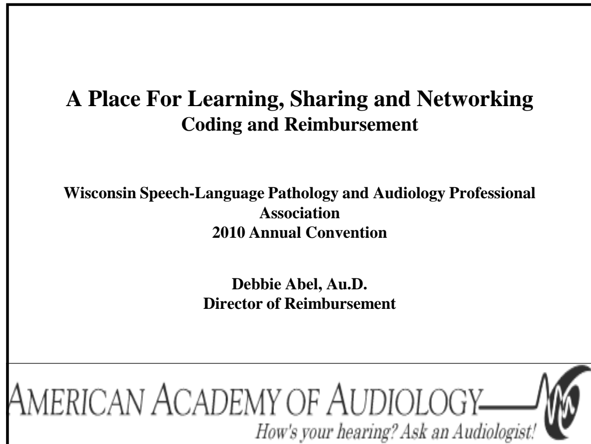


Agenda (cont.)

- Coding systems: CPT, ICD-9-CM, HCPCS
- Bundling vs. Itemization
- Contract negotiations
  - Should I?
  - Balance billing and other caveats
- Documentation
- PQRI and future initiatives

Basics

CODING MANUALS:

- **CPT** (Current Procedural Terminology): Procedure codes
- **ICD-9-CM** (International Classification of Diseases): Diagnoses codes
- **HCPCS** (Healthcare Common Procedure Coding System): Supplies and several procedures codes:
  - Can be purchased via:
    - https://catalog.ama-assn.org/Catalog/home.isp
    - **http://www.ingenix.com/CodingResources/100040/**
    - http://www.decisionhealth.com/store/category.aspx?CategoryId=PhysicianOffices-Coding-Books(DecisionHealth08)

Other Resources:

- The American Academy of Audiology
  - www.audiology.org
- *Capturing Reimbursement*
  - www.audiology.org
- Centers for Medicare and Medicaid (CMS)
  - www.cms.hhs.gov

Audiology Clinical Practice Algorithms and Statements

http://www.audiology.org/NR/rdonlyres/0BFA4442-81FA-4D06-A60A-C56DF888BAD3/0/ClinicalPracticeAlgorithms.pdf

Coding Systems:

- These three coding systems support each other when filing claims
- Required:
  - CPT and/or HCPCS **AND** ICD-9
- If billing HCPCS codes
  - May also be billing one or more CPTs simultaneously
  - Always have to have a minimum of one ICD-9 code with each claim

Coding Mantra:

- Code with **signs and/or symptoms**
  - Why the patient presented to your office
- Code by **patient complaints (medical necessity)**
  - Tinnitus?
  - Hearing loss?
  - Disequilibrium?
- Code by **outcome** of the procedure results
  - SNHL?
  - Tinnitus?
  - Conductive hearing loss, middle ear?

Considerations:

- CPT codes (procedures) selected must be obvious to an insurance company as to why they were selected
- CPT codes must be ones typically performed by audiologists
- CPT codes must support the diagnosis code you've selected

Other considerations:

- ICD-9-CM codes must be diagnoses that are selected by audiologists
- ICD-9-CM codes must support the CPT procedures performed

Code by Patient Complaints

- The patient presented with tinnitus
- It is within acceptable coding practices to use one of the following ICD-9-CM (diagnosis) codes:
  - 388.30 Tinnitus, unspecified (not the most specific)
  - 388.31 Subjective tinnitus
  - 388.32 Objective tinnitus

Sensorineural Hearing Loss

- Does the diagnosis of 389.10 (SNHL, unspecified) begin and end with 92557?
- Differential diagnosis:
  - OAE's
  - Tympanometry/Reflexes
  - HINT

389.11 (sensory hearing loss, bilateral)
389.12 (neural hearing loss, bilateral)
389.14 (central hearing loss)
389.18 (SNHL, bilateral)

Case-Building for Differential Diagnosis

- This is what differentiates us from the non-audiology provider
- Proves our worth in the healthcare system as the *only* qualified hearing health care provider
- Proves your worth to the facility/practice that employs you
  - It's all about productivity! May be based on relative value units (RVUs)

Interactive website for CMS 1500 form:

http://www.palmettogba.com/Internet/cms1500.nsf/CMS1500.html#

CMS 1500 Claim Form:

- Lists the CPT(s), ICD-9(s) and HCPCS codes and demonstrates their interaction:
  - What you performed (CPT)
  - Diagnosis results (ICD)
  - Resulting recommendations if product (HCPCS)
- Ties the coding systems together

Current Procedural Terminology

Procedures/Tests

Current Procedural Terminology (CPT)
AND
International Classification of Diseases (ICD-9)

- These codes need to support each other
- Needs to be apparent that what procedures performed would result in the disease code chosen
- What is being billed has to be appropriate to what you are licensed to perform
- Chart documentation has to reflect the above points

CPT Codes

- Examples:
  - 92557 Basic comprehensive audiometry
    - For many years, was the ***only*** audiology bundled code:
      - 92553 (Pure tone air and bone conduction audiometry)
      - 92555 (SRT) and 92556 (WRS)
  - Effective 1/1/10: Three new bundled codes
    - CPT 92540 Vestibular (92541, 92542, 92544, 92545)
    - CPT 92550 Tympanometry, ART (92567 and 92568)
    - CPT 92570 Tympanometry, ART, ARD (92567, 92568, 92569)

CPT^TM five-digit codes, descriptions, and other data only are copyright 2007 by the American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT^TM. CPT^TM is a trademark of the American Medical Association.

CPT Codes Utilized By Audiologists

Vestibular Function Tests, Without Recording

- 92531 Spontaneous nystagmus, including gaze
- 92532 Positional nystagmus test
- 92533 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
- 92534 Optokinetic nystagmus test

CPT codes (cont.)

