Coding and Reimbursement Workshop

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Agenda

- CPT, ICD-9, ICD-10, HCPCS codes
- Medicare guidelines
- PQRS (2014)
- Documentation
- Valuing and itemizing your services
- Affordable Care Act and Trends

Polling Question

In 2014, there will be audiology coding changes to these current systems:
1. CPT
2. ICD-9
3. HCPCS
4. All of the above
5. None of the above

Basics

Need CPT, ICD-9-CM, ICD-10-CM and HCPCS manuals:
- www.ama-assn.org
- www.ingenix.com

Other resources:

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

Coding Thoughts:

- These three coding systems support each other for filing claims
- Required:
  - CPT (and/or HCPCS) AND ICD-9/10
- If billing HCPCS codes
  - May also be billing CPT simultaneously
  - Always have to have a minimum of one ICD code with each claim
Coding Mantra:

- Code for the **reason** for the visit (Medicare transmittal 84)
- 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?

Thoughts:

- Case-building for differential diagnosis
- Differentiates us from non-audiology providers
- Provides our worth in the healthcare system
- Provides your worth to the facility that employs you
  - Many are evolving into reimbursing you via relative value units (RVU) reimbursement
  - Productivity
  - Take the surveys!

Considerations:

- CPT codes 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 mesh in supporting the diagnosis code you have chosen


- Codes must support each other
- Needs to be apparent that procedure(s) performed would → the disease code chosen
- What you bill has to be appropriate to what you are licensed to perform
- Documentation has to reflect the above points
  - ICD-10’s are more specific, documentation more critical

Claim Form

- Lists the CPT(s), ICD(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

CPT codes

- Examples:
  - **92557** Basic comprehensive audiometry
    - Was the **only** audiology bundled code before 1/1/10:
      - 92553 (Pure tone air and bone conduction audiometry)
      - 92555 (SRT) and 92556 (WRS)

CPT® codes and descriptions are copyright 2014 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association (AMA).
CPT Codes (cont.)

– 3 bundled codes as of January 1, 2010:
  • CPT 92540 Vestibular (92541, 92542, 92544, 92545)
  • CPT 92550 Tympanometry, ART (92567 and 92568)
  • CPT 92570 Tympanometry, ART, ARD (92567, 92568, 92569)
  • CPT code 92569 has been deleted

Due to the NCCI edits, from 1/1/10 until 9/30/10, could not file claims for the individual codes of 92541, 92542, 92544 and 92545 if you performed 1-3 of these codes

As of 10/1/10, you can file for 1-3 of these codes, but must use the –59 modifier (distinct procedural service)

– Document as to why you didn’t choose to do all 4 tests if filing the claim with 1-3 individual codes

CPT Codes Utilized by Audiologists:

• 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

Medicare does not recognize these 4 codes as they do not include “with recording.”

CPT codes (cont.)

• 92540 Basic vestibular evaluation
• 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
• 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)
• 92558 Evoked OAEs, screening (qualitative measurement of distortion product or transient evoked OAEs), automated analysis (1/1/12)
• 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
• 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)
  – Tones and speech
• 92582 Conditioned play audiometry (CPA)

Polling scenario:

• I have a patient for whom we complete 8 frequencies in each ear.
• Should I bill CPT code 92587 or 92588?

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 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 (1/1/12)
• 92588 comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report (1/1/12)
### 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

### IONM and Nerve Conduction Study CPT Codes (1/1/13)
- Effective 1/1/13 (These 2 new codes replace CPT code 95920)
  - **CPT code 95940:**
    - Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes
      - Must bill with 92585
  - **CPT code 95941:**
    - Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour
      - Must bill with 92585
      - Can't bill outside of OR to Medicare
IONM (cont.)

- **G0453** Continuous IONM from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes
  - List with 92585
  - Billed in units of 15 minutes

IONM and Nerve Conduction Study CPT Codes (cont.)

- CPT codes 95905-95913
- CPT code 95905
  - Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report
- Code chosen is dependent on the number of completed studies:
  - CPT code 95905: Report only once per limb studied
  - CPT code 95907: Nerve conduction studies 1-2 studies
  - CPT code 95908: 3-4 studies
  - CPT code 95909: 5-6 studies
  - CPT code 95910: 7-8 studies
  - CPT code 95911: 9-10 studies
  - CPT code 95912: 11-12 studies
  - CPT code 95913: 13 or more studies

CPT Codes (cont.)-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 92558, 92587-8
- IONM codes:
  - CPT 95940-1, G0453

Polling question:

- For any procedure that does not have a dedicated CPT code, should I use 92700?
2014 Academy Superbill/Encounter Forms


and


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 92540-92548)
    - 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 92540-92548)
    - 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** Technical component
  - 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 cannot be filed by an audiologist when performed by another provider, including another audiologist
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
    • Can be appended to indicate that not all requirements of the code were completed
    • Not recognized by all carriers
    • 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 (per NCCI)
  – When?
    • ONLY if performing 1-3 tests of the 4 code bundle
    • For services provided after 10/1/10

Modifiers (cont.)

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

Medicare Modifiers

• **GA** – “Waiver of Liability Statement Issued as Required by Payer Policy”
  – To be used when a denial is expected and an ABN is on file
  – No ABN, no billing the patient, if Medicare denies the claim
• **GX** – “Notice of Liability Issued, Voluntary Under Payer Policy”
  – For services that are non-covered, statutorily excluded
• **GY** – “Notice of Liability Not Issued, Not Required Under Payer Policy”
  – Often used when a secondary insurance has a hearing aid benefit
• **GZ** – “Item or Service Expected to Be Denied as Not Reasonable and Necessary”
  – To be used when there is no ABN on file
  – Likely to be utilized in an emergent situation
  – Patient is not responsible for payment

Other modifiers...

• **RT** (for right side of body, ear included)
• **LT** (for left side of body, ear included)
Polling scenario:
- A patient with dementia has to be constantly re-instructed during 92557.
- What modifier could you use to indicate your repetition of the directions, bringing them back to task, etc.?

For those things that are statutorily excluded:
- Anything not medically necessary
- What is medical necessity?
  - May be located in the LCD
  - 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)

What is Medical Necessity?
- Title XVIII of the Social Security Act, section 1862 (a)(1)(a):
  - Notwithstanding any other provisions of this title, 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

Polling Question:
- Do you file claims with Evaluation and Management Codes (99201-5, 99211-5)?
  - 1. Yes
  - 2. No
  - 3. I’m afraid to tell you

Evaluation and Management Codes (E/M)
- Time, complexity and review of systems are required
- Medicare and commercial payors (e.g., TriWest, Aetna) do not recognize audiologists for E/M codes—do not file to Medicare
- BE CAREFUL:
  - Audiologists should not up-code—be realistic with what you are doing and DOCUMENT
    - Personal thought: would not code beyond a level 2 so as not to trigger an audit
    - Read the CPT codebook’s first section for information
    - Read CMS’ Medlearn Guide on E/M codes

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
- Hematologic/lymphatic/immunologic

E/M Codes

- CPT 99201
  - A problem focused history
  - A problem focused examination
  - Straightforward medical decision making
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - Typical time spent: 5 minutes

E/M Codes (cont.)

- CPT code 99212
  - A problem focused history
  - A problem focused examination
  - Straightforward medical decision making
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - 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
  - “Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs”
  - Physicians spend 40 minutes face-to-face with the patient and/or family
Polling Question:

• Do you bill for cerumen management?
  – 1. Yes
  – 2. No

Cerumen Management-69210

• Is in the scope of practice of audiology
• Unless cerumen is **impacted**, should not be billing for it separately
  – July 2002, *CPT Assistant* defines impaction

“Cerumen Impaction”

• Defined by the American Medical Association publication *CPT Assistant* (*CPT Assistant*, July 2005) must meet one or more of the following conditions to be considered “Impacted”:
• Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition;
• Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.;
• Associated with foul odor, infection or dermatitis;
• Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations”

CPT Assistant (cont.)

• The *CPT Assistant* article further states “removing wax that is not impacted does not warrant the reporting of CPT code 69210 [Removal of impacted cerumen (separate procedure), 1 or both ears].”
• Documentation of cerumen removal should include the time, effort, method(s) and equipment to provide the service
• Removal of impacted cerumen requires visualization with an otoscope, head loupes, or operating microscope and the use of specialized tools such as curettes, forceps, lavage, and/or suction for proper removal

CPT Code Change for 69210 (Effective 1/1/14)-**CAUTION!!!**

• CPT code 69210
  – “Removal impacted cerumen requiring instrumentation, unilateral
    *(For bilateral procedure, report 69210 with modifier 50)*”

Cerumen Management (cont.)

• Check with state licensure laws
  – Some state licensure laws do not allow CM to be performed by an audiologist
    • If they do, removal restrictions may apply
• Can offer a voluntary ABN
### 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/HCPCS codes to be utilized
    - Original retained in chart, copy to patient
    - Not the same as the ABN (Medicare only)

### Waivers (cont.)

- Do your commercial payors have their own?
- Will they allow the usage of a generic waiver?
- Will they allow one that your office generates?

