Case Based Options for Coding Audiology Services

Annette A. Burton, Au.D.
Director, Easterseals Center for Better Hearing
Anna M. Jilla, Au.D., Ph.D.
Jo Mayo Endowed Assistant Professor, Lamar University
Erin L. Miller, Au.D.
Professor, University of Akron/Northeast Ohio AuD Consortium

No financial disclosures

Annette A Burton, AuD – employed by, Easterseals Center for Better Hearing

Anna M Jilla, AuD, PhD – employed by, Lamar University

Erin L Miller, AuD – employed by, The University of Akron

American Academy of Audiology and other professional organizations

Learner Outcomes

Describe alternatives for coding of audiology services that fall outside of those currently defined by the Current Procedural Terminology (CPT)™ code set.

Identify ethical and legal options to code for non-covered audiology services.

Summarize how coding for non-covered audiology services can elevate the value of audiology services to consumers.

Current Payment Policy: Covered Services

Medicare

Only reimbursed for certain diagnostic services

Commercial Health Plans

Contract specific

Audience Question: One

Besides the actual diagnostic test, CPT 92557, what other services do you provide prior to or after completion of PT A/B, SRT and WRS?

ⓘ Start presenting to display the poll results on this slide.

Dissecting a diagnostic code

- Reimbursement for DX procedures are based on the RVU (value) for the code
- Specific activities or tasks are part of each CPT code

Case 1: Dissecting diagnostic code 92557 (PT A/B, SRT, WRS)

- **Activities/Tasks during encounter:**
  - Pre-time: 3 minutes
  - Intra-time: 20 minutes completion of PT A/B, SRT and WRS
  - Post-time: 5 minutes
  - Approximate time for completion of code: 28 minutes

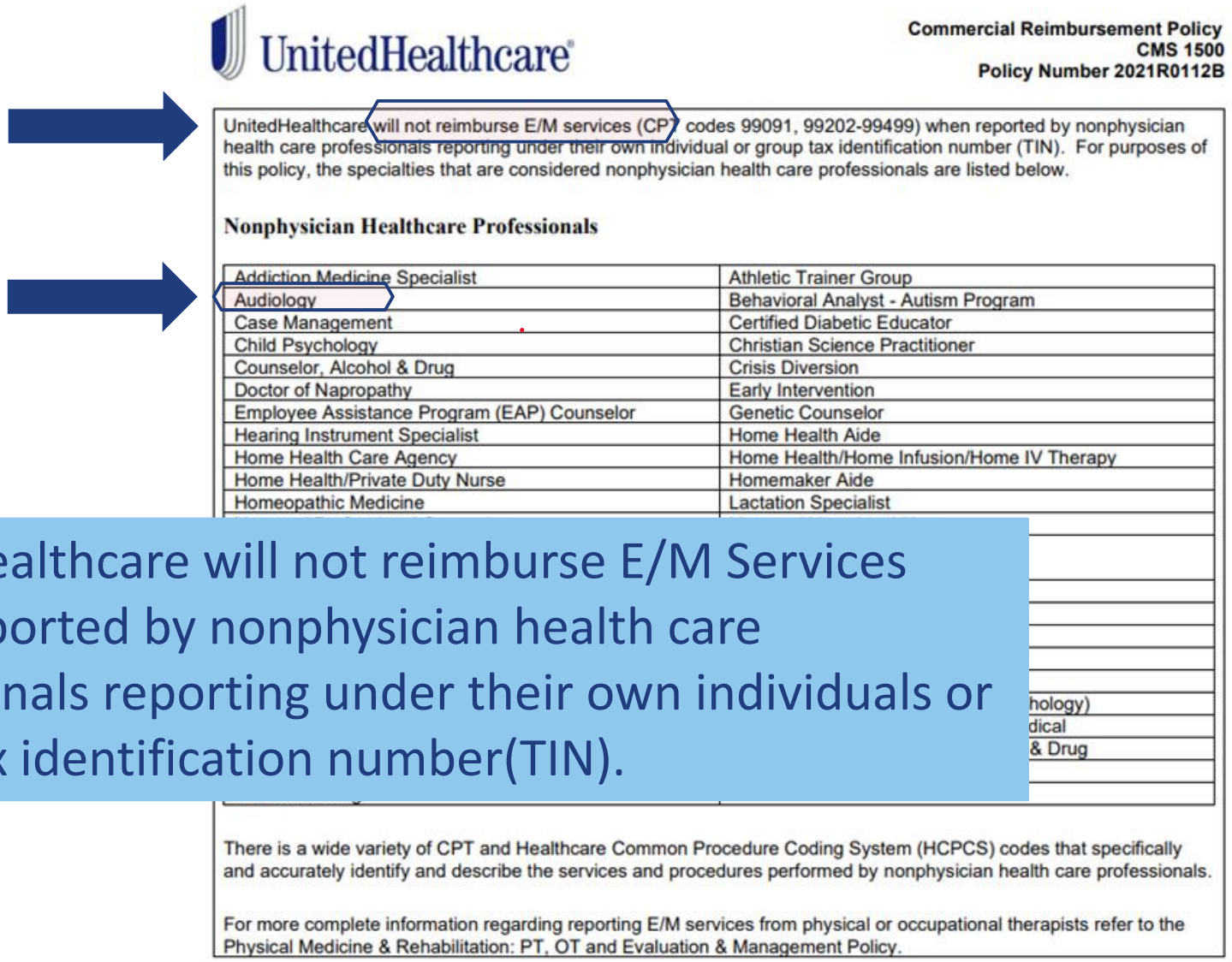
Coverage for the evaluation and management services

