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The Essentials of Audiology Item and Service Coding: CPT, Modifiers, Place of Service and HCPCS

AudiologyOnline 2015

CPT Basics

- CPT is the acronym for Current Procedural Terminology.
- CPT is a listing of codes and their descriptions that outline medical services and procedures.
- CPTs are added, deleted, and modified annually (first Monday in November) by their creator, the American Medical Association.
- As of October 2003, HIPAA requires that all insurance carriers, including Medicare and Medicaid, use CPT codes.
- CPTs are five digit, numeric codes. Most codes that apply to audiology begin with the numbers 92xxx.
- Audiology can be involved in this code creation through ASHA and AAA.

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Vestibular Testing: Without Recording

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

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Vestibular Testing: With Recording

- 92540: Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording
- 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
- 92544: Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
- 92545: Oscillating tracking test, with recording

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Vestibular Testing: 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

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Audiology Codes

- 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
- 92557: Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

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Audiology Codes

- 92562: Loudness balance test, alternate binaural or monaural
- 92563: Tone decay test
- 92564: Short increment sensitivity index (SISI)
- 92565: Stenger test, pure tone
- 92577: Stenger test, speech

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Immittance Codes

- 92550: Tympanometry and reflex threshold measurements
- 92567: Tympanometry (impedance testing)
- 92568: Acoustic reflex testing, threshold
- 92570: Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
  - Reflex thresholds should be established both ipsilateral and contralateral test conditions at at least three frequencies

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CAPD Codes

92620: Evaluation of central auditory function, with report; initial 60 minutes

92621: Evaluation of central auditory function, with report; each additional 15 minutes

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CAPD Codes

- 92571: Filtered speech test
- 92572: Staggered spondaic word test
- 92575: Sensorineural acuity level test
  - In some PQRS measures
- 92576: Synthetic sentence identification test

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Pediatric Codes

- 92579: Visual reinforcement audiometry (VRA)
  - "Is a test technique that can be performed using either loudspeakers or earphones, which uses flashing lights, moving toys, or video to reinforce a head-turn response to sound stimuli, and it may be used with either tonal or speech stimuli"
- 92582: Conditioning play audiometry
  - "Is a test technique in which the patient is taught a game that requires a response to tonal stimuli. A variety of play responses can be used with CPA, such as dropping a toy in a container or putting pegs in a board. It is typically done using earphones."
- 92583: Select picture audiometry

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Evoked Potential Codes

- 92516: Facial nerve function studies (e.g. ENoG)
- 92584: Electrocochleography (e.g. ECoG) or for CI NRT
- 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

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OAE Codes

- 92558: Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis
- 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
- 92588: Comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

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Hearing Aid Codes

- 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
- 92595: Electroacoustic evaluation for hearing aid; binaural

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Cochlear Implant Codes

- 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
- 92603: Diagnostic analysis of cochlear implant, age 7 years or older; with programming
- 92604: Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming

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Audiology Codes

- 92596: Ear protector attenuation measurements
- 92625: Assessment of tinnitus (includes pitch, loudness matching, and masking)
- 92626: Evaluation of auditory rehabilitation status; first hour
- 92627: Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)
- 92630: Auditory rehabilitation; prelingual hearing loss
- 92633: Auditory rehabilitation; postlingual hearing loss
- 92640: Diagnostic analysis with programming of auditory brainstem implant, per hour

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Other Audiology Related Codes

- 69210: Removal impacted cerumen, with instrumentation, unilateral
  - Technically, a surgical code
  - While can be billed as two units or with -50 modifier, it typically only is reimbursed as one unit
- 95992: Canalith repositioning procedure(s), per day

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Other Audiology Related Codes

- 99366: Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more, participation by non-qualified health care professional
- 99368: Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more, participation by non-qualified health care professional

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Use of 92700

- To classify procedures that do not have CPT codes
- Individually reviewed
- ABN required
- If reporting 92700, submit report with:
  - Copy of Patient Report
  - Description of procedure
  - Clinical Utility of the Procedure
  - Time
  - Skills of Tester
  - Equipment used
  - Benefit to patient
  - Usual and Customary Fee

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Common Uses of 92700

- VEMPs
- High-frequency audiometry
- Audiometric Weber
- Eustachian tube function testing
- ASSR
- Middle/late latency response
- Use of goggles
- Saccade testing
- Sensory organization test
- Head shake testing
- Speech in noise testing
- Tinnitus management
- Removal of incidental cerumen
- Fistula testing

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CPT Tips

- Always have the coding legitimately represent all of the procedures that were completed on each individual patient on a given date of service.
- Make sure you are using the most up to date codes.
- Make sure you have a 2013 or newer CPT Manual in your office.
  - Will need a 2016 manual
- It is legitimate to bill for attempted procedures with the appropriate documentation.
- Use modifiers when needed.