### ICD-9 Codes

- Code by the most specific code
  - Not 3, 4 digit codes
  - Not those that end in 0
  - May not have other options
- Hearing loss codes are in the 389 family
  - 389 Hearing loss

### Other ICD-9 codes

- 380 Disorders of the external ear
- 381 Nonsuppurative OM and ETD
- 382 Suppurative and unspecified OM
- 383 Mastoiditis and related conditions
- 384 Other disorders of TM
- 385 Other disorders of middle ear and mastoid

### Other ICD-9 Codes (cont.)

- 386 Vertiginous syndromes and other disorders of vestibular system
  - 386.11 BPPV
- 387 Otosclerosis
- 388 Other disorders of ear
  - 388.0 Degenerative and vascular disorders of ear
  - 388.01 Presbyacusis
  - 388.02 Transient ischemic deafness

### Other ICD-9 Codes (cont.)

- 388.1 Noise effects on inner ear
- 388.10 Noise effects in inner ear, unspecified
- 388.11 Acoustic trauma (explosive) to ear
- 388.12 Noise-induced hearing loss
- 388.2 Sudden hearing loss, unspecified
Other ICD-9 Codes (cont.)

- 388.3 Tinnitus
  - 388.30 Tinnitus, unspecified
  - 388.31 Subjective tinnitus
  - 388.32 Objective tinnitus
- 388.4 Other abnormal auditory perception
  - 388.40 Abnormal auditory perception, unspecified
  - 388.41 Diplacusis
  - 388.42 Hyperacusis
  - 388.43 Impairment of auditory discrimination
  - 388.44 Recruitment
  - 388.45 Acquired auditory processing disorder

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

Other ICD-9 Codes (cont.)

- 388.5 Disorders of acoustic nerve
- 388.6 Otorrhea
- 387.7 Otalgia
- 388.8 Other disorders of ear
- 388.9 Unspecified disorder of ear

Other ICD-9 codes (cont.)

- 389 Hearing loss

Other ICD-9 Codes (cont.)

- 389.0 Conductive hearing loss
  - 389.00 Conductive hearing loss, 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 CHL of combined types
Other ICD-9 Codes (cont.)

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

ICD-9 Codes (Cont.)

- 389.2 Mixed conductive and sensorineural hearing loss
  - 389.20 Mixed HL, unspecified
  - 389.21 Mixed HL, unilateral
  - 389.22 Mixed HL, bilateral
  - 389.7 Deaf, nonspeaking, not elsewhere classifiable
  - 389.8 Other specified forms of HL
  - 389.9 Unspecified HL

Even more…

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

Additional Codes

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

Additional codes (cont.)

- 960.3 Erythromycin and other macrolides
  - Oleandomycin
  - Spiramycin

- 960.6 Antimycobacterial antibiotics
  - Cycloserine
  - Kanamycin
  - Rifampin
  - Streptomycin

Additional Codes (cont.)

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

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

Additional Possibilities

• 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

Additional Possibilities (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

• Last resort, likely to be denied
  – Address specific events, not disease

• INVALID
  – V72.1 Examination of ears and hearing

ICD-9 vs ICD-10

• ICD-9-CM has 17,000 codes
• ICD-10-CM has 69,000+ codes
• Proposed deadline
  – Compliance date of October 1, 2013 for ICD-10 delayed; now October 1, 2014

Polling Question:

• When would be a good time to start working on ICD-10’s in my office?
  – 1. Yesterday
  – 2. Monday AM
  – 3. 2 months from now
  – 4. September
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

Diseases of Inner Ear
H80-H83

- H80 Otosclerosis
- H81 Disorders of vestibular function
  - H81.0 Ménière's disease
  - H81.1 Benign paroxysmal vertigo
  - H81.2 Vestibular neuritis
  - H81.3 Other peripheral vertigo
  - H81.4 Vertigo of central origin
    - Central positional nystagmus
  - H82 Vertiginous syndromes in diseases classified elsewhere
  - H83 Other diseases of inner ear
    - H83.0 Labyrinthitis
    - H83.1 Labyrinthine fistula
    - H83.2 Labyrinthine dysfunction
    - H83.3 Noise effects on inner ear

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/
    - H90.41 SNHL, right ear
    - H90.42 SNHL, left ear
- 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 neuritis
  - H81.3 Other peripheral vertigo
    Lempert's syndrome
    Vertigo:
    - Aural
    - Otogenic
    - Peripheral NOS (not otherwise specified)

ICD-10-PCS codes (cont.)

- H81.4 Vertigo of central origin
  Central positional nystagmus
- H81.8 Other disorders of vestibular function
- H81.9 Disorder of vestibular function, unspecified
  Vertiginous syndrome NOS

ICD-10-PCS codes (cont.)

- H82 Vertiginous syndromes in diseases classified elsewhere
- H83 Other diseases of inner ear
- H83.0 Labyrinthitis
- H83.1 Labyrinthine fistula
- H83.2 Labyrinthine dysfunction
  Hypersensitivity
  Hypofunction } of labyrinth
  Loss of function
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.)

• H90.0 Conductive hearing loss, bilateral
• H90.1 CHL, unilateral with unrestricted hearing on the contralateral side
• H90.2 CHL, unspecified
  Conductive deafness NOS
• H90.3 Sensorineural hearing loss, bilateral
• H90.4 SNHL, unilateral with unrestricted hearing on the contralateral side

ICD-10-PCS codes (cont.)

• H90.5 Sensorineural hearing loss, unspecified
  Congenital deafness NOS
  Hearing loss:
  
  Central
  Neural NOS
  Perceptive
  Sensory
  Sensorineural deafness NOS

ICD-10-PCS codes (cont.)

• H90.6 Mixed conductive and sensorineural hearing loss, bilateral
• H90.7 Mixed CHL and SNHL, unilateral with unrestricted hearing on the contralateral side
• H90.8 Mixed CHL and SNHL, unspecified

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.
ICD-10-PCS codes (cont.)

- H91.1 Presbycusis
  Presbyacusia
- H91.2 Sudden idiopathic hearing loss
  Sudden hearing loss NOS
- H91.3 Deaf mutism, not elsewhere classified
- H91.8 Other specific hearing loss

ICD-10 (cont.)

- H91.9 Hearing loss, unspecified
  Deafness:
  - NOS
  - High frequency
  - Low frequency
- H92 Otalgia and effusion of ear

ICD-10-PCS codes (cont.)

- H93 Other disorders of ear, not elsewhere classified
- H93.0 Degenerative and vascular disorders of ear
  Transient ischaemic deafness
- H93.1 Tinnitus

ICD-10-PCS codes (cont.)

- H93.2 Other abnormal auditory perceptions
  Auditory recruitment
  Diplacusis
  Hyperacusis
  Temporary auditory threshold shift
  Excludes: auditory hallucinations (R44.0)

ICD-10-PCS codes (cont.)

- H93.3 Disorders of acoustic nerve
  Disorder of 8th cranial nerve
- H93.8 Other specified disorders of ear
- H93.9 Disorder of ear, unspecified

- Organized in 21 chapters. Each chapter is uniquely identified by letter. Letter does not indicate content
  - 1st digit—always alphabetic (HL is H90-H95)
  - 2nd and 3rd digits—always numeric
  - 4th, 5th, and 6th digits—may be letters or numbers, or may be a placeholder (x)
  - There is always a decimal after the first three digits.
  - First 3 digits—define the code category
  - Second three digits—etiology, anatomical site, or severity
  - Seventh digit—"extension" describes the encounter type (initial, subsequent, sequela) for certain conditions such as TBI and ototoxicity
Other codes (NEC, not elsewhere classified). Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate “other” codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.

Unspecified codes (NOS, not otherwise specified). Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the “other specified” code may represent both other and unspecified. Should be avoided.

Coding and Laterality

- 1 = Right
- 2 = Left
- 3 = Bilateral

EXCEPT:
H90.0 Conductive HL, bilateral
H90.11 or H90.12 Unilateral CHL
H90.3 SNHL, bilateral
H90.41 or H90.42 SNHL, unilateral
H90.6 MHL, bilateral
H90.71 or H90.72 MHL, unilateral

Polling Question:

- Would you expect that the RT and LT modifiers will no longer be utilized?
  - 1. Yes
  - 2. No

ICD-10’s (cont.)

