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2013 Coding and Reimbursement Update

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Medicare Fee Schedule

- The fiscal cliff negotiations and legislation yielded some positive outcomes, at least in the short term, for audiologists who provide testing and services to Medicare beneficiaries. The American Taxpayer Relief Act, also known as the Middle Class Tax Relief Act passed both the US House and Senate on December 31, 2012/January 1, 2013.

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Medicare Fee Schedule

- This legislation allowed for the following as it pertains to Medicare reimbursement:
  - The Current Medicare physician fee schedule for your locality is extended through Dec. 31, 2013. The scheduled 26.5 percent cut required by the sustainable growth rate (SGR) formula has been averted at this point. As a result, audiology reimbursement through Medicare should stay consistent with 2012 rates, at least through February 2013.
    - The 2013 conversion factor will be $34.0230
    - January 2013 claims will be held for payment until January 15, 2013
    - CMS is extending the 2013 annual participation enrollment period. Physicians now have until Feb. 15 to change their Medicare participation status for 2013
  - The current Geographic Work Adjustment is extended through Dec. 31, 2013.
  - The planned 2% sequestration cuts (which could have some impact on an audiologist's reimbursement or coverage for Medicare or Medicaid patients) have been delayed for two months.
  - Funding for PQRS has been authorized for another year.

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PQRS Background

The 2006 Tax Relief and Health Care Act (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. CMS named this program the Physician Quality Reporting System (PQRS). Audiologists could report on PQRS beginning in 2010.

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PQRS Facilitates An Opportunity for Care Coordination

- Care coordination helps ensure a patient's needs and preferences for care are:
  - Understood by care providers
  - Shared between providers, patients, and families as a patient moves from one healthcare setting to another.
- Patient care must be:
  - Well-coordinated to avoid duplication;
  - Communicated to avoid conflicting plans of care.

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PQRS Facilitates An Opportunity for Care Coordination

- Given the high-risk nature of transitions in patient care, **PQRS** builds upon ongoing efforts among varied health care providers and their associations and/or academy's to establish principles for effective patient hand-offs across clinicians and providers.

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Audiology Physicians Quality Reporting System (PQRS)

- PQRS is a program designed to improve the quality of care to Medicare beneficiaries.
- Audiologists who bill Medicare Part B beneficiaries must participate in 2013 to avoid deductions in reimbursement in 2015.
  - Does not apply to Part B hospital or skilled nursing facilities

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How PQRS works…

- Audiologists can begin any time
- Until December 31, 2014, a 0.5% bonus will be given for all Medicare eligible cases when reporting on 50% of eligible measures

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What Happens in 2015 Matters Now…

- Beginning January 1, 2015, the voluntary incentive program is slated to end and a reimbursement adjustment will be made if eligible professionals (such as audiologists) do not report on at least one PQRS measure.
- The 2015 reduction is based on reporting in 2013
  - In 2015, the reduction is 1.5% of all 2013 eligible claims
  - In 2016, the reduction is 2.0% of all 2014 eligible claims

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Are There Quality Measures That Audiologists Can Report On?

- Measure #188: Congenital or traumatic deformity of the ear
- Measure #261: Referral for otologic evaluation for patients with acute or chronic dizziness
- Measure #130: Documentation and verification of current medications in the medical record
- Measure #134: Screening for clinical depression and follow-up plan
  - Avoid reporting this one

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Eliminations

- Measures #189 (active drainage) and #190 (sudden or rapidly progressive hearing loss) will be permanently retired in 2013.
- **Do not report on these measures as of January 1, 2013!**

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How Would An Audiologist Report On These Measures?

- These measures are reportable via the CMS 1500 claim form or your electronic billing system. The audiologist would add Medicare directed, CPT Category II or G-Codes, which are available in the HCPCS system, to the claim to report the measures to CMS. These codes must be reported on the same claim as the patient diagnosis and diagnostic procedure to which the PQRS code applies.

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How Does Participation Work?

- The audiologist must be a Medicare provider. This means that in addition to having one's own NPI number, the audiologist must have completed the Medicare form 855I for formally registering with Medicare as a provider and, if necessary, an 855R form to inform Medicare where regular payments should be directed.
- The incentive payment is calculated after the end of the year based on all qualifying claims submissions throughout the year.

