Foundations in Coding in Audiology: A Primer

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- [Christy] Welcome everyone to the classroom. I would like to introduce today's presenter Dr. Kim Cavitt, who was a clinical audiologist and preceptor at the Ohio State University and Northwestern University. Since 2001, Dr. Cavitt has operated her own audiology consulting firm, Audiology Resources Inc. Audiology resources provides comprehensive operational compliance and reimbursement consulting services to hearing healthcare providers. Dr. Cavitt is also the past president of the Academy of Doctors of Audiology. She serves as the chair of the state of Illinois speech pathology and audiology licensure board and she serves on the audiology quality consortium. Welcome Dr. Cavitt and at this time, I'll hand the mic over to you.

- [Kim] Thank you, thank you so much to Christie and Kim and everyone at AO and it's always been great working with all of you. So today, we're going to talk about the foundations of coding in audiology and this is a foundational primer. So here are the learning outcomes. After this course, you'll be able to define the several CPT and HCPCS codes that are used for audiology services, describe the modifiers and their uses and define several ICD 10 codes that are commonly used for patients receiving audiological services. So here's a disclaimer from the AMA that these just so you know and we'll talk about this in just a second, current procedural terminology or CPT codes are owned by the American Medical Association and they're trademarked by them and we are just using them for educational purposes today. So the first thing is, why do we code? And I think that audiologists believe that we code solely for coverage but that's not actually, in a lot of ways not always the most valuable reason why we code. We code for not just coverage but for data. The data will help your practice make business decisions rather than emotional decisions. You will be able to look at this, the procedures you provided and look to see how many of this did I do? How many of that did I do? How many happened with this provider or in this location? That's what that coding data can give you. We code to reflect productivity so again, how busy is this office or this provider? And we do code for reimbursement but there is a difference between coverage and reimbursement. Coverage is when a third party payer pays in whole or in part for the cost of an item or service. Lack of coverage though does not

mean lack of reimbursement because reimbursement is when you the provider get paid. Some of that money will come from the insurance plan or company and some will come from the patient. We need to start caring more about reimbursement and not just coverage. Because all of the items and services we provide don't all have coverage. And that's when as we're looking at coding, sometimes the code is going to drive a patient, a procedure or service that is for patient responsibility. So let's jump right in CPT, HCPCS and ICD 10 changes. CPT or current procedural terminology and HCPCS codes, that's a Healthcare Common Procedure Coding System, those changes always go into effect on January 1 of each year. ICD 10 or the International Classification of Diseases the 10th rendition, those coding changes go into effect on October 1, so they don't go into effect at the same time. October 1 for ICD 10, January 1 for the other code sets.

Let's start with CPT. CPT stands for current procedural terminology. It's codes and their descriptions that is solely around services, procedures, audiology, diagnostic and rehabilitative services. CPTs are added, deleted and modified annually by their owner and creator, the American Medical Association and I'm gonna add here that the AMA controls everything about what a code means and how it's to be used. They explain that in things called CPT changes so when a new code comes out, they will print a publication that will explain the code, what it means and how it's used. And they'll give you what's called a vignette or an example patient. They also publish something every month called CPT assistant. And so every month any interpretation or any changes about what a code means is published in this publication. You have to buy access to that publication either in its paper or in some electronic format. It's not something they provide to people at no charge, it's something that you would need, if you want access to that you would need to have software or booklets that provide that kind of access. So they determine, the American Medical Association determines how a code is used. CPTs are five digit numeric codes. Most codes that apply to audiology begin with the numbers 92, with again, three digits following the 92. All of the codes except for the cochlear implant, the auditory brainstem implant and cerumen removal codes imply

two ears or binaural. So if you only test one ear, it's going to, we're gonna have to use a modifier which we'll talk about in a little bit. And again, as I already indicated, they're updated every January 1st. So let's start with vestibular testing without recording. One thing that I'm gonna really focus on is, are there other codes in the similar testing without recording? Yes. Would anyone actually practically do them? No. So I'm focusing on codes that people are practically doing. So vestibular testing without recording the most common procedures would be spontaneous nystagmus testing, including gaze, it's 92531 or 92532, which is positional nystagmus test. This could be used again for that Hallpike in isolation without recording or any position whether it's one position or eight positions that you might be doing but without goggles or without any sort of electronic recording. The codes without recording are non covered by Medicare.

So these two procedures 92531 or 92532 are non covered by Medicare, non covered by most payers as a result so in that case these would be private pay procedures. Now, here's the vestibular family of codes with recording. 92540 is a bundled code so 92540 encompasses the procedures of 92541, 92542, 92544, 92545 performed on the same patient, on the same date of service. So 92540 is spontaneous, with a gaze fixation, positionals, minimum of four positions and a Hallpike would be a position of positionals, with recording, optic kinetic, bi-directional foveal or peripheral stimulation with recording and oscillating tracking. So if you did all of those four on the same patient on the same day of the service you use the bundle code. Many vestibular folks though, don't do all four. It's very common now especially to do 92541 and 92542 in isolation and not do the rest of it. So if you do these, any of the four procedures 92541, 92542, 92544, 92545, if you do two or three of those four, on the same patient on the same day of the service you would list them individually and you would add a 59 modifier to each of them. A 59 modifier we will talk about in a little bit, but that is to show that it's a distinct procedural service, that you're not trying to unbundle a bundle. You also see here the TC/PC split. So TC is technical component, PC is professional component. These procedures are procedures that could be performed by a

technician. A technician would have to serve for Medicare and most payers under the direct supervision of a physician. It could also be a situation where the audiologist performs the technical component and the physician performs the professional component. So these procedures can actually be performed by two different providers and one would add a TC modifier and one would add a PC modifier. There's also the caloric testing so 92537 is caloric vestibular test with recording bithermal, bilateral, so that means you're doing a warm and a cool in each ear. If you only perform three irrigations, you would add a 52 modifier. If you perform more than four irrigations, you would add the 22 modifier, more than four might be iced water, but more than four you add that 22 modifier. 22 means increase procedural service, 52 means reduce service. So 52 means you did not meet the criteria of the code or you only tested one ear. 22 means you did more than the code descriptor. Now, when we get to those modifiers I'll talk about what they mean from a compensation standpoint. 92538 is bilateral but monothermal. You're only doing you're doing both ears, but you're only doing to each ear with cool or each ear with warm. If you only did again, one irrigation, you would add the 52 modifier there.

Again, this is another code that another set of codes that have that TC/PC split, that the services can be performed by a technician or by two separate providers. Here is the remainder of the vestibular family of codes, more of them actually not the remainder 'cause they're not all in one slide. 92546 is rotational chair testing. This code is only if you have a rotational chair. The only reason this code should ever be used, 92546 is you actually have a rotational chair regardless of payer, so it's not for vHIT and it's not for head thrust, it's for rotational chair testing only. 92547 is the use of vertical electrodes. So it's an add on code. So how that add on code is used is let's say you were doing a basic vestibular evaluation with recording, you would put 92540 and then 92547 below it, that's your add on code to 92540 to show that you used vertical electrodes, then you'd have 92538, 92537 most likely because bilateral bithermal and then you'd have another add on code for the use of vertical electrodes with the caloric testing. Now, use of vertical electrodes is for ENG only, except for

Florida Medicare. Every other payer it's for ENG only, except for Florida Medicare as a general rule of thumb. And again, these procedures have that TC/PC split in them. Now we have new code for 2020, around posturography, these are new codes. So we have 92548, that was the old posturography code but it's now been reworded so it is computerized dynamic posturography sensory organization tests. Six conditions including interpretation and report so you must again, interpret it yourself and have a report on this. Minimum of six conditions so if you don't do six conditions, you have to add a 52 modifier. You also for these codes 92549, 92548 or 92549 you must have a platform. This is not for foam, you must have a platform. That's that computerized dynamic posturography, that's what that means. Then 92549 is again the same procedures as 92548 but with the addition of a motor control test and an adaptation test.