- A dash (-) indicates additional specificity in the 5th and 6th digit positions (H91.0-)
- “x” indicates a placeholder
  - Used as a 5th character placeholder for certain 6 digit codes

Sample Codes-SNHL

- H90.3 Sensorineural hearing loss, bilateral
- H90.41 Sensorineural unilateral hearing loss with unrestricted hearing on opposite side, right ear
- H90.42 Sensorineural unilateral hearing loss with unrestricted hearing on opposite side, left ear

Sample Codes-CHL

- H90.0 Bilateral conductive hearing loss
- H90.11 Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
- H90.12 Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
Sample Codes-Tinnitus

• Only one tinnitus code, not 3:
  • H93.1
    – H93.11 Tinnitus, right ear
    – H93.12 Tinnitus, left ear
    – H93.13 Tinnitus, bilateral

Polling Question:

• Do you think there should be more than just one tinnitus code?
  – 1. Yes
  – 2. No

Auditory Symptoms

✓ R42 Dizziness and giddiness
  • Light-headedness
  • Vertigo NOS
  • Excludes 1: vertiginous syndromes (H81.-)
✓ R94.12 Abnormal results of function studies of ear and other special senses
  • R94.120 Abnormal auditory function study
  • R94.121 Abnormal vestibular function study
  • R94.122 Abnormal results of other function studies of ear and other special senses

Supplemental Codes

✓ Z45 Encounter for adjustment and management of implanted device
  • Z45.320 Encounter for adjustment and management of bone conduction device
  • Z45.321 Encounter for adjustment and management of cochlear device
  • Z45.328 Encounter for adjustment and management of other implanted hearing device
✓ Other Useful Codes
  • Z46.1 Encounter for fitting and adjustment of hearing aid
  • Z57.0 Occupational exposure to noise
  • Z71.2 Person consulting for explanation of examination or test findings
  • Z76.5 Malingering (Person feigning illness with obvious motivation)
  • Z77.122 Contact with and (suspected) exposure to noise

Supplemental Codes

✓ Z83.52 Family history of ear disorders
✓ Z86.69 Personal history of other diseases of the nervous system and sense organs
✓ Z96.20 Presence of otological and audiological implant, unspecified
✓ Z96.21 Cochlear implant status
✓ Z96.22 Myringotomy tube(s) status
✓ Z96.29 Presence of other otological and audiological implants
✓ Z97.4 Presence of external hearing-aid
<table>
<thead>
<tr>
<th>Lost Codes</th>
<th>Lost Codes (cont.)</th>
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</table>
| • No longer more specific tinnitus codes (objective, subjective)  
  – H90.0x  
• Conductive HL codes are no longer specified as to anatomy  
  – H90.0x  
• SNHL are not categorized as sensory nor neural  
  – H90.3 is SNHL  
• Impairment of auditory discrimination  
  – 388.43 (use H93.29)  
| • 315.92 (developmental CAPD) is included in H93.25  
• 388.45 (acquired CAPD) is included in H93.29  
• Otalgia details are now coded as H92.0-  
• Otorrhea is now coded as H92.2- |

<table>
<thead>
<tr>
<th>New Codes</th>
<th>ICD-10-CM</th>
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</table>
| • Laterality is addressed with codes to indicate such  
• Threshold shift codes  
  – H93.24-  
• Ototoxicity code  
  – H91.0-  
• Intra-operative and post procedural complications  
  – H95  
| • Effective on 10/1/14  
• Check with your clearinghouse vendors for compliance and filing capabilities  
  – Testing capabilities  
• If you file hard copy claims, will need the revised CMS 1500 form (02/12) no later than April 1, 2014 |

<table>
<thead>
<tr>
<th>ICD-10-CM (cont.)</th>
<th>ICD 10-CM (cont.)</th>
</tr>
</thead>
</table>
| • Everywhere ICD-9 is located in your office will need to be ICD-10  
  – Codebook  
  – Computer systems  
  – Patient insurance eligibility processes  
  – Physician Quality Reporting System (PQRS  
  – Superbill and encounter forms  
| • Create new superbills  
  – Academy will have these available  
  – May modify for your own office  
• If you create your own:  
  – Add in new codes monthly  
  – Staff training, 6 months prior  
• Maps for ICD-9 to ICD-10 transition  
  – Academy will have these available |
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 for data logging
  • Documentation requirements will need to be more specific and detailed
  • Payment may be slower
    – Have $$ available

ICD-10 (cont.)

• Documentation will be more critical
  – Medical necessity must be met
  – Chief complaint(s) detailed
  – Reason(s) for the date of service
  – Signs/symptoms reported for the date of service
  – Test results and recommendations

ICD-10 (cont.)

• Establish a budget
  – Software upgrades?
  – Training needs?
  – Productivity loss/gain
  – Staff time
• Establish a timeline
  – Stick to it

Small to Medium Practices

• Centers for Medicare and Medicaid Services Timeline:
• CMS Implementation Guide for Small and Medium Practices:

Large Practices

• CMS Implementation Guide for Large Practices:

References

http://www.audiology.org/practice/coding/ICD-10-CM/Pages/default.aspx
http://www.cdc.gov/nchs/icd/icd10cm.htm
A glimpse behind and forward…

- Budget neutral system
  - Audiology suffered:
    - 20% decrease in 2009 and 2010
    - 6% in 2011
    - 5% in 2013
    - 1% of combined impact for 2014
  - Sustainable Growth Rate (SGR)
    - 24.7% cut across the board without Congressional action effective January 1, 2014

Medicare Requirements for Audiologists

- 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 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.)
• Chapter 15-Covered Medical and Other Health Services
  - 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

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(II)(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.)

• Payment of audiological diagnostic tests is allowed for other reasons and is not limited, for example, by:
  – Any information resulting from the test including:
    • Confirmation of a prior diagnosis;
    • Post-evaluation diagnoses; or
    • Treatment provided after diagnosis, including hearing aids, or
    • The type of evaluation or treatment the physician anticipates before the diagnostic test; or
    • Timing of re-evaluation.

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 (92540-92546, 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)

New Requirement:

- Ordering/referring providers must be enrolled in PECOS or your claim will be denied
  - Was to be effective 5/1/13, now pushed back until ?
- Contact their staff to ensure your referral sources are enrolled in PECOS

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.)

• “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 (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 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

• “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.”
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.

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, at 100% of what is allowed, from the same physician fee schedule as physicians, with the audiologist's NPI.

Medicare Enrollment

- Provider Enrollment Chain, Ownership System (PECOS)
  - Online system for initial enrollment
  - Update current information
  - Check enrollment status
  - Must report changes to contractor no later than 90 days after the change unless
    - A change in ownership or managing interest (within 30 days)
    - DMEPOS must notify the National Supplier Clearinghouse of changes in enrollment (within 30 days)

https://pecos.cms.hhs.gov/pecos/login.do

Medicare Enrollment (cont.)

- Enrollment forms:
  - 855 I for individuals, applies to most audiologists (Provider Transaction Access Number)
  - 855 R to reassign the benefits to another provider
- ENT employs an audiologist
  - Audiologist files the 855 I to get their PTAN
  - Audiologist files the 855 R to assign the funds back to their employer who is filing the claim with the NPI of the audiologist and being paid for those services

- 588/Electronic Funds Transfer
- EDI (Standard Electronic Data Interchange) for those who submit electronic claims to Medicare
- 460 Medicare participating physician or supplier agreement (agree to accept assignment for all covered services)
  - Mid-November-December of calendar year, can charge participation status for the following year
  - Check with your contractor for the dates of open enrollment
  - Renews automatically with no change in status if nothing is submitted during the open enrollment period
Medicare Enrollment (cont.)

• Independent, contracting audiologists should have an 855R for all facilities where they provide services
  – Each one needs to be itemized on the 855I
  – Addresses, names of facilities need to match
  • Site visits are being conducted to ensure the legitimacy of the facility

Medicare Enrollment

– If the sole proprietor, don’t need to file an 855R for your practice
– If sole owner of a professional corporation completes the 855I, the 855R does not need to be completed
– If a part owner of a professional corporation and will be rendering services through that corporation, complete the 855I and the 855R
– Check with your contractor to ensure you are filing the correct forms for your individual situation

Medicare Enrollment (cont.)

• Revalidation
  – All providers who have enrolled in Medicare prior to March 25, 2011 are required to re-enroll (ACA)
  – Request will come in a colored envelope to denote its difference, prior to March 23, 2015
  – Must return it in 60 days or risk deactivation
  • Can revalidate via PECOS or 855I
  • Sign the certification statement
  • Submit supporting documents and statement to your MAC
• Are to revalidate every 5 years
  – MLN Matters SE 1126 Revised:
    • “All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC (Medicare Administrative Contractors)”

Medicare Enrollment (cont.)

• Deactivation
  – If you have not submitted claims for 12 months
  • Begins on the 1st day of the 1st month of no claims submissions through the last day of the 12th month
  • May not reactivate until ready to submit a new claim
  • If any change of information on enrollment form has not been updated within 90 calendar days of when the change occurred
  • Change of ownership not reported within 30 calendar days
• Must submit a complete 855
  – If you have never completed an 855
  – If you have not completed an 855 since 2003

Two CPT Codes -Non-facility

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<th>Code</th>
<th>Description</th>
<th>Participating</th>
<th>Non-Par</th>
<th>Limiting Charge</th>
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Status within Medicare

• Participating provider
• Non-participating provider
• Limiting Charge provider
## Medicare Beneficiary “Rights”

- **Social Security Act (§ 1848(g)(4))** “requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990.”
  - Applies to all providers who provide covered services to Medicare beneficiaries
  - “The requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment”

(CMS MLN Matters Number SE0908)

## Advanced Beneficiary Notice

- **Required (mandatory)**
  - Provider believes Medicare may deny the service due to not meeting medical necessity
  - Provider uncertain if Medicare does cover for some diagnoses, may not be for this particular instance
- **Voluntary**
  - Non-covered, statutorily excluded, services such as treatment or rehabilitation
    - Vestibular rehabilitation
    - Cerumen management
    - Tinnitus management
    - Other applications

## ABNs

- **Mandatory ABN:**
  - “When Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare Program standards.”
- **Voluntary ABN:**
  - “…not required for care that is statutorily excluded or for services for which no Medicare benefit category exists.”
  - “Example of Medicare Program exclusions are:
    - Hearing aids and hearing examinations"
ABN (cont.)

