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- Email customerservice@AudiologyOnline.com
2019 Coding and Reimbursement Update

Kim Cavitt, AuD
Audiology Resources, Inc.

Learning Outcomes

After this course, participants will be able to

- List the new HCPCS codes for 2019.
- Evaluate the changes to United Healthcare hearing aid coverage.
- Describe the audiologists’ role in the Merit Based Incentive Payment System.
CPT and ICD 10 Changes

- CPT (Current Procedural Terminology) code changes go into effect on January 1 of each year.
- ICD 10 (International Classification of Diseases, 10th revision) go into effect October 1 of each year.

There are no audiology centric CPT or ICD 10 changes for 2018/2019.

HCPCS Changes

- HCPCS (Healthcare Common Procedure Coding System) code changes go into effect on January 1 of each year.
- The Centers for Medicare and Medicaid Services (CMS) has created a new code set related to CROS/BICROS technologies. These codes went into effect on January 1, 2019.
  - A CROS system is where a patient wears a “hearing aid,” functioning as a receiver, on the normal hearing ear and a “hearing aid,” functioning as a transmitter, on the “unaidable” ear. A BICROS system is where a patient wears a hearing aid/receiver on the better hearing ear and a “hearing aid,” functioning as a transmitter, on the “unaidable” ear. The hearing aid and “hearing aid” receivers and “hearing aid” transmitters can be in-the-ear (ITE), in-the-canal (ITC), and/or behind-the-ear (BTE) types/styles and the patient can be fit with different types/styles in each ear. The new codes will now reflect these options.
PLEASE NOTE: Before utilizing this new code set, please consult your payer fee schedules, agreements, and websites. Some payers, especially State and Managed Medicaid programs, may not recognize the new code set. THE EXISTENCE OF A CODE IS NOT A GUARANTEE OF THIRD-PARTY COVERAGE OR PAYMENT NOR IT IS A GUARANTEE OF AN INCREASED ALLOWABLE RATE.

### Cros/bicros – New codes

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>OFFICIAL 2019 HCPCS DESCRIPTION</th>
<th>CLINICAL UTILIZATION OF THE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5171</td>
<td>Hearing aid, contralateral routing device, monaural, in the ear (ITE)</td>
<td>The patient has an existing hearing aid or CROS receiver that was dispensed on a previous date of service; this code represents a new or replacement ITE transmitter for the “unaidable” ear.</td>
</tr>
<tr>
<td>V5172</td>
<td>Hearing aid, contralateral routing device, monaural, in the canal (ITC)</td>
<td>The patient has an existing hearing aid or CROS receiver that was dispensed on a previous date of service; this code represents a new or replacement ITC transmitter for the “unaidable” ear.</td>
</tr>
<tr>
<td>V5181</td>
<td>Hearing aid, contralateral routing device, monaural, behind the ear (BTE)</td>
<td>The patient has an existing hearing aid or CROS receiver that was dispensed on a previous date of service; this code represents a new or replacement BTE transmitter for the “unaidable” ear.</td>
</tr>
<tr>
<td>V5211</td>
<td>Hearing aid, contralateral routing system, binaural, ITE/ITE</td>
<td>The patient is receiving a new CROS/BICROS system (both the transmitter and hearing aid/receiver) on the same date of service; this code represents a system where both ears have an ITE device.</td>
</tr>
</tbody>
</table>
Cros/bicros – New codes

V5212  Hearing aid, contralateral routing system, binaural, ITE/ITC The patient is receiving a new CROS/BICROS system (both the transmitter and hearing aid/receiver) on the same date of service; this code represents a system where one ear has an ITE device and one ear has an ITC device.

V5213  Hearing aid, contralateral routing system, binaural, ITE/BTE The patient is receiving a new CROS/BICROS system (both the transmitter and hearing aid/receiver) on the same date of service; this code represents a system where one ear has an ITE device and one ear has a BTE device.

V5214  Hearing aid, contralateral routing system, binaural, ITC/ITC The patient is receiving a new CROS/BICROS system (both the transmitter and hearing aid/receiver) on the same date of service; this code represents a system where both ears have an ITC device.