So again, let's say you do all six conditions of 92548, but you just do the motor control test, you would do 92549, but with a 52 modifier because you didn't do the adaptation test. Anytime you don't meet all the requirements of the code, you need to add a 52 modifier. And again, here's your TC/PC split that's going to exist in these codes it can be performed by a technician or by two separate providers. Here are the basic wheelhouse audiology codes. Now 92551 is a screening test pure tone air. This is a pass/fail test. This is when you set that audiometer at 20 or 25 decibels and they hear it or they don't. This is not a threshold test, this is a pass/fail. This is non covered by traditional Medicare but may be covered by some third party payers. Some third party payers consider this your routine test, which is consistent across healthcare that the screening is what's routine and that's what they cover. So that's what you need to look at is that the procedure that is considered routine, rather than the comprehensive audiogram. 92552 is pure tone threshold air only. Some other payers also consider this to be your routine, just the air conduction. Again, because this is part, 92552 is part of 92557, you can't give that procedure away and still charge for 92557. 92551 you could as long as you never charged anyone, but 92552 now you're getting into the parts of 92557 and that's a procedure that you can't give away at no charge and then turn

around and bill Medicare for the same procedure or for 92557. So 92552 is air only, 92553 is air and bone only in isolation. 92555 is an SRT or an SAT, 92556 is an SRT or SAT or plus speech recognition testing. So bone and speech recognition testing can't be done independently of other things. And then 92557 the wheelhouse code, air, bone, SRT or SAT and word recognition testing done on the same patient, on the same date of service. If you bill two of 92552, 53, 55 or 56 on the same patient on the same date of service, each procedure needs to have that 59 modifier. It's a good time to note that you do not see the TC/PC split here, the reason being is because it doesn't exist. So these procedures to be covered by Medicare or Medicaid must either be personally provided by an audiologist or a physician or someone in their state like a nurse practitioner or physician's assistant who within their scope of practice is allowed to provide these for coverage. So this cannot be provided by an audio tech or audiology assistant or a technician and be billed to a payer. These require again, they don't have that split where part of it can be billed by one provider and part of it can be billed by another.

Here's your Immittance codes. I'm going to again go through their descriptions because these codes have been changed, they actually have some very firm use and description. So 92550 is tymps and reflexes done on the same patient on the same date of service. 92567 is tympanometry done in isolation. 92568 is acoustic reflex testing done in isolation, where that has the most utility is used for eSRT. That is where you use acoustic reflexes to program a cochlear implant. So that's the most common use of acoustic reflex test in an isolation, which would be around an eSRT. 92570 is tymps reflex thresholds, acoustic reflex testing thresholds and decay done on the same patient on the same date of service. Decay cannot be billed in isolation of tymps and reflexes. Unless again, you would have use 92570 and add a 52 modifier. Now to bill reflex testing, you have to establish thresholds, both ipsilaterally and contralaterally at at least two frequencies. So that screening 1000 hertz reflex that is pass or fail that is not billable because that is not a threshold and you have to establish thresholds, ipsi and contra at least two frequencies. If you just do ipsi or you just do contra or you only

do one frequency, you have to again add that 52 modifier to reduce the service. Okay, so the pediatric codes. The pediatric codes, had a CPT assistant article written on them a few years ago and now as a result they have very clear descriptions and very clear uses. And for that reason, that's why it's in quotes. It's in quotes directly from CPT assistant. So we're gonna go through them and I'm gonna interpret them for you. 92579 is visual reinforcement audiometry or VRA. This 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. It may be used for tones or speech. And again, this procedure could be repeated with speech, warble tones, narrow band noise, frequency specific noisemakers. Now, so VRA stands alone as a procedure. So if you use a head turn response, under headphones or sound field, speech or noise, it's one code. One code. You don't add another code to this. Because again, that's the way this was written in the CPT assistant. So you can't again necessarily add something on to this because this encompasses, again, tones and speech inserts or headphones and sound field.

Okay, so that's why that's all that encompasses in that one code. Now condition play is different, 92582. Condition play 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 in condition play audiometry, such as dropping a toy in a container or putting pegs in a board. It's typically done using earphones. So this condition play only represents tones. So if you did a speech awareness threshold with speech separately, you would bill that speech awareness threshold of 92555. If the patient, the child pointed at a picture board, either for spondee testing or for speech recognition testing, you would add 92583 to represent the speech, which is select picture audiometry. Again, none of these three codes are method code, so they are not add ons, they are not added on to a comprehensive audiogram. They all stand alone to represent their aspect of the procedure. Now, let's get to the CAPD battery of codes. So 92620 is the first of the timed codes. This is the evaluation of central auditory function with report initial 60 minutes. So this is for your battery, your test battery, this is actual procedures, not

talking to the family or counseling at the end. This is the test procedures plus the report. So you need to spend at least 31 minutes to use this code so it has to be the initial 31 to 60 minutes. You really should document start and end time of both the test battery and the report in the medical record. Now, you can actually use report writing time, you can charge for that because with report is built into the code descriptor. I'm gonna give you a but though, many payers put limits on the amount of 92621 that they will allow. So while you can bill for it and it will help to reflect in productivity and for good data to show really how much time are you spending on this, you may have limited coverage or reimbursement because they're not going to allow you to have an unlimited use of 92621. So 92621 is each additional 15 minutes, over the first hour of central auditory function testing and report writing. Again, you need to use, this you need to spend seven minutes or more so what's that? Seven to 15 minutes and it's billed as units.

So let's say you have a 90 minute battery and in report writing, it would be one unit of 92620 and two units of 92621. Now they do allow you to bill for the procedures, three procedures in isolation if you perform them in isolation, that's filtered speech test, that is not the QuickSIN or speech or any other speech noise testing that's not what that represents. There are actual central auditory processing procedures that are filtered speech tests and you would only use this code if you provided that procedure in isolation of any other procedures. Same with SSW, same with SSI. But I wanna stress that filtered speech test is not for the QuickSIN or speech noise testing. Also 92507 can be used for treatment of an auditory processing disorder individual. That is actually in a speech pathology typical code set and it's not covered by Medicare provided by an audiologist but some third party payers will recognize an audiologist for the provision of this service for auditory processing, rehabilitation, counseling, training, things of that nature. Now we're into the evoked potential family. And this is the first code that I'm gonna be able to say can be billed incident to, okay. What incident to means is you the audiologist provided the procedure, did it, did the technical actual performance of the procedure but you're billing it out under the patient's attending or

treating physician. The only for Medicare, Medicare requires that with a few exceptions, which we're gonna talk about these exceptions that if you the audiologist provided it, it must be billed out under you the audiologist NPI to Medicare. Facial nerves function studies is the first one that is not considered on the audiology code list. So that means it can be billed incident to the physician and that is ENoG or facial nerve function studies. 92584 is electrocochleography, that code can be used for either true ECoG, electrocochleography, or for CI cochlear implant neurotelemetry either done intraoperatively or post operatively. The problem with the code for CI neurotelemetry postoperatively is there is a, there's an edit, that means that if you bill for programming of a cochlear implant and ECoG on the same patient on the same day of the service, they're only gonna pay for one of those procedures because there's an edit that will mean that the other procedure is non covered and in an edit, you can't bill the patient for the non covered procedure.