Option 1. Bill Medicare, have patient sign the ABN, which allows you to bill the patient if the claim is denied
Option 2. Don’t bill Medicare
Option 3. Patient declines procedure
  • Itemizes:
    – Patient’s name
    – Date of service
    – Procedure(s) performed
    – Costs to be incurred

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

GA: “Waiver of Liability Statement Issued as Required by Payer Policy”
  -- 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: “Item or service expected to be denied as not reasonable and necessary”
  -- To be used when there is no ABN on file, likely to be utilized in an emergent situation; patient is not responsible for payment

Considerations

– A Medicare patient cannot pay more for a 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, can then write it off, on a case-by-case basis
  • For all patients, have a financial agreement to collect the required co-pay
Polling Question:

- I reported on 2013 PQRS measures:
  - 1. Yes
  - 2. No

Physician Quality Reporting Initiative/Systems

- Methodology designed to move away from fee-for-service to outcome measures
  - 2010 was the first year audiologists could report on eligible measures
  - Audiologists were the most correct, highest reporting non-physician provider!

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)
PQRS
• Designed to improve quality to Medicare beneficiaries
• Applies only to Medicare enrolled Part B eligible providers (EP)
  – Not Part B hospital or Skilled Nursing Facilities
• Must report in 2014 or face a 2% penalty on ALL 2016 Medicare claims
• Until 12/31/14, may still qualify for the 0.5% bonus on all eligible charges
• Just add a code to your claim form—it’s that simple!

PQRS (cont.)
• Audiology Quality Consortium (AQC) step by step guide:

2014 PQRS Changes
• Measure #188 (Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear) was retired effective 1/1/14
• Now we only have 3 measures, one audiology specific
• PQRS requirement is to report on 9 measures for at least 50% of an EP’s Part B patients to whom the measure applies
• Since we don’t have 9 measures, the Measure Applicability Validation (MAV) process applies to audiology measures

PQRS (cont.)
• To avoid penalties for 2014 claims:
  – Must report on at least 50% of the eligible patient visits to whom the measure applies
  – For #261, Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness, report on one patient visit/year
    Must report with:
  – For #130, Documentation of Current Medications in the Medical Record, report on at least 50% of the patient visits
    • Can report #130 without #261

Measure-Applicability Validation (MAV)
• Eligible Professionals (EP) that has <9 measures or < than 3 domains are subject to the MAV process
• This allows the profession to have viable reporting options since we don’t have the required 9 measures on which to report
• Allows CMS to determine whether an EP should have reported quality data codes (QDC) for additional measures
• We are predominantly claims based, which may transition to registry based

Domains
• The 9 measures needed to cover 3 National Quality Forum domains:
  – Patient safety
  – Person and Caregiver-Centered Experience and Outcomes
  – Communication and Care Coordination
  – Effective Clinical Care
  – Community/Population Health
  – Efficiency and Cost Reduction
WHY?
– Care coordination; quality of care improvement; best practices
  • Medicare is transitioning away from the traditional fee-for-service method of payment for many types of care; quality outcomes are likely to be the new methodology
  • You may need to adjust office protocol
    – Measure #130 (medications) is an example
  • Physician Compare initiative
  • Website of PQRS reporting data for public/consumer to access providers and view their “report card”

Polling Question:
• Is there an easy step-by-step guide that describes all of this?
  – 1. Yes
  – 2. No

UPDATED PQRS RESOURCE!
2014 Step-by-Step Guide

Each measure has qualifying numerators and denominators and specific G codes
• NUMERATOR
  – Clinical action required for performance
• DENOMINATOR
  – Eligible patients for which a clinical action was performed
• DENOMINATOR EXCLUSION
  – Patients who fit in the denominator, but are not eligible for specific reasons

10 audiology organizations have been working on audiology quality measure development since 2008
• American Academy of Audiology
• Academy of Doctors of Audiology
• American Speech-Language-Hearing Association
• Academy of Rehabilitative Audiology
• American Academy of Private Practice in Speech Pathology and Audiology
• Association of VA Audiologists
• Directors of Speech and Hearing Programs in State Health and Welfare Agencies
• Educational Audiology Association
• Military Audiology Association
• National Hearing Conservation Association
PQRS Measure #261

- **Descriptor**
  - Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness
- **Numerator**
  - Patients referred to a physician for an otologic evaluation subsequent to an audiologic evaluation who present with acute or chronic dizziness
  - Note: The physician receiving the referral, or providing care currently, should preferably be specially trained in disorders of the ear

- **Denominator**
  - Patients aged birth and older

- **CPT codes:**
  - 92540, 92541-92548, 92550, 92557, 92567, 92568, 92570, 92575

- **ICD-9 codes for dizziness:**
  - 780.4 (dizziness and giddiness)
  - 386.11 (BPPV)

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PQRS Measure #261 (cont.)

- **G8856:** Referral to a physician for an otologic evaluation performed

- **G8857:** Patient is not eligible for the referral for otologic evaluation measure (e.g., pts who are already under the care of a physician for acute or chronic dizziness)

- **G8858:** Referral to a physician for an otologic evaluation not performed, reason not specified

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Clinical Example for #261

- 75 year old female referred by PCP for an audiological evaluation
  - CPT codes 92557 and 92570 were performed
  - ICD-9 codes: 389.18 (SNHL, AU), 388.31 (subjective tinnitus) and 780.4 (dizziness and giddiness)
  - G 8556: Referral to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation

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PQRS Measure #130

- **Documentation and Verification of Current Medications in the Medical Record**
  - This measure is to be reported at each visit occurring during the reporting period for all patients aged 18 years and older
  - To determine if documentation of a current medication list occurred
  - **Description:**
    - Percentage of patients aged 18 years and older with a list of current medications (includes prescription, OTC, herbals, vitamin/mineral/dietary (nutritional) supplements) documented by the provider, including drug name, dosage, frequency and route
CPT Codes for #130

- CPT Codes:
  - 92541
  - 92542
  - 92543
  - 92544
  - 92545
  - 92547
  - 92548
  - 92549
  - 92626

Clinical Example #130

- With CPT code(s) from previous slide, ICD-9 code not specified, can report on this measure with G8427 if the following are documented to the best of your ability:
  - The name of the drug, OTC, herbal, vitamin/dietary (nutritional) supplements
  - The dosage of the drug
  - The frequency that it is taken
  - The route of administration (pathway of how it is taken)
  - Topical? IV? Sub-lingual? etc.

- If patient is not on any medications, report G8427

PQRS Measure #130 (cont.)

- G8427: Current Medications Documented. Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability. This list must include all prescriptions, over-the-counter, herbs, vitamins/mineral/dietary (nutritional) supplements and must contain the medication's name, dosages, frequency and route of administration. This code should also be reported if the eligible professional documented that the patient is not currently taking any medications. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

- G8430: Current Medications Not Documented, Patient not Eligible. Eligible professional attests the patient is not eligible for medication documentation. A patient is not eligible if they are in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

- G8428: Current medications with Name, Dosage, Frequency or Route not documented as obtained, updated or reviewed by the eligible professional, reason not given

PQRS Measure #134

- Screening for Clinical Depression and Follow-up
- This measure is to be reported a minimum of once per reporting period for all patients aged 12 years and older seen by the clinician
- Not mandatory to report on this measure
- Description
  - Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

PQRS Measure #134 (cont.)

- CPT codes: 92557, 92567, 92568, 92625, 92626
- ICD-9 codes: None specified for this measure

- G8431: Positive screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented
- G8510: Negative screen for clinical depression using an age appropriate standardized tool, follow-up not required
- G8433: Screening for clinical depression using an age appropriate standardized tool not documented, patient not eligible/appropriate
**PQRS Measure #134 (cont.)**

- If you choose to report on this measure, check with your state licensure law to ensure that it is within your scope of practice in your state.
- If you select this measure for reporting, you will report:
  - Whether or not the patient was screened for depression using a standardized tool (PHQ9, BDI or BDI-II, CES-D, DEPS, DADS, GDS, PRIME MD-PHQ2, PHQ-A, and BDI-PC).

**Clinical Example for #134**

- 67 year old male referred by PCP for an audiologic and tinnitus assessment.
- Chief complaint is tinnitus x 6 months.
- Depression screening performed routinely by this practice.
- CPT codes performed: 92557, 92570 and 92625.
- ICD-9 code: 388.31 (subjective tinnitus).
- G code: G8431 (positive screen for clinical depression, f/u plan documented).

**Sample Claim for Reporting on 2 measures (#261 and #130)**

**How To Report On Measures On The CMS 1500 Form:**

- Report on all applicable CPT/ICD-9 code criteria combinations.
- Report all applicable corresponding G codes for the CPT code(s) in each measure.
- For 2014, report on 50% of patients who meet the criteria of a measure.
- While several measures may not be utilized often, if at all, the medications measure qualifies if specifications of the medications are met.
  - Most EHR systems require a list of medications.
What goes where on the CMS 1500?