V5215  Hearing aid, contralateral routing system, binaural, ITC/BTE The patient is receiving a new CROS/BICROS system (both the transmitter and hearing aid/receiver) on the same date of service; this code represents a system where one ear has an ITC device and one ear has a BTE device.

V5221  Hearing aid, contralateral routing system, binaural, BTE/BTE The patient is receiving a new CROS/BICROS system (both the transmitter and hearing aid/receiver) on the same date of service; this code represents a system where both ears have a BTE device.

Cros/bicros – Revised codes

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>OFFICIAL 2019 HCPCS DESCRIPTION</th>
<th>2018 HCPCS DESCRIPTION</th>
<th>CLINICAL UTILIZATION OF THE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5190</td>
<td>Hearing aid, contralateral routing, monaural, glasses</td>
<td>Hearing aid, CROS, glasses</td>
<td>The patient is receiving a new CROS device housed in eyeglasses; this code represents the eyeglass CROS device in the monaural configuration.</td>
</tr>
<tr>
<td>V5200</td>
<td>Dispensing fee, contralateral, monaural</td>
<td>Dispensing fee, CROS</td>
<td>The patient is receiving a new CROS device; this code represents the dispensing fee surrounding the fitting of this device.</td>
</tr>
<tr>
<td>V5230</td>
<td>Hearing aid, contralateral routing system, binaural, glasses</td>
<td>Hearing aid, BICROS, glasses</td>
<td>The patient is receiving a new BICROS device housed in eyeglasses; this code represents the eyeglass device in the binaural configuration.</td>
</tr>
<tr>
<td>V5240</td>
<td>Dispensing fee, contralateral routing system, binaural</td>
<td>Dispensing fee, BICROS</td>
<td>The patient is receiving a new BICROS device; this code represents the dispensing fee surrounding the fitting of this device.</td>
</tr>
</tbody>
</table>
Cros/bicros – Revised codes

- The dispensing fee is the facility fee surrounding the evaluation, selection, ordering, programming, and fitting of a CROS/BICROS device that is not represented by another CPT or HCPCS code.

- Some payers, specifically State and Managed Medicaid programs, consider the dispensing fee code to represent the fitting and orientation of the device (V5011).

Cros/bicros – Deleted codes

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>OFFICIAL 2018 AND 2019 CODE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5170</td>
<td>Hearing aid, CROS, in the ear</td>
</tr>
<tr>
<td>V5180</td>
<td>Hearing aid, CROS, behind the ear</td>
</tr>
<tr>
<td>V5210</td>
<td>Hearing aid, BICROS, in the ear</td>
</tr>
<tr>
<td>V5220</td>
<td>Hearing aid, BICROS, behind the ear</td>
</tr>
</tbody>
</table>
Cros/bicros

- Some payers, specifically State and Managed Medicaid programs, may have difficulty transitioning to the new code set.
- Practices may need to file appeals, especially at the outset of 2019, detailing the replacement codes.

CROS Billing Example

- Patient receives a new BTE CROS system, with a behind the ear device in each ear.
- Coding:
  - V5221 - CROS devices (represents both units)
  - V5220 - Dispensing fee
  - V5011 - Fitting and orientation
  - V5020 - Real-ear measurement
  - V5264/5 - Earmold or insert, each
  - V5266 - Battery (each)
Bicros Billing Example

- Patient has profound hearing loss in their left ear and a moderate hearing loss in their right ear. The patient wears a behind-the-ear hearing aid in their right ear that was purchased in 2018. They would like to add a behind-the-ear transmitter to their left ear in 2019.

