AGENDA

- Reimbursement basics –
  - Coding
  - Coverage
  - Payment
- 2013 Medicare Reimbursement rates for bone anchored hearing systems

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What is Reimbursement….

- **Coding:**
  - Services, Devices, Drugs, etc
  - Patient's Diagnosis
- **Coverage:**
  - Contract/Policy Provisions – specific exclusions and limitations
  - Medical Necessity – clinical coverage guidelines
- **Payment:**
  - Various Methodologies

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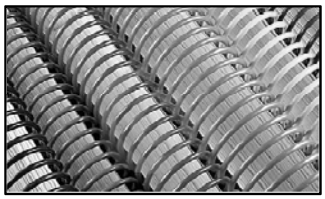
CODING



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Applicable Coding Systems

Coding System	Used to Describe
CPT	Describes medical, surgical, and diagnostic services
HCPCS	Products, supplies, drugs, and DME
ICD-9-CM Diagnosis	Patient's primary, secondary, etc. diagnosis that prompted the treatment/visit

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CPT®

- Current Procedural Terminology
- CPT® is registered trademark of the American Medical Association (AMA)
- Listing of codes and descriptive terms for reporting medical services and procedures
- Level I HCPCS codes
- 5 numeric digits

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Applicable Surgical CPT® Codes

CPT Code	Description
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715	... with mastoidectomy
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	... with mastoidectomy
69399	Unlisted procedure external ear

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HCPCS

- Healthcare Common Procedure Coding System
- The HCPCS is divided into two sub-systems:
  - Level I (CPT® codes)
  - Level II (commonly referred to as "HCPCS codes")
- HCPCS codes (Level II) are developed and maintained by The Centers for Medicare & Medicaid Services (CMS)
- HCPCS codes (Level II) are used primarily to identify products, supplies, and services not included in the CPT® codes
- Alpha-numeric with one letter followed by four digits

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Applicable HCPCS

HCPCS	Description
L8690	Auditory osseointegrated device, includes all internal and external components **(Implant, Abutment and Sound Processor)**
L8691	Auditory osseointegrated device, external sound processor, replacement **(Replacement processor)**
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment **(Softband and Sound Processor)**
L8693	Auditory osseointegrated device abutment, any length, replacement only **(Replacement abutment)**

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L8690

L8691

L8692

L8693

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ICD

- International Classification of Diseases (ICD) code sets
  - Currently*: International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
    - Based on the World Health Organization's Ninth Revision, International Classification of Diseases
- Used to identify/report patient diagnoses and inpatient procedures
- The National Center for Health Statistics (NCHS) and CMS are the U.S. gov agencies responsible for changes and modifications

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ICD-9 Diagnosis Codes – sample list of applicable codes

388.2	Unspecified sudden hearing loss
388.5	Disorders of acoustic nerve
389.0	Conductive hearing loss
389.00	Unspecified conductive hearing loss
389.01	Conductive hearing loss, external ear
389.05	Conductive hearing loss, unilateral
389.06	Conductive hearing loss, bilateral
389.08	Conductive hearing loss of combined types
744.0	Congenital anomalies of ear causing impairment of hearing
744.00	Unspecified congenital anomaly of ear causing impairment of hearing
744.01	Congenital absence of external ear causing impairment of hearing
744.02	Other congenital anomaly of external ear causing impairment of hearing
744.03	Congenital anomaly of middle ear, except ossicles, causing impairment of hearing
744.09	Other congenital anomalies of ear causing impairment of hearing
744.23	Microtia

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*Transition of ICD-9 to ICD-10

- **ICD-9 codes** *(numeric 3 to 5 digits)* ➡ 17,000 codes
- **ICD-10 codes** (*alpha-numeric 3 to 7 characters)* ➡ 141,000 codes approx.
  - **ICD-10-CM** (diagnosis)
  - **ICD-10-PCS** (inpatient procedure)
- More specific ICD-10 codes means many ICD-9 codes will now map to multiple ICD-10 codes

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*Transition of ICD-9 to ICD-10

- REQUIRED!! Everyone covered by the Health Insurance Portability Accountability Act (HIPAA)
- CMS set implementation date as October 1, 2014
  - Claims for date of service on or after the compliance deadline must use ICD- 10 diagnosis and inpatient procedure codes
  - General Equivalence Mappings (GEMs) avail on CMS site