- CPT code(s)-Box 24D
- ICD-9 code(s)-Box 21
- G code(s)-Box 24D
- Your NPI-Box 24J

What Do You Get From CMS?

- .5% bonus until 12/31/14 on all Medicare claims
- Remittance Advice (EOB)
- N365: "This procedure code is not payable. It is for reporting/information purposes only.
  - Indicates that the PQRS codes were received
  - Does not guarantee that reporting was correct
  - If satisfactorily reported, N365 indicates the claim "will be used in calculating incentive eligibility" (CMS)
  - Must be received by 2/28/14
  - Payment will be noted as "PQRS 2013"
  - Should have received in 2nd or will in the 3rd quarter of 2014

PQRS Resources

- http://www.audiology.org/practice/PQRI/Pages/default.aspx

CMS PQRS Resource-
QualityNet Help Desk

Available Monday – Friday; 7:00 AM–7:00 PM CST
- General CMS Physician Quality Reporting System and eRx Incentive Program information
- Portal password issues
- Feedback report availability and access
- PQRI-IACS registration questions
- PQRI-IACS login issues
Phone: 1-866-288-8912 TTY: 1-877-715-6222
Email: Qnetsupport@sdps.org
• “To allow consumers to search for physicians and other health care professionals enrolled in the Medicare program (ACA).”
• “The purpose of Physician Compare is to help consumers make informed choices about healthcare they receive through Medicare.”
• No later than early 2014, consumers can select providers based on “robust and reliable quality of care data”

Physician Compare (cont.)

• Information currently provided:
  – Medicare enrolled providers’ names, addresses, phone numbers, specialties, training, gender
  – Languages spoken other than English
  – Hospital affiliations
  – If provider is accepting new Medicare patients
  – If provider is participating, accepting assignment
  – Information about providers who participate in PQRS and/or e-prescribing
**Physician Compare (cont.)**

- Information currently provided:
  - Medicare enrolled providers’ names, addresses, phone numbers, specialties, training, gender
  - Languages spoken other than English
  - Hospital affiliations
  - If provider is accepting new Medicare patients
  - If provider is participating, accepting assignment
  - Information about providers who participate in PQRS and/or e-prescribing

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**Documentation**

- A chart is a legal document
  - Can be subpoenaed
- Provides continuity of care between health care professionals
- Third party payer requirement
- Quality Assessment/Peer Review
- 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

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**What else?**

- Who is the 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
    - May want to avoid referral pads with your practice name
    - Check with your Medicare contractor (Noridian)
And…

- HIPAA forms
  - Notice of Privacy Practices (NPP)
    - Update annually

Documentation (cont.)

- Sign and date the audiogram and chart notes
- Must provide user instructional brochure for hearing aids and note it in the record
- Must obtain medical clearance for hearing aids or provide waiver
- "If I can’t code your encounter form from your documentation, then your documentation is inadequate.”
  - Kyle Dennis, personal e-mail

And?

- Date of service
- Reason for the visit
- Case history

Case History

- Adult
  - Familial hearing loss
    - Age of onset, syndromes?
  - Surgeries? Amplification?
  - Medications, past and present
    - Herbals, over-the-counter meds
    - Occupational noise exposure
    - Recreational noise exposure

  May have to excavate for the history…”

Case History (cont.)

- Pediatric:
  - Prenatal history
  - Delivery history
  - Medications
  - Illnesses

Chart Notes:

- Need to document all that patient relays to you
- SOAP “outline”
- Need to explain and interpret audiogram
  - Don’t assume anyone other than an audiologist understands what it means
SOAP

• Subjective findings
  – History
• Objective finding
  – Physical exam
  – Testing
• Assessment
  – Puzzle piecing
• Plan
  – Recommendations for patient based on the above
  – Referrals to others

Hard Copy Guidance

• No sticky notes!
  – Everything needs to be secured with the patient’s name and date…
• If err, strike through with one single line
  • Do not scribble
• Shred any trash that has Personal Health Information (PHI)

Standardized Billing Form:
The CMS 1500-Update

Polling Question:

• Is the CMS 1500 form going to change in the near future?
  – 1. Yes
  – 2. No

CMS 1500 form

• The National Uniform Claim Committee (NUCC)
  – Voluntary organization, chaired by the AMA
  – CMS partners with NUCC
• Revision due to changes:
  – Meets requirements of several initiatives
  – ICD-10 changes
    • Need more room for longer codes
    • Added 8 additional lines (total of 12 diagnosis codes)
    • Changed from numeric to alphabetic (A-L)
    • Removed the period within the code lines
CMS 1500 form (cont.)

- Changed form date from 08/05 to 02/12
- 1500 rectangular symbol now has a QR (Quick Response Code)
- Other form changes:
  - TRICARE CHAMPUS changed to TRICARE
  - Social Security Number changed to ID#
  - Box 19 changed to "additional claim information"
  - Other changes
    - Balance due is "Rsvd for NUCC Use"

CMS 1500 form timeline

- January 6-March 31, 2014: Payers will accept paper claims on old and new 1500 forms
- April 1, 2014: Payers receive and process paper claims submitted ONLY on the revised version (02/12) claim form
- Consult with your practice management system vendor
- Forms may be ordered here:
  - 1500form@tfupdate.com (1.800.482.9367, ext. 58029)

Interactive CMS 1500:

Bundling vs. Itemization:

- Bundling vs. itemization
  - Gives the practitioner the option to itemize, for optimum reimbursement
  - Gives the insurance company the option to bundle
  - Gives the patient and the applicable third party payer the mechanism to demonstrate professional value and be paid for professional services that may be otherwise lost
  - Transparency (HLAA)
  - Retail vs. medical model

Bundling vs. Itemization (cont.)

- Bundling
  - One payment, one code
  - Specific amounts and codes are undefined
- Itemization (separates service from product)
  - Itemization of all incurred fees, separately:
    - Hearing aid acquisition(s)
    - Dispensing fee(s)
    - Orientation fee
    - Conformity evaluation
    - Earmold(s)
    - Earmold impression(s)
    - Batteries
    - Extended service or warranty packages
      - Office visits?

I currently bundle my fees

- Yes
- No

Polling Question:

- Do you know what your hourly rate is?
  - 1. Yes
  - 2. No

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
- Don’t make decisions out of fear, but out of a thorough evaluation of what your practice needs to survive
- When to restrict product offerings
- When to refer elsewhere
- Insurance waivers
- Denial and termination processes

Hourly Rate Calculation

- How many hours/week?
  - Direct patient care time
- Weeks/year that services are provided
- Number of providers in the practice
- Multiply the hours/week/year by the number of providers
Hourly Rate Calculation (cont.)

- Calculate operating costs
  - Salary/benefits
  - Overhead
    - Rent, equipment, utilities, marketing, etc.
    - Cost of goods (COG):
      - Hearing aids
      - Ear molds
      - Batteries
      - ALDs
      - Hearing aid accessories

To Determine Break-Even Hourly Rate and Profit Margin

- Total annual expenses – COG ÷ annual contact hours (break-even point)
- Total annual expenses-COG + desired profit ÷ annual contact hours

Next step?

- Assign fees for your procedures based on your hourly rate/profit goal
- Load payor allowables into your management system
  - Compare amounts paid with contracted fees
  - Don’t assume the payor’s amount is correct
- Patients should expect to pay for professional services rendered, if not contractually excluded

Next steps (cont.)

- Medical necessity vs. patient care protocols
- Purchase agreement
  - State licensure law requirements
  - Itemization may not be allowed by state licensure
  - Specific tests (e.g., MCLs, UCLs, bone conduction at 250 Hz) may be required in state licensure law(s) when dispensing amplification

HCPCS Codes

- **Healthcare Common Procedure Coding System (HCPCS)**
- Addresses what CPT did not with:
  - Some services
    - V5010 (Assessment for hearing aid)
    - V5020 (Conformity evaluation)
    - S0618 (Audiometry for hearing aid evaluation to determine the level and degree of hearing loss)
  - Supplies:
    - Hearing aids
    - Dispensing
    - Ear mold (and earmold impression)
    - Batteries
    - Assistive Listening Devices

HCPCS Codes (Procedures)

- V5010 Assessment for hearing aid
- V5011 Fitting/orientation/checking of hearing aid
- V5014 Repair/modification of hearing aid
- V5020 Conformity evaluation
HCPCS Codes (cont.)
- V5030 Hearing aid, monaural, body worn, air conduction
- V5040 Hearing aid, monaural, body worn, bone conduction
- V5050 Hearing aid, monaural, in the ear
- V5060 Hearing aid, monaural, behind the ear
- V5070 Glasses, air conduction
- V5080 Glasses, bone conduction

HCPCS Codes (cont.)
- V5090 Dispensing fee, unspecified hearing aid
- V5095 Semi-implantable middle ear hearing prosthesis
- V5100 Hearing aid, bilateral, body worn
- V5110 Dispensing fee, bilateral
- V5120 Binaural, body
- V5130 Binaural, in the ear
- V5140 Binaural, behind the ear
- V5150 Binaural, glasses
- V5160 Dispensing fee, binaural

HCPCS Codes (cont.)
- V5170 Hearing aid, CROS, in the ear
- V5180 Hearing aid, CROS, behind the ear
- V5190 Hearing aid, CROS, glasses
- V5200 Dispensing fee, CROS
- V5210 Hearing aid, BICROS, in the ear
- V5220 Hearing aid, BICROS, behind the ear
- V5230 Hearing aid, BICROS, glasses
- V5240 Dispensing fee, BICROS

HCPCS Codes (cont.)
- V5241 Dispensing fee, monaural hearing aid, any type
- V5242 Hearing aid, analog, monaural, CIC
- V5243 Hearing aid, analog, monaural, ITC

HCPCS Codes (cont.)
- V5244 Hearing aid, digitally programmable analog, monaural, CIC
- V5245 Hearing aid, digitally programmable analog, monaural, ITC
- V5246 Hearing aid, digitally programmable analog, monaural, ITE
- V5247 Hearing aid, digitally programmable analog, monaural, BTE

HCPCS Codes (cont.)
- V5248 Hearing aid, analog, binaural, CIC
- V5249 Hearing aid, analog, binaural, ITC
- V5250 Hearing aid, digitally programmable analog, binaural, CIC
- V5251 Hearing aid, digitally programmable analog, binaural, ITC
- V5252 Hearing aid, digitally programmable, binaural, ITE
- V5253 Hearing aid, digitally programmable, binaural, BTE
### HCPCS Codes (cont.)

