Bibbity-Bobbity-Billing: The Magic of Getting Paid for Your Services

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Let me introduce myself…

- Jo Mayo Endowed Assistant Professor of Audiology at Lamar University in Beaumont, Texas
- Clinical interests: medical audiology, hearing aids, AR, vestibular assessment & rehabilitation
- Research interests: health policy and advocacy
- Current Chair of the AAA Coding and Reimbursement Committee

LAMAR UNIVERSITY

I’m devoted to making your coding/billing dreams come true…

But, the magic is already inside of you!

And, this party does not stop at midnight!

What to expect for today

- Mini-lectures
- Case studies
- Resources

Learning Objectives

1. Determine appropriate CPT and ICD codes to report given case vignettes.
2. Identify primary resources for payer information.
3. Characterize good practices in documentation and compliance.

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Outline

- Determining Coverage
- Finding Coverage Guidance
- Correct Coding (CPT)

Section 1. Determining Coverage

Types of Insurers

- **Medicare - Federally Funded**
- Medicaid - Federally supported, state administered
- SCHIP - State Children's Health Insurance Program
- Private/Commercial Third-Party Payers
- Vocational Rehabilitation (BRS/BVR)
- Military Healthcare

Why can't we go over all of these?!
Many of these principles from Medicare apply to other areas. Also, our time today is limited. ☹

4 Parts of Medicare Program

TRADITIONAL MEDICARE

Part A

- Inpatient hospital care
- Inpatient skilled nursing facility care
- Home health and hospice care

Part B

- Physician and non-physician practitioner services
- **Diagnostic Tests**
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Ambulance Transportation
- Outpatient Services
- Certain Preventative Care

SUPPLEMENTAL MEDICARE

Part C (Medicare Advantage Plans)

- Has minimum coverage requirements
- Benefits can include items not covered by traditional Medicare such as:
  - **Hearing Aids**
  - Dental and/or Vision
  - Routine and preventative care

Part D

- Prescription Drug Benefit

Warning!

This section only pertains to Medicare Part B services!

Audiologists and the Medicare Program

- Audiology services payable under Section 1861(s)(3) of the Social Security Act
- Covers **mostly diagnostic testing** for hearing, tinnitus, auditory processing, and vestibular function
- Covers **programming and diagnostic analyses of implantable devices** (currently only cochlear and auditory brainstem implants; BCHAs do not have procedure codes)
- List of Audiology codes covered through traditional Medicare
  - https://www.cms.gov/files/zip/audiology-code-list-updated-7522.zip

Audiologists and the Medicare Program

MEDICARE DOES

- Define covered and non-covered services
- Define circumstances of coverage under the Medicare program
  - There are legal exclusions for coverage

MEDICARE DOES NOT

- Define professionals' scope of practice
- Clinicians often provide services that do not meet a coverage benefit through Medicare

Mandatory Reporting Requirement

1. Physicians and suppliers must complete and submit claims for beneficiaries.
2. Beneficiaries should not be asked to file their own claims.
3. The claims filing requirement applies to all suppliers who provide **covered** services to Medicare beneficiaries.

This is because this is provided using FEDERAL dollars. This is meant to protect beneficiaries and assure they have access to their benefits as outlined in FEDERAL LAW.

This is why you need to know what is covered and what's not!

Medical Necessity

Medicare pays for diagnostic tests that are considered **reasonable and necessary** for the **diagnosis or treatment of an illness** […] within a statutorily defined benefit category to improve the functioning of a malformed body part or covered preventative services.

"Payment […] is determined by the reason the tests were performed, rather than by the diagnosis or the patient's condition" –Medicare Benefit Policy Manual Ch 15 Section 80.3

Reasons for Ordering Audiologic Exams

- Suspected change in hearing, tinnitus, or balance
- Evaluation of the cause of hearing, tinnitus, or balance disorders
- Determination of the effect of medication, surgery, or other treatment
- Re-evaluation per medical diagnosis (e.g., cholesteatoma)
- Failed screening (but screening itself is non-covered)
- Diagnostic analysis and programming of cochlear or auditory brainstem implant
- Diagnostic exam pre- and post-implantation

Medicare Benefit Policy Manual Ch 15 Section 80.3

Medicare Requirements: "Audiology Services"

- 2 elements required for reimbursement for all diagnostic audiologic tests covered under Medicare
  1. **Physician** [MD, DO] **or other qualified non-physician provider (NPP) order**
     - *What is an NPP?* Non-physician provider [NPP]- physician assistant, nurse practitioner, clinical nurse specialist
     - Until Jan 1 2023, there were no exceptions to this. *Come to the Featured Session Friday at 7:45-9:15am!*
  2. **Medical necessity**
     - Hearing loss, tinnitus, aural pain, pressure, dizziness, change in hearing, sudden loss

Medicare Covered Audiology CPT Codes (Effective 1/1/23; Revised 11/1/22)

CPT/HCPCS	Short Descriptor
92517	cVEMP, cervical w/inter & report
92518	oVEMP, occular w/inter & report
92519	VEMP, cervical and ocular w/inter & report
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
92540	Basic vstblr evaluation
92541	Spontaneous nystagmus test
92542	Positional nystagmus test
92544	Optokinetic nystagmus test
92545	Oscillating tracking test, with recording
92546	Sinusoidal rotational test
92547	Supplemental electrical test
92548	CDP-SOT 6 cond w/interpretation & report
92549	CDP-SOT 6 cond w/MCT and ADT w/interpretation & report
92550	Tympanometry & reflex threshold
92552	Pure tone audiometric air
92553	Audiometry air & bone
92555	Speech audiometry threshold
92556	Speech audiometry complete
92557	Comprehensive hearing test
92562	Loudness balance test
92563	Tone decay hearing test
92565	Stenger test, pure tone
92567	Tympanometry
92568	Acoustic reflex testing, threshold
92570	Acoustic immitance testing
92571	Filtered speech test
92572	Staggered spondaid word test
92575	Sensorineural acuity level test
92576	Synthetic sentence id test
92577	Stenger test, speech
92579	Visual reinforement audiometry
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92587	Evoked auditory test limited w/ interpretation & report
92588	Evoked auditory test complete w/interpretation and report
92601	Cochlear implant f/up exam, pt <7 years of age
92602	Reprogram cochlear implant, pt <7 years of age
92603	Cochlear implant f/up exam, pt ≥7 years of age
92604	Reprogram cochlear implant, pt ≥7 years of age
92620	Auditory function test w/report, initial 60 minutes
92621	Auditory function test w/report, additional 15 minutes
92625	Tinnitus assessment
92626	Eval aud function surgical, first hour
92627	Eval aud function surgical, each additional 15 min
92640	Aud brainstem implt program, per hour
92651	AEP, broadband, w/ inter & report
92652	AEP, threshold estimation w/inter & report
92653	AEP, threshold, dx w/inter & report