- **92540** Basic vestibular evaluation (do not report with 92541, 92542, 92544 or 92545)
- 92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
- 92542 Positional nystagmus test, minimum of 4 positions, with recording
- 92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording

CPT Codes (cont.)

- 92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
- 92545 Oscillating tracking test, with recording
- 92546 Sinusoidal vertical axis rotational testing
- 92547 Use of vertical electrodes (list separately in addition to code for primary procedure)
- 92548 Computerized dynamic posturography

CPT Codes (cont.)

- **92550** Tympanometry and reflex threshold measurements (do not report in conjunction with 92567, 92568)
- 92551 Screening test, pure tone, air only
- 92552 Pure tone audiometry (threshold), air only
- 92553 Pure tone audiometry (threshold); air and bone
- 92555 Speech audiometry threshold
- 92556 Speech audiometry threshold, with speech recognition

CPT Codes (cont.)

- 92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
- 92559 Audiometric testing of groups
- 92560 Bekesy audiometry, screening
- 92561 Bekesy audiometry, diagnostic
- 92562 Loudness balance test, alternate binaural or monaural

CPT Codes (cont.)

- 92563 Tone decay test
- 92564 Short increment sensitivity index (SISI)
- 92565 Stenger test, pure tone
- 92567 Tympanometry (impedance testing)
- 92568 Acoustic reflex testing, threshold
- ~~92569 Acoustic reflex testing, decay~~
- **92570** Acoustic immittance testing (do not report in conjunction with 92567, 92568)
- 92571 Filtered speech test

CPT Codes (cont.)

- 92572 Staggered spondaic word test
- 92575 Sensorineural acuity level test
- 92576 Synthetic sentence identification test
- 92577 Stenger test, speech
- 92579 Visual reinforcement audiometry (VRA)
- 92582 Conditioned play audiometry (CPA)

Code Clarification:

- 92579 VRA Vignette:
  - Sound field
  - Speech stimuli
  - Frequency specific sounds from 500-4000Hz
- 92582 CPA Vignette:
  - Earphones
  - Minimum response levels from 250-6000 Hz, right and left ears

CPT Codes (cont.)

- 92583 Select picture audiometry
- 92584 Electrocochleography
- 92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system, comprehensive
- 92586 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system, limited

CPT Codes (cont.)

- 92587 Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
- 92588 Evoked otoacoustic emissions, comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)

CPT Codes (cont.)

- 92590 Hearing aid examination and selection, monaural
- 92591 Hearing aid examination and selection, binaural
- 92592 Hearing aid check, monaural
- 92593 Hearing aid check, binaural
- 92594 Electroacoustic evaluation for hearing aid, monaural

CPT Codes (cont.)

- 92595 Electroacoustic evaluation for hearing aid, binaural
- 92596 Ear protector attenuation measurements
- 92601 Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming
- 92602 Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent reprogramming

CPT Codes (cont.)

- 92603 Diagnostic analysis of cochlear implant, age 7 years or older with programming
- 92604 Diagnostic analysis of cochlear implant, age 7 years or older with reprogramming
- 92620 Evaluation of central auditory function, with report; initial 60 minutes
- 92621 Evaluation of central auditory function, with report; each additional 15 minutes

CPT Codes (cont.)

- 92625 Assessment of tinnitus (includes pitch, loudness matching, and masking)
- 92626 Assessment of auditory rehabilitation status; first hour
- 92627 each additional 15 minutes
- 92630 Auditory rehabilitation; prelingual hearing loss
- 92633 Auditory rehabilitation; postlingual hearing loss

CPT Codes (cont.)

- 92640 Diagnostic analysis with programming of auditory brainstem implant, per hour
- 92700 Unlisted otorhinolaryngological service or procedure

CPT Codes--An Aside"

- CPT 92626 and 92627
  - Per the vignette (a "typical patient" scenario):
    - "To determine current abilities to instruct the use of residual hearing provided by a CI or hearing aid"
      - How to use auditory input
      - Tread carefully with Medicare…
      - Patient can be billed for services if not contractually excluded
      - Medicare beneficiaries can be billed for services that are non-covered with the appropriate alerting notice

CPT Codes (cont.)

- Vestibular codes:
  - CPT 92540-92548
- Audiologic procedures:
  - CPT 92550-92583
- Evoked potential codes:
  - CPT 92585-6
- OAE codes:
  - CPT 92587-8

CPT Codes (cont.)

- Hearing aid related codes:
  - CPT 92590-92596
- Cochlear implant codes:
  - CPT 92601-92604
- Central auditory test codes:
  - CPT 92620-1
- Tinnitus code:
  - CPT 92625

CPT Codes (cont.)

- Audiologic (aural) (re)habilitation
  - CPT code 92626-92633
- "Nameless codes"----unlisted otorhinolaryngological service or procedure
  - CPT 92700
    - Tinnitus treatment for example

Modifiers (cont.)

- Requires documentation to be submitted attesting to why additional time and/or work was necessary
- An audit and/or a delay in payment may occur

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 92541-92548)
    - ABR (CPT 92585)
    - OAE (CPT 92587, 92588)
  - Utilized:
    - When someone else performed the procedure
    - You do the interpretation and prepare the report
  - Example: 92585-26

Modifiers (cont.)

- TC Technical component
  - Utilized with:
    - ENG (CPT 92541-92548)
    - 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

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
    - May not be recognized by your Medicare contractor
    - 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.)

- -76 Procedure was performed more than one time on the same date of service
  - Glycerol or urea test
  - Ototoxicity monitoring

-NEW-

Standards of Classification Codes SOC Bureau of Labor Statistics

10 years to make a change!