- **V5254** Hearing aid, digital, monaural, CIC
- **V5255** Hearing aid, digital, monaural, ITC
- **V5256** Hearing aid, digital, monaural, ITE
- **V5257** Hearing aid, digital, monaural, BTE

### HCPCS Codes (cont.)

- **V5258** Hearing aid, digital, binaural, CIC
- **V5259** Hearing aid, digital, binaural, ITC
- **V5260** Hearing aid, digital, binaural, ITE
- **V5261** Hearing aid, digital, binaural, BTE

### HCPCS Codes (cont.)

- **V5262** Hearing aid, disposable, any type, monaural
- **V5263** Hearing aid, disposable, any type, binaural
- **V5264** Earmold/insert, not disposable, any type
- **V5265** Earmold/insert, disposable, any type

### HCPCS Codes (cont.)

- **V5266** Battery for use in hearing device
- **V5267** Hearing aid or ALD supplies/accessories, not otherwise specified (1/1/13)
- **V5268** Assistive listening device, telephone amplifier, any type
- **V5269** Assistive listening device, alerting, any type
- **V5270** Assistive listening device, television amplifier, any type

### HCPCS Codes (cont.)

- **V5271** Assistive listening device, television caption decoder
- **V5272** Assistive listening device, TDD
- **V5273** Assistive listening device, for use with cochlear implant
- **V5274** Assistive listening device, not otherwise specified
- **V5275** Ear impression, each

### HCPCS Codes (cont.)

- **V5281** Assistive listening device, personal fm/dm system, monaural, (1 receiver, transmitter, microphone), any type
- **V5282** ALD, personal fm/dm system, binaural (2 receivers, transmitter, microphone), any type
- **V5283** ALD, personal fm/dm neck, loop induction receiver
- **V5284** ALD, personal fm/dm, ear level receiver
### HCPCS Codes (cont.)

- **V5285** ALD, personal fm/dm, direct audio input receiver
- **V5286** ALD, personal blue tooth fm/dm receiver
- **V5287** ALD, personal fm/dm receiver, not otherwise specified
- **V5288** ALD, personal fm/dm transmitter

### HCPCS Codes (cont.)

- **V5289** ALD, personal fm/dm adapter/boot coupling device for receiver, any type
- **V5290** ALD, transmitter microphone, any type
- **V5298** Hearing aid, not otherwise classified
- **V5299** Hearing service, miscellaneous

### Hearing Aid Modifiers

- May be payor dependent
- RT indicates right side (ear)
- LT indicates left side (ear)
- May need to bill monaural codes with modifier for each ear separately instead of binaural codes

### Consideration for itemizing binaural hearing aids

- **S0618** Audiometry for hearing aid examination to determine the level and degree of hearing loss
- **V5010** Assessment for hearing aid
- **92590** Hearing aid examination and selection, monaural
- **92591** Hearing aid examination and selection, binaural

### Monaural BTE (example)

- **92590** (Hearing aid examination and selection, monaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5241** Dispensing fee, monaural hearing aid, any type
- **V5257** Hearing aid, digital, monaural, BTE
- **V5264** Earmold/insert, not disposable, any type (1 unit)
- **V5266** Battery
- **V5275** Earmold impression, each
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

### Binaural BTEs, with earmolds

- **92591** (Hearing aid examination and selection, binaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5160** Dispensing fee, binaural
- **V5261** Hearing aid, digital, binaural, BTE
- **V5264** Earmold/insert, not disposable, any type (This will need to be filed with 2 units for 2 earmolds)
- **V5266** Battery for use in hearing device
- **V5275** Earmold impression, each (This will need to be filed with 2 units for 2 earmold impressions)
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

*For receiver in the canal (RIC) technology, the receiver could be billed as V5267, hearing aid supplies/accessories.*
Binaural Hearing Aids with Payer Required LT/RT modifiers

- 92591 (Hearing aid examination and selection, binaural) or V5010 (Assessment for hearing aid). Your choice of the code may be payer dependent.
- V5011 Fitting/orientation/checking of hearing aid
- V5257-RT Hearing aid, digital, monaural, BTE
- V5257-LT Hearing aid, digital, monaural, BTE
- V5241-RT Dispensing fee, monaural hearing aid, any type
- V5241-LT Dispensing fee, monaural hearing aid, any type
- V5264-RT Earmold/insert, not disposable, any type
- V5264-LT Earmold/insert, not disposable, any type
- V5275-RT Earmold impression, each
- V5275-LT Earmold impression, each
- V5267-RT Hearing aid supplies/accessories, if indicated
- V5267-LT Hearing aid supplies/accessories, if indicated
- V5020-RT Conformity evaluation
- V5020-LT Conformity evaluation
- V5266-RT Battery for use In hearing device
- V5266-LT Battery for use In hearing device

Polling Question:

- I bill a BICROS hearing aid:
  - 1. With the BICROS code(s)
  - 2. With the BICROS and hearing aid code(s)
  - 3. Depends

BICROS (example)

- 92590 (Hearing aid examination and selection, monaural), or V5010 (Assessment for hearing aid). Your choice of the code may be payer dependent.
- V5011 Fitting/orientation/checking of hearing aid
- V5220 Hearing aid, BICROS, behind the ear
- V5240 Dispensing fee, BICROS
- V5266 Battery for use In hearing device
- V5264 Earmold/insert, not disposable, any type (This would be filed with the number of earmolds utilized)
- V5275 Earmold impression, each (This will need to be filed with the number of EMIs taken)
- V5299 Hearing service, miscellaneous (extended warranty packages, for example)

Academy Encounter Form and Guide to the Itemization Your Professional Services


Electronic Health Care Records

- Medicare requires only Eligible Providers (EP) to be in compliance
  - Includes physicians, e-prescribing providers
  - Currently does NOT include audiologists
    - Legislative change will likely result in non-physician compliance
    - If not an EP, not eligible for the incentives
    - Not eligible for the disincentives

Resources

- http://www.audiology.org/practice/reimbursement /medicare/Pages/Medicare_FAQ.aspx
Deadlines for 2014

• October 1, 2014: ICD-10 code system transition date
• December 31, 2014: Must have reported on 2014 PQRS eligible measures to avoid the 2016 2% disincentive
  – Last day to report on a PQRS measure to qualify for the .5% bonus on eligible audiology measures

Future Changes:

• Medicare is moving away from fee-for-service to:
  – Outcome measures
  – Value Based Purchasing
  – Accountable Care Organizations
• CMS Bundled Payments for Care Improvement Initiative
  – Acute hospital stays
• More insured Americans
  – Opportunity: More people being evaluated and treated for hearing and balance disorders

Other concurrent changes for providers, including audiologists...

CMS CPT Bundling

• CMS required those services performed 90% of the time or more on the same date of service (DOS) to be bundled (2010)
• Applied to all professions, not just audiology
  – 92540, 92550 and 92570 (previously 92557 was the only audiology bundled code)
• Bundling decreases reimbursement
  – 92550 reimbursement amount is ~50% of what 92541 + 92542 + 92544 + 92545 is combined

Bundled Payments for Care Improvement (BPCI) Initiative

• CMS will test bundled payments for 48 clinical episodes
• Models/ phases, began 1/31/13
• Diabetes, CHF, COPD, renal failure, etc.
• 4 models of acute care hospital and acute care combos
• Care coordination, lower overall costs
• Bundled payment based on episode of care
• Participants will provide a discount to CMS, providers partner to reduce readmissions, duplicative care and complications

But before going into the details of the Affordable Care Act, let's look at a few applicable trends...
Interesting Facts:

• Currently 91 million Americans have inadequate or no health insurance
  – 51 million have none, 40 million are underinsured
• By 2025, 1 in 5 Americans will be 65 years old or older
  – By 2030, 19.6% will be 65 years old or older
• Approximately one-quarter of Medicare expenditures are for last-year-of-life
• 1 out of 6 Americans are covered by Medicare
• 10% account for 57% of Medicare spending
• By 2024, Medicare Part A Trust Fund is expected to have insufficient funds to pay all hospital bills

Physician Trends…

• Bureau of Labor Statistics reports 25% of physicians are self-employed
  – Physicians employed by hospitals has increased by 32% since 2000 (A. Charles, MD, MPH, UNC)
• AMA projects that 1 in 3 will be a practice owner in 2013
• Physician practices, especially solo practices, are being purchased by:
  – Hospitals
  – Hospital systems
  – Large clinics
  – Creating near monopolies, may have significant bargaining power
• Antitrust issues due to potential market share control
  – Precedent set with an FTC settlement with Renown Health, Reno, NV

Physician Trends (cont.)