Medicare does NOT cover

- **Screenings**
- Procedures that do not meet the guidelines for coverage (i.e., **excluded services** such as hearing test for purpose of a hearing aid)
- **Routine exams** (no new signs or symptoms)
- Services without a physician's order (new provisions for 2023 – some services covered without physician order)
- Procedures **not covered when performed by particular practitioner** (e.g,. students)
- Services denied as **bundled** or included in basic allowance of another service

Medicare Non-Covered Services

- You can bill the patient—just make sure they are aware of the charges
- Examples of non-covered services under Medicare Part B:
  - Cerumen management
  - Canalith repositioning maneuvers
  - Hearing test for purpose of fitting/adjusting hearing aid
  - Routine (annual) hearing tests
  - Hearing aids and related services
  - Auditory rehabilitation, vestibular rehabilitation

Important to note

“Does not cover” ≠ “cannot perform”

The patient is responsible.

Don't give your professional services away for free.

Medicare: Students

- 100% supervision is required when seeing a Medicare beneficiary
- 4th year placements fall under this requirement
- Spirit of this is for 3-way interaction
  - Patient
  - Audiologist
  - Student

Medicare: Documentation Requirements

- Reason for the test
- Referring/Ordering MD
- Procedures completed and outcomes
- Clinical assessment
- Recommendations
- Provider name
- Signature
- Date of service
  - Start/stop time of service if timed code

Resource: Morrison & Rincon 2022 (Audiology Today Sep/Oct 2022)
https://www.audiology.org/news-and-publications/audiology-today/articles/coding-and-reimbursement-ensuring-documentation-supports-reimbursement-potential/

Case Studies!: Covered vs. Non-Covered

- Break into small groups (3-5 people)
- Work the cases
- You have 5 minutes!
- We will discuss 1 together
- Answers and justification will be provided in additional handouts

REMINDER! 2023 Medicare Changes

- **New! Limited direct access provision for select audiology services**
  - Does not require physician order
  - For non-acute hearing issues (e.g., presbycusis)
  - 1x/12mo
- Does not change medical necessity criteria
  - Note: these are for non-acute issues; acute issues would still require an order
- Codes other than the 36 listed will continue to require a physician order prior to testing
- Audiologists may continue as usual by obtaining an order for all audiology codes reimbursable through Medicare

Want more? Come to…
FS301 - Coding and Reimbursement in Review: 2022-2023
Friday 7:45 am – 9:15am

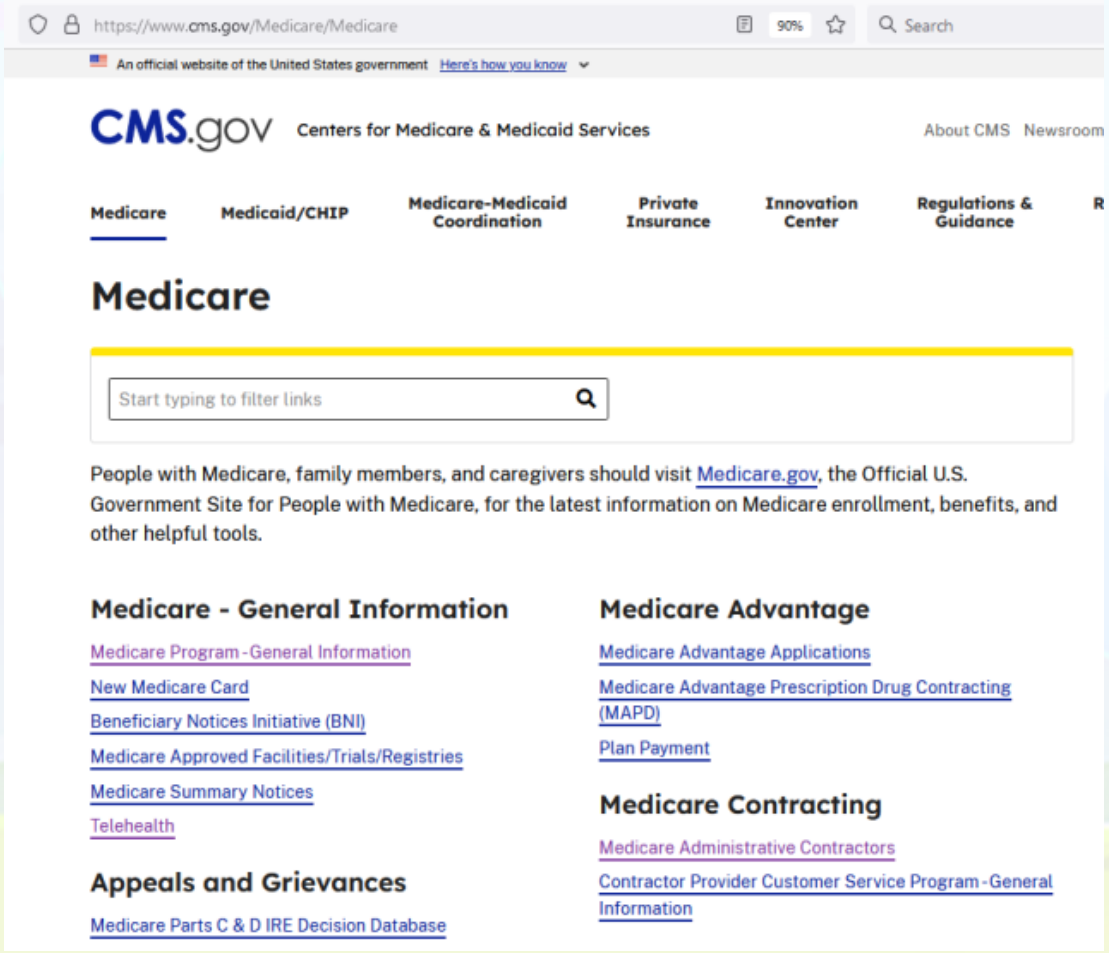
Limited Code Set Available Under New Limited Direct Access Provision