So that's really the only edit that's not common sense that exists so again, if you're doing neurotelemetry on the same day of programming a cochlear implant, they're not gonna pay for both procedures and you're not gonna be able to bill the patient for the procedure that they don't cover. 92585 is a comprehensive AVR that's either if it's a threshold search that took you three hours audio neurologic that took you 15 minutes. Again, that procedure has that TC/PC split again and it can be performed by two separate providers or a technician working under the supervision of a physician. 92586 is, whole purpose is unlimited ABR is for newborn hearing screening. It is a pass/fail ABR and again, it has that TC/PC split capacity. Now we're in the OAE family of codes, I'm gonna actually reword them a little bit, the first code is 92558. It is a pass/fail OAE screening, automated analysis. It is not covered by Medicare. It is really not considered diagnostic in nature. Its whole purpose for creation was around newborn hearing screening programs. 92587 and 92588 are covered by Medicare and most payers, they also have that technical professional component split there and they do require an interpretation report so you cannot have a pass/fail protocol in your system. You have to be interpreting the OAEs and writing a report. I'm gonna reword the first one here so

92587 is the distortion product evoked otoaccoustic emissions limited evaluation to confirm the presence or absence of hearing disorder, three to 11 distinct frequencies per ear or transient evoked otoaccoustic emissions and again, you have to have that interpretation report. Why I reworded that is 92558 in order to be able to bill that you have to do at least 12 distinct frequencies per ear. So 92587 would be three to 11 and 92588 would be 12 or more. Please make sure that when you start billing these codes that you are actually billing the correct thing and that your equipment is actually has the capacity to perform what you're billing for. And again, neither 92587 or 92588 are pass/fail, you actually need to interpret and write a report. Here is the hearing aid family of codes that is in the CPT code set. So 92590 and 92591 are that hearing aid exam and selection, that's where you sit down and talk to the patient and determine the make and model of hearing aid that they need. This to me is not diagnostic in nature, in a minute we're gonna talk about a different procedure that is, this is that, again, that assessment for hearing aid, that hearing aid console, that hearing aid exam, that hearing aid eval. 92590 is if the patient only has a hearing loss in one ear, it's not that they only got one hearing aid, it's that they only have a hearing loss in one ear. 92591 is a hearing loss in two ears.

So 92592 and 92593 are about the number of products you have. So a hearing aid check 92592, a hearing aid check, oh 92592 is monaural, 92593 is binaural. This is your hearing aid evaluation management, your hearing aid follow up code. This is what represents those cleaning checks, those follow up visits, this is the code that represents that visit. And in the checking of the hearing aid that happens in that visit this is what that purpose of this code is. 92594 and 92595, or an electro acoustic analysis of a hearing aid, 94 one hearing aid, 95 two hearing aids and this is in a HIT, this is running a hearing aid in a HIT box. This isn't for real ear, this isn't for live speech mapping, this is actually running a hearing aid in a HIT box and I strongly recommend that people do this. So most data that you'll see around this and this is not the fault of the manufacturer, this is the fault of the shipping and delivery process is that somewhere between 10 and 20% of new or repair hearing aids will not meet the spec

when they arrive in your office. And the first thing you need to check if they don't meet spec is to check the directional mic because that is usually what gets out of kilter in shipping. So please, if you're asking people to spend thousands and thousands of dollars on hearing aids, please spend the time to make sure they're functioning when they arrive in your office. None of these codes, 92590 through 92595 are covered by traditional Medicare and they're typically only covered by payers that offer a hearing aid benefit. Now, here's your cochlear implant programming codes 92601 and 92603 are the initial programming of, so that's your initial tune up of a new cochlear implant or an upgraded processor, not a replacement processor for repair that they have upgraded to processors. So 92601 is anyone, zero to six years of age and 92603 is anyone seven years to 150 years, wherever however it is on the other end of the equation. 92602 and 604 are that subsequent that's that reprogramming. So if on the same date of service, you perform neural telemetry, evaluation of AR status, or ESR key, please add a 59 modifier to each of the procedures to show that these are each distinct procedures.

And again like I said before 92584 performed on the same date of service you won't be able to collect payment for both procedures. Now let's talk about bilateral programming and there are really a few ways to approach this. One is you add the 50, now, of all the few ways to approaches, some work for some payer, some don't work for others, there's a lot of experimentation here but I'm gonna give you the best options. You can add the 50 modifier, 50 means bilateral, you can do two, or you can do two line items. So you do 92601 RT, 92601 LT, two line items with the right left modifier. I would never bill two units of the one, of that code that's going to get non covered. But I have seen some success with the 50 modifier and I've seen some success with two line items with the right left modifier to represent each ear. Intraoperative monitoring, the first thing about intraoperative monitoring is it's how it's allowed by state licensure. Are audiologists in your state allowed to monitor and if so what are the rules around that? But let's say you are providing intraoperative monitoring, all of these things can be billed incident to a position. 95907 is nerve

conduction studies, one or two studies, that means you might be monitoring the facial and the auditory nerve. Another option would be 95940, or 95941, 92940 means that you are in the OR, you're doing one on one monitoring and you would bill it as units of each 15 minute increment. You would also bill if you use one of these two codes the ABR because that's showing what you are monitoring. Typically in our case 95941 means that you're outside the operating room and you might be monitoring more than one case, you might be monitoring multiple operating rooms and again this is a per hour code but again would be billed with units and you could, of hours not 15 minutes and you can again, add that 92585 ABR code to show what you are monitoring. Here's some additional audiology codes, 92565 the pure-tone Stenger, 92577 the speech Stenger, 92596 this is ear protection attenuation measures, there are payers including many Medicare plans that will cover you to show that your ear protection is reducing volume but that coverage is typically limited to people who have tinnitus, to people who have misophonia hyperacusis things of that nature not just show that a musicians plug 'cause remember, insurances don't pay for things like musicians plugs or noise monitors for occupations, that's something that's the responsibility of either the patient or their employer.

So this would be around the medically necessary use for a medical condition that they cover evaluation of attenuation. 92625 is assessment of tinnitus that means you have to do pitch, loudness matching and masking. If you do not do all of those components again, you need to add that 52 modifier. 92626 and 92627 were changed codes in 2020. Their whole description changed their utility was what their utility was always intended to be, but their descriptions changed because people were using these codes outside of their utility. So 92626 is evaluation of auditory function for surgically implanted devices, candidacy or post operative status of a surgically implanted device, first hour. Again, you need to spend at least 31 minutes, and you wanna document start and end time in the medical record. 92627 is each additional 15 minutes above the first hour. Again, you need to spend at least seven minutes and you document that start and end time in the medical record and it's billed with units. And then 92640 is

that diagnostic analysis of an auditory brainstem implant that's per hour and if it's more than one hour, you would, once you get to an hour and 31 minutes, you could bill that as two units. Let's talk about 92626 and 92627 separately. These codes only purpose for third party coverage is candidacy determination testing and post operative assessment of a cochlear middle ear osseointegrated or auditory brainstem implant. It has no utility, it'd be inappropriate to use it for any other situation and you must spend at least 31 minutes to bill 92626. This code is not to be used for hearing aid related visits outside of candidacy determination. It is not for a BAHA or cochlear implant fitting or troubleshooting. It is not for tinnitus evaluation management. It is not for speech in noise testing outside of implant candidacy and post operative assessment. And it is not for aided testing outside of again implant candidacy or post operative assessment. If you're using it for any other purpose please stop. It's only around implantable devices and again, the description completely changed on January 1 of 2020.

Here's some other audiology related codes and again, this is all about what is allowed by your state scope of practice. So 69200, removal of a foreign body from the external ear canal without general anesthesia, that foreign body could be a dome or multiple domes, it could be a wax guard, it could be a bean, whatever it is that you are removing from the ear without anesthesia, again, not covered by traditional Medicare, it can be billed, all of these things can be billed incident to the patient's attending physician, with the physician providing direct supervision. So that you would need if you're, if you work in a medical environment that patient's attending physician would have to be available to provide care. That's why a lot even in those settings, it's not easy, really not possible oftentimes to have the patient only there when their attending physician is there. So 69200 removal of foreign body, 69209 its removal of impacted which is underlined cerumen using irrigation or lavage and that's unilateral. All these codes are unilateral. Now impacted, that means that wax is blocking clinically significant portions of the ear canal. That is not the little brown ball that you can see around that you want out. This is clinically significant portions of the ear canal, that's

when these codes come into play. So 69209 is irrigation lavage, 69210 is any other instrumentation, an alligator clip, a curate, whatever else you might, whatever else you might be using. None of these are covered by traditional Medicare, they can be billed incident to a physician and while they can have a 50 modifier, it's typically most payers still only while you can add that bilateral modifier of 50, they're typically only gonna reimburse you for one irrigation when they do have coverage. Let's talk about rehabilitation/habilitation codes, 92507 is that treatment of the, none of these are covered by traditional Medicare if provided by an audiologist.