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Why Is PQRS Important For Audiology?

- PQRS is important for many reasons
  - Focuses audiology's place in the Health Care arena
  - Recognizes audiology as providing significant influence on the quality of health care we provide
  - Offers 0.5% bonus payment on the qualifying submitted procedures at year end for 2013 and 2014
  - Accepted measures focus on problems and disorders that go beyond routine issues and focus on those that have significant impact on long-term outcomes and quality of life.

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PQRS Reporting Step #1: Review the Measures and Their Codes

- Measure #188: Congenital or traumatic deformity of the ear
- Measure #261: Referral for otologic evaluation for patients with acute or chronic dizziness
- Measure #130: Documentation and verification of current medications in the medical record
- Measure #134: Screening for clinical depression and follow-up plan
  - Avoid reporting this one

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PQRS Reporting Step #2: Review the Codes for Each Measure

- Each measure is reportable via the CMS 1500 claim form using the International Classification of Diseases Ninth Revision, Clinical Modification (ICD-9-CM) codes, Current Procedural Terminology (CPT) codes, and G-codes.
  - CPT Codes
    - Indicate the procedure performed on the patient.
    - This is what drives whether or not you report a measure.
    - Represents the measures' *denominator (the eligible patients for a measure) in conjunction with the ICD-9-CM codes.*
  - ICD-9-CM codes
    - Indicate the diagnosis of the patient.
    - Represent the measures' *denominator (the eligible patients for a measure) in conjunction with CPT codes.*
  - G-Codes
    - Represents the measures' *numerator (action required by the measure for reporting and performance) as well as when the action does not occur because the patient fits into the denominator exclusion (patient that fits into the denominator but is not eligible for the measure).*
    - Some measures have CPT Category II codes to represent the numerator as well as when the action does not occur because the patient fits into the *denominator exclusion. When there are no CPT Category II codes for a measure, CMS creates temporary G-codes.*

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Codes for Referral for Congenital or Traumatic Deformity of the Ear

- **CPT Codes**
  - 92550, 92557, 92567, 92568, 92570, 92575
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - 744.01, 744.02, 744.03, 744.09, 380.00, 380.01, 380.02, 380.03, 380.10, 380.30, 380.31, 380.32, 380.39, 380.51, 380.81, 380.89, 380.9
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

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Codes for Referral for Congenital or Traumatic Deformity of the Ear

- G8556
  - *Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation*
- G8557
  - *Referral not performed because patient is not eligible (denominator exclusion) (e.g., patients for whom an assessment of the congenital or traumatic deformity of the ear has been performed by a physician (preferably a physician with training in disorders of the ear) within the last 6 months, patients who are already under the care of a physician (preferably a physician with training in disorders of the ear) for congenital or traumatic deformity of the ear, etc.*
- G8558
  - *Referral not performed, but reason not specified.*

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Codes for Referral for Acute or Chronic Dizziness

- **CPT Codes**
  - 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - 780.4 OR 386.11
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

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Codes for Referral for Acute or Chronic Dizziness

- G8856: Referral to a physician for otologic evaluation
- G8857: Patient is not eligible for the referral for otologic evaluation (i.e. patients who are already under the care of a physician for acute or chronic dizziness)
- G8858: Referral to a physician for an otologic evaluation not performed, reason not specified

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Codes for Documentation of Current Medications

- **CPT Codes**
  - 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - None specified (so all included)
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

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Codes for Documentation of Current Medications

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

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Codes for Screening of Clinical Depression

- **CPT Codes**
  - 92557, 92567, 92568, 92625, 92626
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - None specified (so all included)
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

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Codes for Screening of Clinical Depression

- G8431: Positive screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented
- G8510: Negative screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented
- G8433: Screening for clinical depression using an age appropriate standardized tool not documented, patient not eligible/appropriate
- G8432: No documentation of clinical depression screening using an age appropriate standardized tool
- G8511: Positive screen for clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified

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PQRS Reporting Step #3: Fill Out the HCFA 1500 Claim Form

- A sample 1500 claim form is available on the CMS Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2012PQRSMadeSimple_PrevCareMGs_PMBR_01-30-2012_508.pdf.
  - ICD-9 codes are placed in box 21
  - CPT codes are placed in box 24D
  - G-codes are placed in box 24D following the CPT code

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MOST IMPORTANT THING TO NOTE:

- **Do not recommend any reporting of the Screening of Clinical Depression Codes**
- This screening may or may not be within your state defined scope of practice
- Audiology community is working to get Audiology removed from this measure.