- Coding:
  - V5181 – CROS transmitter
  - V5240 – Dispensing fee
  - V5011 - Fitting and orientation
  - V5020 - Real-ear measurement
  - V5264/5 - Earmold or insert, each
  - V5266 - Battery (each)

Third-party Medical policies 2019 – UHC Medicare Part C

- Patients may choose to purchase aids through hihealth Innovations or EPIC.
- Limit two aids every two years.
- From hihealth:
  - $300 - $370 copayment for each aid.
- From Epic:
  - $400 - $2025 co-payment for each aid.
Third-party Medical policies 2019 –
UHC Commercial

- “Standard plans include coverage for wearable Hearing Aids that are purchased as a result of a written recommendation by a Physician.
- Benefits are provided for the Hearing Aid and for charges for the associated fitting and testing. The wearable Hearing Aids benefit does not include batteries, accessories, or dispensing fees.
- If more than one type of Hearing Aid can meet the member’s functional needs, benefits are available only for the Hearing Aid that meets the minimum specifications for the member’s needs. If the member purchases a Hearing Aid that exceeds these minimum specifications, UnitedHealthcare will pay only the amount that it would have paid for the Hearing Aid that meets the minimum specifications, and the member will be responsible for paying any difference in cost”.
  - I would recommend a waiver that clearly reflects this fact.

Third-party Medical policies 2019 –
Aetna

- [http://www.aetna.com/cpb/medical/data/600_699/0612.html#dummyLink2](http://www.aetna.com/cpb/medical/data/600_699/0612.html#dummyLink2)
- “Air conduction hearing aids are considered medically necessary when the following criteria are met:
  - hearing thresholds 40 decibels (dB) HL or greater at 500, 1000, 2000, 3000, or 4000 hertz (Hz); or
  - hearing thresholds 26 dB HL or greater at three of these frequencies; or
  - speech recognition less than 94 percent”.
- “Aetna considers implantable hearing aids and semi-implantable hearing aids experimental and investigational for all other indications because its effectiveness for indications other than the ones listed above has not been established”.

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Third-party Medical policies 2019 – BCBS

- Every, individual state BCBS plan/product can have their own medical policies and coverage guidelines.
- Examples:
  - https://provider.bluecrossma.com/ProviderHome/wcm/connect/b3ca4194-3167-4d04-a28e-8a637b3c12d/audiology_payment_policy.pdf?MOD=AJPERES&CONVERT_TO=URL&CACHEID=ROOTWORKSPACE-b3ca4194-3167-4d04-a28e-8a637b3c12d-mqTIfcV

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Third-party Medical policies 2019 – FEHP

- https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/
- FEHP hearing aid benefits are not “one size fits all”.
- Allowable rates are payer dependent.
- BCBS FEHP plan:
  - “Hearing aids for children up to age 22, limited to $2,500 per calendar year.
  - Hearing aids for adults age 22 and over, limited to $2,500 every 3 calendar years. Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.”
  - The patient is responsible for all costs which exceed $2500.
Telehealth

- Telehealth is “the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications”.
  - Store and forward is asynchronous telehealth.

Telehealth and HIPAA

- Audiologists have to ensure, before they begin providing telehealth, that their transmission systems all meet the HIPAA security requirements that “ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit”.
  - Cannot use Facetime, SMS, Skype, or unencrypted email (to store and forward) for telehealth.
  - Please consult an IT consultant when setting up a telehealth program for your practice.
    - [https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/](https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/)
Telehealth Coding - Modifiers

- Telehealth services can only be provided by audiologists as allowed by state law and once the HIPAA security requirements are met.
- Medicare and most payers do not cover telehealth services provided by audiologists.
- Place of Service Code: 02
- Modifiers:
  - GQ: Telehealth provided via interactive audio and video telecommunications systems.
  - GT: Telehealth provided via an asynchronous telecommunications system.

Healthcare Reform: 
Merit Based Incentive Payment System (MIPS)

- The Merit-based Incentive Payment System (MIPS) consolidates three existing quality reporting programs: the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VBPM), and meaningful use (MU). The system also adds a new performance category, called improvement activities (IA).
  - [Link](https://qpp.cms.gov/)
  - [Link](https://qpp.cms.gov/mips/quality-measures)
Why MIPS is important?

- Audiology does not want to be excluded.
- The measures and activities illustrate our value to the patient and healthcare system.
- The activities differentiate us from OTC and hearing aid dispensers in the marketplace.
- These activities illustrate the evidence based, patient centric practice of audiology.
Merit Based Incentive Payment System (MIPS): What We Do Know

- Audiology, SLP, OT, PT and clinical social work are eligible for the program in 2019.
  - Participation Options
    (https://qpp.cms.gov/mips/individual-or-group-participation)

What type of setting do you practice in?