So 507 is treatment of an auditory processing disorder individual. 92630 is auditory rehabilitation, prelingual hearing loss, 92633 auditory rehabilitation postlingual hearing loss. These procedures actually are things that you could provide via telehealth but again, you're going to have to have someone, the patient is gonna be financially responsible in most cases for the provision of this care. And again, you can only provide telehealth as allowed by your state license. You also have canalith repositioning 95992 this is per day, it's not covered by traditional Medicare provided by an audiologist and can be billed incident to a physician. 97112 is neuromuscular reeducation of movement balance coordination, kinesthetic sense, posture, proprioception, proprioception and it's again, it's allowed by state licensure laws and not covered by Medicare if provided by an audiologist. And 97112 would really represent balance and gait training, or some form of vestibular rehab outside of canalith repositioning. Here's some additional, again, rehabilitation/ habilitation codes. These are new or revised for 2020. That's the interventions, therapeutic interventions that are around cognitive function that you're doing cognitive behavioral therapy. Some of the listening therapies kind of fall into that and again, the first one is direct one on one patient contact initial 15 minutes. You need to again document that start and end time and these are only as allowed by state licensure. So the first one again is the focus on cognitive function, the second one is each additional 15 minutes after the initial 15 minutes. So the first one is the initial 15 minutes, the others are each additional 15 minutes and billed as units after the original 15. And again, can you in

your state, do you have the appropriate training and can you in your state license provide these procedures? This is another thing that could be again, as allowed by state law provided via telehealth but again, there's no coverage from a third party payer here if this is provided by an audiologist. Medicare does not cover audiology services that are rehabilitative in nature. They don't cover them, we are diagnostic only profession in the eyes of Medicare and then many private insurances follow that same guidance. Here's some assessment and screening codes and these are again all as allowed by state licensure. 96112, that's a developmental screen, developmental milestones survey, speech language screen, these are screenings with scoring and documentation per standardized instrument. If you do more than one standardized instrument, you would bill this as more than one unit. 96127 is that brief emotional behavioral assessment with scoring and documentation per standardized instrument, this could be around screening for depression. Again, as allowed by state licensure and would be billed as units if you did more than one brief behavioral or emotional assessment.

And then the third one is 97750, a physical performance test or measurement with written report, each 15 minutes. This could be for your balance gait or falls risk assessment would be billed as units if it took more than 15 minutes and again as allowed by state scope of practice. So there are many procedures that we provide that don't have a code and that's when we use 92700 is to classify procedures that don't have a CPT code. Coverage of 92700 is very limited. Each of these, each of these submissions are individually reviewed. So what's typically going to happen is you're going to submit the code electronically, then they're going to deny it, they're going to push it back for additional documentation because of and these because these codes are again, typically non covered, you would wanna have an advanced beneficiary notice in place for traditional Medicare beneficiaries or a notice of non coverage for other payers. Because you're using an ABN or notice of non coverage, you can collect payment for these procedures at time of visit which I would strongly recommend that you do and that you and these procedures you can have more than one 92700

procedure on a single claim, they would all be listed not as units but as individual line items on a claim. So they're going to deny for additional documentation, what you would send in is a copy of the patient's report from that date of service, you would also have a sheet that you would have for all the procedures that you use 92700 for and the sheet would be specific to that procedure and would have a description of the procedure, the clinical utility of the procedure, the time it takes to complete the procedure, the skills of the tester, the equipment used, the benefit to the patient and your office's usual and customary fee. So here I've given you example of documentation for events. It talks about the description of the procedure, what it means, the time it takes to test it and then I would compare it to other procedures that have similar time, the skills of the tester, the practice expense, how much it costs you to provide this procedure, that usual and customary fee and any references or guidelines that show its efficacy.

Here are some very common 92700 procedures, a communication needs assessment, which is to me a diagnostic procedure where you are really evaluating the patient's whole communication paradigm and trying to create a care plan for that that might include a hearing aid, might not, VEMPs high frequency audiometry, behavioral observation audiometry, eustachian tube function testing, ASR, FFR, the late latency response, use of goggles, saccade, use of goggles. So remember, in EMG in a lot of cases you are not using, oh, you're not allowed to bill if you're doing VMG for electrodes, so use of goggles could be where you're trying to recoup some of the monies for the maintenance and calibration and purchase of goggles. So use of goggles, saccade testing, head thrust testing, speech in noise. Speech in noise testing falls under 92700, tinnitus management, removal of incidental cerumen, fistula testing, Vhit, vestibular autorotation test, fukada, acceptable noise level testing, prosthetic device fitting or service, so the fitting and orientation of a cochlear implant and auditory brainstem implant, an osseointegrated device and then any evaluation of AR status that is less than that 31 minutes. Codes are used with caution. If your employer or your colleagues are telling you to bill these procedures in your office and you don't, you're

not actually doing them or you don't know what they mean, please, please look into this before you start using these codes. They include binocular microscopy that actually requires a microscope and it is the looking in someone's ears with a microscope. 92533 and again, in your scope of practice or in your coverage, is it covered for an audiologist to provide this service? 92533 and 92534 are these vestibular procedures without recording, Bekesy, loudness balanced test, short increment sensitivity tests, sensorineural acuity tests. Are you actually performing these procedures and are they medically necessary for the patient in front of you? I'm just gonna show you the category three codes to just let you know that Medicare has been collecting data on automated or computerized audiometry for many, many years and this for physicians that are using these procedures, this is how they've been collecting this data is with these category three codes, there's no coverage assigned to them, they're for data collection purposes only.

And again, audiologists need to be prepared that I suspect that in the next five years there will be limited coverage for automated audiometry. NCCI edits is when these two codes or these code combinations cannot be billed together on the same date of service for the same patient and be paid by both codes because they conflict like so let's give an example, you can bill for 92587 and 92588 on the same patient on the same date of the service because 92588 encompasses 92587 that would be a coding edit. And again, you can't have a patient sign an advanced beneficiary notice and bill them privately if a coding edit exists, you're only gonna get coverage for one, one of the procedures. We're gonna go through some of the modifiers now so these are are things that you would use to modify a CPT code and I'll talk to you about the ones that can be used to modify a HCPCS codes but these are the common modifiers for CPT codes. 22, increased procedural service that you spent more time than the typical. This doesn't always lead to increased coverage, you could have a separate price for like thresholds or JBR, or a functional hearing assessment, you could have a separate price that went along with this 22 modifier but typically, you're not going to get additional coverage. You will though that 22 can help reflect productivity and data

collection of really how much time you're spending on these procedures. A 25 modifier is an evaluation management service on a day when another service was provided to the patient by the same position. Now, we're not going to get into evaluation and management in this particular webinar, there is a webinar specifically around that. To be able to provide evaluation management services as an audiologist, most payers do not cover them, not all but Medicare does not cover evaluation management provided by an audiologist and you have to have in your scope of practice the ability to evaluate and manage because the whole code set starts with the underlying premise that it's in your scope of practice to evaluate and manage, in the United States that is determined by your state licensure board.

So if for example though, you were doing an evaluation management service on the same day, like let's use an example, it might not be uncommon to assign evaluation of management to a tinnitus evaluation 'cause you're really doing a lot of evaluation of management type services in a true tinnitus evaluation, let's say you were billing 99202 and 92625 on the same patient on the same date of service, both of those procedures would need to have the 25 modifier added to them to show that they are distinct and separate entities. But again, audiologists can only provide evaluation management as allowed by state license and if they know what the codes mean and how to use them. And again, there's a separate webinar specifically on that. 26 modifier that's a professional component, that means that you interpreted and reported the item or service but you didn't physically perform it yourself. It would be very uncommon for an audiologist to perform only the professional component because we can't have technicians working incident to us, they have to work incident to a physician so it'd be very odd for an audiologist to be able to report a professional component. A 32 modifier is for a mandated service that might mean that you might not have medical necessity but that it's mandated. So for example, there are states where someone with mental retardation has to be tested every so many years, on those tests if you lacked medical necessity, you could add the 32 modifier and have that show that this was because of a state mandate. 33 is for preventative service. The only purpose of a 33

modifier in audiology is when billing for that newborn hearing screening test, test scenario. So anything from birth to that child mean diagnosis hard of hearing, or normal, any procedures in that window of time should always have the 33 modifier added to every one of them. Bilateral procedure that means that it's cerumen removal or a cochlear implant or an auditory brainstem implant, if you have binaural bilateral, then you can add that 50 modifier and see if that aids in coverage. 52 means reduce service. That means maybe you only tested one ear, you didn't meet all the components of the code. You don't reduce the fee, you submit your and usual customary fee and you let the payer reduce accordingly. You just add the modifier and let them reduce. 59 is a distinct procedural service. It's used in situations where you're unbundling parts of an unbundled code like 92540, 92557 or with the programming of the CI codes and you're adding 92626 or 27 or 92568 so that they can show that these are distinct procedural services.