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Modifiers

- -22: Increased procedural service
  - Some examples to consider are middle and late latency response ABR, high frequency audiometry
  - Could select 92700 instead
- -32: Mandated Service
- -33: Preventative service
  - When billing for follow-up newborn hearing screening only

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Modifiers

- -50: Bilateral Procedure
  - Could use with 92601-92604
- -52: Reduced service
  - Only tested one ear
  - Did not meet all of the components of a code

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-59 Modifier

- The -59 modifier is used in situations where you are providing aspects of a bundled code, such as 92557 or 92540.
- Many may have seen mention of the new modifiers that could replace the -59 modifier.
  - These new X- modifiers are not appropriate for audiologic services.
  - I recommend you continue to use the -59 modifier in these situations.

Modifiers

- -RT: Right ear
- -LT: Left ear
  - Use with hearing aids, cochlear implants, and auditory osseointegrated devices.

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Modifiers

- -GY: Item or service statutorily excluded or does not meet the definition of a Medicare benefit.
  - You want a Medicare denial
  - Used with –GX modifier only

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Advanced Beneficiary Notice (ABN)

- Required ABN
  - Use of 92700 or L9900
  - Local Coverage Determination in place in your locality
  - For traditional Medicare ONLY
    - GA Modifier required
      - Waiver of liability on file

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Local Coverage Determinations

- Removal of Impacted Cerumen
  - CGS
- Vestibular and Auditory Testing
  - Novitas
- Tympanometry
  - First Coast
- Vestibular Testing Only
  - First Coast
- Vestibular Testing
  - Also affects 92557
  - Palmetto
  - Noridian

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ABN

- Voluntary ABN
  - Serves as a Notice of Non-Coverage for when an item or service is never covered
    - GX Modifier required

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Voluntary ABN Uses

- Routine or annual audiologic testing where medical necessity was not met.
- Hearing aids or testing for the sole purpose of obtaining a hearing aid.
- Treatment services such as cerumen removal, canalith repositioning, tinnitus management, and aural rehabilitation.
- Tinnitus maskers and devices.
- Evaluation and Management codes.
- Audiologic and/or vestibular testing where a physician order was not obtained prior to testing.
- Audiologic evaluations that were the result of solicitation (e.g. reminder cards, marketing events).
- Audiologic and/or vestibular testing that was completed by a student in the absence of 100% personal supervision by an audiologist or physician.
- Audiologic testing that requires the skills of an audiologist or physician but was completed by a technician.
- Screenings.

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Medicare Advantage

- Advanced Beneficiary Notices are not applicable
  - May need pre-service organization determination from the payer prior to perform the service or dispensing the item
  - You need to consult each payer for their guidance on pre-service organization determination process
    - 92700
    - L9900
    - V5298
    - V5299

HCPCS Basics

- HCPCS is the acronym for Healthcare Common Procedure Coding System.
- HCPCS is a listing of codes and their descriptions that outline items and supplies and the services that surround them.
- HCPCS are added, deleted, and modified annually by the Centers for Medicare and Medicaid Services (CMS).
- As of October 2003, HIPAA requires that all insurance carriers, including Medicare and Medicaid, use HCPCS.
- HCPCS are a letter followed by four numbers. Most codes that apply to audiology begin with the letters L (cochlear implants or BAHA) or V (hearing aids).
- Anyone can submit an application for HCPCS codes.

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HCPCS "L" Codes

- L8627: Cochlear implant, external speech processor, component, replacement
- L8628: Cochlear implant, external controller component, replacement
- L8629: Transmitting coil and cable, integrated, for use with CI device, replacement

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HCPCS "L" Codes

- L8690: Auditory osseointegrated device, includes all internal and external components
- L8691: Auditory osseointegrated device, external sound processor, replacement
- L8692: Auditory osseointegrated device, ext sound processor, used without osseointegration, body worn, includes headband or other means of ext attachment
- L8693: Auditory osseointegrated device abutment, any length, replacement only
- L9900: Orthotic/prosthetic supply, accessory and/or service component of another HCPCS L code (can be used for an abutment revision)

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HCPCS "S" Codes

- S1001: Deluxe item, patient notified
  - May help with upgrades.
  - Need to determine how each private payer recognizes and reimburses this code.
- S0618: Audiometry for hearing aid evaluation to determine level and degree of hearing loss
  - Not for Medicare.
  - Need to determine how each private payer recognizes and reimburses this code.

