



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION



# **Audiology Coding Update**

**Health Care Economic  
Committee**

# ASHA

Health Care Economics Committee  
Government Relations & Public  
Policy Board



## Health Care Economics Committee

- ASHA Standing Committee
- 10 Members
  - 5 AUD
  - 5 SLP
- Appointed by ASHA Executive Board
- Serve for a 3 Year Period



# Members

- Nancy Swigert, Chair
- Constance Barker
- Becky Cornett
- Kyle Dennis
- Robert Fifer
- R. Wayne Holland
- Dee Adams Nikjeh
- Thomas Rees
- Gwenlynn Reeves
- Walter Smoski
- Catherine Gottfred - ASHA Executive Board
- Steven White - National Office Ex-Officio



# Purpose

- Assist GRPP to determine current economic issues
- Develop goals for equitable reimbursement for audiologists and speech language pathologists



# Some committee activities include:

- Present and oversee new codes to the **AMA** CPT process
- Defend time and practice expense to the **AMA** RUC
- Defend existing codes through **AMA** PEAC
- Anticipate future needs and expand number of codes



# CPT Editorial Panel - WHO?

- **16 Members**
  - **11 nominated by AMA**
  - **5 appointed by the AMA Board of Trustees**
    - ◆ **Blue Cross-Blue Shield**
    - ◆ **CMS**
    - ◆ **\*HCPAC\*** - ASHA is represented here
    - ◆ **American Hospital Association**
    - ◆ **Health Insurance Association of America**



# Health Care Professionals Advisory Committee - HCPAC (2)

- ASHA's representation to the CPT Panel and to the RUC
- Represent limited license practitioners and allied health professionals
- ASHA's representatives
  - R. Wayne Holland, PhD - CPT HCPAC
  - Robert Fifer, PhD - RUC HCPAC



# Current Procedure Terminology (CPT) Codes

**Where do they come from?**



# History

- **First published  
1966**
- **Published annually  
since 1983**



# Purpose

- **Provide uniform language**
  - **Physicians**
  - **Patients**
  - **Third Parties**
- **Administrative management**
  - **Claims processing**
  - **Development of guidelines**
  - **Utilization comparisons**



# AMA Review Panel

- **Unique procedures**
- **Significant contribution**
- **Definable by work units**
- **Cannot be an unbundled procedure**



# AMA Review Panel (cont'd)

## Example:

- **92557 Basic comprehensive audiometry**
- **92553 Pure tone audiometry (air and bone)**
- **92556 Speech audiometry (threshold and discrim)**
- **Multi-specialty uses**



# Description

- **Five digit code**
- **Describes accepted procedure**
- **(Not investigational)**
- **Relies on input from AMA related groups**



# Modifiers

- **Prolonged evaluation (-21)**
- **Decrease of procedure (-52)**
- **Part of a procedure was performed (-52)**
- **Procedure was provided more than once (-51)**
- **Unusual events occurred (-22)**
- **Additional code 099XX**



# Unlisted Procedure

- **92700**
- **Special report**
  - **Service that is rarely provided,**
  - **unusual, variable, or new.**
  - **Include definition, description of the**
  - **extent and need plus time, effort, and**
  - **equipment.**



# Audiology codes

- **69210 Removal impacted cerumen**
- **92557 Basic comprehensive audiometry**
- **92567 Tympanometry**
- **92568 Acoustic reflex testing**
- **92577 Stenger test, speech**
- **92582 Conditioned play audiometry**
- **92584 Electrocochleography**



- **92585 Brainstem evoked response**
- **92587 Evoked otoacoustic emissions; limited**
- **92588 Evoked otoacoustic emissions; comprehensive**
- **92590 Hearing aid examination and selection; monaural**
- **92592 Hearing aid check; monaural**
- **92594 Electroacoustic evaluation for hearing aid; monaural**