No Coverage	Contract Specific
Medicare	Commercial Payers

Payer Specific Policy Example

Commercial Reimbursement Policy
CMS 1500
Policy Number 2021R0112B

Nonphysician Health Care Professionals Billing Evaluation and Management Codes Policy, Professional



UnitedHealthcare

Commercial Reimbursement Policy
CMS 1500
Policy Number 2021R0112B

UnitedHealthcare will not reimburse E/M services (CPT codes 99091, 99202-99499) when reported by nonphysician health care professionals reporting under their own individual or group tax identification number (TIN). For purposes of this policy, the specialties that are considered nonphysician health care professionals are listed below.

Nonphysician Healthcare Professionals

Addiction Medicine Specialist	Athletic Trainer Group
Audiology	Behavioral Analyst - Autism Program
Case Management	Certified Diabetic Educator
Child Psychology	Christian Science Practitioner
Counselor, Alcohol & Drug	Crisis Diversion
Doctor of Napropathy	Early Intervention
Employee Assistance Program (EAP) Counselor	Genetic Counselor
Hearing Instrument Specialist	Home Health Aide
Home Health Care Agency	Home Health/Home Infusion/Home IV Therapy
Home Health/Private Duty Nurse	Homemaker Aide
Homeopathic Medicine	Lactation Specialist

There is a wide variety of CPT and Healthcare Common Procedure Coding System (HCPCS) codes that specifically and accurately identify and describe the services and procedures performed by nonphysician health care professionals.

For more complete information regarding reporting E/M services from physical or occupational therapists refer to the Physical Medicine & Rehabilitation: PT, OT and Evaluation & Management Policy.

UnitedHealthcare will not reimburse E/M Services when reported by nonphysician health care professionals reporting under their own individuals or group tax identification number(TIN).