92550 Tympanometry & reflex thresh	92582 Conditioning play audiometry
92552 Pure tone audiometry air	92583 Select picture audiometry
92553 Audiometry air & bone	92584 Electrocochleography
92555 Speech threshold audiometry	92587 Evoked auditory test limited
92556 Speech audiometry complete	92588 Evoked auditory tst complete
92557 Comprehensive hearing test	92601 Cochlear implt f/up exam <7
92562 Loudness balance test	92602 Reprogram cochlear implt <7
92563 Tone decay hearing test	92603 Cochlear implt f/up exam 7/>
92565 Stenger test pure tone	92604 Reprogram cochlear implt 7/>
92567 Tympanometry	92620 Auditory function 60 min
92568 Acoustic refl threshold tst	92621 Auditory function + 15 min
92570 Acoustic immitance testing	92625 Tinnitus assessment
92571 Filtered speech hearing test	92626 Eval aud funcj 1st hour
92572 Staggered spondaic word test	92627 Eval aud funcj ea addl 15
92575 Sensorineural acuity test	92640 Aud brainstem implt programg
92576 Synthetic sentence test	92651 Aep hearing status deter i&r
92577 Stenger test speech	92652 Aep thrshld est mlt freq i&r
92579 Visual audiometry (vra)	92653 Aep neurodiagnostic i&r

Section 2. Finding Coverage Guidance

Medicare Website

- General Program information
- CMS forms
- Medicare coverage
- Medicare contractors
- Quality Payment Program
- Medicare Physician Fee Schedule



Medicare Policies

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs
- General Information
- Benefit Policy Manual (Audiology is in Chapter 15)
- Claims Processing Manual
- Program Integrity Manual
- Medicare Managed Care Manual (Part C: Medicare Advantage)

Medicare Online Manuals

- Manuals
- Future Updates to the IOM
- **Internet-Only Manuals (IOMs)**
- Paper-Based Manuals

Internet-Only Manuals (IOMs)

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.

Show entries: 10 per page

Filter On

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Showing 1-10 of 25 entries

Publication #	Title
100	Introduction
100-01	Medicare General Information, Eligibility and Entitlement Manual
100-02	Medicare Benefit Policy Manual
100-03	Medicare National Coverage Determinations (NCD) Manual
100-04	Medicare Claims Processing Manual
100-05	Medicare Secondary Payer Manual

Audiology Services
(MBPM Ch 15, Section 80.3)

- https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf
- Hearing / balance assessment services covered under **"other diagnostic tests"**
- Information on orders, medical necessity
- **"Coverage […] determined by the reason the tests were performed, rather than the diagnosis"** (Section 80.3, C)
  - Medicare doesn't cover tests for no new signs or symptoms
  - Test ordered for purpose of fitting or modifying a hearing aid
- Documentation requirements
- No provision to pay for therapeutic audiology services

Medicare Covered Audiology CPT Codes (Effective 1/1/23; Revised 11/1/22)

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92652	AEP, threshold estimation w/inter & report
92653	AEP, threshold, dx w/inter & report

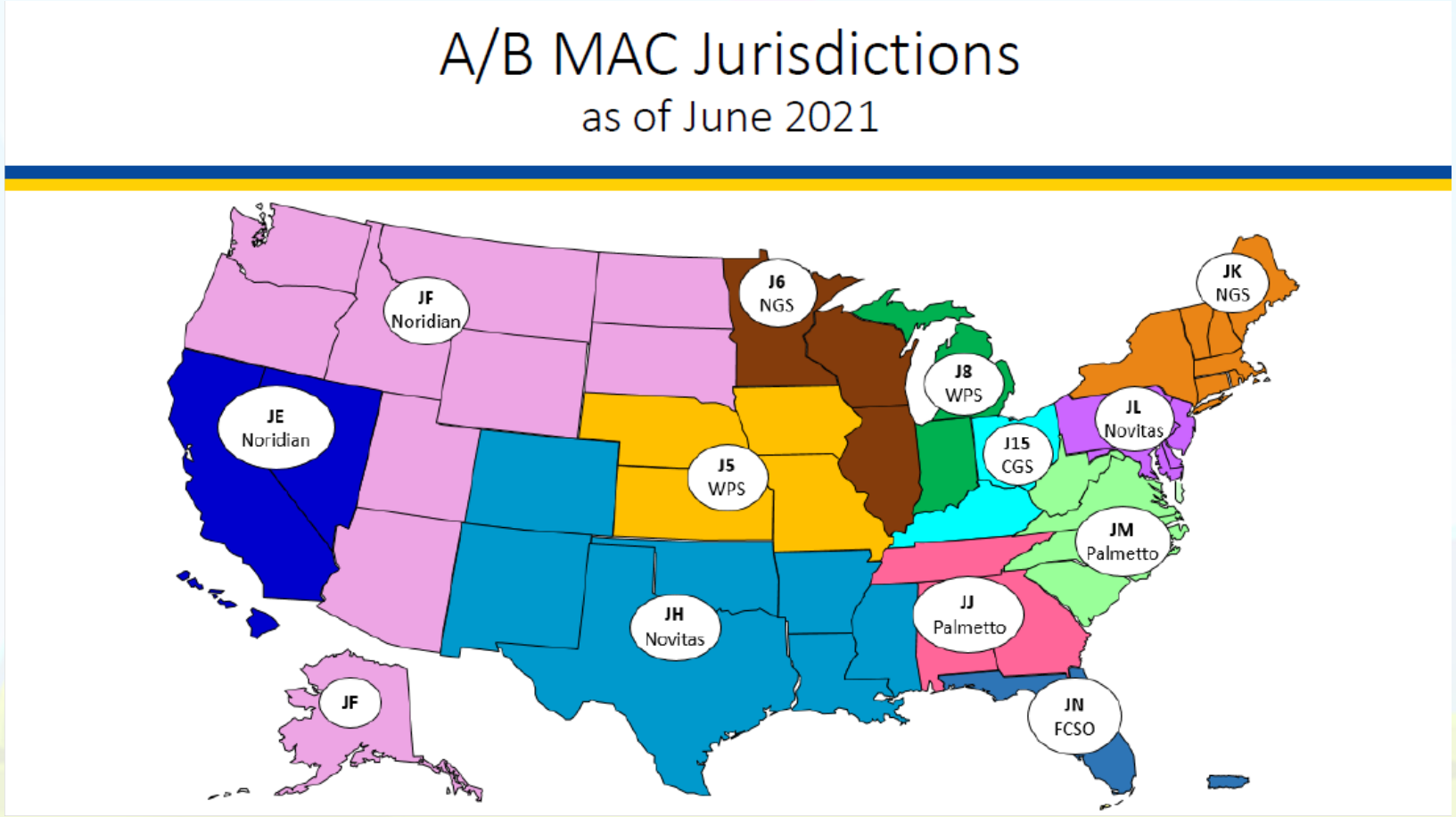
List of Audiology Services Covered Under Medicare