And again, a 76 modifier is the services and procedures that were repeated or provided by the same qualified health provider. That means you would add it, let's say you did two audios in one day, it could potentially be around gentamicin injections or that's my best example that I'm able to think of today that you're doing multiple audios on the same patient in the same day, you would add the 76 modifier to the repeated procedure and again, you don't bill it as units separate line items with the 76 on the separate procedure. 95 which is synchronous telemedicine that's services rendered via real time interactive audio and video that means that you are, the patient and you are in real time telepractice. Remember, telehealth is a different provision of service, it's not a new service so that's why you would need to have a 95 modifier. So let's say you're doing auditory rehabilitation with a postlingually hard of hearing adult, you would add, you would fill 92633 with a 95 modifier 'cause you're doing it in real time again, for audiology most of the services that we can provide via telehealth are non covered services because again, Medicare and many payers don't cover treatment provided by an audiologist and that's most of what we're able to provide via telehealth and they don't cover evaluation management provided by audiologists which is another thing we

could provide via telehealth, but even evaluation management will be very limited by an audiologist because most of our evaluation is around test procedures that are challenging for us to provide via remote practice. 96 would mean a habilitative service, that means the patient never had the skill and you're teaching them a new skill that they didn't have, or 97 a rehabilitative service that you wanna be able from a data perspective to differentiate between your vestibular rehabilitation or your auditory rehabilitation. This is not really about coverage, these two modifiers it's about data that you wanna know are you teaching a new skill or you are teaching them to adapt to a previously learned skill? So let's say you're teaching them a new skill, it might be a vestibular rehab, you're teaching them to like a balancing gait train, you're teaching them a skill that they had never adapted but adapting to a previously learned skilled, rehabilitative might be you're teaching listening skills, they had the ability to listen but now you're previously you're helping them adapt to that ability to listen now with a hearing loss. A GW modifier is a service, is not related to the terminal hospice condition.

So let's say you're seeing a hospice patient, either in your office or at the hospice, you would always wanna add the GW modifier because that's gonna show that this is not at all what you're providing, is not at all related to the hospice condition. And a TC modifier is technical component, that means that you performed the procedure but you didn't interpret the results or report the results. It would not be uncommon for an audiologist to provide the technical component of vestibular or auditory brainstem testing and then a physician interpret. So you would bill for the provision of the service, the physician would bill for the interpretation. And again if you want some great information on modifiers I've put some links here. Some HCPCS modifiers, these are modifiers that can modify HCPCS codes. LT, left ear, RT right ear, NU new item to distinguish between a new and a replacement, RA is a replacement item, UE used and then the modifiers for rentals if that is something that is allowed in your state or locality. Again, your telehealth modifiers, telehealth can only be provided by audiologists as allowed by state law. Medicare doesn't cover telehealth services provided by

audiologist because most again of the services that we provide if it's not covered in a face to face interaction is not gonna be covered via telehealth. So, and again, there's your GQ modifier, that some payers recognize GQ, some recognize 95 to show that it's via interactive audio and video telecommunication systems. Here are Medicare only modifiers. Your GA means a waiver of liability on file. That means that you had an ABN or an advanced beneficiary notice sign for a required notification such as use of 92700 or the existence of a local coverage determination. GX, that you issued ABN but was for voluntary patient notification purposes only. GY means the item or service is statutorily excluded from Medicare coverage or does not meet the definition of a Medicare benefit. This is when you want that Medicare denial that these are services that are never covered if provided by an audiologist and this can be used with a GX modifier. And GZ, that means the item or service expects to be denied is not reasonable or necessary. You should have had an ABN signed but you didn't.

So it's important that also that we consider place of service codes. Place of service codes is when we see a patient somewhere else that we change the code of where we see them. So you change your setting, you change your place of service code. So here are the place of service codes that apply to audiology. Telehealth means again, that you provided it via remote. I'm gonna really focus on the ones that have some hiccups to them. So the ones with two asterisks place of employment, a birthing center, a comprehensive outpatient rehabilitation center, audiologic testing is never covered by Medicare if provided in this places of service. Things with one asterisk an outpatient hospital, an inpatient hospital, on an campus outpatient hospital, an ambulatory surgery center, a skilled nursing facility or a hospice. When you are in those scenarios, the facility is the biller because the patient is under a part A stay and you are a part B provider. So in those cases, you would need to have that facility compensate you. It's not going to be the patient's insurance coverage, it's going to need to be that facility and so before you jump into these arrangements, make sure that that is all worked out ahead of time as to who is the responsible financial party. And again, I've outlined that here for a little bit more information. Otherwise the patient is gonna be responsible and

I would recommend an advanced beneficiary notice if we're talking about Medicare, so please same with home health. Home health is not something if the patient is under a home health stay, that means they can't leave that but the things that you might provide might not be covered and again, this is where ABNs can be very useful. Pediatric testing you can bill for attempted if as long and that you didn't get to the end as long as you're really documenting what happened, why were you unable to complete the testing and did you spend at least half the time of the typical test attempting the procedure. Documentation is key. You don't need a modifier here, you can bill for the full procedure but please explain what happened because this child will come back and we will need to have that information.

Again, billing for impacted cerumen again, Medicare doesn't cover audiologists to remove cerumen so Medicare patients can be billed privately for the removal of impacted cerumen on the same date of service as an audiogram, but they cannot be billed privately for removal of incidental or non impacted cerumen that is inclusive to the audiogram. You could bill for the removal of non impacted cerumen if it was on a separate date of service of any audiologic diagnostic testing, but if it's on the same date of any audiologic test, it's inclusive, if it's on a different date of service you could bill the patient privately. But impacted cerumen is always something that you can bill a patient privately for. Again, VA, Workers Comp, Medicaid, do not follow the coding conventions that we're always talking about here today, you really really need to look in this scenario at what the rules are for that payer and follow those rules. Now we're gonna go into ICD 10 which is the international classifications of diseases, the 10th revision. These are listings of codes to classify diagnoses and symptoms. They're created by the World Health Organization and the Centers for Disease Control here in the United States. They consist of up to seven characters and they are changed every October 1. Now, really important in ICD 10, that you code with the patient, their family or physician report in their case history or on their order. Your case histories need to focus on the whole patient, not just the auditory system because co-morbidities are very important in driving medical necessity. And so sometimes you may need to reach

out to the primary carer or ordering physician to get a list of the patient's diagnoses. Once you get it from someone that it's in their scope of practice to diagnose that, then you can use it on your claims, you just need to have it in your documentation or your medical record where you got that diagnosis. You can't make a diagnosis of autoimmune disease or MS or diabetes, or otitis media, but other people can and they can give you that diagnosis that you can use on your own claims. You also wanna code what you measure and what you visualize, like extotosis or cauliflower ear. Please do not code diagnosis for coverage, we don't know if the repeal of the Affordable Care Act will have allow for pre existing conditions. So you could be putting a diagnosis on there that they don't have just to drive the coverage of the $30 audiogram that could haunt someone down the line as a pre existing. So you never code what you know, you only code what you can, what you know they have, what you can see, what you can measure not things that you've already ruled out.