Non-Covered Services

- Patient Responsibility for services not covered by payer
- Must meet obligations of codes billed to payer
- If other non-covered service are provided, determine value in your practice base on analysis of time and resources
- Fee established for:

Patient Notification

- **Our practice – University Audiology and Speech Center**
  - Advised that the payer does not cover counseling and other services associated with visit
  - Implemented during COVID – some costs associated with increased use PPE
  - Patient advised of charge when they called to schedule appointment
  - Informed current patients on website, via newsletter and patient notification at first office visit after implementation

Patient Reaction

~85%	~10%	~5%
Understood necessity for charge	Upset, complained	Decided not to reschedule routine visit
	Ultimately continued to schedule return visits	Many have returned when needed, not on routine schedule

Increase in Revenue

- Immediate increase in revenue for services with no additional expenses
- Rather than reduce appointment times (see more patients), able to continue providing quality services
- For our clinic: No marketing of services, positive patient outcomes result in word-of-mouth referrals

Audience Question: Two

Do you provide auditory processing evaluations in your practice?

If not, would you, if you could be fairly reimbursed for services?

ⓘ Start presenting to display the poll results on this slide.

Case 2: Dissecting diagnostic code 92620 (add on 92621, each additional 15 minutes)

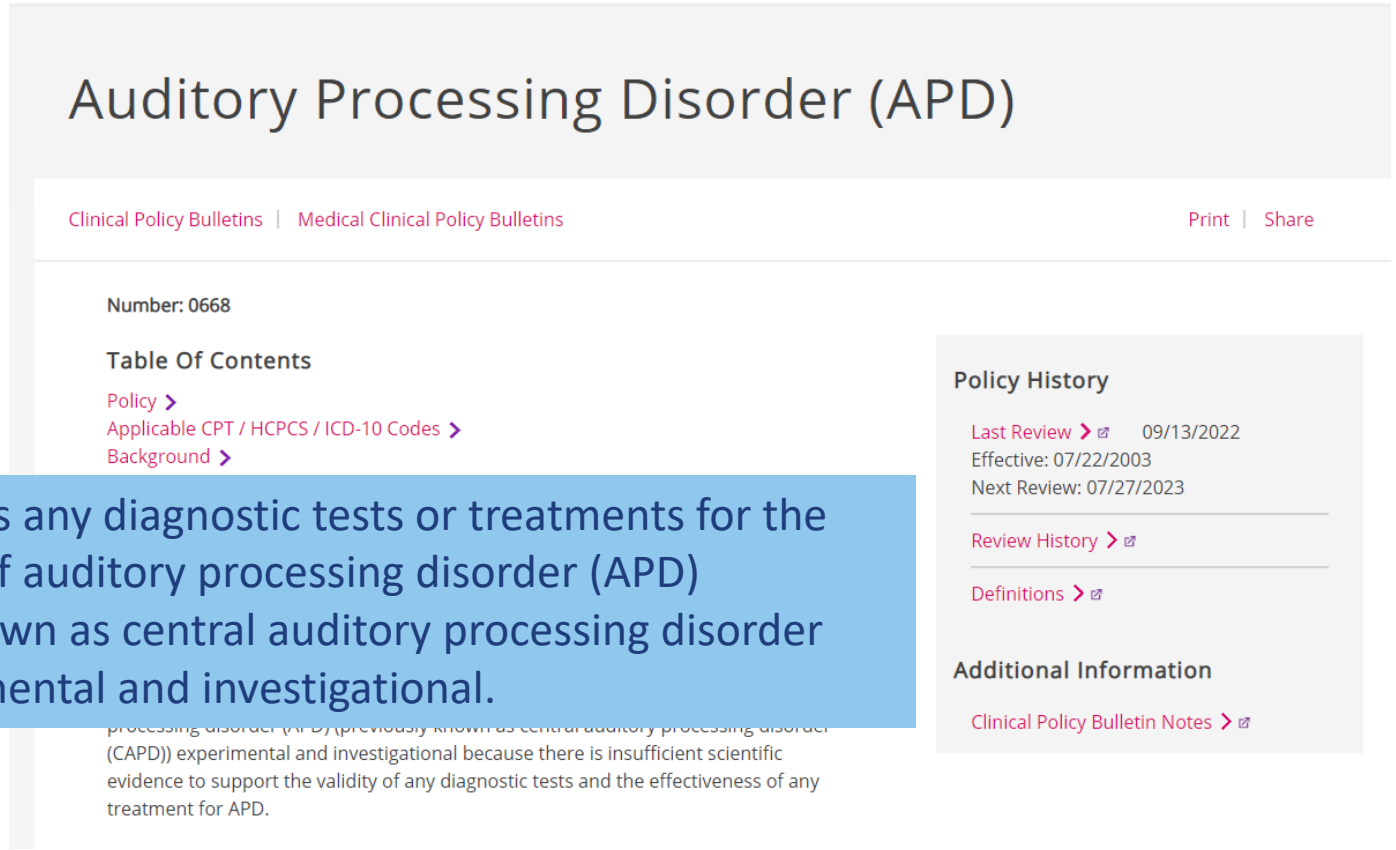
- **Activities/Tasks during encounter: (time base codes)**
  - Pre-time: 7 minutes
  - Intra-time: 60 minutes (Completion of battery of tests needed, time based)
  - Post-time: 10 minutes
- **Time for completion of code: 77 minutes**
  - Initial 60 minutes
  - CPT 92621: each additional 15 minutes