# International Classification of Diseases - 9th Revision (ICD-9)

- **ICD-9 History**
  - **17th Century (London Bills of Mortality)**
  - **1937 International lists of causes of death**
  - **1948 WHO tracking of morbidity and mortality**
  - **ICD series**
- **ICD-9 published in 1977**



# ICD-9 Purpose

- **Statistical tracking**
- **Standardized insurance reporting**
- **Clinical picture of each patient**



# ICD-9 Description

- **Three to five digit code**
- **XXX.XX (e.g., 389.9  
Unspecified hearing loss)**
- **Primary, secondary, tertiary  
diagnoses**
- **No allowance for normal**
- **Closest, most accurate  
description**



# ICD-9-CM

- **386 Vertiginous syndromes and other disorders of vestibular system**
- **387 Otosclerosis**
- **388 Other disorders of ear**
- **389 Hearing loss**



# 389.1 Sensorineural Hearing Loss

- **389.10 Sensorineural hearing loss, unspecified**
- **389.11 Sensory hearing loss**
- **389.12 Neural hearing loss**
- **389.14 Central hearing loss**
- **389.18 Sensorineural hearing loss of combined types**



# V-Codes

- **Supplemental codes to deal with occasions other than disease or injury**
  - **When a person who is not sick seeks health care services for a specific purpose**
  - **When a person with known disease or injury seeks specific treatment for that disease or injury (e.g., cast change)**
  - **When a problem or circumstance arises that influences a person's health status, but itself is not the current disease of concern**



# CPT Process

- **Use of current codes**
- **Generation of new codes**
- **Timeline of the process**



