Headset/headpiece for use with cochlear implant device, replacement	This is to be used when providing a replacement headset/headpiece or any component of those items to a cochlear implant recipient; this is not to be used to bill an initial device fitting; bill Part B
L8616	Microphone for use with cochlear implant device, replacement	This is to be used when providing a replacement microphone or any component of those items to a cochlear implant recipient; this is not to be used to bill an initial device fitting; bill Part B
L8617	Transmitting coil for use with cochlear implant device, replacement	This is to be used when providing a replacement transmitting coil or any component of those items to a cochlear implant recipient; this is not to be used to bill an initial device fitting; bill Part B
L8618	Transmitter cable for use with cochlear implant device, replacement	This is to be used when providing a replacement transmitter cable to a cochlear implant recipient; this is not to be used to bill an initial device fitting; bill Part B
L8619	Cochlear implant, external speech processor and controller, integrated system, replacement	This code covers the acquisition/device cost of a replacement or upgraded integrated speech processor/controller for use with a cochlear implant; bill Part B
L8621	Zinc air battery for use with cochlear implant device, replacement, each	This code is used to bill for replacement batteries for a cochlear implant; this is billed per battery so it must be multiplied; bill Part B
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each	This code is used to bill for replacement batteries for a cochlear implant; this is billed per battery so it must be multiplied; bill Part B
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	This code is used to bill for replacement batteries for a cochlear implant; this is billed per battery so it must be

ICD-10-CM Codes

- https://www.audiologist.org/_resources/documents/resources/reimbursement/Codes-ICD10.pdf

ICD10 CODES	
CODE	DESCRIPTION
R94.120	Abnormal auditory function study
H93.293	Abnormal auditory perception, bilateral
H93.292	Abnormal auditory perception, left ear
H93.291	Abnormal auditory perception, right ear
H93.299	Abnormal auditory perception, unspecified ear
R94.121	Abnormal vestibular function study
R94.112	Abnormal visually evoked potential
H93.8X3	Acoustic nerve disorder, bilateral
H93.8X2	Acoustic nerve disorder, left ear
H93.8X1	Acoustic nerve disorder, right ear
H94.03	Acoustic neuritis, bilateral*
H94.02	Acoustic neuritis, left ear*
H94.01	Acoustic neuritis, right ear*
D33.3	Acoustic neuroma/vestibular schwanoma
H61.113	Acquired deformity of pinna, bilateral
H61.112	Acquired deformity of pinna, left ear
H61.111	Acquired deformity of pinna, right ear
H61.303	Acquired stenosis of external ear canal, bilateral
H61.302	Acquired stenosis of external ear canal, left ear
H61.301	Acquired stenosis of external ear canal, right ear
F90.9	ADHD
H93.213	Auditory recruitment, bilateral
H93.212	Auditory recruitment, left ear
H93.211	Auditory recruitment, right ear
Q16.1	Aural atresia
T70.0XXA	Barotrauma, initial encounter
T70.0XXS	Barotrauma, long-term follow-up
T70.0XXD	Barotrauma, subsequent encounter
G51.0	Bell's Palsy
H81.13	Benign paroxysmal vertigo, bilateral
H81.12	Benign paroxysmal vertigo, left ear
H81.11	Benign paroxysmal vertigo, right ear

There's an app for that…

In addition…

- Code for co-morbidities as long as addressed in your chart notes

co·mor·bid·i·ty

- (kō-mōr-bid'i-tē) **1.** A concomitant but unrelated pathologic or disease process.
- **2.** EPIDEMIOLOGY Coexistence of two or more disease processes. [co- + L. *morbidus*, diseased]
    - http://medical-dictionary.thefreedictionary.com/comorbidity

  - Diabetes
  - Falls/dizziness
  - Depression

It's not just about hearing loss or balance!

Rules (cont.)

- Be aware of the codes in other chapters:
  - **F:** Mental, Behavioral and Neurodevelopmental Disorders
  - **Q**: Congenital malformations, deformations and Chromosomal Abnormalities
  - **R**: Symptoms, Signs and Abnormal Clinical and Laboratory Findings
  - **T**: Injury, Poisoning, and Certain Other Consequences of External Causes
  - **Z**: Factors Influencing Health Status and Contact with Health Services

Medicare Regulations/Requirements for Audiologists (in brief)

Medicare Requirements

- Many commercial payers' guidance is based on that of Medicare's
- Audiologists can **not** opt out of Medicare
- Must enroll if providing diagnostic services and billing for them
- If a Medicare beneficiary requests you file the claim, you must due to the mandatory claim statute
- Medicare requires a physician order and the audiologic and/or vestibular evaluations are to be based on medical necessity

What is Medical Necessity?