Coverage for the evaluation of auditory processing disorders

Covered Benefit	Contract Specific
Medicare	Commercial Payers

Payer Specific Policy Example

https://www.aetna.com/cpb/medical/data/600_699/0668.html#:~:text=Aetna%20considers%20any%20diagnostic%20tests%20or%20treatments%20for,and%20the%20effectiveness%20of%20any%20treatment%20for%20APD.



aetna™

Auditory Processing Disorder (APD)

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Print | Share

Number: 0668

Table Of Contents

Policy
Applicable CPT / HCPCS / ICD-10 Codes
Background

Policy History

Last Review 09/13/2022
Effective: 07/22/2003
Next Review: 07/27/2023

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes

(CAPD)) experimental and investigational because there is insufficient scientific evidence to support the validity of any diagnostic tests and the effectiveness of any treatment for APD.

Aetna considers any diagnostic tests or treatments for the management of auditory processing disorder (APD) (previously known as central auditory processing disorder (CAPD) experimental and investigational.

Options for APD Service Coverage

- **School Age Children**
  - Educational Report
    - Reports often are complex and take considerable time
    - Often have phone calls with SLP or school staff
    - Significant counseling and discussion for treatment options
      - Not simply confirming/refuting condition

Options for APD Service Coverage

- **Adult Patients**
  - Consultation for APD Treatment
  - Reports often are complex and take considerable time
    - Often have phone calls with treating physician or NPP, SLP, etc.
    - Significant counseling and discussion for treatment options

Other Treatment Options

- **Confirmed AP diagnosis may lead to:**
  - Hearing device consultation
    - Traditional amplification
    - OTC
    - PSAP
    - Other treatment options

Case 3: Practice vs. Policy

- Options for non-covered auditory rehabilitation

Audience Question: Three

Do you provide auditory rehabilitation services in your practice?

How many of you would like to?

ⓘ Start presenting to display the poll results on this slide.