Also again, the documentation of that case history, the test results, the plan of care is very important in ICD 10 coding especially if you work in a hospital system or someone on the back end is checking your coding before the claim goes out. Please, please have good case histories, good plans of care, well documented test results, so that again the coding is reflected as it goes out the door. Unrestricted means normal, restricted means abnormal as we talked about these codes. Local coverage determinations are important and we're talking about ICD 10 coding because this is where a Medicare administrative contractor or who administers Medicare in your community has decided that for us to pay for X procedure, the patient must have one of wide diagnoses so that's why this is important to know. Here are the local coverage determinations that exists today in audiology, please just take a look at these and see how they impact you. You'll see the link here at the bottom of this page that you can go to there and look up them for yourself. But these are your contractors listed and then the local coverage determinations that apply. Here's an example of a local coverage determination why I use this one, it's the only one that will fit on a singular page, is if you do a stenger, for coverage for this contractor which is Novatos, you

would need to have one of those diagnoses or the procedure would not be covered. So again, when you have local coverage determinations in place, advanced beneficiary notices are very, very important. I am not going to read all of these diagnosis codes to you as we go through this webinar, I'm gonna really focus on the highlights. They're all here because they have an implication audiology but I am just gonna focus on the ones that may need a little bit of more descriptor. Let's start with abnormal auditory perception. Abnormal auditory perception doesn't really have a definition but really and there are some payers because of that don't consider it a true diagnosis so this should not be something that should blanketly be used. Abnormal auditory perception why I would use it, if it were me, I would use it to represent that hidden hearing loss, the person that reports a hearing handicap but you have normal audio metrics. And I would use this as a precursor to cognitive or auditory processing evaluation that you're getting all these normal audios it's not explaining why they're having communication difficulties. That's when I would use abnormal auditory perception. The benign neoplasms of the cranial nerve that is your vestibular schwannoma. Here's your cauliflower ear recruitment.

Okay, here are, we're now starting your hearing losses. You're gonna see a slide in a minute that's going to show you how do you code two different types of hearing loss in two different ears. So, H90.12 and H90.11 means that one ear has a conductive hearing loss and one ear has normal hearing. That's what the unrestricted means normal. R62 a delayed milestone in childhood R62.0, diplacusis, dizziness is a symptom not a diagnosis, I would never have R42 be my primary or only code. Please this is where co-morbidities are super important. I would never have that be my first code listed or my only code listed, there's a lot of payers that just deny R42. Z51.11 here's a good time to talk about the Z codes. The Z codes are very useful for data collection, they can some of them be problematic for coverage. This would be one that would probably not be problematic for coverage but a good rule of thumb with Z codes it should never be your first code listed and it should never be your only code listed. Never be the first and never be the only 'cause when Zs are the first or the only that's

when you tend to see denials and this would be that you are maybe doing ototoxicity monitoring of a cancer patient. Foreign body, let's talk about the foreign body in the ear. Foreign body initial encounter is the first time you saw that individual to remove that foreign body. Subsequent would be the second time you saw that individual to remove that foreign body. Sequela is the third or more time you saw that individual to remove that foreign body. So initial is always the first time, subsequent is the second and sequela is the third or more. Let's talk hearing conservation treatment Z code again. Health insurers do not pay for hearing conservation. Z01.110 hearing examination following failed screening this is a Z code that you would use it for a child who failed a newborn hearing screening. This is one that I would be fighting whether it's an adult or a child for coverage if this was my only option, if this was my only option because Medicare is very clear that they cover hearing tests that are a result of a failed screening that's clearly documented so are the newborn hearing screening guidelines.

So those are ones that you can fight denials based upon mandates or based upon policy. So that would be probably one of the only Z codes that you might be able to appeal and get coverage if it was the first or only. I would never make it first but if it was the only. Z01.10 is that hearing examination without abnormal findings, it was normal. And that is again one that you will often time see denials if it's the first or only that's when you might wanna consider co-morbidities, abnormal auditory perception if they actually have a hearing handicap that you've documented or anything else that you visualized. Z01.118 is hearing examination with other abnormal findings. Maybe you found that they failed a cognitive screening, maybe you found that they failed an APD screening but you can't diagnose that condition yet. Maybe you found a hematoma. Maybe you found external otitis, that you found something else that was abnormal. History of falling, there's another Z code that you again, could probably fight for some coverage if that's the only code that you have an option 'cause everything was normal in vestibular but they had this significant history of falling. Impacted, remember, this is codes for impacted cerumen, not that little incidental. Intellectual disabilities, these you're going to need to get from the family or the facility or from the

patient's primary physician, what is their classification and once you have that you can use that accordingly. Long term use of aspirin, long term use of the antibiotics, those again could be great for data collection as we're looking at toxicity. Oh, let's go back to meniere's, meniere's is now not classified as active or inactive it just is so if the patient has a meniere's diagnosis, you'll use this even if they're asymptomatic. Again, your mixed hearing loss, Z96.22 would be another Z code that, again shouldn't drive a denial, I would really try very hard to not make this primary instead I would get from the physician, the otitis media code that is used but myringotomy tube status is a great way to represent those temps to see if the tube is patent. Observation evaluation of a newborn for other specified condition ruled out.

This is a Z code that you may get stuck with and you may have to use as only if it's a baby that's born at home that's 100% a normal baby with no co-morbidities, no nothing they were born at home, you're doing the very first newborn hearing screening and it's normal, this might be your only code option. There's Otorrhagia. Otorrhagia those diagnosis codes can also represent fullness or pressure because on a pain scale, people will oftentimes measure those on a pain scale so otorrhagia can represent fullness and pressure as well. Let's talk about the ototoxic hearing loss, you can only use the code for an ototoxic hearing loss when you can confirm that the hearing loss is due to the toxic agent. But you can use the poisoning without the ototoxic hearing loss but you can't use the ototoxic hearing loss without the poisoning. So let's say you have someone who you're doing a baseline on, a baseline ototoxicity monitoring, they haven't had any chemo at all. The cancer would be the primary diagnosis and then anything you measured or saw. So let's say then the patient comes back after they've had like four weeks later after they've had chemo. Then you would add the poisoning the antineoplastic, the initial encounter of the poisoning. If they had a change in hearing then you could call it an ototoxic hearing loss. If they had no change in hearing, you would just have the poison plus the cancer plus anything you saw or measured, any other co-morbidities and again, its initial subsequent sequela as before. Pulsatile tinnitus is separated from non-pulsatile tinnitus, there's our wheelhouse sensorineural

hearing loss bilateral. And again, H90.42 would be sensorineural hearing loss in the left ear, normal hearing in the right, we'll talk about the different hearing losses in different ears on a singular slide. It will make so much more sense there. Here's your speech language delays. Some of these you're going to have to get the diagnosis from the pediatrician, from the primary care or from the speech pathologist. The sudden idiopathic, here's your tinnitus and I would only use a tinnitus diagnosis if the tinnitus is bothersome or debilitating not if it's just comes and goes only the bothersome or debilitating tinnitus. Vertiginous disorder of vestibular functions. So let's say the patient is having a vertiginous incident, this will be a great way to separate active meniere's from inactive meniere's. So there is active, they have vertiginous order of vestibular function and the underlying disease is meniere's. And now here are your vertigos aural, central and peripheral.

Okay, here's where the different hearing losses in different ears. So here's what needs to happen. You need to select two of the above codes to represent the different hearing losses in different ears. So you need to have one code represent the right ear and one code to represent the left. So let's say for example, they have a conductive hearing loss in the right ear but a sensorineural hearing loss in the left, it would be H90.A11 to represent the right ear and to represent the left ear would be H90.A22 to represent the sensorineural hearing loss in the left ear. So you just need two of them one represent the right ear and one represent the left. Again, here's your chemotherapy, here's your cancer, if they've had the chemo, you can add the poisoning and you wouldn't code the ototoxic hearing loss until you can prove that the poison caused the hearing loss. Asymmetric, you code the hearing losses themselves and you disregard the asymmetry. Right now there is no way to code an asymmetry. So for example, a bilateral asymmetric hearing loss is coded as the bilateral sensorineural hearing loss. That bilateral asymmetric sensorineural hearing loss is coded as a bilateral sensorineural hearing loss. Routine, there's no CBT or HCPCS code for routine hearing test, the diagnosis codes that get as close to routine is Z01.10, that's that examination of hearing ears ears and hearing without abnormal

findings or that encounter following a failed screening, or the encounter with other abnormal findings. You can't again, don't code things you've already ruled out, once you know they don't exist because you could be giving someone a pre existing condition and again, sometimes it's, excuse me, it's the patient's responsibility to fight for that coverage, not yours. You can't code something they don't have just so that they can get something covered. Coding normal hearing with no other co-morbidities. Maybe you have again that hearing vestibular exam without abnormal findings or you code, abnormal auditory perception if they report communication difficulties, have a hearing handicap or poor speech in noise results but a normal audiogram. Normal vesib it could be your history of falling or the co-morbidities that drove the medical necessity.