# “The Process”

**Arduous**

***Complex***

**Grueling**



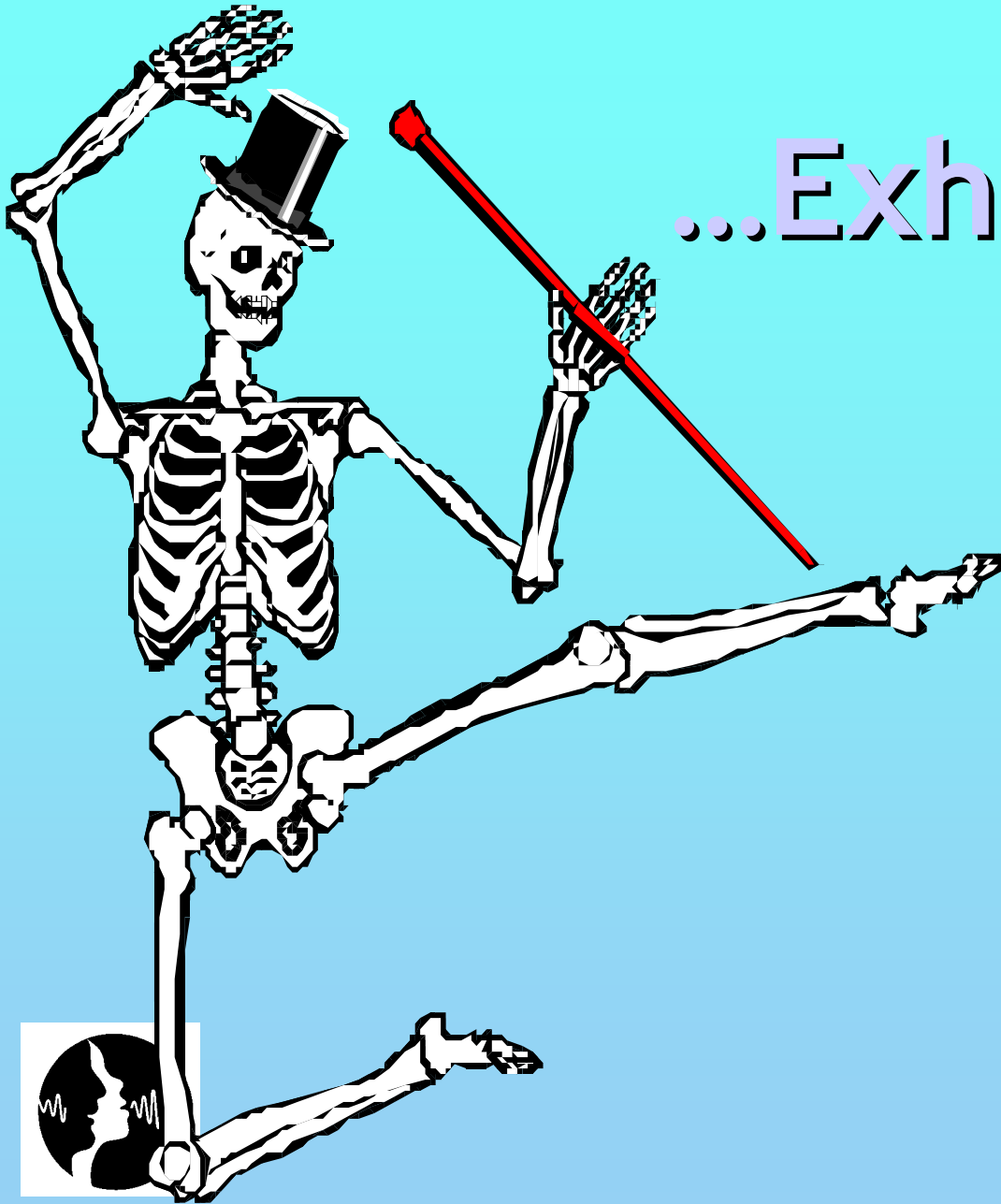
**TEDIOUS**

**L e n g t h y**

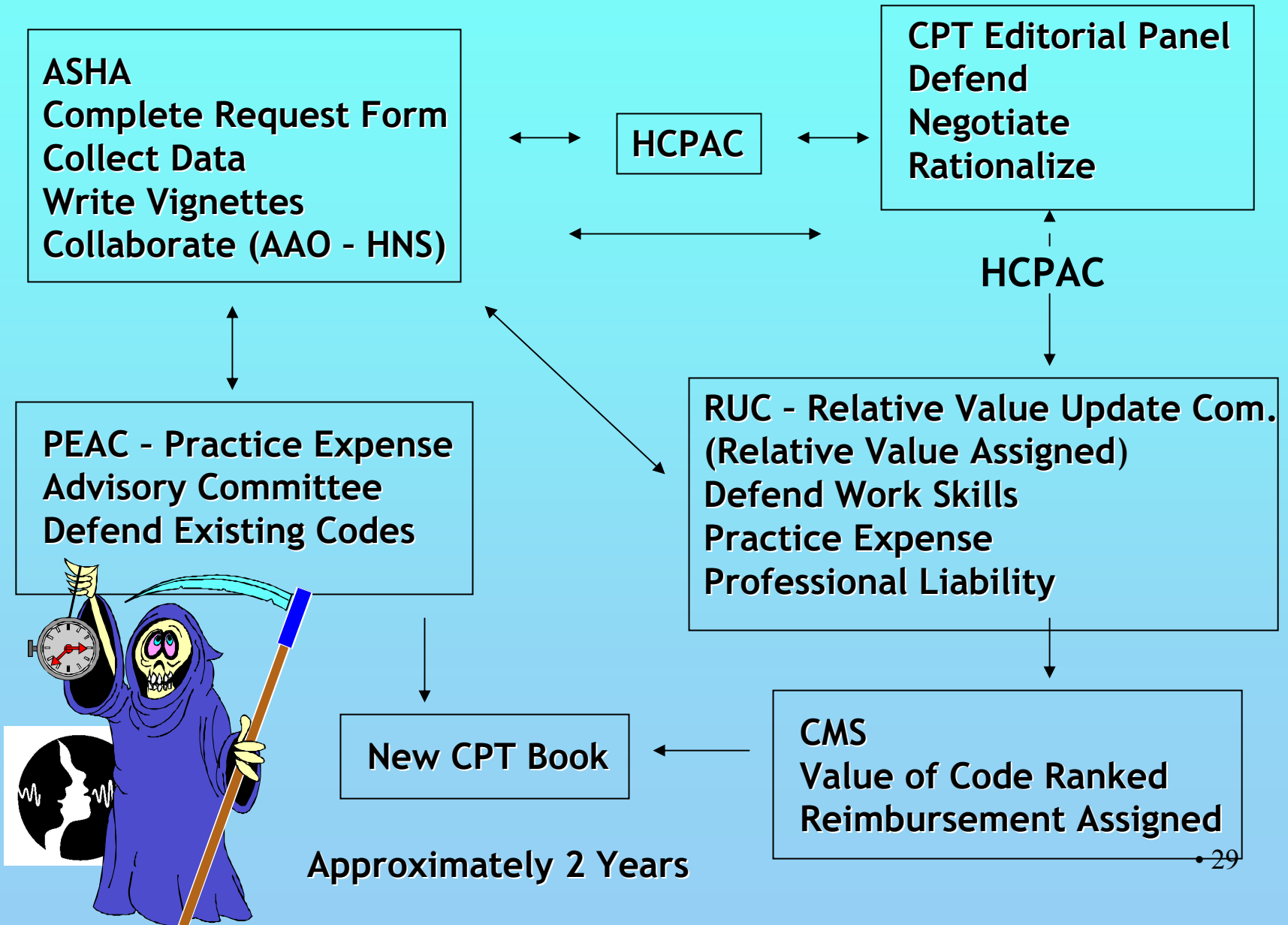
**Not Easy or  
Expeditious!**



...Exhilarating!!



# CPT Process



Approximately 2 Years

**The CPT Process**

**The RUC Process**

Deadline for Submission of CPT Proposals	CPT Agenda Books Mailed	<b>CPT Meeting</b>	LOI Sent to Specialty Societies	LOI Due to AMA	Customized Surveys Mailed to Specialty Societies	RUC Recommendations Due to AMA	Agenda Books Mailed to RUC and Specialty Societies	<b>RUC Meeting</b>
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**CPT 2004 and the 2004 Medicare Payment Schedule**

3-Jan-02	3-Apr-02	<b>May 3-5, 2002</b>	8-May-02	17-May-02	21-May-02	Sept. 3, 2002	Sept. 10, 2002	<b>September 27-29, 2002</b>
1-Apr-02	3-Jul-02	<b>August 2-4, 2002</b>	7-Aug-02	16-Aug-02	20-Aug-02	Jan. 7, 2003	Jan. 15, 2003	<b>Jan. 30 – Feb. 2, 2003</b>