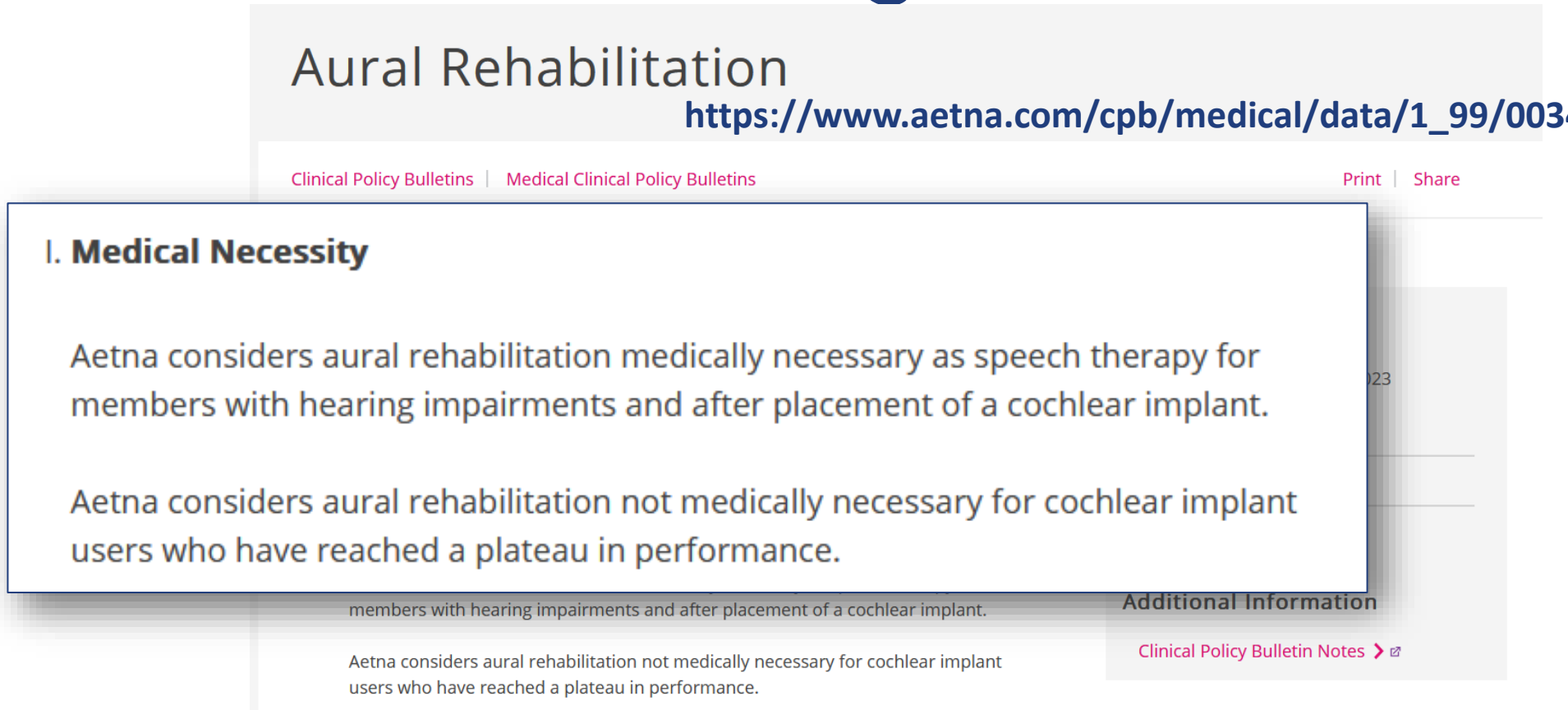
Coverage for Auditory Rehabilitation Services

Covered Benefit	Contract Specific
Medicare	Commercial Payers

Traditional Medicare (A/B): Auditory Rehabilitation

- **Medicare has no provision to reimburse audiologists for therapeutic services (e.g., auditory rehabilitation treatment) Medicare Benefit Policy Manual; Chapter 15; Section 80.3**
- **Treatment related to hearing may be covered when performed by speech-language pathologists Medicare Benefit Policy Manual; Chapter 15, Section 230.3**
- **What does this mean?**
  - Payment for non-covered services becomes the responsibility of the patient
  - Inform patients of charges and coverage policies

Dissecting Private Payer Policy for AR Programs



Dissecting Policy for AR Programs

Aural Rehabilitation

https://www.aetna.com/cpb/medical/data/1_99/0034.html#

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Print | Share

II. Experimental and Investigational

Aetna considers aural rehabilitation experimental and investigation for individuals with hearing loss and without a cochlear implant and for the treatment of tinnitus because of insufficient evidence of this approach.

members with hearing impairments and after placement of a cochlear implant.