- IF you practice in a hospital, multi-disciplinary clinic, or otolaryngology or physician practice, you MAY have different reporting requirements, reporting methods, and guidelines.
  - In these situations, PLEASE immediately reach out to your practice administration to determine your MIPS requirements.
    - Your practice could be enrolled in an alternative payment model, which has very different MIPS requirements.
Merit Based Incentive Payment System (MIPS):

What We Do Know

- Audiology, SLP, OT, PT and clinical social work are eligible for the program in 2019.
- Participation Options (https://qpp.cms.gov/mips/individual-or-group-participation)
  - Participate as an individual
    - An individual is defined as a single clinician, identified by their individual National Provider Identifier (NPI) tied to a single Taxpayer Identification Number (TIN).
    - If you report only as an individual, you’ll report measures and activities for the practice(s)/TIN(s) under which you are MIPS-eligible and be assessed across all 4 performance categories at the individual level. Your payment adjustment will be based on your Final Score derived from the 4 MIPS performance categories.
  - Report as a Group
    - A group is defined as a single TIN with 2 or more clinicians (at least one clinician within the group must be MIPS eligible) as identified by their NPI, who have reassigned their Medicare billing rights to a single TIN.
    - If you report only as a group, you must meet the definition of a group at all times during the performance period and aggregate the group’s performance data across the 4 MIPS performance categories for a single TIN. Each MIPS-eligible clinician in the group will receive the same payment adjustment based on the group’s performance across all 4 MIPS performance categories.

Merit Based Incentive Payment System (MIPS): What We Do Know

- Low Volume Threshold (2019)
  - Dollar Amount ($90,000) or
  - Number of Beneficiaries (200) or
  - Number of Covered Professional Services (200)
MIPS Scoring

- Four Performance categories make up the MIPS scores.
  - Quality (85%)
    - This performance category replaces PQRS. This category covers the quality of the care you deliver, based on performance measures created by CMS, as well as medical professional and stakeholder groups.
    - Providers have to be able to report up to six measures of performance.
    - Can be reported via claims, registries, or EHR.
  - Improvement Activities (15%)
    - 2 high-weighted activities or
    - 1 high-weighted activity and 2 medium-weighted activities or
    - At least 4 medium-weighted activities.
      - Must occur for 90 days or more.
      - Documented by attestation.

MIPs STEP #1: determine eligibility

- Go to MIPS Participation Status link.
- Insert your National Provider Identifier in the box provided.
- **Only the Performance Year (PY) 2018 Participation Status is CURRENTLY available.** The Centers for Medicare and Medicaid Services (CMS) plan to have the site updated by early December 2018 and make a PY2019 Participation Status Tool Available.
  - The PY2018 Participation Status summary, for your NPI, will give you a snapshot of your Medicare claims data for determination periods between September 1, 2016 – August 31, 2017 or September 1, 2017 – August 31, 2018.
    - While this snapshot will provide you with information on your status for 2018 Participation ONLY, it does give you some interim information on your enrollment date, the number of Medicare patients you have seen in the review period, and the amount of Medicare allowed charges you have billed during the review period.
    - If, when you check your MIPS eligibility status on the PY2019 tool (which is not yet available), it indicates that you are eligible to report because of participation in an Alternative Payment Model (APM), please immediately reach out to the practice manager of your facility to determine your specific reporting requirements and mechanisms (as the claims-based reporting option might not be available to you).
      - Typically, APMs only exist in large hospitals, medical centers, and multi-disciplinary clinics.
MIPS STEP #2: determine if you are exempt

- Audiologists are MIPS EXEMPT for participating in the MIPS program if, individually, they:
  - Have $90,000 or less in Medicare Part B allowed charges for covered professional services; OR
  - Provide care to 200 or fewer Medicare beneficiaries; OR
  - Provide 200 or fewer covered professional services under the Medicare Physician Fee Schedule (PFS).

These exemptions are collectively called the low volume threshold.