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MOST IMPORTANT THING TO NOTE:

- **EVERYTIME** YOU PERFORM 92557 ON A MEDICARE PART B PATIENT THERE IS AT LEAST ONE MEASURE TO REPORT ON!!!!
  - **THIS IS REGARDLESS OF THEIR CHIEF COMPLAINT AND CASE HISTORY**

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MOST IMPORTANT THING TO NOTE:

- **EVERYTIME** YOU PERFORM 92540 AND YOUR REPORT DIZZINESS OR BPPV ON A MEDICARE PART B PATIENT THERE IS AT LEAST ONE MEASURE TO REPORT ON!!!!
  - **THIS IS REGARDLESS OF THEIR CHIEF COMPLAINT AND CASE HISTORY**

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PQRS Reporting Step #4: Make Sure You Meet the CMS Minimum Reporting Requirements

- CMS requires that PQRS participants report on at least 50% of eligible patients to be eligible for the **incentives** in 2013 and 2014.
  - Therefore, an audiologist would need to report on 50% of the patients they see that fit into any of the available measures

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PQRS Reporting Step #4: Make Sure You Meet the CMS Minimum Reporting Requirements

- CMS requires that PQRS participants report on at least one measure in 2013 and 2014 to not be penalized in 2015 and 2016.
  - Therefore, an audiologist would need to report on 50% of the eligible patients they see that fit into one measure to not be penalized.

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Example #1

- Patient A is a 70 year old male.
  - He reports hearing loss and tinnitus
  - You did not document current medications and your did not screen for depression.
  - You perform 92557
  - After testing, you diagnose 389.18 and 388.30

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Example #1

- In this case, you would report:
  - Measure #130 (because it contains the CPT code) using G8428 (you did not document current medications),

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Example #2

- Patient B is a 70 year old female.
  - She reports hearing loss and dizziness
  - You did not document current medications and your did not screen for depression.
  - You perform 92557
  - After testing, you diagnose 389.18 and 780.4
  - Referred patient for otologic evaluation for dizziness

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Example #2

- In this case, you would report:
  - Measure #261 (because because it contains both the CPT and ICD9 you have reported for this patient) using G8856,
  - Measure #130 (because it contains the CPT code) using G8428 (you did not document current medications),

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Example #3

- Patient C is a 70 year old male.
  - He reports hearing loss
  - Otoscopy revealed prominent exotoses in both ear canals
  - You did not document all of the components of current medications and your did not screen for depression.
  - You perform 92557
  - After testing, you diagnose 389.18 and 380.81

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Example #3

- Measure #188: Congenital or traumatic deformity of the ear (because it contains the CPT code) using G8556 (because you referred the patient to an otolaryngologist for the exotoses before proceeding with amplification),
- Measure #130 (because it contains the CPT code) using G8428 (you did not document current medications),

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For More Information:

- Consult the CMS Website
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/15_MeasuresCodes.asp
- Consult the websites of these Audiology Quality Consortium member organizations:
  - Academy of Doctors of Audiology
    - http://www.audiologist.org/publications20/reimbursement/pqrs
  - American Academy of Audiology
    - http://www.audiology.org/practice/PQRI/Pages/default.aspx
  - American Speech-Language-Hearing Association
    - http://www.asha.org/Advocacy/audiologyPQRI/

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HCPCS FM Family of Codes

- There is now a new family of HCPCS codes that can be used to bill for FM/DM assistive listening devices and systems, as well as many of their individual components.
- **These new codes into effect on January 1, 2013.**
  - It will be important for each practice to obtain a 2013 HCPCS Coding Manual. These are available though many online vendors. Their cost is $75-100 each.

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HCPCS FM Family of Codes

- As we all know, the mere existence of a code does not guarantee coverage.
  - It will be important for audiologists to review their current third-party contracts and contact their third-party payers and determine how these codes will be processed and potentially covered by each individual payer.
  - Audiologists may need to renegotiate their contracts to account for these codes and their accompanying reimbursement and coverage.