– Physician lifestyles, call schedules
– Physician frustration with all third party payors, especially Medicare
  • Opting out
  • Boutique practices
– Shortage of 52,000 primary care physicians by 2025
  • Annual salary ~$212,840, $384,467 specialists (Medical Group Management Association)
– Influx of 27-32 million newly insured under the ACA

Physician Trends (cont.)

• Growing trend is a professional services agreement (PSA)
  – Financial relationship between a physician practice and a hospital; contractual
  – Practice remains autonomous
  – Physicians are compensated by the hospital at fair market value
  – Staff is employed by the hospital
  – Physician compensation is typically based on RVUw and a compensation to RVUw conversion factor

Physicians trends…recent federal survey reveals…

• 96% of physicians accept new patients
• 80% are accepting new Medicare patients
• 31% of physicians do not see new Medicaid patients
  – 69% accept new Medicaid patients, especially in Wyoming
• ACA provision increases Medicaid payment for PCPs in 2013 and 2014
• 2013 Medicare Physician Fee Schedule will provide an uptick in payment for PCPs
• Some physicians are seeing more than 1 patient/visit: 3’s a crowd
Audiology Trends?

The Shifting Sands of Audiology Practices

- Audiology practices, especially solo practices, are being purchased by:
  - Large practice management entities (e.g., Audigy, Sonus (franchise owners), others)
  - Timing is critical
    - Many owners are retiring
    - The number entering the profession is insufficient to fill the positions available
    - Increase of those needing audiologic services

Considerations for Audiology:

- More baby boomers into the health care system
- More (insured) beneficiaries into the system
- More commercial payors offering a hearing aid "benefit"
- Tax break for practice owners providing health insurance for employees for those < 25 employees and average wage up to $50,000
- Potential penalties for practice owners with at least 50 FTEs

Changes Due to the ACA (2010)
Supreme Court Ruling: 6/29/12


- Guarantees quality affordable health insurance to virtually all U.S. citizens (or pay a penalty)
  - ACA prohibits insurance companies from denying pre-existing conditions and paying more for coverage
  - By October 1, 2013, states are to have exchanges in place; open enrollment; 26 don't, HHS steps in
  - By 2016, 32 million are expected to have health care coverage, if most states proceed with Medicaid expansion
  - By 2019, 23 million are expected to remain uninsured

Changes (cont.)

- This reform will touch nearly every American, either as a business or as a consumer
- "Applicable large employers" (those with > 50 at 30 hrs/week) must provide minimum essential coverage to FTEs or face a penalty on the number of FTEs
  - While PT employees are figured into the mix, will not be penalized for not providing coverage for PT employees
- Starting in 2014, the Individual Shared Responsibility provision calls for each individual to either have:
  - Minimum essential health coverage for each month
  - Qualify for an exemption, or
  - Make a payment when filing his or her federal income tax return
By 2014, will be able to purchase private health insurance through competitive marketplaces (exchanges) for essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity/newborn care
- Prescription drugs
- Mental health/substance abuse, including tx
- (Re)habilitative svs and devices
- Laboratory services
- Preventative/wellness and chronic disease management
- Pediatric services, including vision/oral care

Changes (cont.)

- As a small business employer (<25 FTEs), tax credit could save you $$$
  - Was 35% for 2010-13, is 50% for 2014 for those who pay ½ of single coverage for their employees
- Play or pay? (1/1/14)
  - Those who pay will not offer coverage and will be subject to a $2,000/employee/year tax – 30 if one FTE is eligible for a tax credit or coverage through the state based exchange
  - May have to pay if the plan falls short of the law’s requirements
  - May have to pay a penalty: $3,000/year tax/per FTE, up to a max of $2000 X the # of FTEs-30
  - Penalty increased annually by growth in premiums
- Independent contractors or job sharing opportunities? Change complexion?

Changes (cont.)

- Wellness program
  - Participatory wellness
  - Health contingent wellness
  - Rewards for normal status
- In 2018, “Cadillac Tax” will be effective
  - Large excise taxes when a plan’s premium costs exceed a certain threshold
  - Employers will need to reduce risk in the plan by enhancing the health profiles of employees
  - U.S. Department of Labor is reviewing plans, ensuring compliance with ACA
    - Epstein, Becker and Green, 2013

Changes Due to the ACA (cont.)

- Individuals earning > $200,000, married couples earning > $250,000 will pay 0.9% additional payroll tax
- $2500 limit on flexible spending accounts for 2013 (IRS)
- New federal money for Medicaid
  - States will be allowed to make the rules
- As of October, 2012, Medicare rewards hospitals for quality care
  - Quality vs. quantity
  - The > the cost reduction + quality improvements, * $$$
  - Up to $10 billion dollars in savings to Medicare
- Accountable Care Organizations (ACOs)
  - Medicare shared savings program (MSSP) which encourages ACOs to facilitate cooperation among providers for improving quality and reducing costs

Considerations

- Let’s look at the facts as of 2/22/14:
  - Affordable Care Act (2010)
    - Accountable Care Organizations (ACOs)
    - Cost sharing/risk taking
    - Medicare’s recognition of wellness
      - Initial Preventative Physical Examination (IPPE)
      - Annual Wellness Visit (AWV)
      - Questionnaire on HL (HII-E)
      - Questionnaire on dizziness (DHI)
  - Due to ACA, 71 million Americans received coverage for at least 1 free preventative service in 2011 and 2012 via their private plan
  - Unknown initiatives with unknown ramifications
  - Ordering and referring physicians are required to be enrolled in the Provider Enrollment, Chain Ownership System (PECOS)
**Facts (cont.)**

- PQRS
  - A tasting menu of the future?
- Health care to transition to a patient centric model
- Care coordination
  - CMS has several initiatives to incentivize/promote, not including PQRS
  - Medical home models
- Value based, outcome based, function based
- Medicaid expansion programs

**More…**

- Health insurance exchanges-2014
  - Buyers of health insurance, offering choices and more control, consumer education
  - Medical centers are increasing their financial counseling staffs on definitions, options, network rules, co-pays, etc.
  - Open enrollment ends 3/31/14; for 2015: 11/15/14-1/15/15
  - Will be a web portal, Options Finders
    - Help consumers to navigate health insurance options
      - Includes plan names, types, deductibles, premiums, benefits, providers, ability to compare plans

**ACA (cont.)**

- Actuarial value (AV)
  - Percentage of total average costs for covered benefits that plan will cover
  - “Metal levels” allow comparison
    - 60% bronze plan (patient responsible for ~ 40%)
    - 70% silver plan (~30%)
    - 80% gold plan (~20%)
    - 90% platinum plan (~10%)

**We will need to be agents of change, not victims of change…**

- Accountable Care Organizations (ACOs)
  - 106 ACOs/4 million Medicare beneficiaries have access
  - Can choose providers in or out of the ACO
  - ACOs share savings with Medicare
  - Lower growth in costs while meeting standards for quality care
    - Includes quality care coordination/safety/preventative health services
- Hospital purchases of private practices
- Hospital mergers
- Medical Home
  - Primary care delivery for access, care, prevention, quality and safety

**Medicare Advantage Upgrades-ACA proviso**

- Medicare Advantage Plans are rated for quality (1-5 stars)
  - 1 is the worst, 5 the best
  - Gold star icon for the top rated 5 star plans
  - Different stars for poor performers
- 127 four or five star MA plans
- Those in a *** for < x 3 years can upgrade to a ****

**Agents of Change (cont.)**

- Telehealth
- Outcome measures
- Best practices
- Electronic Health Records (EHR)
  - HHS goal for 2013: 50% of physician offices should have EHR
  - Blue Button Initiative-beneficiaries accessing medical record online
  - Meaningful use
  - Communication between systems
Electronic Health Care Records

- Medicare requires only Eligible Providers (EP) to be in compliance
  - Includes physicians, e-prescribing providers
  - Currently does NOT include audiologists, but it may sooner than later...
  - If not an EP, not eligible for the incentives
  - Not eligible for the disincentives

More facts to consider...

- Number of people without health insurance has declined by 1.3 million from 2010 to 2011 (now 48.6 million)
- The decade before, it had increased by 12 million!
- For job-based family health plans, only a 4% increase this year
  - Was a 9% increase last year, 7% expected for 2013
  - Annual premium averaged $15,745
    - USA Today, 9/11/12
  - Still continues to rise faster than overall inflation
  - Estimated that about $.30/dollar is spent on unnecessary paperwork, procedures, fraud

More considerations:

- Many patients have very high deductibles ($5000/year)
  - Leaves less money for care (e.g., hearing aids)
  - High deductibles have increased 18% between 2011 and 2012
- Retail clinics are growing in popularity
  - Has doubled every year between 2007-9
    - 1.5 million in 2007 to 6 million in 2009

Changes as a result of the ACA (cont.)