- Audiology Services Homepage
  - https://www.cms.gov/audiology-services
- Medicare Audiology Code List https://www.cms.gov/files/zip/audiology-code-list-updated-7522.zip

Medicare Physician Fee Schedule

- Outlines Medicare coverage policies
  - What is covered
  - Under what circumstances
- Released annually by the CMS
- Complete listing of maximum fees CMS will reimburse for covered services

Coordinating Medicare Benefits:
Medicare Administrative Contractors (MACs)

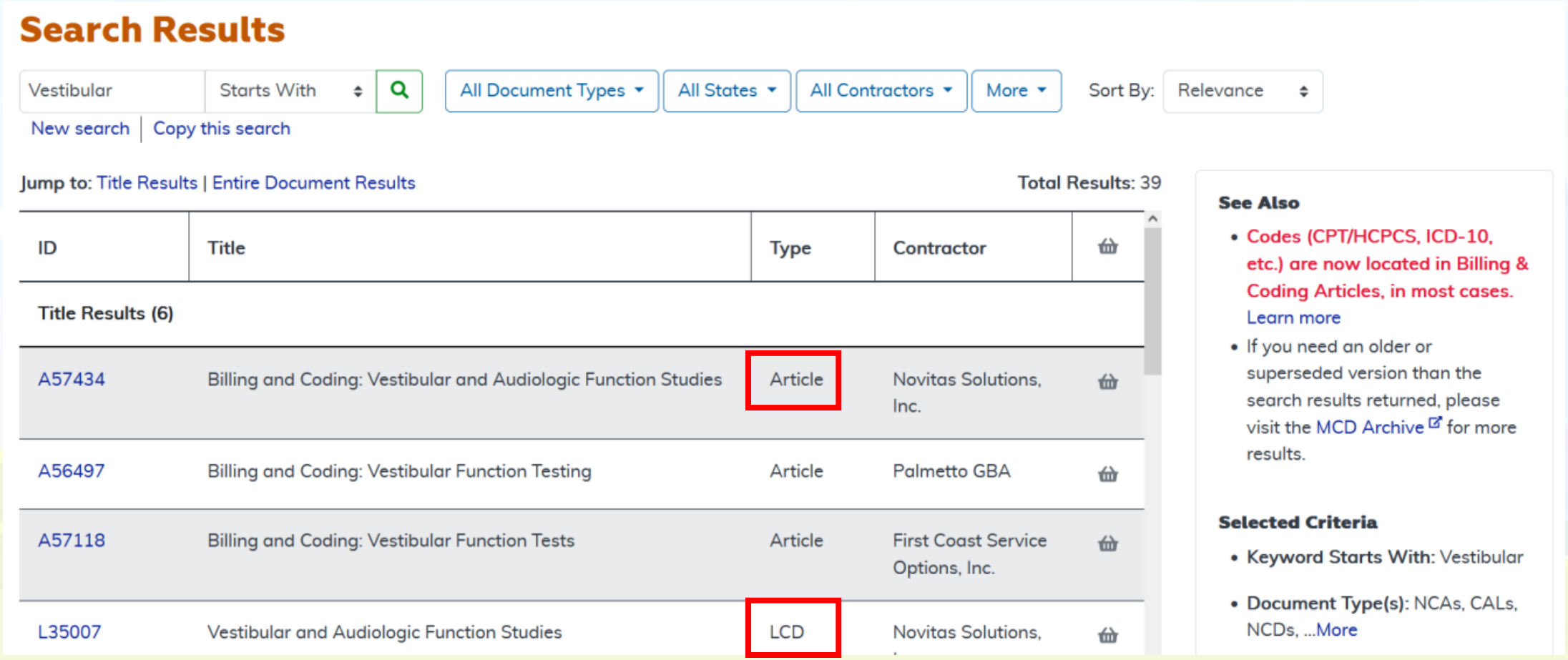


Centers for Medicare and Medicaid Services: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs#MapsandLists

National & Local Coverage Determinations

- https://www.cms.gov/medicare-coverage-database/search.aspx
- **National Coverage Determination (NCD)**
  - Same coverage policy for all Part B Medicare beneficiaries
  - If an NCD does not exist, it is left to the MAC to determine policy through Local Coverage Determination (LCD)
- **Local Coverage Determination (LCD)**
  - Determined by the Medicare Administrative Contractor (MAC) for that geographic region
  - Each MAC may have a different coverage policy for audiology services
- Pro-Tip:
  - Start by reading a NCD or LCD policy, not an article
  - Articles can be helpful when seeking more detailed coverage policies (e.g., which ICD-10 code supports medical necessity)
  - Transmittals also important

LCD Example: Vestibular MAC: Novitas



Search Results

Vestibular | Starts With | All Document Types | All States | All Contractors | More | Sort By: Relevance

New search | Copy this search

Jump to: Title Results | Entire Document Results

Total Results: 39

ID	Title	Type	Contractor
Title Results (6)			
A57434	Billing and Coding: Vestibular and Audiologic Function Studies	Article	Novitas Solutions, Inc.
A56497	Billing and Coding: Vestibular Function Testing	Article	Palmetto GBA
A57118	Billing and Coding: Vestibular Function Tests	Article	First Coast Service Options, Inc.
L35007	Vestibular and Audiologic Function Studies	LCD	Novitas Solutions,

See Also

- Codes (CPT/HCPCS, ICD-10, etc.) are now located in Billing & Coding Articles, in most cases. Learn more
- If you need an older or superseded version than the search results returned, please visit the MCD Archive for more results.

