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Coding and Reimbursement Update for 2017 & Beyond

Presenter: Kim Cavitt, AuD
Audiology Resources

Moderator: Carolyn Smaka, AuD, Editor in Chief, AudiologyOnline

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Learning Objectives

- List the new ICD 10 coding changes effective October 1, 2016.
- Describe health care reform, its impact on audiology and on quality reporting.
- Explain medical necessity and its role in audiology.
PQRS 2017 and Beyond

The Physician Quality Reporting System (PQRS) is scheduled for retirement on December 31, 2016.

- Audiologists need to continue to positively report on at least 50% of eligible traditional Medicare patients through December 31, 2016 for all six measures they are eligible to report on (based upon the procedure provided) in order to avoid the 2% penalty in 2018.

PQRS, MIPS and Audiology

- The replacement system, the Merit-Based Incentive Payment System (MIPS), does not include audiologists as a qualifying provider until at least, January 1, 2019.

So, What Does This All Mean for Me?

- Audiologists will have VOLUNTARY reporting responsibilities in 2017.
- Audiologists will be able to report via claims, a registry, or EHR.
- There may be no means of getting information on your reporting.
- Quality reporting and outcome-driven payment will still be the norm throughout healthcare.
- MACRA (Medicare Access and CHIP Reauthorization Act), which outlines MIPS, was bi-partisan legislation in 2015.
  - Payment for performance began as bi-partisan legislation in the Bush administration.
  - Repeals of Affordable Care will, most likely, have little impact on MIPS.
- The former/current PQRS measures are part of MIPS.
- Electronic medical records may also be required.
- Registry reporting, rather than claims based reporting, may be required.
- Audiology’s role in MIPS is still very ill defined at this point. We should know more within the next year.

So, What Does This All Mean for Me?

- These measures, related to falls risk, medication, smoking, and depression are about QUALITY PATIENT CARE, not just payment.
  - We may also see measures related to blood pressure, pain and body mass index added to our reporting responsibilities in the new system.
- These actions differentiate audiologists, to the patient and to referral sources, from the marketplace, especially big box stores, online retailers, and hearing aid dispensers.
- These are actions audiologists should be undertaking regardless of any government requirement due to the affects on the auditory and vestibular systems and their impact on our diagnoses and plans of care.
- Our hope is that audiologists will continue to pose these case history questions and undertake these procedures, even if they are not required for payment.
CPT and HCPCS and 2017

- There are no new audiology specific CPT or HCPCS changes for audiology for 2017.

October 1, 2016 ICD-10 Changes

- There are several new codes, but the ones with the biggest impact affect coding for different type of hearing loss in different ears.
- Restricted means abnormal.
- You would need to select two of the above codes to reflect different hearing losses in different ears.
- The new codes are:
  - H90.A11: Conductive hearing loss, unilateral, right ear, with restricted hearing loss on the contralateral side
  - H90.A12: Conductive hearing loss, unilateral, left ear, with restricted hearing loss on the contralateral side
  - H90.A21: Sensorineural hearing loss, unilateral, right ear, with restricted hearing loss on the contralateral side
  - H90.A22: Sensorineural hearing loss, unilateral, left ear, with restricted hearing loss on the contralateral side
  - H90.A31: Mixed conductive and sensorineural hearing loss, unilateral, right ear, with restricted hearing loss on the contralateral side
  - H90.A32: Mixed conductive and sensorineural hearing loss, unilateral, left ear, with restricted hearing loss on the contralateral side
### October 1, 2016 ICD 10 Changes

- Other new codes to consider are:
  - H93.A1 Pulsatile tinnitus, right ear
  - H93.A2 Pulsatile tinnitus, left ear
  - H93.A3 Pulsatile tinnitus, bilateral
  - H93.A9 Pulsatile tinnitus, unspecified ear
  - H95.41 Postprocedural hemorrhage of ear and mastoid process following a procedure on the ear and mastoid process
  - H95.42 Postprocedural hemorrhage of ear and mastoid process following other procedure
  - H95.51 Postprocedural hematoma of ear and mastoid process following a procedure on the ear and mastoid process
  - H95.52 Postprocedural hematoma of ear and mastoid process following other procedure

### What We Have Learned About ICD 10 a Year Later

- The Medicare grace period for using unspecified codes ended on October 1, 2016. As a result, you need to avoid the use of unspecified codes unless allowed by your Medicare contractor through their local coverage determination. Please consult guidance from private insurers related to whether or not they allow the use of unspecified codes. Sometimes you may need to contact the ordering/referring physician or primary care physician for guidance on specific diagnoses for medical necessity.
- Avoid the use of a Z code as a primary diagnosis. This can drive a denial.
- Do not use rule out diagnoses once you know the diagnosis does not exist.

