2012 Billing and Reimbursement Changes: Are You Ready?

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New 2012 CPT Code and Code Descriptions for Audiologists

This guidance was compiled in collaboration with and authored by representatives of the Academy of Doctors of Audiology (ADA), the American Academy of Audiology (AAA), and the American Speech-Language-Hearing Association (ASHA).

Effective January 1, 2012, there will be a new OAE Current Procedural Terminology (CPT®) code, 92558, to describe evoked otoacoustic emissions screening and new code descriptors for two existing OAE codes, 92587 and 92588, to clarify the otoacoustic emissions evaluations.

The CPT code descriptors set forth below appear in the 2012 CPT Manual under the heading: Special Otorhinolaryngologic Services, Audiologic Function Tests. The new code descriptors will guide the audiologist in how to correctly select the appropriate OAE code and file an OAE claim. When determining how to select the correct code, an audiologist should base his or her decision upon the purpose for performing the test and the diagnostic capability of the test equipment (i.e., the number of frequencies performed).

Background

The Centers for Medicare and Medicaid Services (CMS) had previously identified CPT code 92587 for review due to rapidly growing utilization. In calendar year 2011, this service was surveyed by the audiology specialty societies. After reviewing the survey data, the specialties concluded that more than one service was being represented under this code. As a result, three codes were created. CPT 92558 was created to describe automated OAE screening; CPT 92587 was clarified to describe the procedure commonly used to determine the presence or absence of auditory disorder as a follow-up to screening or as an objective verification of disorder; CPT 92588 was clarified to describe the procedure used for "cochlear mapping" commonly aimed at fine-resolution monitoring of cochlear function. Services billed on or after January 1, 2012, must be coded with one of these three codes as described below.

CPT Code Descriptions and Guidance

CPT 92558 Description: Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis.

Guidance: CPT 92558 should be used when an automated pass/fail screening is performed, via a fixed number of frequencies at a single intensity level, when administered by support personnel, an audiologist, or a physician. This procedure has been designated by CMS to be a non-covered service under the Medicare program.

It is important that audiologists consult the specific guidance that will be provided by regional and federal payers such as Medicare Administrative Contractors (MACs) and Medicaid, as well as guidance from their private third-party payers. Some third party payors may dictate the use

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of specific codes, modifiers, and coverage determinations specific to the state or location where the service is performed.

CPT 92587 Description: Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report.

Guidance: CPT 92587 is to be used when 3-6 frequencies are tested bilaterally and includes the interpretation of the test, with a reporting of the results in the patient’s medical record. If you perform both distortion product and transient evoked otoacoustic emissions, you may seek additional reimbursement using the –22 modifier in conjunction with CPT 92587. Again, audiologists should be aware that third party payors may dictate the use of specific codes, modifiers, and coverage determinations specific to the state or location where the service is performed.

CPT 92587 is a global procedure code comprised of both a technical component (TC) and professional component (PC). If the audiologist is performing the procedure, providing the interpretation of the results and making a report of the results in the patient’s medical record, this code should be reported without a modifier.

Under the Medicare program, otoacoustic emissions testing may be performed by a technician, who is working under the direct supervision of a physician. Testing performed by a technician should be reported using the TC modifier. Audiologists should be aware that services performed by a technician which are billed under the NPI of an audiologist are not covered under the Medicare program.

CPT 92588 Description: Comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report.

Guidance: CPT 92588 is to be utilized when a minimum of 12 frequencies are tested bilaterally and includes the interpretation of the test, with a reporting of the results in the patient’s medical record. If fewer than 12 frequencies were performed, file the claim with CPT 92587.

CPT 92588 is a global procedure comprised of both a technical component (TC) and professional component (PC). If the audiologist is performing the procedure, providing the interpretation of the results and making a report of the results in the patient’s medical record, this code should be reported without a modifier.

Under the Medicare program, otoacoustic emissions testing may be performed by a technician, who is working under the direct supervision of a physician. Testing performed by a technician should be reported using the TC modifier. Audiologists should be aware that services performed by a technician which are billed under the NPI of an audiologist are not covered under the Medicare program.

Notes
*Consult your otoacoustic emissions equipment manufacturer or equipment service provider to learn the diagnostic capabilities of the OAE equipment. Your ability to utilize a specific code may be restricted by equipment limitations (e.g. you may not bill using CPT 92588 if the required minimum 12 frequencies cannot be met by the equipment used).
*The code descriptions are listed in the 2012 CPT Codebook out of numerical order (e.g., 92586 is immediately followed by 92558, which is followed by 92587 and 92588 and so forth) in order to keep all three OAE codes together as an easy reference for audiologists and other professionals seeking reimbursement under these codes.