Aetna considers aural rehabilitation not medically necessary for cochlear implant users who have reached a plateau in performance.

Additional Information

Clinical Policy Bulletin Notes

Options for Coverage: Auditory Rehabilitation

- Evaluation for program (e.g., individualized, group; computer-based)
- Orientation to and conduct of program
- Monitoring, reporting, and interpretation of multi-tooled rehabilitative assessments
- Discharge notes
- Educational or Vocational Reports

What other professional work and supplies are needed?

92630 Auditory rehabilitation; pre-lingual hearing loss
92633 Auditory rehabilitation; post-lingual hearing loss

Audience Question: Four

What vestibular diagnostic tests have no CPT code available to report those activities?

Case 4: Non-Covered Vestibular Services

- **Vestibular assessments with no CPT code**
  - Video head impulse test

Using 92700

- Other otorhinolaryngological service or procedure
- For use when a procedure does not have a CPT code (if one exists, use the existing code)
- Fee set by provider; payment set by contract with insurance
- Not customary to bill multiple units of 92700 on same date
- Documentation requirements may vary by payer

92700: Documentation

- **Copy of patient report/results**
- **Description of procedure:**
  - Nature (What did you do?)
  - Extent (What was your required effort?)
  - Need for procedure (What is the clinical utility of this procedure? Why is this medically necessary?)
  - Amount of time required for the procedure
  - Professional skill required (Why does this require a professional?)
  - Equipment and supplies used (e.g., equipment, supplies)
- **How activities in this procedure are distinct from existing CPT procedure codes**

Stephens B. (2018) Demystifying CPT code 92700. *Audiol Today* 30(6):75–76.

Audience Question: Five

After a defined period, do you charge for follow-up visits for your self-pay hearing aid patients?

What about for patients who have coverage through a 3rd party payer contract?

Hearing Aid 3rd Party Administrators

- The proliferation of 3rd party contracts is increasing.
- 2023 – over 51% of Medicare patients are enrolled in a Medicare Advantage Plan.
- Over 92% of Medicare Advantage Plans now have a supplemental hearing aid benefit.

Hearing Aid 3rd Party Payers

- **Review contracts carefully. You can negotiate before signing on the dotted line.**
  - Carve outs (participation only applies to certain contracts)
  - Negotiate follow up visit allowable charge rates
  - Negotiate the ability to bill insurance for medically necessary diagnostic testing
  - Don’t sign on to unreasonable contracts (e.g., free care for the life of the instrument)

What is Typically Covered?

Yes	No
New hearing aids (designated time period)	Replacement hearing aid (less than designated time period)
New earmold for new hearing aids	Replacement earmolds
Follow up visits for certain time period	Visits for the life of the hearing aid
Repairs (maybe)	Routine maintenance
	Routine accessories
	Batteries

After fitting charges

- **Consider offering packages for self-pay patients that includes professional bundled services and items, for a certain time period. Limitless care is NOT sustainable.**
- **All patient contracts are not the same. Charge for services that are not covered or payable by the 3rd party payer.**
  - office visits after defined time period.
  - supplies
- **Visits for patients that have aids were covered by a 3rd party payer but are new to your practice.**