Selected Criteria

- **Keyword Starts With:** Vestibular
- **Document Type(s):** NCAs, CALs, NCDs, ...More

LCD Example: Vestibular MAC: Novitas (cont)

Frequency Limitations

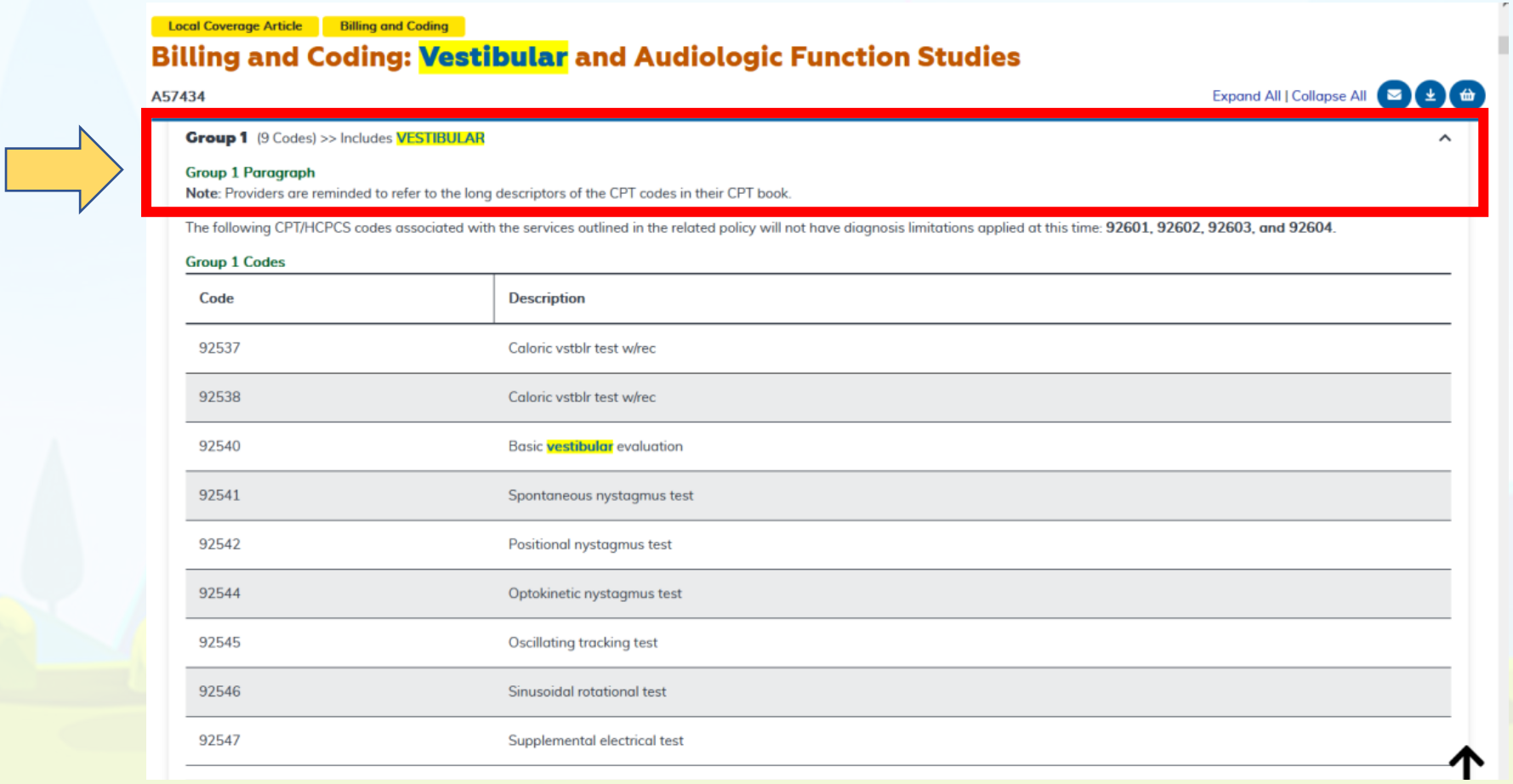
Consistent with the utilization outlined in the related LCD:

- CPT codes 92553, 92557, 92567 and 92568 may be reported once a month when a beneficiary is receiving ototoxic medications
- The following may only be reported once during a session (same date of service)
  - CPT codes 92541, 92542, 92544,92545 and 92546
- CPT code 92542 should not be billed two times for two positions or any multiple increments.
- Payment may be made for two of the following services per patient per year:
  - CPT codes 92541, 92542, 92544, 92545 and 92546

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

LCD Article: CPT Codes are Grouped



Local Coverage Article | Billing and Coding

Billing and Coding: Vestibular and Audiologic Function Studies

A57434

Expand All | Collapse All

Group 1 (9 Codes) >> Includes VESTIBULAR

Group 1 Paragraph

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

The following CPT/HCPCS codes associated with the services outlined in the related policy will not have diagnosis limitations applied at this time: **92601, 92602, 92603, and 92604**.