8-Jul-02	7-Oct-02	<b>Nov. 7-10, 2002</b>	Nov. 13, 2002	Nov. 22, 2002	Nov. 26, 2002	Jan. 7, 2003	Jan. 15, 2003	<b>Jan. 30 – Feb. 2, 2003</b>
7-Oct-02	7-Jan-03	<b>Feb. 7-9, 2003</b>	Feb. 12, 2003	Feb. 21, 2003	Feb. 25, 2003	1-Apr-03	9-Apr-03	<b>April 24-27, 2003</b>

**CPT 2005 and the 2005 Medicare Payment Schedule**

3-Jan-03	1-Apr-03	<b>May 2-4, 2003</b>	7-May-03	16-May-03	20-May-03	27-Aug-03	Sept. 4, 2003	<b>September 18-21, 2003</b>
7-Apr-03	7-Jul-03	<b>August 8-10, 2003</b>	13-Aug-03	22-Aug-03	26-Aug-03	Jan. 6, 2004	Jan. 14, 2004	<b>Jan. 29 – Feb. 1, 2004</b>
7-Jul-03	6-Oct-03	<b>Nov. 5-9, 2003</b>	Nov. 12, 2003	Nov. 21, 2003	Nov. 25, 2003	Jan. 6, 2004	Jan. 14, 2004	<b>Jan. 29 – Feb. 1, 2004</b>
6-Oct-03	6-Jan-04	<b>Feb. 6-8, 2004</b>	Feb. 11, 2004	Feb. 20, 2004	Feb. 24, 2004	1-Apr-04	7-Apr-04	<b>April 22-25, 2004</b>