CMS website:
http://cms.gov/Medicare/Coding/ICD10/index.html

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Coding ✓

Coverage ☐

Payment ☐

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COVERAGE

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Coverage

- The circumstances under which a payer will reimburse a provider for services, procedures, devices, drugs etc…
- Coverage decisions are based on:
  - Contract Provisions
  - Medical Necessity

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Coverage

- Outlined in the member's Certificate of Coverage
- Specific exclusions from benefits – i.e. cosmetic surgery
- Specific riders for additional benefits – i.e. hearing aid coverage
- Coverage Policies - meet certain clinical/medical requirements
- Can vary by payer and by the plans offered by the same payer (employer plans, individual plans, HMOs, PPOs, etc.)

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Coverage

What is Medical Necessity?

- Coverage Policies - meet certain clinical/medical requirements for either diagnosis or treatment of a medical condition
  - Particular diagnosis
  - Test Results
- Must meet accepted standards of medical practice
  - Not considered experimental or investigational
- "Reasonable & necessary"

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Coverage – Medicare

- **Benefit Policy Manual - Chapter 16 - General Exclusions From Coverage**
  - No payment may be made for expenses incurred for hearing aids
- November 2005: CMS modified the "hearing aid" definition to exclude certain implanted devices from the category of "hearing aid"
- Osseointegrated implants are prosthetics

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Coverage – Medicare

Defined in Medicare's hearing aid definition:

- *"….Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve are payable by Medicare as prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss, or surgery…."*

Found at: **Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage**
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf

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Coverage - Medicare

"…The following are prosthetic devices:

- *Cochlear implants and auditory brainstem implants; that is, devices that replace the function of cochlear structures or auditory nerves and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays.*
- *Osseointegrated implants; that is, devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer."*

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Replacement Sound Processor Coverage - Medicare

- Loss
- Irreparable damage
  - Specific accident or natural disaster (like a flood)
- Irreparable wear
  - Deterioration sustained from day-to-day usage over time
  - Reasonable Useful Lifetime - 5 yrs
  - During the reasonable lifetime Medicare will cover the repair of the device
- Change in the patient's condition
  - Medical documentation

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Coverage - Medicaid

- Funded jointly by the state & federal gov.
- Managed by the states
- Variations in coverage

Coverage - Medicaid

Medicaid Coverage Scenarios:

- Surgery & device
- Surgery, not device (confusing!)
- Softband and sound processor as a hearing aid
  - Sometimes due to state mandates for ha coverage
- Age restrictions for both treatment methods

Coding ✓
Coverage ✓
Payment ☐

PAYMENT

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Payment

- The $$$ amount paid to health care professionals or facilities for the provision of services
- Methodologies vary
- Like contract terms & conditions – payment is negotiable w/ private payers

- Importance of evaluating costs v. reimbursement rates during contract negotiation

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Payment - Medicare

- **Fee Schedule:**
  - Listing of fees used by Medicare to pay doctors or other providers/suppliers
  - Fee for Service
- **Prospective Payment System:**
  - Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount
  - Payment amount is based on the classification system of that service - - like APC or DRG

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Payment - Medicare Payment Methodologies

Physician	Medicare Physician Fee Schedule
Hospital Outpt	Outpatient Prospective Payment System or OPPS Ambulatory Payment Classifications or APCs
Ambulatory Surgery Ctr	Ambulatory Surgical Center System
Hospital Inpt	Inpatient Prospective Payment System or IPPS Diagnosis Related Groupings or DRGs

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Medicare Physician Fee Schedule

	2013 Nat'l Payment Amount
69714	$ 1,109.15
69715	$ 1,362.62
69717	$ 1,161.89
69718	$ 1,376.57

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Medicare Physician Fee Schedule

Fee Schedule Look-Up:

Found at: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

- Search:
  - Pricing
  - National payment amount
  - Specific Carrier/Medicare Administrative Contractor (MAC)
  - Specific Carrier/Medicare Administrative Carrier (MAC) locality
  - Single, List or Range of codes
  - Modifiers