- In the 2000 SOC, audiologists were classified as therapists
- In the 2010 SOC, audiologists are in the "diagnose and treat" category
  - 29-1171
- Hearing Instrument Specialists are in the "Health Technologists and Technicians" category

Evaluation and Management Codes

(For some non-Medicare patients)

Evaluation and Management Codes (E/M)

- Time, complexity and review of systems are required
- Medicare will not reimburse audiologists at this point in time for E/M codes
- BE CAREFUL:
  - Audiologists should not upcode
    - Be realistic with what you are doing
    - Personal thought: would not code beyond a level 3 so as not to trigger an audit

E/M (cont.)

If it is not a Medicare patient, you could use an Evaluation and Management (E & M) code, with the requirements of the code being met. The CPT manual lists these for each code

- Time
- Review of Systems (18)
- Complexity of visit
- New vs. established patient criteria

E/M

- New and established patient codes
  - **New**: CPT 99201-99205
  - **Established**: CPT 99211-99215

Need to include Review of Systems (ROS):

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

ROS (cont.)

- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hemotologic/lymphatic/immunologic

E/M Codes

- CPT 99201
  - A **problem focused** history
  - A **problem focused** examination
  - Straightforward medical decision making
    - Physicians typically spend **10** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT 99202
  - An **expanded** problem focused history
  - An **expanded** problem focused examination
  - Straightforward medical decision making
    - Problems are of low-moderate severity
    - Physicians typically spend **20** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT 99203
  - A **detailed** history
  - A **detailed** examination
  - **Medical decision making of low complexity**
    - Problems are of moderate severity
    - Physicians typically spend **30** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT 99204
  - A **comprehensive** history
  - A **comprehensive** examination
  - Medical decision making of **moderate** complexity
    - Problems are of moderate to high severity
    - Physicians typically spend **45** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT 99205
  - A **comprehensive** history
  - A **comprehensive** examination
  - Medical decision making of **high** complexity
    - Problems are of moderate to high severity
    - Physicians typically spend **60** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT code 99211
  - May not require a physician's presence
  - Minimal problem
  - Typical time spent: **5** minutes
    - Performing or supervising

E/M Codes (cont.)

- CPT code 99212
  - A **problem focused** history
  - A **problem focused** examination
  - Straightforward medical decision making
  - Problems are minor
  - Physicians typically spend **10** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT code 99213
  - An **expanded** problem focused history
  - An **expanded** problem focused examination
  - Problems are of low to moderate severity
  - Medical decision making of **low** complexity
  - Physicians typically spend **15** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT code 99214
  - A **detailed** history
  - A **detailed** examination
  - Medical decision making of **moderate** complexity
  - Physicians typically spend **25** minutes face-to-face with the patient and/or family

E/M Codes (cont.)

- CPT Code 99215
  - A **comprehensive** history
  - A **comprehensive** examination
  - Medical decision making of **high** complexity
  - Problems are of moderate to high severity
  - Physicians spend **40** minutes face-to-face with the patient and/or family

Cerumen Management-69210

- Is in the scope of practice of audiology
  - http://www.audiology.org/publications/documents/practice/
- Unless cerumen is impacted, should not be billing for it separately as it is "included" in the CPT code
- Some states licensure laws (NJ, PA) do not allow CM to be performed by an audiologist
- Can be billed to the patient with the CMS-R-131, the ABN/NEMB form and the appropriate modifier

HCPCS Codes

(Healthcare Common Procedure Coding System)

HCPCS Codes

- Healthcare Common Procedure Coding System (HCPCS)
- Addresses what CPT did not with:
  - Some services
    - V5010 (Assessment for hearing aid)
    - V5020 (Conformity evaluation)
  - Supplies:
    - Hearing aids
    - Dispensing
    - Earmolds (and earmold impression)
    - Batteries
    - Assistive Listening Devices

HCPCS

- HCPCS Codes "fill in" the blanks of what CPT does not address
- Supplies and some procedures
- CMS "rules"
- "V" is for vision
  - V5000-V5999

HCPCS (cont.)

- Earmold related codes:
  - V5264 Ear mold/insert/not disposable, any type
  - V5265 Ear mold/insert/disposable,any type
  - V5275 Ear impression, each
- Batteries!!
  - V5266 Battery for use in hearing device

HCPCS Codes (cont.)

- V5020 Conformity evaluation
  - Needs to include outcome measures and/or real ear measures and/or functional gain measures
- V5014 Repair/modification of a hearing aid

New HCPCS codes for 2010

- **L8692**:Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment
- **L8627**: Cochlear implant, external speech processor, component, replacement
- **L8628**: Cochlear implant, external controller component, replacement
- **L8629**: Transmitting coil and cable, integrated, for use with cochlear implant device, replacement

ICD-9-CM

International Classification of Diseases
9th Revision

ICD-9 Recommendations

- 5 digits codes are the most specific and recommended
  - Less prone to denials
- **Avoid those that are 3 and 4 digits and those than end in 0**
- Diagnostic V codes should be avoided
  - Sometimes impossible
- Program Memorandum AB-01-144
  - http://www.drg.irp.com/refinfo/hcfapm/AB-01-144.htm

Avert the denial

Do **NOT** use unspecified hearing loss codes
- 389.9
  - Unless there is no other choice
  - Likely to be denied

ICD-9-CM

Disease codes
(Diagnostic codes)

Conductive Hearing Loss -389.0

- 389.00 Conductive Hearing Loss (CHL), unspecified
- 389.01 CHL, external ear
- 389.02 CHL, tympanic membrane
- 389.03 CHL, middle ear
- 389.04 CHL, inner ear
- 389.05 CHL, unilateral
- 389.06 CHL, bilateral
- 389.08 Conductive HL of combined types

Sensorineural Hearing Loss-389.1

- 389.10 Sensorineural hearing loss, unspecified
- 389.11 Sensory hearing loss, bilateral
- 389.12 Neural hearing loss, bilateral
- 389.13 Neural hearing loss, unilateral
- 389.14 Central hearing loss, bilateral
- 389.15 Sensorineural hearing loss, unilateral
- 389.16 Sensorineural hearing loss, asymmetrical
- 389.17 Sensory hearing loss, unilateral
- 389.18 Sensorineural hearing loss, bilateral