# RUC Process

**RUC = Relative Value  
Update Committee**

**HCPAC = Health Care  
Professions Advisory  
Committee**



# Disadvantages of New Codes

- **CPTs versus RVUs**
  - **More is not always more...**
- **CMS's role in CPT codes:**
  - **Medicare**
  - **Medicaid**
  - **RBRVS**



# Relative Value Scales

- **Overhead**
- **Work**
  - **Professional**
  - **Technical**
- **Malpractice**



# HCPAC / RUC

- **Physician work versus no Physician work**
- **Valuation from this committee is not reviewed by RUC**
- **Valuation is passed to CMS for RVUs**
- **CMS revises and issues new RBRVS scale for all codes**
- **Third party payers use this information for payment**



# Medicare Modification of RVUs

- **Location**
- **Risk/benefit outcomes**
- **Work:**
  - **Time**
  - **Difficulty of decisions**



# RVUs for non-MD/DO Providers

- **Time**
- **Capital equipment**
- **Disposable supplies**
  
- **Medicare uses all-physician salary rate**



# Documentation and Coding

- **The audiogram CANNOT be the report!**
- **Elements of a report**
  - **History (reason for visit, symptoms, complaints, background history)**
  - **Description of test procedures and findings**
  - **Interpretation of test findings**
  - **Recommendations**
  - **Original signature and date**



# Documentation and Coding

- **Essentially all patients must be treated as an HMO patient**
- **Basis of payment is for medical necessity**
- **Evaluation requires physician referral**
  - **Arranged when appointment is made**
  - **Fax communication**



# Documentation and Coding

- **Walk in patients versus appointments**
  - Referral necessities to be “audit-proof”
  - Maintenance of documentation and communication with physician
  - **DO NOT** solicit a referral on your letterhead
- **Difference between medical referral and medical clearance for a hearing aid**



# Documentation and Coding

- **State the referral source in your history statement (i.e., name of referring physician)**
- **Communicate with physician after the evaluation (send report to physician's office)**
- **DO NOT e-mail a report (HIPAA)**
- **Be sure to include diagnosis in the narrative report**



# PEAC Process

**PEAC = Practice Expense Advisory  
Committee**



# PEAC

- **In the resource-based relative value scale (RBRVS) system, payments for services are determined by the resource cost needed to provide them.**



# PEAC

- **The cost of providing each service is divided into three components:**
  - **1. Physician Work**
  - **2. Practice Expense**
  - **3. Professional Liability Insurance**
- **Payments are calculated by multiplying the costs of that service by a conversion factor.**



# PEAC

- **As recently as 1997, physician work accounted for 54% of the total value of each service.**
- **Practice expense accounted for 41% of the total relative value for each service.**



# PEAC

- **Up to 1997 practice expense relative values were based on a formula using average Medicare approved charges from 1991.**



# PEAC

- **The formula has been replaced by using relative values based on the resource costs involved in each service.**



# PEAC

- **In November, 1998, the AMA established the Practice Expense Advisory Committee (PEAC).**
- **The PEAC is charged to review direct practice expense for individual CPT codes**



# PEAC

- WHY IS THIS IMPORTANT TO AUDIOLOGISTS?



# PEAC

- **Audiologists are paid from the practice expense component.**
- **Audiologists are not paid from the physician work portion of the cost component.**



# PEAC

- WHAT DOES DIRECT PRACTICE EXPENSE INCLUDE?