And again, you're going to need to get those co-morbidities oftentimes from their primary care physician or from the order. Newborn hearing screening follow up, any pre or post natal conditions, any co-morbidities, code anything you see or measure if they previously failed that hearing screening code Z01.110. Add that 33 modifier to every procedure in that window of time, from birth to evaluation of hard of hearing or normal and again, you could consider that Z05.8 for those babies that are 100% normal but born at home and you're doing that initial newborn hearing screening. Again, make sure to add the 33 modifier but sometimes this is going to be your best option if everything is normal and this was their initial test. Again, for things outside your scope of practice, they might come on your order, you might need to reach out to that attending physician or to that provider and document it in your medical record where you got those diagnoses before you start to use them. Again, you code what you learn and find, you don't code for coverage. Don't use rule out diagnoses once they've been ruled out, here's a great article from one of the Medicare contractors where they talk about this. You put the co-morbidities or confirm reasons for the test first and you can code up to 12 diagnoses per claim. But again, you wanna make sure you put those co-morbidities and what's driving the medical necessity first. You can link diagnoses to procedure, what's called the diagnostic pointer. So that's why you

wanna put the most robust diagnoses first and then you can say for your audiogram, there'll be a box called the diagnostic pointer, which are the first four diagnoses are the ones that really are why you did this particular procedure. You wanna use the most specific code whenever possible. Please don't use unspecified or nonspecific codes, they will oftentimes, unspecified will be denied, nonspecific will oftentimes be denied it depends on the payer and use of Z codes can drive denial. Please use other codes when possible but really try to avoid the Z code being the first code listed or the only code listed for diagnoses. And again, you're gonna see here, your diagnostic pointer is here in this box E and then you would put the letters that correspond to that procedure on that line there. Now let's get into our HCPCS codes. We're on the homestretch of coding, everyone take a breath. HCPCS is the acronym for healthcare common procedure coding system. It's a listing of codes and their descriptions, the outline items and supplies and the services that surround them. These codes are added, deleted and modified annually by the Centers for Medicare and Medicaid Services or CMS. They are a letter followed by four numbers and they go into effect on January 1 of each year.

So you're going to see throughout this that I'm gonna have big things in bold and underlined that you need to determine in some cases how the payer recognizes and processes this code before you use it. Some of these codes are used to represent things they are not for coverage. It's not about coverage, it's about you being able to represent this separately for data and to collect payment from the patient. So A9901 is durable medical equipment delivery, setup or dispensing service component of another HCPCS code. So this could be the shipping to the patient that could be how you could represent that separately. L8692 is that auditory osseointegrated device external sound processor without osseointegration body worn, includes headband and other means of external attachment. This could be for your Adhear or your BAHA. It's not covered by Medicare if it's not implanted. And so some payers may not cover it if it's not implanted. My advice always on anything in the implant space is to see if the patient can directly purchase this through the manufacturer and not purchase this through you

because some of you would have to, if we're dealing with Medicaid, let's say you might have to become a DME provider that could cost you time, that could cost you money and time to go through that application process so you really always wanna see if you, if the patient can directly purchase implant, things like this, that are non implanted whether it's a cord, whether it's a battery, or whether it's a sound processor for to be weared with a soft band, you wanna see if you can do that directly through the manufacturer. So again, this is about representation S1001 means deluxe item patient notified. Sometimes for payers that allow for upgrade, which is only United Healthcare Commercial and BlueCross BlueShield, once a patient has been offered something within their benefit and they've chosen to upgrade, you can oftentimes use the S1001 code to follow the hearing aid code to represent that this was a deluxe item so that the EOB will represent the upgrade amount. Again, it's only gonna work if the payer recognizes that code. And again, upgrades are only allowed when the payer allows for upgrades. I am also recording a new version of my webinar on hearing aids in a managed care world where we're gonna talk about this greater. But again, this code is to represent that upgrade if it's recognized by the payer. S0618 is a hearing test for hearing aids for hearing aid evaluation.

So this is a hearing test for the sole purpose of getting hearing aids. Some payers may consider this the code for routine and many payers will consider this not Medicare. This is not a Medicare code. But many private insurances will recognize this code for a hearing test for the sole purpose of getting a hearing aid. And again, have different coverage criteria and different allowable amounts. These are again, more treatment and rehabilitative so it's not gonna be covered by Medicare, but it might be covered by some payers. Home modifications per visit, this could be any home falls, hazards assessments or modification, patient education, either individual or group per session if you have an established patient education event this is again to represent them not for coverage, especially when we're talking about telehealth there is no coverage for most audiology services that are non diagnostic. And then S9476 should be a vestibular rehab program per day. Again, there's not coverage here but this could be to represent

things separately in your data collection. S9981, medical records administrative copying fee. N9982, a medical records copying fee per page. Your state medical records policies will dictate what you can charge and how you can charge, they can this can be billed as units. So again, what those dollar amounts look like is gonna determine N units based upon how your state outlines these copying fees. And then S9999, how you can represent sales tax and again, these codes are not submitted to third parties for coverage, there is not covered here but it's represented individually to the patient so that they can private pay for these procedures. Now let's get through the hearing aid family of codes.

So V5008 is hearing screening. It means the exact same thing as 92551. Which code would you use? My first question is which code does the specific payer allow? And second, if they allow both, which code has a higher allowable rate, that's the code I would use. V5010 assessment for hearing aid, that's the same as 92590 and 92591, which is a hearing aid exam and selection. That is that hearing at consult, hearing aid eval, hearing aid exam appointment that people are typically doing now this is not a communication needs assessment. Those are more diagnostic in nature if you're truly doing a true communication needs assessment and that should then be represented by 92700. V5011 is fitting orientation or checking of hearing aid. That's that the checking aspect is the same as 92592 and 93, but the fitting orientation is your hearing aid fit appointment, that's the date you fit a hearing aid, not an osseintegrated device, not a cochlear implant, you're fitting a hearing aid. Again, the checking could this code could be billed instead of 92592 or 92593 for hearing aid check. They can be used interchangeably for the check. V5014 can be used for many different things, repair and modification of a hearing aid, not an ear mold, not a BAHA, not a cochlear implant, not an accessory these are for hearing aids. And you could have this represent many different things with many different descriptors and I recommend that you do have different descriptors. When the same code can mean other things, have that code have different descriptors so you can query them separately 'cause it is about data too, you wanna know how many in house repairs, how many manufacturer repairs, how many

reprogrammings, that's what you wanna have this do. So V5014 can represent repairs and I wanna apologize that in my spell check I did not pick up cab. So repairs can be billed as units if you're repairing two hearing aids at the same time, the same date of service. So this can represent in warranty repairs with a six month, with a one year warranty. In-house repairs, manufacturer repairs have different lengths where there's a charge. Reprogramming 'cause you are modifying the hearing aid, recase, replate you want them to all have different descriptors. V5020 is your conformity evaluation or your form of verification. That could have a different descriptors as well really your measurement, live speech mapping, functional gain testing that could be what you could use that for, it's your verification. Now we're going to get into the product, V5050, 5060, 5130 and 5140 are hearing aids without technology, that means that they do not define that it is going to be whether it's digital, digitally programmable, it is without a distinction of technology.