99% of individual audiologists in the United States, whose practice is not enrolled in an Alternative Payment Model (APM), will be exempt from MIPS reporting in 2019.
Mips step #3: determine if you want to report

- Exempt audiologists (audiologists who do not meet the low volume threshold) may decide to voluntarily participate in the MIPS program. This can be accomplished by two means:
  - Voluntary Participation:
    - Audiologists will not formally sign up/enroll in this type of reporting.
    - Audiologists can participate via the same mechanism they reported Physician Quality Reporting Systems (PQRS) Measures.
      - Reporting G-Codes via Medicare Part B claims.
    - Audiologists will also "attest" to the Improvement Activities (IA).
  - Opt-In Participation:
    - Audiologists will officially and formally "opt in" (the form or process is not yet available).
    - Audiologists can participate via the same mechanism they reported Physician Quality Reporting Systems (PQRS) Measures.
      - Reporting G-Codes via Medicare Part B claims.
    - Audiologists will also "attest" to the Improvement Activities (IA).
    - Audiologists would be eligible for payment incentives and payment reductions, based upon their overall MIPS score and performance.

MIPS voluntary participation STEP #1: EIDM enrollment

- This account will allow you to track your Quality Payment Program (QPP) performance and score.
- You can register (or login to an existing account) at https://portal.cms.gov/wps/portal/unauthportal/home/.
  - Select “PQRS” from the pulldown screen.

DO NOT INADVERTENTLY OPT IN TO THE MIPS PROGRAM AS PART OF EIDM REGISTRATION PROCESS.
MIPS voluntary participation STEP #2: report MIPS quality measures

- MIPS Quality Measures are reported EXACTLY the same way by which your practice reported for the Physician Quality Reporting System (PQRS) from 2012-2016. The six quality measures are the EXACT same six quality measures that audiologists reported for PQRS is 2016. They are:
  - Documentation and verification of current medications in the medical record.
  - Screening for clinical depression and follow-up plan.
  - Falls Risk Assessment
  - Falls Risk Plan of Care
  - Screening for Tobacco Use/Cessation
  - Referral for otologic evaluation for patients with acute or chronic dizziness.

- Audiologists must complete quality measures and report on their outcomes for at least 50% of all eligible patients.

- Audiologists can get a refresher on "what" and "how" to report these measures at:
  - https://audiologyquality.org/measures/
  - https://audiologyquality.org/reporting-pqrs-measures/
  - https://qpp.cms.gov/mips/quality-measures

- Audiologists who are voluntarily reporting MIPS Measures will report via their CMS 1500 claim form or 857 formatted electronic claims using the PQRS Measure codes (just as they did PQRS).
Codes for Referral for Acute or Chronic Dizziness

- Report a minimum of once per calendar year for 50% of eligible patients.
- CPT Codes:
  - 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575
- Patients that have any of these CPT codes (as well as the ICD-9 CM codes below) fit into the measure’s denominator (the eligible patients for a measure).
- ICD-10 Codes:
  - R42 or H81.11, H81.12 or H81.13
Codes for Referral for Acute or Chronic Dizziness

- G8856: Referral to a physician for otologic evaluation.
- G8857: Patient is not eligible for the referral for otologic evaluation (e.g. patients 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.

PQRS and ICD 10

- Only affects Referral for Acute or Chronic Dizziness measure
  - Eligible to report this measure if you perform 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575
  - And you have a diagnosis of R42 or H81.11, H81.12 or H81.13
Codes for Documentation of Current Medications

- Report at every patient visit for 50% of eligible patients.
- Code to the best of your ability and document fully that fact.
- CPT Codes:
  - 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626
  - Patients that have any of these CPT codes (as well as the ICD-9 CM codes below) fit into the measure’s denominator (the eligible patients for a measure).
- ICD-10 Codes
  - None specified (so all included).