Sensorineural Hearing Loss

- 389.1 Sensorineural hearing loss
  - Perceptive hearing loss or deafness
  - Excludes 388.40, abnormal auditory perception

Mixed CHL and SNHL Hearing Loss-389.2

- 389.20 Mixed hearing loss, unspecified
- 389.21 Mixed hearing loss, unilateral
- 389.22 Mixed hearing loss, bilateral

Even more…

- 315.34 speech and language development delay due to hearing loss (often not reimbursed)

And more…

- 388.41 Diplacusis
  - Perception of a single auditory sound as two sounds at two different levels of intensity
- 388.42 Hyperacusis
  - Exceptionally acute sense of hearing caused by such conditions as Bell's palsy; this term may also refer to painful sensitivity to sounds

And even more…

- 388.43 Impairment of auditory discrimination
  - Impaired ability to distinguish tone of sound
- 388.44 Recruitment
  - Perception of abnormally increased loudness caused by a slight increase in sound intensity; **it is a term used in audiology"**
- 388.45 acquired auditory processing disorder

Additional Codes

- 389.7 Deaf, non-speaking, not elsewhere classifiable
- 389.8 Other specified forms of hearing loss
- 389.9 Unspecified hearing loss
- 783.42 Delayed milestones (late talker, late walker)

Additional codes (cont.)

Need to be filed with a primary ICD-9

- 960.3 Erythromycin and other macrolides
  - Oleandomycin
  - Spiramycin
- 960.6 Antimycobacterial antibiotics
  - Cycloserine
  - Kanamycin
  - Rifampin
  - Streptomycin

Additional Codes (cont.)

Need to be filed with a primary ICD-9

- 961.4 Antimalarials and drugs acting on other blood protozoa
  - Chloroquine
  - Cycloguanil
  - Primaquine
  - Proguanil (chloroguanide)
  - Pyrimethamine
  - Quinine
- 965.1 Salicylates

Toxic Effects-Other metals

Need to be filed with a primary ICD-9

- 985.0 Mercury and its compounds
- 985.1 Arsenic and its compounds
- 985.2 Manganese and its compounds

Diagnostic V codes

- Last resort, likely to be denied
  - Address specific events, not disease
- INVALID
  - V72.1 Examination of ears and hearing

Additional V codes

- V49.85 Dual sensory impairment
- V65.2 Person feigning illness
- V65.5 Person with feared complaint in whom no diagnosis was made
- V68.01 Disability examination
- V72.12 Encounter for hearing conservation and treatment

Diagnostic V codes (cont.)

- V72.11 Encounter for hearing examination following failed hearing screening
- V72.12 Encounter for hearing conservation and treatment
- V72.19 Other hearing examination of ears and hearing

Diagnostic V Codes (cont.)

- V49.8 Other specified conditions influencing health status
- V49.85 Dual sensory impairment
- V68.01 Disability examination

Tie it Together

- Superbill, encounter form
  - Needs to have the CPT, ICD-9-CM and HCPCS codes useful for your office
- Example:
  - CPT: 92557
  - ICD-9: 389.15
  - HCPCS: V5160 and V5261 (unbundling)

ICD-9 vs ICD-10

- ICD-9 has 17,000 codes
- ICD-10 has 68,000 codes
- Will need 5010 HIPAA standard for ICD-10
  - Utilize 4010 HIPAA standard for ICD-9
- Proposed deadlines
  - January 1, 2012 for 5010
  - October 1, 2013 for ICD-10

ICD 10-PCS

- First diagnostic coding change in 30 years
  - U.S. is one of the last to utilize
    - Some of the terms may not be considered politically correct and/or are reimbursable in the U.S.
- Codes will be numeric and alphabetic
  - Up to 7 characters
    - 7th digit (extension) utilized to determine initial encounter or follow-up visit

ICD-10-CM

- Will be alphabetic and numeric:
  - H900 Conductive hearing loss, bilateral
  - H903 Sensorineural hearing loss, bilateral
  - H910 Ototoxic hearing loss
  - H912 Sudden idiopathic hearing loss
  - H931 Tinnitus

ICD-10-PCS (cont.)

- Examples of hearing related codes:
  - H90.3 Sensorineural hearing loss, bilateral
    - www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm.
    - http://www.who.int/classifications/icd/en/
- Laterality is addressed
  - Lose "asymmetry" (circa 2007)
  - Gain some that have never been addressed:
    - Ototoxicity

ICD-10-PCS codes (not an exhaustive list)

- Diseases of inner ear: H80-H83
- **H81 Disorders of vestibular function**
  Excludes: vertigo: NOS (R42), epidemic (A88.1)
  - **H81.0 Ménière's disease**
    Labyrinthine hydrops
    Ménière's syndrome or vertigo
  - **H81.1 Benign Paroxysmal vertigo**
  - **H81.2 Vestibular neuronitis**
  - **H81.3 Other peripheral vertigo**
    Lermoyez' syndrome
    Vertigo:
    - Aural
    - Otogenic
    - Peripheral NOS (not otherwise specified)

ICD-10-PCS codes (cont.)

- **H83.3 Noise effects on inner ear**
  Acoustic trauma
  Noise-induced hearing loss
- **H83.8 Other specified diseases of inner ear**
- **H83.9 Disease of inner ear, unspecified**

ICD-10-PCS codes (cont.)

Other disorders of ear (H90-H95)

- **H90 Conductive and sensorineural hearing loss**
  Includes: congenital deafness
  Excludes: deaf mutism NEC (H91.3) (not elsewhere classified)
  deafness NOS (H91.9)
  hearing loss:
  - » NOS (H91.9)
  - » Noise-induced (H83.3)
  - » Ototoxic (H91.0)
  - » Sudden (idiopathic) (H91.2)

ICD-10-PCS codes (cont.)