Title XVIII of the Social Security Act, section 1862 (a)(1)(a):

Notwithstanding any other provisions of this tile, no payment may be made under Part A or Part B for any expenses incurred for items or services, which are not ***reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member***

For those things that are statutorily excluded:

- Anything not medically necessary
- What is medical necessity?
    - ***"…necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."***
    - May be located in the Local Coverage Determination policy
    - Needed for the diagnosis or treatment of a medical condition
    - Provided for the diagnosis, direct care and treatment of the patient's medical condition
    - Meets the standard of good health practice
    - Is not for the convenience of the patient or health care practitioner
        - Williams, Burton and Abel, Audiology Today. Vol. 20 (6)
        - http://www.audiology.org/resources/audiologytoday/Documents/AudiologyToday/2008ATNovDec.pdf
- Also check *Audiology Today* Sept/October 2018, page 71

Medicare Enrollment

- Audiology services are in the “other diagnostic test” category for Medicare
- “Other diagnostic tests” are **not (or ever)** to be billed “incident to”
- In April, 2008 the Centers for Medicare and Medicaid Services issued Transmittal 84
  - Recognition by CMS
    - Clarification of widely accepted incorrect billing practices of audiologic diagnostic services
- https://www.cms.gov/PhysicianFeeSched/50_Audiology.asp

Medicare Requirements for Audiologists

- Audiology statute allows reimbursement only for diagnostic procedures:
  - **Sec. 1861. [42 U.S.C. 1395x] of the Social Security Act**
    - The term "audiology services" 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

Medicare (cont.)

- (B) The term “qualified audiologist” means an individual with a **master's or doctoral degree in audiology** who—
- (i) **is licensed as an audiologist by the State in which the individual furnishes such services, or**
- (ii) in the case of an individual who furnishes services in a State which does not license audiologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary.

Medicare (cont.)

- Audiologists are ***not*** on the list of providers who may opt out of Medicare
  - You must be enrolled unless all services for all patients is at no charge
- Learn the rules for your contractor and monitor the Local Coverage Determination policies:
  - http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=198&ContrVer=1&CntrctrSelected=198*1&name=First+Coast+Service+Options%2C+Inc.+%2809202%2C+MAC+-+Part+B%29&s=46&DocType=All&bc=AggAAAAAAAAAA%3D%3D&
- Chapter 15: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Tidbits

- A Medicare patient cannot pay more for the same service than another patient (OIG)
- All patients must be charged the same amount for services
- For those Medicare patients on whom you cannot collect, if you show a "good faith effort" in collecting, on a case-by-case basis, fees can then be written off
  - For all patients, have a financial agreement to collect the required co-pay

Other Tidbits

If required by a third party payer, referring provider must be on the CMS 1500 claim form

- Medicare provider orders:
  - On the physician's letterhead or prescription pad
  - May want to avoid referral pads with your practice name to avoid solicitation
  - Check with Medicare contractor for guidance

Medicare (cont.)

- **Chapter 15-Covered Medical and Other Health Services, Medicare Benefits Policy Manual**
  - **-80 Requirements for Diagnostic X-ray, Diagnostic Laboratory, and Other Diagnostic Tests**
  - **80.3 Audiological Diagnostic Testing**
  - **A. Benefit.** 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).

Medicare (cont.)

- 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". See Pub. 100-04, chapter 13 for general diagnostic test policies.

Medicare (cont.)

- Medicare considers us to be only diagnosticians by virtue of the "other diagnostic tests" category
- Requires a physician order for a medically necessary reason
  - Medicare services are predicated on "medical necessity"
  - Direct Access will remove the order requirement, but medical necessity will remain in effect and will be required
  - Medical necessity is not just a Medicare requirement
    - Required by all payers

Medicare (cont.)

- “When a qualified physician or qualified nonphysician practitioner orders a specific audiological test using the CPT descriptor for the test, only that test may be performed for that order.
- Further orders are necessary if the ordered test indicates that other tests are necessary to evaluate, for example, the type or cause of the condition. Orders for specific tests are required for technicians.” (MBPM Chapter 15)

Medicare (cont.)

- “When the qualified physician or qualified nonphysician practitioner orders diagnostic audiological tests by an audiologist without naming specific tests, the audiologist may select the appropriate battery of tests.” (MBPM, Chapter 15)

Medicare (cont.)