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HCPCS FM Family of Codes

- You will also need to work with your state audiology organizations to create a coordinated approach to Medicaid and many larger payers in your state and/or community.
  - Please make sure that organizations are careful about recommending pricing as this type of action can be construed as a violation of antitrust laws.
  - Pricing and coverage specifics should be determined and negotiated by each independent audiologist based upon their breakeven plus profit needs and costs of goods.

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FM Code Specifics

- V5281
  - Assistive listening device, personal fm/dm system, monaural, (1 receiver, transmitter, microphone), any type
  - This code is appropriate when fitting an entire monaural system, regardless of the type of receiver or transmitter used. This does not include the boot, as it is coded separately.
- V5282
  - Assistive listening device, personal fm/dm system, binaural, (2 receivers, transmitter, microphone), any type
  - This code is appropriate when fitting an entire binaural system, regardless of the type of receiver or transmitter used. This does not include the boots, as they are coded separately.

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FM Code Specifics

- V5283
  - Assistive listening device, personal fm/dm neck, loop induction receiver
  - This code is appropriate when dispensing a neck loop receiver in isolation (replacement, extra receiver, etc.) that is coupled with the t-coil of a hearing aid.
- V5284
  - Assistive listening device, personal fm/dm, ear level receiver
  - This code is appropriate when dispensing an ear level receiver in isolation (replacement, extra receiver, etc.). This code is for an ear-level device for those with normal hearing. The code is per receiver.

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FM Code Specifics

- V5285
  - Assistive listening device, personal fm/dm, direct audio input receiver
  - This code is appropriate when dispensing a direct audio input receiver (the receiver is the cord which connects to the boot) in isolation (replacement, extra receiver, etc.). This does not include the boot, as each is coded separately.
- V5286
  - Assistive listening device, personal blue tooth fm/dm receiver
  - The code is appropriate when dispensing a streamer in isolation (replacement, extra receiver, etc.).

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FM Code Specifics

- V5287
  - Assistive listening device, personal fm/dm receiver, not otherwise specified
  - This is for any existing or yet to be released receiver that is not represented by another code above.
- V5288
  - Assistive listening device, personal fm/dm transmitter assistive listening device
  - This code is appropriate when dispensing any type of fm/dm transmitter in isolation (replacement, extra receiver, etc.).

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FM Code Specifics

- V5289
  - Assistive listening device, personal fm/dm adapter/boot coupling device for receiver, any type
  - The code is appropriate for the audio boot dispensed in any situation. This code is per boot. A initial, binaural FM fitting would constitute two boots.
- V5290
  - Assistive listening device, transmitter microphone, any type
  - This code is appropriate when dispensing any type of fm/dm microphone transmitter in isolation (replacement, extra receiver, etc.).

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FM Code Specifics

- V5267
  - Hearing aid or assistive listening device/supplies/accessories, not otherwise specified
  - This code is used to represent any FM/DM accessory or supply that is not otherwise listed or captured by another new or existing code.

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Intraoperative Monitoring

- 95940
  - Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes
    - Add-on to 92585
- 95941
  - Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour
    - Add-on to 92585

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Standby Services

- 99360
  - Standby service, requiring prolonged attendance, each 30 minutes

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Nerve Conduction Studies

- 95907-95913
  - Nerve Conduction Studies
    - Selected by number of studies being completed

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Office of Inspector General Work Plan

- Compliance and enforcement projects and priorities for the coming year
  - Those which could impact audiology:
    - "Incident to" billing
    - Inappropriate payments for Evaluation and Management codes
    - Inappropriate payments from the use of the –GA, -GZ, -GY and –GX modifiers
    - Non-compliance with assignment rules and excessive billing to Medicare beneficiaries

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Local Coverage Determinations

- This is where Medicare Area Contractors specifically dictate the coverage terms of audiology and/or vestibular procedures
  - They exist for:
    - Palmetto and Novitas: Audiology and Vestibular
    - First Coast: Vestibular
    - CGS and Novitas: Cerumen Removal

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Evaluation and Management Codes

- Several payers are now disallowing claims/payment for Evaluation and Management codes provided and billed by audiologists
  - Examples in some localities:
    - Aetna
    - Cigna
    - BCBS