Group 1 Codes

Code	Description
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
92540	Basic vestibular evaluation
92541	Spontaneous nystagmus test
92542	Positional nystagmus test
92544	Optokinetic nystagmus test
92545	Oscillating tracking test
92546	Sinusoidal rotational test
92547	Supplemental electrical test

Each Group has List of ICD-10 Codes that Support Medical Necessity

Local Coverage Article | Billing and Coding

Billing and Coding: Vestibular and Audiologic Function Studies

A57434

Expand All | Collapse All

Group 1 (87 Codes) >> Includes VESTIBULAR

Group 1 Paragraph

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claims(s) submitted

The following ICD-10-CM codes support medical necessity and provide coverage for **CPT codes 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546 and 92547**:

Group 1 Codes

Code	Description
H81.01	Meniere's disease, right ear
H81.02	Meniere's disease, left ear
H81.03	Meniere's disease, bilateral
H81.09	Meniere's disease, unspecified ear
H81.10	Benign paroxysmal vertigo, unspecified ear
H81.11	Benign paroxysmal vertigo, right ear
H81.12	Benign paroxysmal vertigo, left ear
H81.13	Benign paroxysmal vertigo, bilateral

Medicaid

- Coverage policies
- Fee schedules

Example: Texas

Provider Manuals

Texas Medicaid Provider Procedures Manual

CSHCN Services Program Provider Manual

Texas Medicaid Provider Procedures Manual

Last updated on 1/31/2023

The *Texas Medicaid Provider Procedures Manual* was updated on January 30, 2022, and contains all policy changes through February 1, 2023. The manual is available in both PDF and HTML formats.

Claim form examples referenced in the manual can be found on the claim form examples page.

See the release notes for a detailed description of the changes.

For previous editions of the manual, visit the manual archives.

February 2023 Texas Medicaid Provider Procedures Manual	
Complete Book	**Individual Chapters**
Complete Book (HTML) Complete Book (PDF)	Vol. 1 Preliminary Information (71.61 KB) Vol. 1 Provider Enrollment and Responsibilities (354.87 KB) Vol. 1 Texas Medicaid Fee-for-Service Reimbursement (125.39 KB) Vol. 1 TMHP Electronic Data Interchange (EDI) (86.85 KB) Vol. 1 Client Eligibility (188.87 KB) Vol. 1 Fee-for-Service Prior Authorizations (170.82 KB) Vol. 1 Claims Filing (428.74 KB) Vol. 1 Appeals (143.2 KB) Vol. 1 Third Party Liability (TPL) (126.35 KB)

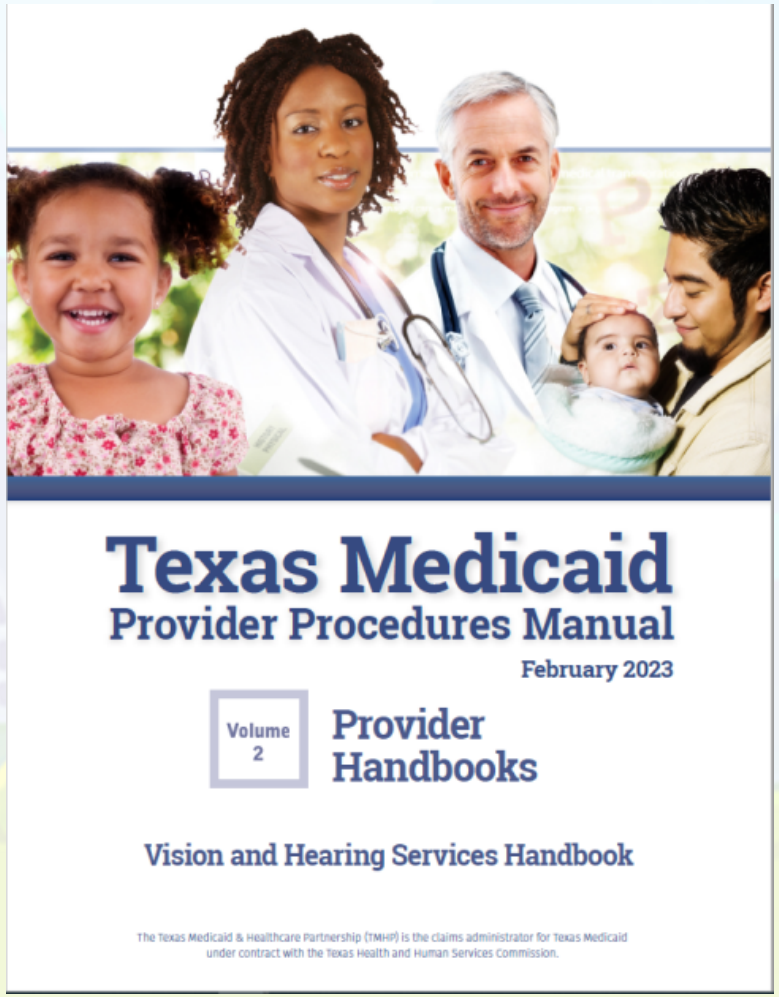
Appendix B: HIV/AIDS (83.55 KB)
Appendix C: Acronym Dictionary (80.61 KB)
Ambulance Services Handbook (846.29 KB)
Behavioral Health and Case Management Services Handbook (1.14 MB)
Children's Services Handbook (1.8 MB)
Clinics and Other Outpatient Facility Services Handbook (926.24 KB)
Certified Respiratory Care Practitioner (CRCP) Services Handbook (783.32 KB)
Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (1.52 MB)
Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (973.35 KB)
Health and Human Services Family Planning Program Services Handbook (788.32 KB)
Healthy Texas Women Program Handbook (826.65 KB)
Home Health Nursing and Private Duty Nursing Services Handbook (920.68 KB)
Inpatient and Outpatient Hospital Services Handbook (1.12 MB)
Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (1.79 MB)
Medical Transportation Program Handbook (786.75 KB)
Medicaid Managed Care Handbook (939.71 KB)
Outpatient Drug Services Handbook (1.1 MB)
Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (912.59 KB)
Radiology and Laboratory Services Handbook (913.01 KB)
School Health and Related Services (SHARS) Handbook (967.55 KB)
Telecommunication Services Handbook (820.1 KB)
Vision and Hearing Services Handbook (1003.41 KB)