- **H91 Other hearing loss**
  Excludes: abnormal auditory perception (H93.2)
  hearing loss as classified in H90.-
  impacted cerumen (H61.2)
  noise-induced hearing loss (H83.3)
  psychogenic deafness (F44.6)
  transient ischaemic deafness (H93.0)
- **H91.0 Ototoxic hearing loss**
  Use additional external cause code (Chapter XX), if desired, to identify toxic agent.

Medicare/Medicaid

- Questions: To accept or not to accept?
  - Weigh the pros and cons of each carrier
- Medicaid
  - Why are you participating? The answer is important.
- Medicare
  - Participation: You bill Medicare, Medicare pays you
  - Non-Participation: You bill Medicare, patient pays you, Medicare pays patient
    - Get less money except if a limiting charge provider
  - Limiting charge: Highest level of reimbursement from Medicare
  - Learn the Rules for YOUR contractor
    - http://www.cms.hhs.gov/mcd/index_lmrp_bycontractor.asp?from2=index_lmrp_by contractor.asp&

Medicare Considerations

- Medicare Participating Provider:
  - Patient pays you their 20% co-insurance
  - You bill Medicare
  - Medicare pays you 80% of the allowable amount per the Medicare Physician Fee Schedule

Medicare Non-Participating

- Non-participating categories:
  - Non-participating
    - 5% less than participating
  - Limiting charge
    - 10% higher than participating
    - Highest level of reimbursement within Medicare

Medicare Non-Participating-Limiting

- Patient pays you their 80% allowable and difference in the limiting fee
- You bill Medicare
- Medicare pays the patient 80% of the allowable amount per the Medicare Physician Fee Schedule

Medicare Non-Par (Limiting)

- Highest level of reimbursement as a Medicare provider
- Likely problematic in an economically depressed area as the patient has to pay at the time of service
- Provider collects from patient up to the limiting charge: difference between limiting charge and 80% of the MPFS

Medicare Tenet:

•If you are a Medicare provider, cannot bill a Medicare patient more than you do another patient for the same procedure

–"The most you charge is the least you charge"

Medicare Resident & New Physician Guide

http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf

And speaking of Medicare…

2010 Medicare Physician Fee Schedule (MPFS)

- American Academy of Audiology responded to the Centers for Medicare and Medicaid (CMS)
  - On the average, a –20% decrease in many codes due to the continuing transition from the Non-Physician Work Pool to "work"
  - Bundling of 3 codes yields a significant reduction
  - CMS is running out of money; cost cutting
  - Budget neutral system

2010 MPFS (cont.)

- Sustainable Growth Ratio reduction: 21.5%
  - If Congress does nothing to fix this, all health care providers will sustain this cut on top of the others scheduled
  - Will have to be fixed by 2/28/10

Reimbursement for 2009/2010

CPT Code	2009 Fees	2010 Fees, no SGR reduction (fix)
92541	$56.99	$39.48
92541 TC	36.79	23.58
92542	59.15	40.34
92542 TC	42.56	26.99
92543	27.41	19.03
92543 TC	22.00	14.77
92544	47.61	32.67
92544 TC	34.62	22.16

More Reductions in Reimbursement

CPT Code	2009 Fees	2010, no SGR fix
92557	$45.08	$31.81
92567	17.67	12.21
92587	38.59	27.27
92587 TC	31.74	21.87

"Dying isn't hard. Getting paid by Medicare is."

-Art Buchwald, 2006

Advanced Beneficiary Notice of Noncoverage (CMS-R-131)

- Required as of March 1, 2009
- ABN and Notice of Exclusions of Medicare Benefits (NEMB) are now on the same form
- Can still utilize the previous NEMB, without the form # in the lower left corner
- **Patient** directs how the claim is to be filed

(A) Notifier(s):
(B) Patient Name: (C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D)__________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D)__________ below.

(D)__________	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D)__________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the (D)__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the (D)__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the (D)__________ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

Three options on the ABN:

1. Bill Medicare
   - By signing and utilizing option 1, you can bill Medicare and bill the patient if the claim is denied
2. Don't bill Medicare
3. Patient declines procedure

- Itemizes:
  - Patient's name
  - Date of service
  - Procedure(s) performed
  - Costs to be incurred

For those things that are statutorily excluded:

- Anything not medically necessary
- What is medical necessity?
  - 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)

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**-NEW: Waiver of Liability Statement Issued as Required by Payer Policy:
  - Used to report when a **required** ABN is issued
    - No ABN, can't bill the patient

Medicare Modifiers: NEW!

- -GX "Notice of Liability Issued, Voluntary Under Payer Policy"
  - Is to be used to report when a **voluntary** ABN was issued
    - Applicable to non-covered services such as annual audiograms, hearing aid related services

New changes are effective **April 1, 2010**

Medicare Modifiers (cont.)

- **GZ**-Item or service expected to be denied as not reasonable and necessary
  - To be used when a denial is expected and an ABN is not on file
    - Can't bill the patient
    - Often utilized in an emergent situation

For Medicare Providers

- Local Coverage Determination Policies (LCDs):
  - Addresses locally what the National Coverage Determination (NCD) sets forth nationally
    - Requirements from contractor
  - May describe what is "medically necessary"
  - May list specific reimburseable codes:
    - CPT
    - ICD-9
  - Your contractor may not have an LCD
    - Not a negative, but look at others (by state, alphabetically or by contractor):
      - http://www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp

Therefore:

- You cannot perform free hearing evaluations
- Why would we want to de-value our own services?
  - Retail vs medical?
  - Impact on autonomy and recognition
  - Medicare *is* doing that…

DOCUMENTATION:

Why is it important and what needs to be done?