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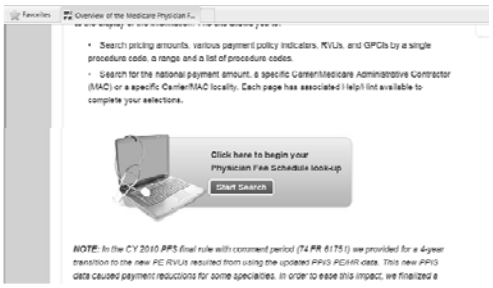
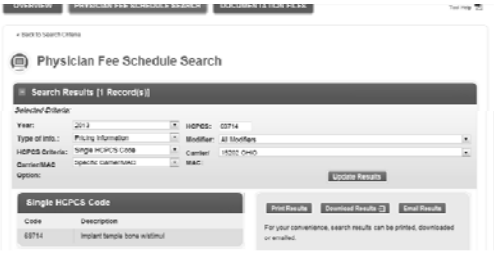
Medicare Physician Fee Schedule



Medicare Physician Fee Schedule



Medicare Physician Fee Schedule

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Medicare Physician Fee Schedule

Look up carrier via the Zip Code to Carrier Locality File found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html

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Medicare – Hospital Outpt

Ambulatory Payment Classifications or APCs

- Hospital Outpatient Prospective Payment System (HOPPS)
- Services in each APC are similar clinically and in terms of the resources they require
- A payment rate is established for each APC
- CPT codes map to APC

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Medicare – Hospital Outpt

APC includes:

- Inexpensive drugs
- Med/Surg supplies
- Recovery Room
- Costs to procure donor tissue (execpt corneal tissue)
- Anesthesia
- IV Therapy
- Facilities are required to bill for services (above) but receive no payment

CMS may make changes to APCs and OPPS quarterly. Significant changes made at the start of each calendar year.

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Medicare – Hospital Outpt

69714 - 69718 map to APC 425

Effective 2013 National Average Payment for APC 425 is **$9,601.88***

Surgery and Device

*Found at: Addendum A.-Final OPPS APCs for CY 2013 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/January-2013-addendum-A.html

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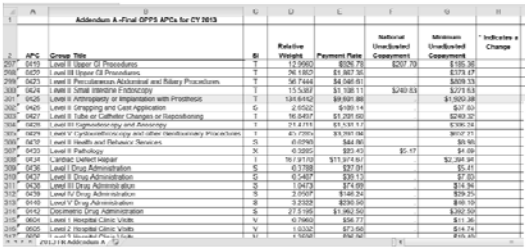
Medicare – Hospital Outpt



	A	B	C	D	E	F	G	H
1	Addendum A.-Final OPPS APCs for CY 2013							
2	APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
207	0419	Level II Upper GI Procedures	T	12.9660	$926.73	$207.70	$185.36	
208	0420	Level III Upper GI Procedures	T	56.1803	$4,017.35		$373.47	
209	0421	Level II Percutaneous Abdominal and Biliary Procedures	T	56.7444	$4,057.81		$809.53	
338	0424	Level II Small Intestine Endoscopy	T	15.5387	$1,108.11	$240.83	$273.63	
301	0425	Level II Arthroplasty or Implantation with Prosthesis	T	134.6452	$9,601.88		$1,920.38	
302	0426	Level II Grepping and Cast Application	G	2.0522	$180.14		$37.50	
303	0427	Level II Tube or Catheter Changes or Repositioning	T	16.8497	$1,201.60		$240.32	
304	0428	Level III Cystourethroscopy and Urodynamics	T	21.4715	$1,531.17		$306.24	
305	0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	45.7395	$3,261.94		$652.31	
306	0430	Level II Health and Behavior Services	S	0.0795	$44.06		$8.96	
307	0433	Level II Pathology	X	0.5665	$23.43	$5.17	$4.69	
308	0434	Cardiac Defect Repair	T	76.7170	$11,974.67		$2,394.94	
309	0436	Level I Drug Administration	S	0.1788	$27.91		$5.61	
310	0437	Level II Drug Administration	S	0.1457	$39.13		$7.83	
311	0438	Level III Drug Administration	S	1.0473	$74.69		$14.94	
312	0439	Level IV Drug Administration	S	3.0907	$146.24		$29.25	
313	0440	Level V Drug Administration	S	3.3325	$230.90		$46.18	
314	0442	Osteomeng Drug Administration	S	27.5195	$1,962.50		$392.50	
315	0604	Level 1 Hospital Clinic Visits	V	0.7960	$56.77		$11.36	
316	0605	Level 2 Hospital Clinic Visits	V	1.0332	$73.66		$14.74	
317	0606	Level 3 Hospital Clinic Visits	V	1.5058	$107.37		$21.48	
318		2013 FR Addendum A						