Texas Medicaid: Coverage

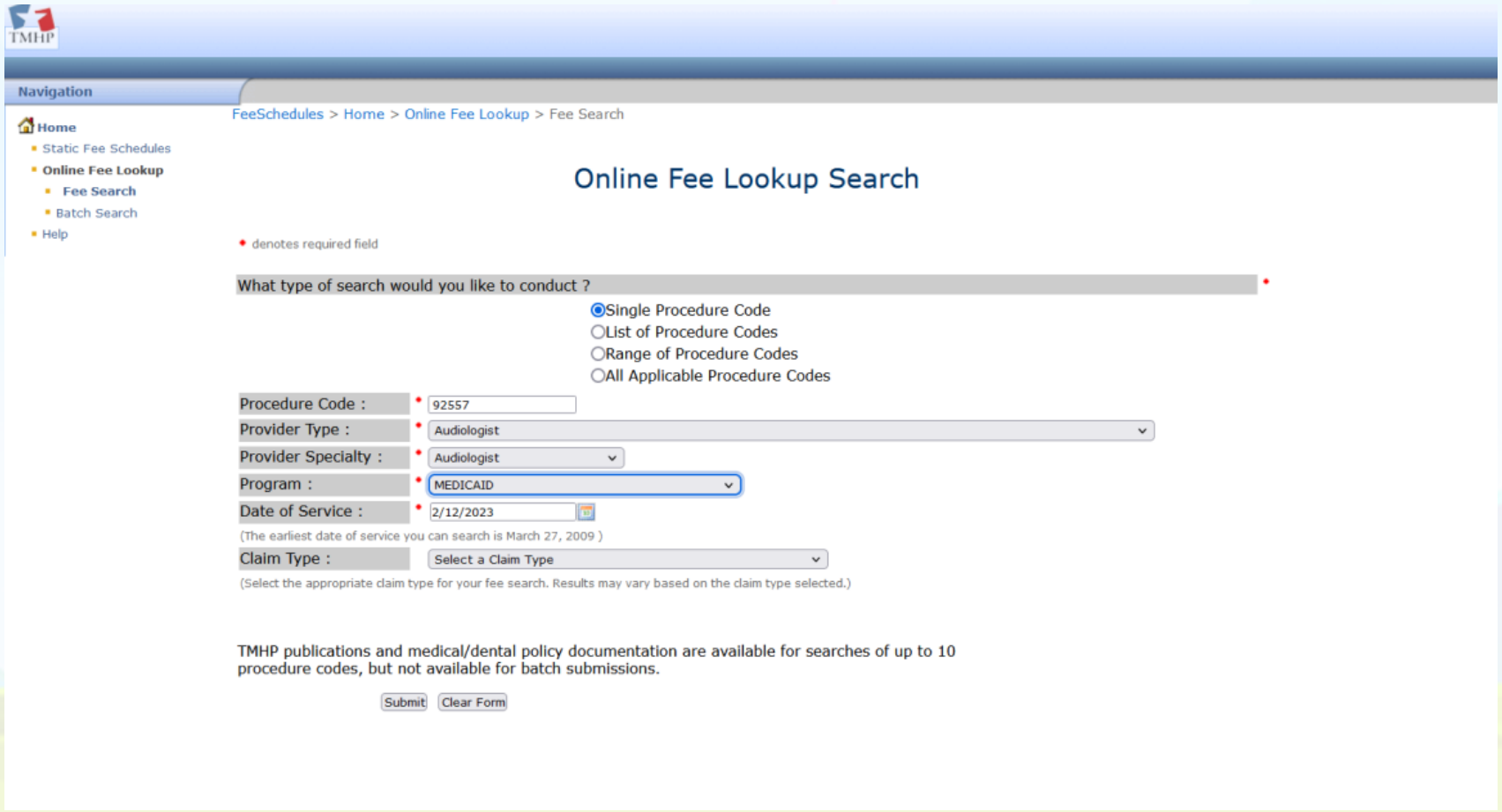
2.2.4 Hearing Aid Devices and Accessories (Nonimplantable)

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following devices and accessories:

Service	Limitation
Hearing aid devices	**Limitation:** • For clients who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every 5 rolling years from the month it is dispensed. • For clients who are 21 years of age and older, if the client has at least a 35 dB hearing loss in both ears, 1 hearing aid device may be reimbursed every 5 years from the month it is dispensed. Either the left or the right may be reimbursed, but not both in the same 5 year period. ***Refer to:*** Subsection 2.2.4.1, "Forms and Documentation" in this handbook for additional medical necessity criteria. Replacement hearing aid devices that are required within the same 5-year period must be prior authorized. Repairs or modifications may be reimbursed without prior authorization once per rolling year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. **Procedure codes:** See below for monaural and binaural procedure codes. Procedure code V5014 may be reimbursed for repairs and modifications. **Date of service:** The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. ***Note:*** *During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid will not reimburse hearing aid repairs or modifications that are rendered during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.*



Texas Medicaid: Fee Schedule



Third-Party Payers

- Terms for a specific plan will be outlined in Evidence of Coverage document
- May differ significantly from broader Coverage Policy
- Benefits are ultimately determined by the terms of each plan
- Be sure to note copay and deductible requirements
- Example: ‘Coverage for hearing aid devices varies across plans. Refer to the consumer’s benefit plan document for additional coverage details’

Case Study
(all together!)

Service	Limitation
Hearing aid devices	**Limitation:** • For clients who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every 5 rolling years from the month it is dispensed. • For clients who are 21 years of age and older, if the client has at least a 35 dB hearing loss in both ears, 1 hearing aid device may be reimbursed every 5 years from the month it is dispensed. Either the left or the right may be reimbursed, but not both in the same 5 year period.

- **20 y and younger:**
  - Are HAs covered for 20y and younger?
  - Is there audiometric criteria for medical necessity?
  - Can you get two hearing aids for these kiddos?
  - Would a CROS or BiCROS setup likely be covered?
- **21 y and older:**
  - Are HAs covered for 21y+?
  - Is there an audiometric criteria for medical necessity?
  - Can you get two hearing aids for these adults?
  - Would a CROS or BiCROS setup likely be covered?