Documentation

- A chart is a legal document
  - Can be subpoenaed
- Provides continuity of care between health care professionals involved in that patient's care
- Third party payor requirement
- Quality Assessment/Peer Review

Documentation

- "If it isn't in the chart, it didn't happen"
- Have to recount everything the patient relays to you
- SOAP "outline"
- Do not use white our or erase
  - ~~Draw one line through~~, sign with 3 initials
  - Do not destroy
- Electronic Medical Records
  - Once a signature is applied, may not be able to change; can amend with a different entry

Chart Notes

Need to explain and interpret audiogram

- Don't assume anyone other than an audiologist understands what it means

What should be included?

- Demographic information
  - Patient's name
  - Address
  - Date of birth
  - Contact information
  - Insurance card
    - Photocopy front and back (need address)
  - Driver's license
    - Medical Identity Theft
    - FTC Red Flag and Address Discrepancy (June 1, 2010)

What else?

- Referring professional if required by a third party payor
- Medicare physician referrals:
  - On the physician's letterhead or prescription pad
  - Not to have the appearance that it was solicited by you
    - No referral pads with your practice name

And?

- Reason for the visit
- Case history
  - Surgeries
  - Medications, past and present
    - Herbals, over-the-counter meds
  - Occupational noise exposure
  - Recreational noise exposure

More…

- HIPAA forms
  - Notice of Privacy Practices (NPP)
- Case history
  - Adult
    - Familial hearing loss
      - Age of onset, syndromes?
      - Treatment plan
        - » Surgeries? Amplification?
    - May have to excavate for the history…

More…

- Pediatric:
  - History:
    - Prenatal
    - Delivery
    - Family

SOAP

- **S**ubjective findings
  - History
- **O**bjective finding
  - Physical exam
  - Testing
- **A**ssessment
  - Puzzle piecing
- **P**lan
  - Recommendations for patient based on the above
  - Referrals to others

Further…

- Six elements:
  - 1. **History**
    - Why did the patient present?
    - What are their chief complaints?
    - Is there sufficient information to justify what was done to and for the patient?

- 2. What did you do?
  - Case history
  - Procedures (includes otoscopy)

- 3. What were your findings?
  - What does it mean?
    - What is your interpretation?
- 4. From your results, recommendation(s)?
  - Your recommendation serves as a logical conclusion of all that was written above

Documentation (cont.)

5. Original signature
   - Electronic signature is acceptable and likely to be more commonly utilized with EMR

6. Date of evaluation
   - May include date of dictation
   - May include an appended note

No sticky notes!

Everything needs to be secured with the patient's name and date…

Further…

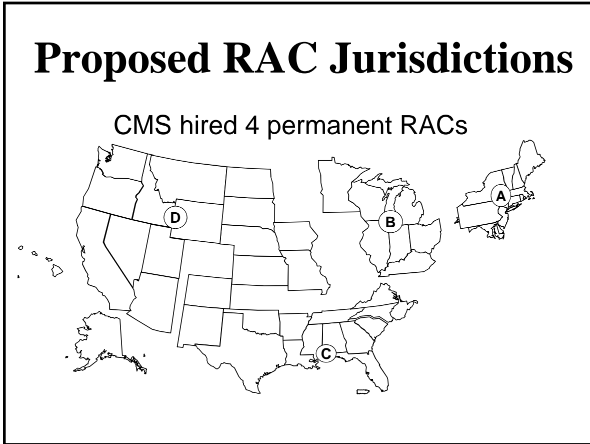
- Initial with your three initials
- Do not use white out
- Do not scribble
- Do not shred chart notes unless beyond record retention timeframe
- **Do** shred anything that has patient's personal health information (PHI)

Recovery Audit Contractors (RAC)

- Pilot program in 2005
  - Created by CMS
    - Overpayments
    - Underpayments
  - Initially only in FL, NY and CA
  - Rolling out to the rest of the country by 2010
- Have targeted vestibular codes; also pediatric codes for age limitations
- Administered by independent "contractors"

Proposed RAC Jurisdictions

CMS hired 4 permanent RACs



RAC Awards

- The RAC in each jurisdiction is as follows:
- REGION A:: Diversified Collection Services (DCS)
  - 1-866-201-0580
- **Region B**: CGI -1-877-316-7222
  - e-mail: racb@cgi.com
- Region C: Connolly Consulting, Inc. 1-866-360-2507
- Region D:: Health Data Insights, Inc.-
  - Part A: 1-866-590-5598
  - Part B: 1-866-376-2319
  - e-mail: racinfo@emailhdi.com

RAC thoughts

- Documentation is critical as charts will be audited
- Be defensive in your documentation!
- It's all about medical necessity and performing what is required
- Dot your i's and cross those t's…

Records Retention

- HIPAA forms need to be retained for 6 years
- Chart information:
  - Check with your state's medical record retention laws
    - Contact your state insurance commission
- Typical:
  - Minors: Up to age of majority (21)
  - Adults: 7 years
    - May want to consider retaining chart longer if any related surgeries were performed

The Present and Future

- **Physician Quality Reporting Initiative (PQRI):**
  - Audiologists were originally/accidentally omitted
- Audiology Quality Consortium was formed in 12/08:
  - AAA -NHCA
  - ASHA -EAA
  - ADA -ARA
  - AVAA -AAPPSA
  - EDHI -MAA
  - Directors of S &H Programs in State Health and Welfare Agencies

PQRI

- Measures submitted to CMS in February by the Audiology Quality Consortium
  - Cochlear and Vestibular Monitoring
    - Baseline and Monitoring
  - 8 FDA red flags
- Same measures submitted to National Quality Forum (NQF); the gold standard for adoption
  - Not adopted in June, 2009

Reportable Measures for 2010

Measures that call for referral of patients (any age) to a physician after an audiological assessment that determines one of these 3 conditions if the patient is not currently under the care of a physician for that condition:

- Measure #188: Visible Congenital or Traumatic Deformity of the Ear
- Measure #189: History of Active Drainage from the Ear within the previous 90 days (for patients who have disease of the ear and mastoid processes)
- Measure # 190: A Sudden or Rapidly Progressive Hearing Loss within the Previous 90 Days

An additional measure retained

- Measure #94: Otitis Media with Effusion (OME): Diagnostic Evaluation-Assessment of Tympanic Membrane Mobility
  - Report, but only on children who receive Medicare benefits

Report Process

- CMS requires 3 measures be reported on
- Must report on 80% of the patients that fit into that measure

PQRI (cont.)