# PEAC

- **1. Minutes of Clinical Services the Audiologist and other clinical staff provide during the:**
  - **a. Pre-service period**
  - **b. Service period**
  - **c. Post-Service period**



# PEAC

- **2. Medical supplies used to provide the service.**
- **3. Medical equipment used to provide the service.**
- **All of these expenses are components determining the PE RVU for each code**



# PEAC

- **The HCEC presents values to the PEAC for the majority of codes used in audiology.**
- **Using surveys and a panel of experts the HCEC determines time values, supply and equipment values.**
- **These values are presented to the PEAC for their review and ultimate acceptance.**



# PEAC

- **The PEAC in turn presents the data to the RUC for acceptance and this information is then turned over to CMS to be used in determining practice expense for each code.**



# PEAC

- **The HCEC has been very successful in having increase values accepted by the PEAC.**



# HCPCS Codes

- **Use of the codes**
- **Development of new codes**



# Service Areas

- **Dental**
- **Prosthetics**
- **Durable medical goods**
- **Injections**
- **Temporary**
- **Experimental codes**
- **Vision**
- **Hearing**



# Hearing Services

- **Hearing codes are found in the “V” section of the HCPCS manual**
- **The origin of the “V” section was first vision and then hearing**
- **The “V” designation of these codes (e.g., V5050) occurs because of their location in the Vision chapter of the manual**
- **These codes must not be confused with the ICD-9 “V” codes**



# Description of Codes

- **Procedure codes begin with "V" and include 4 digits**
- **Equipment codes begin with either "V" or "L" and include 4 digits**
- **CMS approved**
- **Valued less than Level I HCPCS (i.e., CPT) codes**



# Description of Codes

- **“L” codes include cochlear implant components**
- **“V” codes focus on hearing aid services, devices, and accessories (e.g., earmolds)**
  - **Hearing aid services**
  - **Hearing aid product codes (also ALD)**
  - **Dispensing fees**
  - **Earmold impressions**



# Description of Codes

**HCPCS "V" codes are not covered by Medicare**

**However, new code requests are submitted to CMS HCPCS Committee**



# Audiology: HCPCS Codes

- **V5008-hearing screening**
- **V5010-V5298--hearing aid services**
- **V5299--miscellaneous hearing service**
- **L7510--repair of prosthetic device (not hearing aid)**
- **These services are not billable to Medicare**
- **Also includes codes for devices and dispensing fees**



# Development of New HCPCS Codes



# 2004 Code Proposals

- **92589 Central Auditory Function Tests; each test**
- **926X1 Perceptual Loudness Measurement**
- **926X2 Pitch matching**
- **926X3 Inhibition measurement of a perceived sound**



# Aural Rehabilitation

- **Current status**
- **Challenges**
- **Current activities**
- **Anticipated outcome**



# AR Current Status

- **HR3464 has been introduced to allow audiologists to perform rehab services to Medicare patient.**
  - **Medicare Audiologic Rehabilitation Act of 2003**
  - **Allow reimbursement for treatment services with or without a device**



# AR Status

**“Treatment” is intended to include all forms of intervention services that fall into our scope of practice (e.g., hearing, general auditory communication, balance, etc.)**



# AR Challenges

- **Need co-sponsors for bill**
- **Working with AAA, ARA for membership endorsement**
- **Write your congressman!!**



# Development of AR Codes

- **Background preparation**
  - **2003 Omnibus survey (Practice Patterns in Audiology)**
  - **Summary of AR services in ASHA Leader November 4, 2003**
  - **Need for additional surveys**
- **Performing literature search re AR services and efficacy**
- **Development of a code proposal for AMA**



# Anticipated Outcomes

- **Development of code(s) reflecting rehabilitation treatment**
  - **Aural rehabilitation**
  - **Tinnitus rehabilitation**
  - **Balance rehabilitation**



# 2004 Medicare Fee Schedule

**What does it mean for us?**



# For More Information

- [www.cms.gov](http://www.cms.gov)
- **State Medicaid phone numbers**
- **State program overseer for SLP services**
- **State program overseer for Aud services**



# The End