Section 3. Correct Coding (CPT)

Correct Coding Conventions

- Accurate reporting of services rendered
  - Avoiding downcoding or upcoding
  - Choose code which *best represents* the services provided
- Avoiding unbundled reporting of codes for which a bundled code exists and is more appropriate to report
- Avoiding unbundling into two procedures (1x left and 1x right)
  - *Rule of thumb: CPT procedures for audiology are usually considered to be bilateral—testing on both ears*

Documentation to Support Coding

- Documentation should support:
  - What procedure you did
  - Why you did the procedure
- **CPT** procedure codes represent **what** you did
- **ICD-10** diagnosis codes support **why** you did the procedure(s)

Bundled Codes: What to know

- Bundled codes have several component codes
- If you bill a bundled code, assure that all component code requirements have been satisfied
- If you do not complete all services in a bundled code, you report the completed services with a **-59 modifier** (distinct procedural service) appended to each CPT code to indicate these were distinct and separately payable
- Billing for all component codes separately is upcoding and fraudulent

Bundled Codes: Examples

- **92540** basic vestib eval—includes:
  - 92541—spontaneous nystagmus test
  - 92542—positional nystagmus test
  - 92544—optokinetic nystagmus test
  - 92545—oscillating tracking test
- **92557** basic comp audio—includes:
  - 92553—audiometry air + bone
  - 92556—speech audiometry complete (SRT + WR)

EXAMPLE: -59 Distinct Procedural Service Modifier

- **92540 (basic vestibular evaluation)** code for ENG/VNG includes:
  - (1) 92541—spontaneous nystagmus test,
  - (2) 92542—positional nystagmus test,
  - (3) 92544—optokinetic nystagmus test, and
  - (4) 92545—oscillating tracking test
- If you didn't do optokinetics, you cannot bill the 92540 (basic vestibular evaluation) code because you did not complete all of the components of the bundled code
- You would then bill for the 3 out of the 4 component codes you *did* complete and append a **-59 modifier to each**

Pediatric Notes

- **VRA (92579) and CPA (92582)**
  - Do not report in conjunction with pure tone audiometry air (92552) or air-bone (92553)
- **VRA (92579)**
  - Work of this procedure includes both tonal and speech tests (read: do not bill with other speech tests)
  - Ear-specific VRA? Best represented by this code ☺
- **CPA (92582)**
  - Work of this procedure includes tonal stimuli but does not include speech tests
  - CPA may be reported in conjunction with the following (only CHOOSE 1 best representing procedure)
    - Speech threshold audiometry (92555)
    - Select picture audiometry (92583)
    - Speech threshold audiometry + speech recognition (92556)
- ***What happens when we try and try but still get nothing?***
  - The spirit of this code recognizes the realities of clinical practice
  - You may still report the procedures
  - Documentation should include the efforts made to obtain the results; sometimes including the amount of time you spent is also useful to include in your note

Acoustic Reflexes

- **92570 Acoustic immittance testing**—includes:
  - **92567—tympanometry**
  - **92568—acoustic reflex threshold testing**
  - **AND** acoustic reflex decay (no code, since you don't do this as a standalone procedure)
- **92568 Acoustic reflex testing, threshold**
  - Requirements and code description
    - 4 test conditions: two ipsi and two contra
    - No guidance on exact number of frequencies
    - Sufficient number to "obtain the complete diagnostic information"
  - Ipsilateral screenings do not meet the description of this code

Timed Codes

- **92620—Evaluation of central auditory function (first 60m)**
- **92621—” “ (each additional 15m)**
- **92626—Evaluation of auditory function for surgical device candidacy or post-operative status (first 60m)**
- **92627—” “ (each additional 15m)**

- What you need to know:
  - Must have **at least 31 m spent in procedure** to report the first 60m code; do not bill with -52 (reduced services) modifier if procedure was <31m
  - You may bill multiple units of the additional 15m codes, but these are always reported in conjunction with the initial 60m code
  - Document start and stop times in report
  - Do not use for time spent in counseling; these are diagnostic codes

92626 & 92627

- **92626** Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device, first hour
- **92627** " " ; each additional 15 minutes
- Details and description:
  - This is an **evaluative procedure**
  - Used to determine **candidacy for and progress with** implanted devices (not for hearing aid checks that occur without an intent to determine candidacy for implantable device)
  - Can include the use of inventories and booth testing to determine functional hearing capabilities
  - Does not include time spent counseling

Case Studies!:
Correct CPT Coding

- Break into small groups (3-5 people)
- Work the cases
- You have 5 minutes!
- We will discuss 1-2 together
- Answers and justification will be provided

Keep in mind!

- Covered vs. Non-Covered exercises are for Medicare policies
  - Check specific coverage policies for Medicaid, CHIP, and other private plans
- Correct coding exercise is not specific to Medicare
  - Avoid problematic CPT reporting practices (e.g., unbundling, upcoding, etc.)

How’s your pumpkin?

Catch you later! I’m good to go!

I feel the magical transformation happening!

Additional Resources

- American Academy of Audiology
  - https://www.audiology.org/practice-resources/coding/coding-frequently-asked-questions/
  - https://www.audiology.org/practice-resources/coding/coding-articles/
- Centers for Medicare and Medicaid Services
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs
  - https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo
- Texas Medicaid
  - https://www.tmhp.com/resources/provider-manuals/tmppm
  - https://public.tmhp.com/feeschedules/default.aspx

Reference Tool: Modifiers

Modifier	Description	When to use the modifier
-22	Increased procedural services	When additional testing is required for this case which results in increased time and complexity of the procedure
-52	Reduced services	When only one ear is tested When all components of a procedure were not performed Example: Acoustic reflexes—one or more test conditions not performed (e.g., 2 ipsi and only 1 contra OR 2 contra and no ipsi)
-53	Discontinued procedure	When the procedure is electively discontinued by the patient
-59	Distinct procedural service	When you have 2 or more procedures that are usually not reported together, but are appropriate under the circumstances Indicates to the payer that you know there is a bundled code that represents these procedures, but you were not able to complete all of the components in a given circumstance. So, you report the component procedures of the bundled code that you *did* do and append the -59 modifier to each.

Bibbity-Bobbity-Billing: The Magic of Getting Paid for Your Services

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