Some payers hide coverage under these codes and some Medicaid plans still use these codes to represent their devices regardless of technology. Please look at your allowable rate schedules for these particular procedures because sometimes you may have your digital aids be billed on a percentage of dollars billed, paid on a percentage of dollars billed but these have a fixed these codes, these four have a fixed dollar amount. So you wanna know, again, how these codes allowable rates are in all of your insurance plans that you're contracted with. Now we're going to talk about the CROS and BiCROS. These codes changed on January 1 of 2019. The first three codes are for a singular piece. That's assuming that you already either have a hearing aid in one ear and you're just buying the transmitter for the other ear or that you've had a loss and you've had a loss of only one piece you don't bill this as two separate line items of two different things and bill them separately. When you have two pieces, the code says codes that exist for two pieces dispense on the same patient on the same date of service. This is if you're only doing one piece in the ITE, ITC and BTE conditions. The next codes represent CROS or BiCROS and it will show you by configuration. So if you have an ITE in each ear it's V5211 if you have a BTE in each ear, it's V5221. It's all

about the configuration and it represents both pieces you do not add another piece onto this equation. These two represent both pieces. And I do understand that some of the allowable rates are not sufficient. I 100% understand, that's why you're going to then need to renegotiate those allowable rates. You need to explain to your payer, show them an invoice, show them how this works and renegotiate your rates. Here's your hearing aids in the digital condition monaural and binaural. Now, some payers do want them listed as two separate line items of monaural with a right left modifier, some want to see the binaural, I would always start if you fit both unless you know specifically from the payer that they want this two line items with the right left modifier, I would always lead with the binaural code. Always have that be the one that you submit the first time because some of you all have line item restrictions in some of your contracts then you need to restrict the number of line items so again, always lead with the binaural and then if you're denied, then go the other way with the two monaurals with the right left modifier.

Dispensing fee, unspecified hearing aid bilateral, binaural let's talk about the difference. Binaural was for hearing aids, bilateral was for body aid but you can defend either one of them, dispensing fee monaural of your of your contralateral routing device that means for when you're just adding the lost or new piece and then your contralateral routing system that you're doing the whole system on the same date of service and then you're monaural. Now dispensing fees don't have good descriptor. Dispensing fees can for some payers, especially Medicaid programs or third party administrator or network state that's representing your professional fee or representing your fitting fee. But technically, it is a separate procedure that could be billed separately and some payers in their medical policies see that that way as well. So a dispensing fee really should encompass for your practice the ordering, programming and fitting that is not represented by another code. So if you are true unbundled practice, you would bill your dispensing fee separately to represent those services. Again, some payers may see this differently, you follow that payer guidance when they do but when a payer does not define what the dispensing fee means and what it's used for, then it should

be billed separately if you offer an unbundled delivery or if you offer a bundle delivery that you're imploding into its unbundled pieces. Assistive listening devices, here are the individual codes for the assistive listening devices. V5274 is assistive listening device not otherwise specified that could where a PSAP could go, could go into that bucket. Here are your assistive listening devices, your FM and MDM systems, whole systems and then their individual components and then I'm gonna highlight. V5281 is a monaural complete system with a receiver, a transmitter, a microphone. V5282 is a whole system with two receivers, a transmitter and a microphone. Now we're going to get into the individual pieces. V5286 is your Bluetooth receiver. That's a streamer. That's the code that you would represent for a streamer in isolation. V5290 is a transmitter mic, that would be for a Roger mic, that's how you would represent that. I wanna get back to the FM again.

So the others are for the pieces and then the first two are for the whole system. V5264 is ear mold, insert not disposable, that is your custom mold and it's billed per mold so it's gonna be billed as units. So this code again, should have different uses and different descriptors, one for an ear mold, one for a swim plug, one for a monitor, one for a noise plug, any way you wanna break those custom molds down, but they're billed as units. V5265 is a disposable that's your dome or your insert again, billed as units. V5275 and again, you might have different descriptors dome or insert, however you want to be able, the more descriptors you have the more individual data points you can query. Remember, back at the beginning coding is also about data. V525 is your ear impression each. That's if you've decided to unbundle your ear molds, your custom ear molds and that can be billed with units and also lets you bill a patient for the impression when you're not actually doing the mold. V5267, this is all supplies, accessories, devices, anything not otherwise specified and they would all be billed as individual separate line items or a claim. So again, if you want to be able to query this information you would have descriptions for potentially 100 different things in your systems. It can be an Oto-ease, a wax lube, it could be wax guards, it could be a receiver, it could be Huggies, or super seals or a dry and store, anything like that you

can have separate descriptors and line items. So again, how many dry and store did I dispense? How many receivers, replacement receivers did I ever dispense? You can even make your receivers if you want as separate, what type of receiver it was but the important moral of the story is, you really do want to, you don't just say you did five supplies and you bill it as one unit of $1 amount, no they all need to be always individually line item down. 92566 is battery, it should be billed as multiple units unless specifically advised by your payers specifically a state Medicaid program where they consider one unit to be 40 batteries, really look at your state guidelines but typically it's billed by the number of individual cell battery cells. 92598 is a hearing aid not otherwise classified.

I would always bill this as separate line items if I did two, with the right left modifier. This is how you would bill a Lyric. You would not bill a Lyric because it's analog, you would never bill it as something without technology, you would never bill it as an analog well, that's something without technology now because the allowable amount is gonna be so low that it's not gonna cover your invoice costs. In this case using this code, what it's going to do, it's going to allow for that to be individually reviewed, but it is important before you jump in to billing these that you know how your payers process and allow for V5299, 98 is it a percentage of dollars billed is it a fixed dollar amount like what how are they going to process that? And then 92599 is a hearing service miscellaneous and again, billed as individual separate line items. Some procedures that you may use the 5299 for is an extended warranty, a loss and damage deductible, an ear mold service 'cause remember, if you wanna be able to look at here are the number of hearing aid services I did and here's the number of ear mold services I did remember, those were hearing aid codes before repairing, modification of the hearing aid not of an ear mold, you could have that listed separately under V5299. A service plan. If you are offering service plans, an accessory or FM service or fitting this would include syncing of phone to hearing aids. I really want audiologists to start thinking about this a bit and I think this really hit home for me when I was at the Apple Store. Apple does this service. Phone carriers do this service because it's about the phone as

much as it's about the hearing aid and you might start to think about that you will do the pairing the first time, but you don't keep doing the pairings at no charge moving forward. So you could have an accessory FM device fitting for a Roger mic for an FM system where you have a fee for that fitting and service of those products and devices and again, or to represent a return or an exchange visit. You could also create around those implantable devices, creating a service plan like you would for hearing aids around implantable devices that would cover the fitting, the orientation of the processor, troubleshooting visits, counseling, auditory rehabilitation, accessory fitting, to create that type of service plan, you'd have to look at what is your average patient utilized in an average year, this is why coding and why data is really valuable, you would represent this with the V5299 and not gonna be covered by insurance in most cases although the auditory rehabilitation piece might possibly be able to be covered separately.

Some HCPCS tips. First, Medicaid and the VA, Workers Comp see these codes differently, you wanna follow their very specific requirements and guidance, even if it makes no sense if that's what they're telling you to bill and that's what's in their policy that's how you should do it. There is no code for tinnitus devices or maskers, I would recommend you use V5267 or noise generating devices. There are some duplicates again across CPT and HCPCS, which one do you use? Which code does the contract or the payer recognize and which has the highest reimbursement or allowable rate? And again, it's important to always realize that when it comes to the hearing aid code like V5257, digital behind that you're hearing aid that code there's one code to represent a digital behind that your hearing aid, whether that hearing aid cost you $99, or whether a hearing aid cost you $1999 so payers have a rate established for that code irrespective of type of degree of technology. There are times when you're going to have to fit within that benefit because the code there isn't code to show different levels of technology. There's only one code to represent the technology itself. This is a good time, thank you so much for viewing this coding webinar. This is a good time to tell you that this is really based upon my boot camp Through Audiology Resources and

I'm only bringing this up in that we have recorded Through Audiology online, many of the modules so there are gonna, this webinar that you just listened to today was never intended to answer all your questions and to be viewed in isolation. There are other webinars out there that I have created to fill in some of the questions that you may have, whether it's about billing to manage care, whether it is about evaluation of management codes, whether it's about Medicare specifically, there are webinars completely surrounding that that you can view separately and will help answer some of those questions. If you have questions that emerge from this, please reach out to the national associations that you are member of because they may be able to assist you and really look through the slides and the other, again the other modules of the boot camp because again, it may help you fill in the gaps as well. I want to thank you all so much for listening and again, please be safe and healthy out there.