Codes for Documentation of Current Medications

- G8427: List of current medications (includes prescription, over the counter, herbals, vitamin/dietary supplements) documented by the provider, including drug name, dosage, frequency, and route.
- G8430: Provider documentation that patient not eligible for medication assessment.
- G8428: Current medications (includes prescription, over the counter, herbals, vitamin/dietary supplements) with drug name, dosage, frequency, and route partially or not documented by provider, reason not specified.
Important Considerations Regarding Documenting Current Medications

- This is not just about MIPS but also important to patient care, regardless of your practice setting and clinical focus.
- This is something that the patient should be instructed that they need to provide at scheduling.
- Sometimes providers may need to call their primary care physician or pharmacist to obtain this list.
- Many patient now carry this list with them, so do not forget to ask at intake.
  - You can make a copy of their list, verify whether it is current, sign it, date it, and place it in the medical record.

Codes for Screening of Clinical Depression

- This measure is NO LONGER OPTIONAL.
- Report a minimum of once per calendar year for 50% of eligible patients.
- CPT Codes:
  - 92625
- Patients that have any of these CPT codes (as well as the ICD-9 CM codes below) fit into the measure’s denominator (the eligible patients for a measure).
- ICD-10 Codes:
  - None specified (so all included).
Important Factors Related to the Clinical Depression Measure

- Report on measure when:
  - Allowed by your state licensure law (when deemed within the scope of practice of an audiologist within your state; determined through written contact with your state licensing board).
    - It is the responsibility of the provider themselves to do this.
  - You are appropriately trained and competent to perform a depression screening using a standardized tool AND create a patient plan of care based upon the results of the screening.
  - A follow-up plan of care is created, implemented, and documented in the medical record.
    - Must, at a minimum, make a referral to a practitioner who is qualified to diagnose and treat depression

Codes for Screening of Clinical Depression

- 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 and a follow-up plan documented.
- G8433: Screening for clinical depression using an age appropriate standardized tool not documented, patient not eligible/appropriate.
  - Patient refuses to participate
- G8432: No documentation of clinical depression screening using an age appropriate standardized tool.
- G8511: Positive screen for clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified.
### Appropriate Depression Screening Tools

- **Patient Health Questionnaire (PHQ-9)**

- **Beck Depression Inventory (BDI or BDI-II)**

- **Center for Epidemiologic Studies Depression Scale (CES-D)**

- **Depression Scale (DEPS)**

- **Duke Anxiety-Depression Scale (DADS)**

- **Geriatric Depression Scale (GDS)**

- **Cornell Scale Screening**
  - [http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf](http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf)

- **PRIME MD-PHQ2**

### Falls Risk Assessment


- Report at least once per calendar year for 50% of eligible patients.

- **CPT Codes:**
  - 92540, 92541, 92542, or 92548.

- **ICD 10 Codes**
  - None specified (so all included)
Falls Risk Assessment

- Needs to be completed by the audiologist performing the balance assessment.
- Risk assessment must include balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether or not medications are a contributing factor or not to falls within the last 12 months.
  - Medical record must include documentation of observed transfer from a chair and walking or use of a standardized scale or documentation of referral for assessment of balance and gait.
  - Medical record could include documentation that patient is functioning well or not functioning well with vision or documentation of referral for assessment of vision.
  - Medical record could include documentation of counseling on home falls hazards or documentation of inquiry on home falls hazards or documentation of referral for evaluation of home falls hazards.
  - Medical record could include documentation of whether or not the patient’s current medications could be contributing to falls.

Falls Risk Assessment Tools:

- http://www.mnfallsprevention.org/professional/assessmenttools.html
Falls Risk Assessment

- Case history questions:
  - Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? Yes or No
    - If yes, are you feeling dizzy today? Yes or No
    - If yes, please describe: __________________________
    - Frequency of occurrence: _______________________
  - If yes, is it accompanied by nausea, ringing or noises in your ear, hearing loss, visual disturbances, Other
  - Have you fallen within the past 12 months? Yes or No
    - If yes, how many falls have you experienced in the 12 months?
    - If you have fallen, have you been injured? Yes or No
    - Please describe your injury: ____________________

- Do you experience visual difficulties or disturbances? Yes or No
  - If yes, please describe:
    - Do you currently take a Vitamin D supplement? Yes or No
## Falls Risk Assessment