The Revised Advanced Beneficiary Notice (ABN) goes into effect January 1, 2012

As of January 1, 2012, audiologists must be using the ABN dated March 2011. The form dated 2008 will no longer be valid. There are no substantive changes to the form from the 2008 version other than the change of effective date. Please go to http://www.cms.gov/PhysicianFeeSched/02_ABN.asp#TopOfPage to locate a copy of the new form and the instructions on completion.

HIPAA 5010

HIPAA 5010 applies to all practices who submit their claims electronically. The conversion deadline is January 1, 2012. Please contact your office management software and medical claims clearinghouse vendors to ensure that they are HIPAA
5010 compliant. Payers will not be accepting or processing claims after January 1, 2012 if they are not transmitted via HIPAA 5010.

**Medicare Fee Schedule 2012**

The 2012 Medicare Fee Schedules are now available for review from your Medicare Area Contractors (MAC). These fee schedules go into effect January 1, 2012. It is strongly recommended that you consult the MAC website for your area and review the fee schedule and its modifications. Here are some of the issues worth noting:

Unless Congress acts as they have done in previous years, all audiology services are slated to be reduced by 27.4% of their current 2011 value.

- **Otoacoustic emissions:**
  - Code 92558 was not assigned a payment rate because it is a screening code it is assigned an “N” status by Medicare meaning it is not considered covered for Medicare patients. CPT 92558 may require appending a -33 modifier when the procedure is preventive in nature and part of a newborn hearing loss screening program. See [http://www.ama-assn.org/resources/doc/cpt/new-cpt-modifier-for-preventive-services.pdf](http://www.ama-assn.org/resources/doc/cpt/new-cpt-modifier-for-preventive-services.pdf).
  - For 92587, currently the conversion factor is scheduled to be reduced by about 27 percent for 2012. However, we expect that legislation will likely be enacted to prevent this massive reduction in payment. Under and assumption that the 2012 conversion factor will be the same as the current 2011 rate, the national nonfacility payment rate for Code 92587 is $28.20 of which $18.01 is assigned to the PC and $10.19 to the TC.
  - For 92588, the national nonfacility payment rate using the 2011 conversion factor is $42.81 of which $28.20 is assigned to the PC and $14.61 to the TC. The 2012 conversion factor would result in a $31.09 total payment but, again, congress is expected to avert such a cut as they have in previous years.

- **Physician Quality Reporting Initiative**
  - For more information, please consult [https://www.cms.gov/PQRS/](https://www.cms.gov/PQRS/).
  - This program continues for 2012 with a .5% bonus payable for all allowed charges associated with this reporting. The codes available for 2012 are:
    - #188 Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear
    - #189 Referral for Otologic Evaluation for Patients with History of Active Drainage From the Ear Within the Previous 90 Days
    - #190 Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss
    - Referral for Otology Evaluation for Patients with Acute or Chronic Dizziness (number not yet available)

**Medicare Enrollment Revalidation Pushed Back to March 2015**

All audiologists who enrolled in Medicare prior to March 25, 2011 will be required to revalidate their enrollment. The purpose of this re-enrollment process is to institute screening tools in an attempt to prevent and reduce Medicare fraud. The original deadline for completion of this process was March 2013, but, due to the depth and breadth of this process, the deadline has been extended to March 2015.

Audiologists have begun receiving a letter from their Medicare Area Contractor (MAC) requesting that they re-enroll. Do not re-validate until you receive your letter. Please try to re-validate via the PECOS system ([https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do)) as allowed as it will simplify and expedite this process. In your letter, MACs will provide you with information on the steps to completing this process PECOs and submission of signed certification letter) and your deadline for completion (60 days from date letter dated). Failure to complete this re-validation process within the allotted time frame can result in your claims being rejected for payment by Medicare.

Audiologists are not required to pay the $505 application fee as this is exclusive to equipment providers. Please contact your MAC for guidance, prior to submitting the $505 payment, if your clinic provides and submits claims for cochlear and/or auditory osseointegrated implant replacement processors.

If you are unsure if you have received your enrollment re-validation, please consult [https://www.cms.gov/medicareprovidersupenroll/11_revalidations.asp](https://www.cms.gov/medicareprovidersupenroll/11_revalidations.asp) for more information.


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