- If reported correctly, Part B Medicare providers have the opportunity to capture 2% bonus
  - Numerator, denominator, denominator exclusions
- Recognition of the profession
- Member of "care coordination"
- Referrals
- Direct Access??

PQRI (cont.)

- Need to use the qualified:
  - CPT (Box 24 D of the CMS 1500 form)
  - ICD-9 (Box 21of the CMS 1500 form)
  - G codes (Box 24 D of the CMS 1500 form)
    - Example of G code:
      - G 8564: Represents the measure's numerator (action required): Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation

Resources for PQRI

- www.audiology.org/practice/PQRI/Pages/default.aspx
- www.cms.hhs.gov/PQRI/31_PQRIToolKit.asp

A Peek into the Near Future:

- Electronic Health Information
  - **H**ealth **I**nformation **T**echnology
    - Bush mandate: Implementation by 2014
- HIPAA 5010 (from 4010) to be adopted by 1/1/12
- ICD-10-PCS are to be adopted by 10/1/13
  - Will change the coding system tremendously
    - Cost
    - Implementation
      - Will convert from the HIPAA 4010 system to the 5010

GET YOUR CHECKBOOK!

ICD-10-PCS Considerations for Implementation

- Consult with your software and clearinghouse vendors to ensure their transition plans
  - Implementation considerations:
    - Software packages and upgrades
    - Staff time in data logging
    - Secure funding
      - Line of credit
      - Bake sales? Reverse raffles?
- Consider training courses for you and your staff
  - Phase in 6 months prior to implementation

ICD 10-CM (cont.)

- Create new superbills
  - Academy will have these available
    - May modify for your own office
- If you create your own:
  - Add in new codes monthly
- Maps for ICD-9 to ICD-10 transition
  - Academy will have these available
    - http://www.cms.hhs.gov/icd10/downloads/pcs_gemguide_2008.pdf

Insurance and Contracting Suggestions

Why have hearing benefits not been offered through insurance?

- Few specific tests to define present condition or future outcome
- Cost issues
- Stigma issues
- Lack of perceived relative value

Current Healthcare System

- Offered through Employers
- Offered in a continuum of care fashion
- Professional services differentiated from DME/Drugs
- Presented & Perceived as valued healthcare

"Insurance is a mechanism for reimbursement, not a form of payment"

-Kadyn Williams, Au.D., 2005

Contracting Tidbits

- Need to know what your monthly break even point is
  - HAVE TO KNOW WHAT YOUR EXPENSES ARE
- Need to know with each separate contract what you can (or can't afford) to loose
- Sacrifice diagnostics for product?
  - If so, how much of a cost
    - Personally
    - Professionally

Contracting Tidbits

- Don't assume by signing a contract that you are in compliance with:
  - Federal Statutes
    - Anti-Kickback Statutes
    - Safe Harbors
    - Stark Laws
    - Medicare requirements
- Obtain legal counsel to review contracts
  - Not the local divorce atty; someone well-versed in health care law

Contracting Questions:

What is the definition of balance billing?

- Is it the difference between what was billed and what was paid?
- Is it the difference between what was billed and what is *allowable*?
  - What are the allowed charges?
    - Co-pays? (amount)
      - » Are required to be collected
    - Co-insurance? (percentage)
    - Deductibles have to be collected

Contracting Questions (cont.)

- Request fee schedule
  - Monitor it
- In network vs. out of network
- Pay to play? Each office? Each provider? How often?
- What is the credentialing process?
- What is the denial/appeal process?
- What is the termination process?

Contracting Questions (cont.)

- Know your costs!
- Some of these plans actually can cost YOU money
- Track "Benefits" of all 3rd Party Payors
- Limitations to levels of technology?
- Withholds or other administrative fees?
- Review contracts every 6 months
  - Can make changes unknowingly

Other tidbits

- Insurance waivers:
- Patient's acknowledgement of their fiscal responsibility for fees not paid by their insurance benefit
- Have patient sign before providing services
  - Time of patient education
  - Itemize CPT codes to be utilized
    - Original retained in chart, copy to patient
    - Not the same as an ABN/NEMB (Medicare only)

More tidbits

- Insurance waiver:
  - The one your office utilizes
  - The one the third party payor may suggest

Basic Hearing Plan

- Provides standard, consistent protocols
- Decisions are based upon diagnostic data
- Technology is applied based upon data
- Costs are controlled
- Outcomes are measured

Contracting

- Steps to Contracting
  - Request Information
  - Complete Application and Credentialing Process
    - Will need a License, NPI and Tax ID first
  - What if they say no?
  - When should *you*?
  - Fee Schedule: What is acceptable and what is not
    - How often is it updated
    - You can "pre-approve" the rates
  - "Evergreening" of contracts
  - Read the fine print

Third Party Payors

- Third-Party Payors
  - How to decide who you want to contract with
  - Do I want to accept third-party payment?
    - Self pay only?
  - Every contract is NOT necessarily a good one
  - Some will actually cost you money!
  - Third-Party Administrators
    - www.epichearing.com
    - www.hearpo.com
    - www.hearusa.net

Durable Medical Equipment (DME)

- Hearing aids are not considered DME by Medicare
- Hearing aids **MAY** be considered DME by your state's Medicaid
- Hearing aids may be considered DME by other third party payors

DME

- If you are not contracted for DME/hearing aids, you are not held to the payer's fee schedule for DME/hearing aids
- As long as it is not contractually excluded, a patient should expect to pay for services, diagnostic or rehabilitative.