[cgsmedicare.com/partb/pubs/news/2013/0113/cope21072.html]
What are Other Important Things I Need to Consider When Coding ICD-10?

- Be aware of local coverage determinations from your Medicare contractors. These policies determine what diagnoses are required for payment of specific codes. These can also be applied to Medicare Part C (Advantage) plans. Here are the current local coverage determinations that apply to audiology and their associated contactors:
  - Vestibular and Auditory Testing
    - Novitas
  - Tympanometry
    - First Coast
  - Vestibular Testing Only
    - First Coast
  - Vestibular Testing
    - Also affects 92557 when completed with vestibular testing
    - Palmetto

What are Other Important Things I Need to Consider When Coding ICD-10?

- How do I code an asymmetric hearing loss?
  - It is recommended that you just code the loss(es) themselves and do not worry about documenting an asymmetry. For example, a bilateral, asymmetric sensorineural hearing loss is still coded as a bilateral, sensorineural hearing loss or H90.3.

- How do I code a routine hearing test?
  - There is no CPT or HCPCS code for a “routine” hearing test. It is recommended that you explore if the payer recognizes S0618. The best option diagnosis code option is ICD-10 code Z01.10. Please remember that it is sometimes the patient’s responsibility to fight for coverage. Audiologists can only code what is reported, what they document, what they measure, and what they see. Audiologists cannot code for coverage.
Coverage versus Reimbursement

- Coverage is when a third-party is paying all or part of the cost of the item or service.
  - Lack of coverage does NOT mean a lack of reimbursement.
- Reimbursement is when you, the provider, receive payment for the cost of the item or service provided.
- WE NEED TO CARE MORE ABOUT REIMBURSEMENT AND LESS ABOUT COVERAGE!
- Consumers and patients will pay privately for evidence based, medically necessary care.

Medical Necessity

- Medicare defines medical necessity as “Health care services or supplies needed to diagnose or treat an illness or injury, condition, disease, or its symptoms and that meet accepted standards of medicine.” [www.medicare.gov](http://www.medicare.gov) The service must be consistent with the symptoms of the illness or injury, be provided within generally acceptable professional medical standards, not performed for the convenience of the patient or physician, and furnished at a safe level and in a setting appropriate to the patient’s medical needs.
- According to The Medicare Benefit Policy Manual, Chapter 15, section 80.3, “Coverage and, therefore, payment for audiological diagnostic tests is determined by the reason the tests were performed, rather than by the diagnosis or the patient’s condition. Under any Medicare payment system, payment for audiological diagnostic tests is not allowed by virtue of their exclusion from coverage in section 1862(a)(7) of the Social Security Act 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.
- As a result, Medicare does not cover annual or routine hearing testing in the absence of a physician order and medical necessity.
Medical Necessity

- **Who determines medical necessity for Medicaid and private insurance plans?**
  - Medical necessity and/or what constitutes being “medically reasonable or necessary” is outlined in the provider contractual agreement and/or the provider manual of every payer source. It can and does vary payer to payer.
  - That being said, if an audiologist follows the Medicare guidance, they would typically meet the medical necessity requirements of Medicaid and other private insurers for payment.

Your Medicare Data

- This is now publically available information.
Common CPT Coding Issues

- Evaluation of Aural Rehabilitation Status
  - 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)
  - For coverage, these codes are used for pre- and post-implantation auditory prosthetic device testing.
  - This is NOT for coverage for the QuickSIN or routine hearing aid testing.

Common CPT Coding Issues

- Otoacoustic Emissions
  - Otoacoustic emissions are not warranted in every test scenario. The rendering provider must be able to document that the otoacoustic emissions are medically necessary for a specific patient.
  - CPT code 92587, distortion product OAEs, limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or TEOAEs, with interpretation and report, is to be utilized when testing TEOAEs and for DPOAEs, an identifiable data point at each of the 3-6 frequencies tested. You must perform 3-11 frequencies in both the right and left ears in order to bill this code as well as interpret the results of the test and include a report in the patient’s record. The interpretation cannot be merely a “pass/fail” but, instead, must clearly document the ear and frequency specific test results.
  - CPT code 92588, comprehensive diagnostic evaluation (cochlear mapping, minimum of 12 frequencies), with report, is a much more extensive test that involves at least 12 frequencies in the right ear and 12 in the left and the interpretation of the test and the report in the patient's record. This test is indicated, but not limited to, baseline and cochlear ototoxicity monitoring, cochlear mapping, to verify cochlear vs. non-cochlear function, and to verify functional hearing loss.
Common CPT Coding Issues