<table>
<thead>
<tr>
<th>Patient Reports:</th>
<th>Two or more falls in past 12 months or 1 fall with an injury</th>
<th>Two or more falls in past 12 months or 1 fall with an injury</th>
<th>Two or more falls in past 12 months or 1 fall with an injury</th>
<th>Less than two falls in last 12 months and no falls where they were injured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Risk assessment completed by performing a standardized scale of balance/gait using Timed Get Up and Go, Tinetti, or Berg and review and document whether current medications may or may not be contributing to falls, dizziness, imbalance or vertigo.</td>
<td>Risk assessment not performed for medical reasons (patient is not ambulatory, bedridden, immobile, confined to wheelchair)</td>
<td>Risk assessment not performed but there was no medical reason given for the lack of performance of the screening (NEGATIVE REPORTING)</td>
<td>Code on claim 1101F</td>
</tr>
<tr>
<td>Step 2</td>
<td>Perform 92540, 92541, 92542 and/or 92548</td>
<td>Perform 92540, 92541, 92542 and/or 92548</td>
<td>Perform 92540, 92541, 92542 and/or 92548</td>
<td>Code on claim 1101F</td>
</tr>
<tr>
<td>Step 3</td>
<td>When warranted, refer for assessment of supine and standing blood pressure, vision assessment, home falls risk hazards, and/or medication review</td>
<td>Code on claim 3288F with 1P modifier and 1100F</td>
<td>Code on claim 3288F with 8P in modifier box and 1100F</td>
<td>Code on claim 3288F and 1100F</td>
</tr>
<tr>
<td>Step 4</td>
<td>Code on claim 3288F and 1100F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Falls Risk Plan of Care

- Report at least once per calendar year for 50% of eligible patients.
- CPT Codes:
  - 92540, 92541, 92542, or 92548.
- ICD 10 Codes
  - None specified (so all included)
Falls Risk Plan of Care

- ALWAYS must be reported when a patient is screened as a Falls Risk.
  - They have fallen two or more times in the past year and/or they have been injured during a fall at least once in the past year.
- Plan of care must include consideration of vitamin D supplementation AND balance, strength and gait training.
  - Medical record must include documentation that patient was referred to their physician for vitamin D supplement advice.
  - Documentation must include that balance, strength and gait training (vestibular rehabilitation) were provided or referral to an exercise program or physical therapy.

Patient documented to be a falls risk (the patient has fallen two or more times or fallen once with an injury in the past 12 months)

Perform 92540, 92541, 92542, and/or 92548

Step 1
- Create a plan of care for the patient regarding their falls risk which must include referral to the ordering and/or primary care physician for Vitamin D supplement advice, referral of the patient to a vestibular rehabilitation program, and/or providing vestibular rehabilitation within your practice
- Plan of care not documented for medical reasons (patient is not ambulatory, bedridden, immobile, wheelchair bound)
  - PLEASE NOTE: I would still recommend referral to the ordering and/or primary care physician for Vitamin D supplement advice.
- Plan of care not documented but there was no medical reason given for the lack of completion of the plan of care (NEGATIVE REPORTING)

Step 2
- Code on the claim 0518F
  - Code on claim 0518F with 1P modifier
  - Code on claim 0518F with 8P modifier
Screening of Tobacco Use

- Must be reported at least once per calendar year for 50% of eligible patients.
- CPT Codes:
  - 92540, 92557, and 92625.
- ICD 10 Codes
  - None specified (so all included)
- Advise patient to quit tobacco use and refer patient to physician for counseling and pharmalogical options.

Screening of Tobacco Use

- Case history questions
  - Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? Yes or No
    - If yes, how often have you used a tobacco product in the past 24 months?
    - If yes, what type(s) of products have you used?
Screening of Tobacco Use

<table>
<thead>
<tr>
<th>Provider Plans to Perform or Performs:</th>
<th>92540, 92557 and/or 92625</th>
<th>92540, 92557 and/or 92625</th>
<th>92540, 92557 and/or 92625</th>
<th>92540, 92557 and/or 92625</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Reports:</td>
<td>Tobacco use at least once in the past 24 months</td>
<td>Patient was not screened for tobacco use for medical reasons (limited life expectancy, other medical reasons)</td>
<td>Patient was not screened for tobacco use OR cessation intervention was not performed but no medical reason was given for the lack of screening or intervention (NEGATIVE REPORTING)</td>
<td>Patient has not used a tobacco product at least once in the last 24 months</td>
</tr>
</tbody>
</table>