Audit Considerations with a Third Party Payor

- Medical necessity and appropriateness of diagnostic and/or therapeutic services provided
- Site of service
- Accuracy: Services provided have been accurately reported

Contracting (cont.)

- Negotiated rate
  - Can mean different things
- Verification form and process
  - A requirement with EVERY patient
  - Complete before hearing aid evaluation
- Can I balance bill?
  - The MOST important question
  - Under what circumstances?
  - Is it the difference between what is allowed and what is reimbursed?
  - Is it the difference between what the patient owes and what is reimbursed?

Contracting (cont.)

- When to restrict product offerings
- When to refer elsewhere
- Insurance waivers

Contracting (cont.)

- Considerations:
  - Denial process?
  - Termination process?
  - How much liability to carry?

Choices for Hearing Aid Billing:

Bundle:

- One fee
- Does not decipher hardware (product) from service (you and what you provide)
- May be losing money

Unbundle:

- Itemization of fees
- Deciphers what is product vs what is service (you and what you provide)
- Required by some third party payors

Bundling vs Unbundling

- Bundling
  - Patient pays one payment, undefined as to the specific amounts and codes
    - No itemized fees
- Unbundling (separates service from product)
  - Opportunity to be reimbursed for professional fees
  - Itemization of all incurred fees, individually:
    - Hearing aid acquisition(s)
    - Dispensing fee(s)
    - Earmold(s)
    - Earmold impression(s)
    - Batteries
    - Extended service or warranty packages
      - Office visits?

- Unbundling vs. bundling
  - Gives the practitioner the option to unbundle
  - Gives the insurance company the option to bundle
  - Gives the patient and the applicable third party payor the mechanism to demonstrate professional value
  - Retail vs. medical model

The Codes-The Sequel

- Current Procedural Terminology (CPT)
  - Procedure codes (tests)
    - Example: 92557- Comprehensive audiometry threshold evaluation and speech recognition
- ICD9-CM
  - Disease, diagnosis codes
    - Example: 389.18 Sensorineural hearing loss, bilateral
- Healthcare Common Procedure (HCPCS)
  - Hearing aids (ex: V5256 dig, monaural, ITE)
  - Supplies (ex: batteries V5266)
  - Dispensing fees (ex: V5160 disp fee binaural)

Late breaking?

- FTC Red Flag and Address Discrepancy Rule
  - "Creditors"-regularly accepts deferred pmts for goods and services"
  - New date of compliance: **June 1, 2010**
    - Was to have been May 1, 2009, August 1, 2009 and November 1, 2009
  - May involve medical identity theft from another patient or your staff
  - Addresses utilizing another's insurance information without knowledge to access medical services
  - May involve erroneous entries into medical records
  - May involve the creation of fictitious medical records

Requires:

- The development and implementation of a written identity theft program
- Similar to the banking industry

What is a Red Flag?

- "A pattern, practice or specific activity that indicates the possible existence of identity theft."

FTC Red Flags (cont.)

- Required to have a written office identity theft program
- Needs to address:
  - **Identification** of potential risk for identity theft
  - **Creation** of policies and procedures to detect red flag practices that may be theft applications
    - Verify patient identity, insurance info, medical records

FTC Red Flags (cont.)

- **Respond** and prevent identity theft or fraud
  - Plan to verify documentation
  - Gather information if an event occurs
- **Update** policies and procedures as new risks are identified
  - Review the plan
  - Continually assess risk levels
  - Update policies and procedures

Red Flags Rule (cont.)

- Need a compliance officer, similar to HIPAA
- Penalties may be administrative or up to a $2,500 fine per violation

Academy has a downloadable manual and online training seminar available

www.audiology.org

Others…

- Within ARRA, there are changes to HIPAA for those who have business agreements

Final Comments (Finally!)

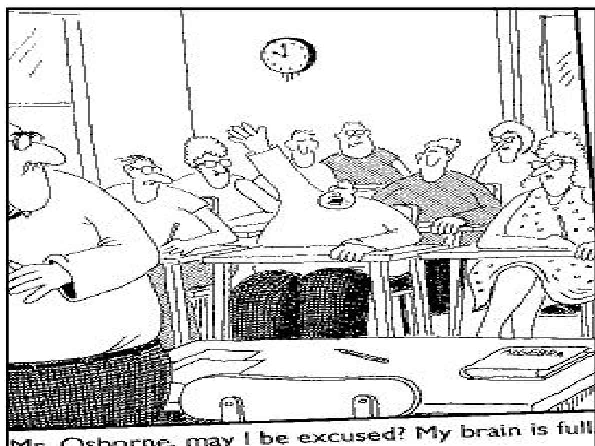
- Will need to prepare your facility for:
  - Conversion from 4010 to 5010 for HIPAA
  - ICD-10's
  - Electronic Medical Records (HIT)
  - Telehealth
  - Other permutations as health care reform progresses

Academy Resources

- *Capturing Reimbursement*
- Business Enhancement Strategies and Technical Committee (BEST) materials
- Audiology Practice Essentials (APE) CD
  - Patient letters
  - Pediatric forms
  - Practice management forms
  - Physician letters
  - Tinnitus forms
  - Vestibular questionnaires
  - In service forms

Other Resources

- *Strategic Practice Management (2008)*
  - *Glaser and Traynor*
- *Audiology Practice Management (2008)*
  - *Hosford-Dunn*



Questions?

THANK YOU!

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