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HCPCS Codes

- V5008: Hearing screening
- V5010: Assessment for hearing aid
- V5011: Fitting/orientation/checking of hearing aid
- V5014: Repair/modification of hearing aid
- V5020: Conformity evaluation

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HCPCS Codes

- V5050: Hearing aid, monaural, in the ear
- V5060: Hearing aid, monaural, behind the ear
- V5130: Binaural, in the ear
- V5140: Binaural, behind the ear

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HCPCS Codes

- V5170: Hearing aid, CROS, in the ear
- V5180: Hearing aid, CROS, behind the ear
- V5200: Dispensing fee, CROS
- V5210: Hearing aid, BICROS, in the ear
- V5220: Hearing aid, BICROS, behind the ear
- V5240: Dispensing fee, BICROS

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HCPCS Codes

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

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HCPCS Codes

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

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HCPCS Codes

- V5090: Dispensing fee, unspecified hearing aid
- V5110: Dispensing fee, bilateral
- V5160: Dispensing fee, binaural
- V5241: Dispensing fee, monaural hearing aid, any type

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HCPCS Codes

- V5268: Assistive listening device, telephone amplifier, any type
- V5269: Assistive listening device, alerting, any type
- V5270: Assistive listening device, television amplifier, any type
- 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

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HCPCS FM Codes

- V5281: Assistive listening device, personal FM/DM system, monaural (1 receiver, transmitter, microphone), any type
- V5282: Assistive listening device, personal FM/DM system, binaural (2 receivers, transmitter, microphone), any type
- V5283: Assistive listening device, personal FM/DM neck, loop induction receiver
- V5284: Assistive listening device, personal FM/DM ear level receiver

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HCPCS FM Codes

- V5285: Assistive listening device, personal FM/DM, direct audio input receiver
- V5286: Assistive listening device, personal Bluetooth FM/DM receiver (streamer)
- V5287: Assistive listening device, personal FM/DM receiver, not otherwise specified
- V5288: Assistive listening device, personal FM/DM transmitter assistive listening device

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HCPCS FM Codes

- V5289: Assistive listening device, personal FM/DM adaptor/boot coupling device for receiver, any type
- V5290: Assistive listening device, transmitter microphone, any type

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HCPCS EM Codes

- V5264: Ear mold/insert/not disposable, any type
- V5265: Ear mold/insert/disposable, any type
- V5275: Ear impression, each

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HCPCS Codes

- V5267: Hearing aid or assistive listening device/supplies/accessories, not otherwise specified
- V5266: Battery for use in hearing device
- V5298: Hearing aid, not otherwise classified
- V5299: Hearing service, miscellaneous

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HCPCS Tips

- V codes represent hearing aid assessment, devices, parts, accessories, earmolds, batteries, ALDs, and services.
- No code for tinnitus devices or maskers.
- There are some "duplicates" across CPT and HCPCS codes.
  - V5010 vs. 92590/1
  - V5014 vs. 92592/3 and 92594/5

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HCPCS Tips

- Use the code covered in your insurance contract, which has the highest reimbursement in your fee schedule, or which is required by the insurance benefit.
- In order to utilize all of the HCPCS codes, practices must create an unbundled hearing aid cost package for use with certain carriers..
- Remember, there is one code for each type of aid (digital BTE, monaural) and it does not take into account level of technology.

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Pediatric Testing

- Can bill for testing that is attempted if documentation of:
  - What happened?
  - Why you were unable to complete the testing?
  - Did you spend at least half of the typical test time attempting the procedure?
  - Documentation is key!
- There are no “method” codes.

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Examples of Pediatric Test Situations: Child Less Than Two Years

- VRA (92579) in soundfield or headphones, includes tones and/or speech
- Tympanometry and reflexes (92550)
- OAEs (92587)
- ABR (92585)

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Examples of Pediatric Test Situations: Child Two to Five Years

- Conditioning play audiometry (92582)
- Select picture audiometry (92583)
- Tympanometry and reflexes (92550)
- OAEs (92587)

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CAPD

- Very hard to do, if participating with third-party payers.
- CAPD evaluation (92620/1).
- Treatment (92507 versus 92633).
  - 92507 cannot be used with Medicare.
  - Know your contract terms and fee schedules.
- Team meeting with patient (99366) and team meeting without patient (99368).
- Evaluation and management codes?

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Evaluation and Management Code Basics

- These are the codes physicians and non-physician practitioners (such as nurse practitioners and physician assistants) utilize to bill for office visits.
  - Per the CPT manual, these codes can be used by "qualified health professionals who are authorized to perform such services within the scope of their practice."
  - Please note: Most E/M code descriptions (except 99211) contain the term "physician."
    - As a result, use of these codes does contain some level of risk.