- **Acoustic Reflexes**
  - To appropriately bill for acoustic reflex testing, the audiologist must perform both ipsilateral and contralateral reflexes for at least 2 frequencies in each ear. If you are only performing ipsilateral reflexes, you must append the -52 modifier to indicate reduced services. An ipsilateral acoustic reflex screening at 1000 Hz does not meet the coding criteria for 92568. (CPT manual 2016)
  - Also, as noted with OAEs, acoustic reflex threshold testing is not warranted in every test scenario. The rendering provider must be able to document that the acoustic reflex threshold testing is medically necessary for this specific patient.

- **Speech in Noise Testing**
  - Speech in noise testing could be included in Comprehensive Audiological Evaluation (92557) or as part of Speech Audiometry with Speech Recognition (92556) evaluation. Or, it could be billed as an unlisted otorhinolaryngological procedure code 92700, with documentation & explanation of the procedure.
  - This code should not be filed to Medicare if utilized as a predictor of hearing aid performance in noise.
  - Speech in noise testing should not be billed as a Filtered Speech Test (92571), as this code is one component of a comprehensive central auditory processing evaluation.
  - 92571 became part of a National Correct Coding Initiative (NCCI) edit by the Centers for Medicare and Medicaid Services (CMS) and was bundled with CPT codes 92572 (Staggered Spondaic Word Test) and 92576 (Synthetic Sentence Identification Test) into CPT codes 92620 and 92621 - evaluation of central auditory function test, first 60 minutes and each additional 15 minutes, respectively.
Common CPT Coding Issues

- Codes to use with caution
  - You need to ensure that you have actually performed the service.
    - 92504: Binocular microscopy
    - 92560: Bekesy audiometry, screening
    - 92561: Bekesy audiometry, diagnostic
    - 92562: Loudness balance test, alternate binaural and monaural
    - 92564: Short increment sensitivity index
    - 92571: Filtered speech test

Common CPT Coding Issues

- 92700 (Unlisted Otorhinolaryngological Service or Procedures)
  - To classify procedures that do not have CPT codes
  - Individually reviewed
  - ABN required for traditional Medicare
  - If reporting 92700, submit report with:
    - Copy of Patient Report
    - Description of procedure
    - Clinical Utility of the Procedure
    - Time
    - Skills of Tester (that it cannot be performed by a technician)
    - Equipment used
    - Usual and Customary Fee
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
- VHit

Third-Party Administrators (TPA)

- TPAs are becoming more and more prolific in the audiology space.
- They exist to:
  - Allow payers a single point of contact and payment for hearing aid related items and services.
  - Defined risk for the payer.
  - Cost containment for the member.
  - An established standard of care for the member.

Audiologists helped create the need for these programs and help maintain their existence through their participation.
Considerations Prior to TPA Participation

- Before you agree to join, please consider the following:
  - Have a done a revenue analysis of participation versus non-participation?
  - Is the plan offering a funded or unfunded benefit?
  - Is your practice bundle or unbundled?
    - Can you create a competitive product offering?
      - Does your practice have access to a value based hearing aid option (low cost of goods)?
  - How many patients do you stand to potentially lose if you do not enroll in the program?
  - How will non-participation affect your referrals?
  - Can I negotiate my own agreement with the payer or employer group or gather a group of colleagues in my area to create a competitive plan?

Food and Drug Administration (FDA) Guidance on the Medical Clearance and Medical Waiver

- “The agency issued a guidance document explaining that it does not intend to enforce the requirement that individuals 18 and up receive a medical evaluation or sign a waiver prior to purchasing most hearing aids. This guidance is effective immediately.”
  [Link](http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm532005.htm)
- [Link](http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/UCM531995.pdf)
- Before removing the issuance and completion of these forms from your practice, please consult your state hearing aid dispensing boards, in writing, for guidance as it relates to dispensing in your state.
- At this point, this has no impact on requirements by third-party payers, specifically Medicaid and worker’s compensation programs, which require a medical clearance prior to obtaining amplification. For more specific guidance, please contact the payer source in writing for clarification.