- "Coverage and Payment for Audiological Services. Diagnostic services performed by a qualified audiologist and meeting the requirements at §1861(ll)(3)(B) are payable as "other diagnostic tests."
- Audiological diagnostic tests are not covered as services incident to physician's services or as services incident to audiologist's services." (MBPM, Chapter 15)

Medicare (cont.)

- "The payment for audiological diagnostic tests is determined by the reason the tests were performed, rather than by the diagnosis or the patient's condition." (MBPM, Chapter 15)

Medicare (cont.)

- "If a beneficiary undergoes diagnostic testing performed by an audiologist without a physician order, the tests are not covered even if the audiologist discovers a pathologic condition." (MBPM Chapter 15)

Medicare (cont.)

- “Payment for audiological diagnostic tests is not allowed by virtue of §1862(a)(7) when:
- The type and severity of the current hearing, tinnitus or balance status needed to determine the appropriate medical or surgical treatment is known to the physician before the test; or
- The test was ordered for the specific purpose of fitting or modifying a hearing aid.” (MBPM, Chapter 15)

Medicare (cont.)

- Re-evaluation:
  - "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 evaluate the results of treatment." (MBPM, Chapter 15)

Medicare (cont.)

- “If a physician refers a beneficiary to an audiologist for testing related to signs or symptoms associated with hearing loss, balance disorder, tinnitus, ear disease, or ear injury, the audiologist’s diagnostic testing services should be covered even if the only outcome is the prescription of a hearing aid.” (MPBM, Chapter 15)

Medicare (cont.)

- “The **technical** components of certain audiological diagnostic tests i.e., tympanometry (92567) and vestibular function tests (e.g., 92541) that do not require the skills of an audiologist may be performed by a qualified technician or by an audiologist, physician or nonphysician practitioner acting within their scope of practice.
- If performed by a **technician**, the service must be provided under the direct supervision [42 CFR §410.32(3)] of a physician or qualified nonphysician practitioner who is responsible for all clinical judgment and for the appropriate provision of the service. The physician or qualified nonphysician practitioner bills the directly supervised service as a diagnostic test.” (MBPM, Chapter 15)

Audiology Codes That Have a Technical and Professional Component

- Vestibular CPT codes (**92537-92546, 92548**)
  - **92547** (vertical electrodes) does **not** have the TC/PC split
    - Florida's Local Coverage Determination Medicare policy specifies this code for use for ENG and VNG
- Comprehensive ABR CPT code (**92585**)
- OAE CPT codes (**92587, 92588**)

TC/PC split

- If a technician performs the test, that can be billed “incident to” the physician, if they directly supervised the test (e.g., 92585-TC)
- The interpretation and report can be billed by an audiologist or physician (e.g., 92585-26)
- If the audiologist performs both the test and does the interpretation and report, it is billed with the global code (92585)
    - TC + PC = Same reimbursement for global code

Medicare (cont.)

- “The “other diagnostic tests” benefit requires an order from a physician, or, where allowed by State and local law, by a non-physician practitioner.” (MBPM, Chapter 15)

Specialties who can order/refer for beneficiary services, Part B and DMEPOS, if allowed by state licensure

- Doctor of Medicine or Osteopathy,
- Doctor of Dental Medicine
- Doctor of Dental Surgery
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Chiropractic Medicine

- Physician Assistant
- Certified Clinical Nurse Specialist
- Nurse Practitioner
- Clinical Psychologist
- Certified Nurse Midwife
- Clinical Social Worker

(CMS Medlearn Fact Sheet: ICN 906223 April 2011)

Medicare (cont.)

- “The reason for the test should be documented either on the order, on the audiological evaluation report, or in the patient’s medical record.
- Examples of appropriate reasons include but are not limited to:
  - Evaluation of suspected **change** in hearing, tinnitus, or balance;
  - Evaluation of the **cause** of disorders of hearing, tinnitus, or balance.
  - Determination of the **effect** of medication, surgery or other treatment” (MBPM, Chapter 15)

Medicare (cont.)

- “The medical record shall identify the name and professional identity of the person who ordered and the person who actually performed the service.
- When the medical record is subject to medical review, it is necessary that the contractor determine that the service qualifies as an audiological diagnostic test that requires the skills of an audiologist.” (MBPM, Chapter 15)

Medicare (cont.)