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Evaluation and Management Code Basics

- Common codes to be considered by audiologists are 99201-99203 and 99211-99213.
  - Avoid 99204-99205 and 99214-99215 as inappropriate for audiologists as this level of code requires a high risk of morbidity and mortality (which otologic issues do not contain).

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The Do's of E/M

- Confirm that your state licensure laws allow for evaluation and management services.
  - Is it in your state defined scope of practice?
- Consult your payer contracts and fee schedules to determine if they allow for the use of E/M codes by audiologists.
  - If they do not, do not use them.
- If you bill one payer for E/M codes, you must bill all (including patients when non-covered, such as Medicare).
- Meet the documentation requirements of E/M codes or don't use them.
- Read the E/M section of your CPT Manual at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf before proceeding.

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The Don'ts of E/M

- Do not utilize these codes for hearing aid visits.
  - These are only for use in diagnostic test situations.
- Do not accept payment from Medicare for these codes
- Do not use these codes if work in an ENT or hospital setting.
  - Risks too great of billing two E/M codes from the same facility for the same patient on the same date of service.

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Vestibular Assessment

- Basic vestibular evaluation (92540):
  - Gaze (92541).
  - Positionals, minimum of four positions (92542).
    - Hallpike testing is a position.
  - Optokinetic (92544).
  - Oscillating tracking (92545).
- Caloric testing, per irrigation (92543 x 4).

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Vestibular Assessment

- Positional testing, without recording (92532)
  - Could be used for Hallpike in isolation.
- Rotational testing (92546)
  - Must have a rotational chair.
- Use of vertical electrodes (92547)
  - For ENG only (except in Florida).
- Dynamic posturography (92548)
  - Need a platform.
- Saccades, VEMPs, and/or use of goggles (92700)

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Auditory Osseointegrated Device

- Need pre-determination in writing, if not clearly listed as a benefit on the patient's contract.
- Candidacy testing, if completed (92626).
- L8690 (implantation with surgery) vs. L8692 (without surgery).
- Fitting (L9900).
  - Patient pays this amount on the date of the device fitting.
- Troubleshooting/service (L9900).
  - Suggest patient be billed and pay privately.

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CI Candidacy

- Audiogram (92557)
- Tymps and reflexes (92550)
- ABR (92585)
- OAEs (92587 or 92588)
- Caloric testing, per irrigation (Calorics x 2)
- Evaluation of A/R status (92626/7)
- Team meeting with patient (99366) versus team meeting without patient (99368)

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CI Surgery

- NRT (92584)
- Standby Service (99360)

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CI Initial Tune-up

- Programming (92601 if less than 7 years or 92603 if 7 years or older)
  - Could bill as two line items, with RT/LT modifiers or add -50 modifier for bilateral implants
- Testing (92626)
- NRT (92584)

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CI: Everything Else

- Re-programming (92602 or 92604)
- NRT (92584)
- Testing (92626)
  - Must spend at least 30 minutes or add a -52 modifier.
- Troubleshooting/service (L9900)
  - Suggest patient be billed and pay privately.
- Recommend you send patients to manufacturer for supplies.
  - More time to bill and collect than you actually receive.
  - L codes exist.

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Cerumen Removal

- Impacted (69210):
  - Can bill Medicare patients privately.
    - Voluntary ABN.
  - Consult your contract for guidance with other payers.
- Non-impacted (92700):
  - Inclusive to audiogram if performed on same date of service for Medicare.
  - Can bill Medicare patients privately if done on a separate date of service.
  - Consult your contract for guidance with other payers.
    - Voluntary ABN.

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Tinnitus Management

- What does your typical patient look like in terms of test battery, case history, and counseling???
  - This will help you determine the codes you use and the prices you set.
- Very hard to do, if participating with third-party payers.
- Medicare does not cover tinnitus maskers.
  - Medicare patients are financially responsible for costs.
  - Consult payer guidance for private insurers.
  - V5299.
- Tinnitus rehabilitation (92700 versus 92633).
  - Consult payer guidance for private insurers.
  - Medicare patients are financially responsible for costs.

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Aural Rehabilitation

- 92630 or 92633
  - Medicare beneficiaries are financially responsible for the costs.
  - Consult payer guidance for private insurers.

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Place of Service Code Examples

- 11: Office
- 12: Home
- 13: Assisted Living Facility
- 14: Group Home
- 21: Inpatient Hospital
- 22: Outpatient Hospital
- 31: Skilled Nursing Facility
- 32: Nursing Facility
- 34: Hospice
  - http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

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