- Those patients who are at 100-133% of the Federal Poverty Level are to be eligible for Medicaid
- Less government support for previously uncompensated care
- Fraud and abuse initiatives
- Medicare revalidation
  - Contractors are sending re-enrollment forms in colored envelopes
    - Must return within 60 days or risk deactivation

Changes as a result of the 2010 Affordable Care Act (cont.)

- Nearly all Americans must obtain qualified health insurance by 2014 or pay a penalty (tax)
  - In 2018, an excise tax on high-value health plans
    - Likely will need to prove on your tax returns
      » is the IRS capable to do this with tax collection?
    - Tax breaks and incentives expected
  - Decrease of uninsured by more than 20-30 million
    - Because more very poor, those older than 65 and more being covered until the age of 26, rate of uninsured decreased from 16.3% in 2010 to 15.7% in 2011
    - Affect on hospital emergency departments? Nursing home shortages?

Changes As A Result of the ACA

- Need for staff resources will increase
- Reimbursement likely to continue to decrease
  - Commercial payors adopting Medicare rates
    - More patients at risk for higher deductibles, balances
- Home based care may increase
More facts to consider...

- Escalating costs of health care
- World Health Organization (WHO) has rated the United States 37th in world performance measures
- We have one of the highest rates of health care expenditures in the world
- How can this not implode?

Outcome Measures

- We don’t have any
- We’d better get some
  - Working on it
- Physician Quality Reporting Systems (PQRS)
  - Glimpse of the future?
  - Incentive now, disincentive later
  - Now better than later

Outcome measures

- Physician Quality Reporting Systems
  - Was voluntary, but...
  - If you don’t report in 2014, you will be penalized 2% on each Part B Medicare claim in 2016
  - No announcement as to non-reporting in 2015 and claims paid in 2017

Buzzwords: Value-Based Purchasing

- Required by the 2010 Affordable Care Act
- CMS is moving away from fee-for-service
- Currently is hospital based; transition to office settings?
- Goals:
  - Improve clinical quality and reduce costs
  - Encourage patient centric care
  - Encourage appropriate use of service
  - Allow for performance results to be viewed/analyzed by consumers; increased transparency

Changes Due to the ACA

- Value Based Purchasing
  - Payment based on quality, not quantity
  - Hospitals are being rolled out first
  - Goals support Partnership for Patients
  - Increase safety, reduce adverse effects
  - Will be needing a modifier by 2017; may be payment ↓
  - Payment adjustments based on cost/quality; budget neutral
  - Public-private partnership designed to save $5 and improve quality, safety and affordability
    - Potential to save $35 billion in health care costs
    - Increase patient safety, reduce adverse effects
    - Committed to prevent patients from becoming injured/ill and improving the transitions between care settings

Value Based Purchasing (cont.)

- Provides VB incentive payments beginning in 2013
  - DRGs will be reduced due to budget neutrality (2013-17)
- VM to assess quality and cost of care provided
- A Value Based modifier (VM) is to begin in 2015, with phase-in complete by 2017 that have more than 25 members
  - <25 are exempt for 2015 requirement
VBM (cont.)

- For groups with ≥ 25 eligible professionals in 2013
  - If non-satisfactorily PQRS reporters, will sustain a 1% decrease in 2015
  - If satisfactorily PQRS reporting, will not be a decrease or increase in 2015
    • If perform poorly, may be a 1.0% reduction
- Likely to be for:
  - Acute (UTI, dehydration, bacterial pneumonia)
  - Chronic (COPD, heart failure, diabetes)

VBM (cont.)

- After 2017, all eligible providers may be required to use VBMs
  - Audiologists are included in this list of eligible providers

Changes Due to the ACA--ACO’s

- Accountable Care Organizations (ACO)
  - CMS is driving a 4 agency initiative in order to bring high quality, low cost care to Medicare beneficiaries across care settings
    • Offices
    • Hospitals
    • Long-term care facilities
  - Patient centered, team approach in order to bridge the gap in the current fragmented system
  - Anticipated to save $960 million over 3 years
  - Began to operate on January 1, 2012

Changes Due to the ACA

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Jackson Healthcare survey data revealed 74% of 2500 physicians will not be joining an ACO in 2012
  • Hospital based physicians more likely to participate
- Partnerships or joint venture arrangements between hospitals and ACO professionals
  • Hospitals employing ACO professionals
- Other Medicare providers/suppliers determined by the Secretary
  • As of 11/12, 150+ Medicare and 150+ commercial ACOs

Changes Due to ACA

- CMS will develop an individual ACO benchmark to compare to ACO performance
  - Determine if you receive shared savings
  - Determine if you are held accountable for any losses
  - Minimum sharing rate to account for normal variations in health care spending
  - ACO would be entitled to shared savings only when those savings exceeded the minimum sharing rate, depending on whether that ACO meets or exceeds quality performance standards

ACO’s (cont.)

- Recent survey conducted by LocumTennens.com noted that 40% of physicians surveyed are not willing to participate in an ACO
AMA CPT code

- Effective 1/1/13, new CPT code for care coordination for those patients with complicated, ongoing health issues who receive care within an ACO

Changes Due to the ACA (cont.)

- Fraud and abuse-program integrity (top priority)
- Fraud (unnecessary services, no documentation, ineligible pts)
  - $48 billion (9.4%) of total improper pmts to Medicare
  - Integrity efforts expected to save $32.3 billion over the next 10 years
- More than $4 billion recovered in 2010
- More than $4.1 billion in taxpayer dollars in FY2011
- More than $4.2 billion in taxpayer dollars in FY2012
- $100 billion each year in Medicaid fraud!
  - Also moving from fee-for-service to a managed care model
    - Filing claims timeline
    - Revalidation
    - Overpayments

False Claims Act

- Criminal offense to submit a false claim to the government
  - Intent is not required, whistleblower provision
- Civil penalty
- Penalty: Fines up to 3 times the loss + $11,000/claim (each item is a claim!)
- Offenses:
  - Submitting a claim for services not rendered
  - Submitting a claim for services not medically necessary
  - Not billing with the appropriate provider number
  - Falsifying a diagnosis
  - Upcoding
  - Unbundling a bundled code (92557, 92540, 92550 and 92570)

Changes Due to ACA

- Referring/ordering physicians must be enrolled in the Provider Enrollment Chain, Access System (PECOS) by May 1, 2013 or claims will be denied
- Overpayments payback in 60 days or else...

Incidentally...

- Senior Medicare Patrons (SMP)
  - 18 states with high fraud rates
    - $9 million awarded for volunteer efforts and outreach
- HEAT (Health Care Fraud Prevention and Enforcement Action Team)-2009
  - HHS + DOJ
    - Strikeforce operations in 9 "hot spots":
      - Miami, LA, Houston, Detroit, Brooklyn, Baton Rouge, Tampa, Chicago, Dallas
    - 270 convictions with > $240 million in fines, penalties, paybacks
Medicare Fraud Strike Force

- On 9/7/11, 91 defendants in 8 cities were involved in approximately $295 million in false billing and...
  - Conspiracy to defraud Medicare
  - For treatments that were medically unnecessary
  - Health care fraud
  - AKS violations
  - Money laundering
  - Included physicians, nurses, other providers
- 5/12: 107 providers 7 cities-highest # of false billings to date
- 10/12: 91 providers in 7 cities
- Automated Provider Screening system has rendered 150,000 providers ineligible and eliminated

Changes Due to the ACA

- 4 agencies, including Medicare are involved in enforcement:
  - Department of Justice and Federal Trade Commission
  - Antitrust
  - Office of the Inspector General
  - Fraud and abuse
  - Self-referral, AKS
  - Internal Revenue Service
  - Tax exempt organizations

Bottom line?

- Health care providers need to change practice methodologies
  - Being done for us
- It’s not about the test, it’s about the patient
- Outcome measures
- Payment methodologies

Considerations for the Future Landscape

- Office efficiencies
  - Monthly review of accounts receivable
  - Check your payor mix
  - Patients who are "on the books" for months
  - Policy on bad debt
  - Farm out extended payment options
- Cost cutting
- Price increases
- Review third party payor contracts annually
  - May need to negotiate new fee schedules
  - Discounts with manufacturers
  - Your negotiations
  - Buying groups

Changing Landscape (cont.)

- Consider providing niche services:
  - Tinnitus treatment
  - Vestibular rehabilitation
  - Central auditory processing diagnostics and treatment
  - Assistive listening devices
  - Support staff
    - Audiology aides/assistance, if recognized by state licensure

The Near Future...

- Physician Quality Reporting System (PQRS)
  - No time like the present…the future is costly
- ICD-10 coding system—10/1/14
- Fee For Service?
  - Value Based Purchasing required by ACA
  - "moving away from being a passive payor…to a purchaser of higher quality, affordable care…”
  - Hospitals first, then physicians, Skilled Nursing Facilities
  - Diagnostic Related Groups for non-hospital applications
  - Bundling bundling
Thank you!

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