- Audiology transmittals (84, 127, 1975, 2007, 2044)
  - Diagnostic services performed by an audiologist are to be billed with the NPI of the audiologist
  - “Contractors shall not pay for services performed by audiologists and billed under the NPI of a physician.”
  - “Contractors shall not pay for audiological services incident to the service of a physician or nonphysician practitioner.”

  http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp

Medicare Requirements

- Audiologists can **not** opt out of Medicare
- Must enroll if providing diagnostic services and billing for them
  - If not enrolled, they are to be free to every patient
- If a Medicare beneficiary requests you file the claim, you must as it is required by the mandatory claim statute
- Many commercial payers' guidance is based on that of Medicare's

Medicare (cont.)

- "The reason for the test should be documented either on the order, on the audiological evaluation report, or in the patient's medical record.
- Examples of appropriate reasons include but are not limited to:
  - Evaluation of suspected change in hearing, tinnitus, or balance;
  - Evaluation of the cause of disorders of hearing, tinnitus, or balance.
  - Determination of the effect of medication, surgery or other treatment" (MBPM, Chapter 15)

Medicare (cont.)

- “The medical record shall identify the name and professional identity of the person who ordered and the person who actually performed the service.
- When the medical record is subject to medical review, it is necessary that the contractor determine that the service qualifies as an audiological diagnostic test that requires the skills of an audiologist.” (MBPM, Chapter 15)

Medicare (cont.)

- “Audiological Treatment. There is no provision in the law for Medicare to pay audiologists for therapeutic services. For example, vestibular treatment, auditory rehabilitation and auditory processing treatment, while they are within the scope of practice of audiologists, are not diagnostic tests, and therefore, shall not be billed by audiologists to Medicare.” (MBPM, Chapter 15)

Medicare Audiology Transmittals

- “Contractors shall not pay for the technical component of audiological diagnostic tests performed by a qualified technician unless the physician or nonphysician supervisor who provides the direct supervision documents clinical decision making and active participation in delivery of the service.”

Medicare Audiology Transmittals

- Audiology services must be personally furnished by an audiologist, or nonphysician practitioner (NPP). Physicians may personally furnish audiology services, and technicians or other qualified staff may furnish those parts of a service that do not require professional skills under the direct supervision of physicians.

Medicare Audiology Transmittals

- "Orders are required for audiology services in all settings.
- Coverage and, therefore, payment for audiological diagnostic tests is determined by the reason the tests were performed, rather than by the diagnosis or the patient's condition."

http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp

Medicare

- **“Medicare will not pay for services performed by audiologists and billed under the NPI of a physician.** In denying such claims, Medicare will use:
- CARC 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
- Remittance Advice Remark Code (RARC) N290 (Missing/incomplete/invalid rendering provider primary identifier.)”

Medicare Audiology Transmittals

- "Contractors shall not pay for services that require the skills of an audiologists when furnished by an AuD 4th year student or others who are not qualified according to section 1861(II)(3) of the Act."
  - "Although AuD 4th year students, and other audiology students, do not meet the current requirements in statute to provide audiology services, they may meet standards equivalent to audiology technicians."
  - 100% line of site supervision

Medicare Guidance

- Revisions and Re-Issuance of Audiology Policies
  - https://www.cms.gov/mlnmattersarticles/downloads/MM6447.pdf
- per Section 1861 (ll) (3) of the Social Security Act, “audiology services” are defined as “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 by covered if furnished by a physician. These hearing and balance assessment services are termed “audiology services,” regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.”

Revisions and Re-Issuance (cont.)

Qualifications

- “The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient’s ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable, are appropriate to the test.”

Revisions and re-issuance (cont.)

- “The opt out law does not define “physician” or “practitioner” to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.”
- http://www.cms.gov/Transmittals/downloads/R132BP.pdf

Revisions and Re-issuance (cont.)

- "When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test."

Revisions and Re-issuance (cont.)

- “The skills required when professionals furnish audiology services **for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability** including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also **required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.”**

Revisions and re-issuance (cont.)

- "Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician."

Revisions and re-issuance (cont.)

- "For claims with dates of service on or after October 1, 2008 audiologists are required to be enrolled in the Medicare program and use their National Provider Identifier (NPI) on all claims for services they render in office settings."

Revisions and re-issuance (cont.)

- “For audiologists who are enrolled and bill independently for services they render, the audiologist’s NPI is required on all claims they submit. For example, **in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished**. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital Outpatient Prospective Payment System (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.”

Revisions and re-issuance (cont.)

- “Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, **no physician supervision is required.”**

Revisions and re-issuance

- "When a physician or supplier furnishes **a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions** of section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, **then the audiologist must submit a claim to Medicare**."

Revisions and re-issuance (cont.)