Step 1
- Patient was provided with tobacco cessation intervention including recommendations in the plan of care regarding referral to their ordering and/or primary care physician for pharmacotherapy options, referral for counseling, and/or providing literature on the importance of smoking cessation
- Code on claim 4004F with 1P modifier
- Code on claim 4004F with 8P modifier
- Code on claim 1036F

Step 2
- Code on claim 4004F

BUT, it must be a positive action

- You MUST report a POSITIVE ACTION (referral, documentation, or screening) for the reporting to count and to assist in avoiding the penalty!
  - Reporting that you DID NOT do something (G8858, G8428, G8432, G8511, or any use of 8P) is JUST LIKE you did not report at all!
Submitting mips quality measures

- A sample CMS 1500 claim form or its electronic equivalent), with MIPS, is available at: www.audiologyquality.org.
- Reporting options change with group reporting.

MIPS voluntary participation STEP #2: complete and attest to improvement activities

- MIPS also has a category known as Improvement Activities.
- Improvement activities are activities designed to improve clinical practice.
- Each audiologist must complete at least four of these activities listed above and each activity must be performed for 90 days or more during 2019.
- Audiologists will attest to their performance of these improvement activities at the EIDM site (https://qpp.cms.gov/login).
- Audiologists can learn more about improvement activities at:
  - https://qpp.cms.gov/mips/improvement-activities
MIPS Improvement Activity Examples

- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement.
- Collection and use of patient experience and satisfaction data on access.
- Completion of an Accredited Safety or Quality Improvement Program.
- Completion of the AMA STEPS Forward program.
- Depression screening.
- Engage Patients and Families to Guide Improvement in the System of Care.
- Engagement of New Medicaid Patients and Follow-up.
- Evidenced-based techniques to promote self-management into usual care.
- Implementation of condition-specific chronic disease self-management support programs.
- Implementation of documentation improvements for practice/process improvements.
- Implementation of episodic care management practice improvements.
- Implementation of fall screening and assessment programs.
MIPS Improvement Activity Examples

- Implementation of formal quality improvement methods, practice changes, or other practice improvement processes.
- Implementation of improvements that contribute to more timely communication of test results.
- Implementation of practices/processes for developing regular individual care plans.
- Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop.
- Improved Practices that Engage Patients Pre-Visit.
- Integration of patient coaching practices between visits.
- Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes.
- Participation in a 60-day or greater effort to support domestic or international humanitarian needs.
- Participation in Joint Commission Evaluation Initiative.
- Participation in Population Health Research.

- Participation in private payer clinical improvement activities.
- Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/).
- Practice Improvements that Engage Community Resources to Support Patient Health Goals.
- Promote Use of Patient-Reported Outcome Tools.
- Provide Clinical-Community Linkages.
- Provide Education Opportunities for New Clinicians.
- Provide peer-led support for self-management.
- Regular training in care coordination.
- Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
- Tobacco use.
- Unhealthy alcohol use.
- Use evidence-based decision aids to support shared decision-making.
- Use of telehealth services that expand practice access.
Planning ahead for MIPS measures and audiology 2020

- Elder Maltreatment Screen and Follow-Up Plan
  - Already a requirement in many state licenses.

- Basic Health Screenings
  - Body Mass Index
  - Blood Pressure
    - [https://www.cdc.gov/steadi/materials.html](https://www.cdc.gov/steadi/materials.html)
    - Can used automatic cuff.
    - Can be useful with vestibular and pulsatile tinnitus.
  - Pain
    - [https://consultgeri.org/try-this/general-assessment/issue-7.pdf](https://consultgeri.org/try-this/general-assessment/issue-7.pdf)
    - One of the warning signs of ear disease.

THANK YOU

[AUDIOLOGYRESOURCESINC](http://audiologyresources.com)  (773) 960-6625

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