Audience Question: Six

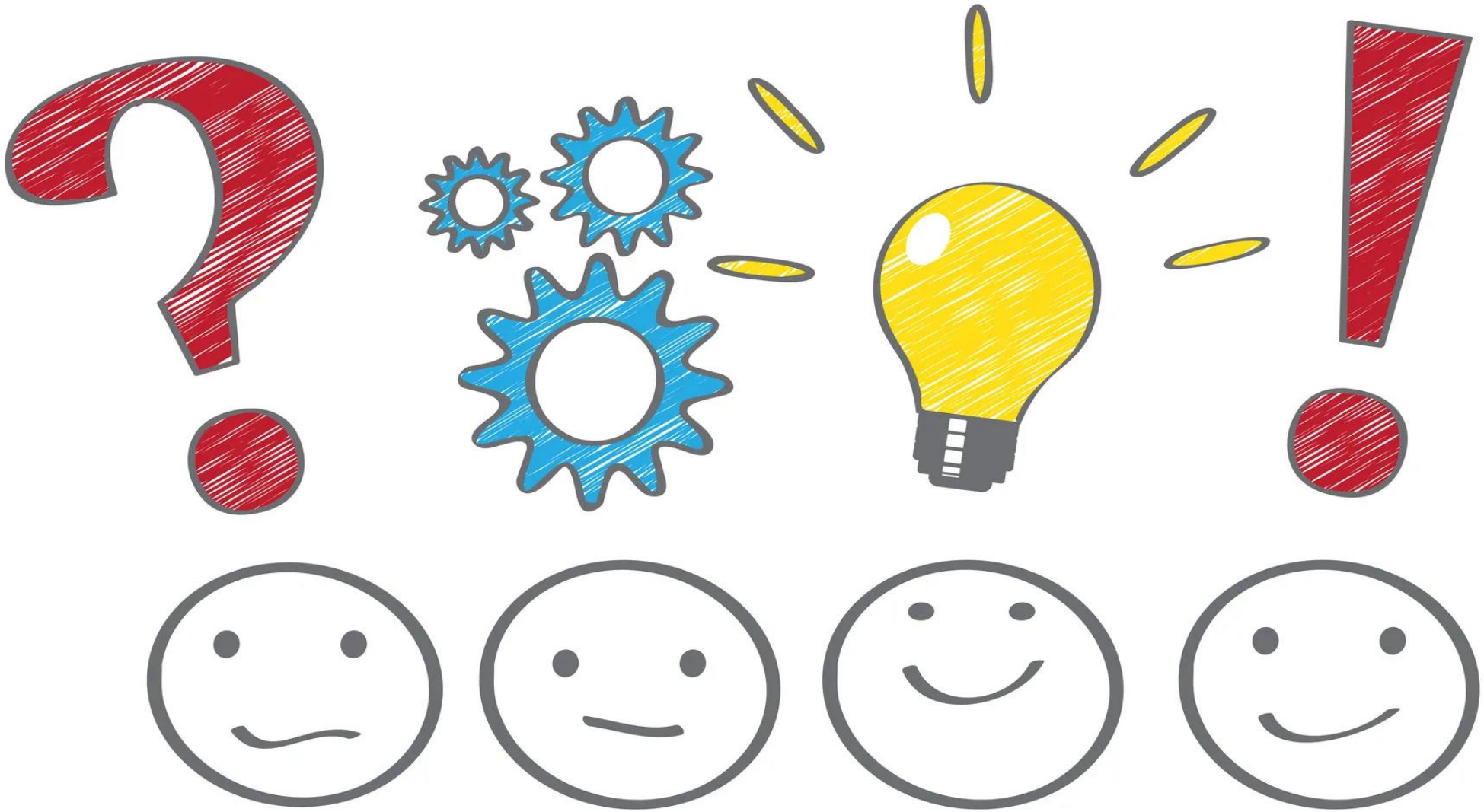
Do you provide a notice of non-coverage for non-covered services?

ⓘ Start presenting to display the poll results on this slide.

Notice of Noncoverage

- ABN is only for Original Medicare
  - Do not use for Medicare Advantage Plans
  - Never covered items – ABN is optional
  - All other payers, check on specific policies of non-coverage if you are an in-network provider.

Your Professional Work Has Value



References

- https://www.aetna.com/cpb/medical/data/600_699/0668.html
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- https://www.hhs.gov/guidance/document/audiology-services
- https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Nonphysician-Healthcare-Professionals-Billing-EM-Codes-Policy.pdf
- https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/