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Medicare – Ambulatory Surgery Ctr

- **ASC:**
  - A distinct entity established exclusively for outpatient surgical services
  - Certified to be a Medicare provider
  - Expanded list of services that can be done in an ASC (safety risks and medical monitoring)
- Payment
  - Based on the cpt code
  - Less than outpatient hospital site of service

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Medicare – Ambulatory Surgery Ctr

Effective 2013 **69714 - 69718** are reimbursed $**7,888.90***
in an ASC.

Surgery and Device

*Found at: Addendum AA -- Final ASC Covered Surgical Procedures for CY 2013 (Including Surgical Procedures for Which Payment is Packaged) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html

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Medicare – Ambulatory Surgery Ctr

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2013 (Including Surgical Procedures for Which Payment is Packaged) to Reflect Revised Payment Rates Based on Changes to the Medicare Physician Fee Schedule Created by the American Taxpayer Relief Act of 2012

CPT codes and descriptions only are copyright 2011 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2011/12 American Dental Association. All Rights Reserved.

	HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	Jan 2013 Payment Indicator	Jan 2013 Payment Weight	Jan 2013 Payment Rate
3601	69714	Implant temple bone w/stimul	Y	J8	183.8176	$7,888.90
3602	69715	Temple bne implnt w/stimulat	Y	J8	183.8176	$7,888.90
3603	69717	Temple bone implant revision	Y	J8	183.8176	$7,888.90
3604	69718	Revisc temple bone implant	Y	J8	183.8176	$7,888.90
3605	69720	Release facial nerve	Y	A2	42.8706	$1,839.88
3606	69740	Repair facial nerve	Y	A2	42.8706	$1,839.88
3607	69745	Renair facial nerve	Y	A2	42.8706	$1,839.88

Jan 2013 ASC AA | Jan 2013 ASC 00 | Jan 2013 ASC 0108 | Jan 2013 ASC 0102 | Jan 2013 ASC EE

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Medicare – Durable Medical Equipment

- CMS publishes Floor and Ceiling Rates and State rates

	Floor	Ceiling
L8691	$2,229.00	$2,972.00
L8692	Non-Covered by Medicare	
L8693	$1,267.52	$1,690.03

Found at: DMEPOS Fee Schedules http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

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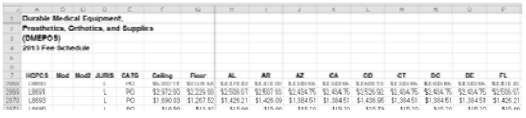
Medicare – Durable Medical Equipment


Durable Medical Equipment,
Prosthetics, Orthotics, and Supplies
(DMEPOS)
2013 Fee Schedule

HCPCS	Mod	Mod2	JURIS	CATG	Ceiling	Floor
L8691			L	PO	$2,972.00	$2,229.00
L8692			L	PO	$1,690.03	$1,267.52

Jurisdiction: "L" = Local Part B Carrier jurisdiction
Category: "PO" = Prosthetics & Orthotics

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Medicare – find your local contacts

Provider Compliance Group Interactive Map

- Allows you to access state-specific CMS contractor contact information

Found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html#ks

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Coding
Coverage
Payment

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We've identified a patient – what next?

- Request benefit/coverage for specific codes
  - Benefits can vary for in-network v. out-of-network providers
- Provide required medical necessity documentation and verify coverage
- Understand the payment methodology and amount
- Is an pre-authorization or pre-certification required?
  - Clarify that procedure
- Document! Document! Document!
  - Contact person
  - Date/time
  - Summary of the conversation
  - Any reference numbers specific to the call

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Oticon Medical Insurance Support

Assistance with the process of determining coverage and obtaining necessary pre-authorizations

Oticon Medical Insurance Support specialists

Oticon Medical
580 Howard Avenue
Somerset, New Jersey 08873
Phone: 1-888-277-8014
Fax: 1-732-868-6949

- Oticon Medical is now a Medicare Durable Medical Equipment provider

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QUESTIONS?

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