- "Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills. Such claims will be denied using Claim Adjustment Reason Code (CARC) 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)."

Revisions and re-issuance (cont.)

- "Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. In denying claims under this provision, Medicare will use:
  - CARC 185 (The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
  - RARC M136 (Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.)"

Revisions and re-issuance (cont.)

- “Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians’ services when the services are not on the list of audiology services at ***http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp*** and are not “always” therapy services and the audiologist is qualified to perform the service.”
  - http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html

Revisions and re-issuance (cont.)

- **“All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.”**

Revisions and re-issuance (cont.)

- **“The interpretation and report shall be written in the medical record by the audiologist,** physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.”

Revisions and re-issuance (cont.)

- "When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician."

Revisions and re-issuance (cont.)

- "The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist."

Revisions and re-issuance (cont.)

- "The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report."

Revisions and re-issuance (cont.)

- "Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure)."

Summary of Medicare Audiology Service Provision

Medicare only reimburses licensed audiologists for diagnostic procedures, with a physician order, for a medically necessary reason, by way of a claim with a date of service not older than one calendar year of filing, from the same physician fee schedule as physicians, with the audiologist's NPI.

Considerations for the Future--OTCs:

- Can my practice offer OTCs and have it be financially feasible?
- Can my practice offer OTCs and have it be beneficial to my practice?
  - Will OTCs attract other patients to my office for other services?
  - Will OTCs attract patients who have been TNTs in the past?
- Do OTCs fit into my practice's vision/mission statement?

Considerations for OTCs (cont.)

- Will OTCs appeal to my demographic base?
- Do I want to deal with the "fallout" of self-inflicted health care?
- Will OTCs derail or enhance opportunities for more advanced hearing aids?
- Should I consider providing other services in my practice to continue to be relevant?

Considerations for OTCs (cont.)

- Will a separate corporate structure for OTCs be advantageous?
- What say your state licensure laws?
- What if someone with a greater than a self perceived mild to moderate hearing loss comes in for an OTC and you offer a hearing aid option as that is not appropriate, would the consumer consider that to be bait and switch?
- Provide community seminars educating consumers on both the OTC and hearing aid options?

Other Considerations

- Will third party payers no longer offer a hearing aid option other than for those mandated pediatric patients, those who have greater than mild-moderate self perceived hearing loss, and other exceptions (e.g., SSD, surgically altered ears, etc.)?
- How will OTCs impact your current insurance contracts and fee schedules?
  - What services will be included in your contract? What will be missing?
  - Will these policies separate OTCs vs. non-OTC hearing aids?
    - Will self-fitting reimbursement exist? Bonuses for patients who don't see a professional?

Other Considerations for OTCs (cont.)

- Will there be two separate fee schedules, one for OTCs and one for non-OTCs?
- Can you carve out hearing aids from the hearing aid plan if OTCs are offered?
- Will need to create policies and fee schedules for OTC patients
- What services will you provide for these devices and for other services?
- Will you have to be credentialed for non-hearing aid devices if there is a separate contract?

Other Considerations for OTCs (cont.)

- How and will this impact your private pay patients?
  - Will they seriously consider these OTC options vs. non-OTC options?
  - Will this vary with new patients vs. established patients?
  - If someone opts to begin with OTCs and then later choose a non-OTC option, is there is a timeline policy with associated fees to make this transition?
  - Will you see generational differences between baby boomers and millennials in this new marketplace?
    - Will you be able to address their needs and wants?

Toolkit: Procedure Codes for OTCs/Online

Choose one of these four options:

- **V5010** Assessment for hearing aid

OR

- **S0618** Audiometry for an HAE to determine the level and degree of hearing loss

OR

- **CPT® 92590** Hearing aid examination and selection, monaural

OR

- **CPT® 92591** Hearing aid examination and selection, binaural

AND

- **V5011** Fitting/orientation/checking of hearing aid
- **V5014** Repair/modification of hearing aid
- **V5020** Conformity evaluation (also use for PSAPs)
- **V5090** Dispensing fee, unspecified hearing aid **OR**
- **V5160** Dispensing fee, binaural **OR**
- **V5241** Dispensing fee, monaural hearing aid, any type
- **V5299** Hearing service, miscellaneous

CPT Codes for OTC Opportunities (cont.)

Other CPT®s:

92557 Comprehensive Audiometry

92594/5 Electroacoustic evaluation for hearing aid, monaural/binaural

92700 Unlisted otorhinolaryngological service or procedure

- QuickSIN™ Speech-in-Noise Test