Audiology Organizations Address FAQs in New Coding Document

By Kate Thomas

Members of the American Academy of Audiology's Coding and Reimbursement Committee (CRC) and the Practice Policy Advisory Council (PPAC) often collaborate with other audiology organizations, including the American Speech-Language-Hearing Association (ASHA) and the Academy of Doctors of Audiology (ADA), to develop coding guidance based on frequently asked questions (FAQs). Most recently, the groups worked together to create guidance addressing various issues related to coding and reimbursement for audiology services. That guidance is detailed below in an FAQ format and discusses medical necessity, proper coding for otoacoustic emissions (OAEs), and other commonly asked coding questions. This information, as well as other collaborative guidance documents, is also available on the Academy's website.

Coding FAQs

What Is "Medical Necessity?"

Insurance companies provide coverage for care, items, and services that they deem to be "medically necessary." Medicare defines medical necessity as "health-care services or supplies needed to diagnose or treat an illness or injury, condition, disease, or its symptoms, and that meet accepted standards of medicine" (Medicare, 2016).

According to the American Medical Association, medical necessity mandates the provision of health-care services that a physician or other health-care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are

1. In accordance with generally accepted standards of medical practice (based on credible scientific evidence published in peer-reviewed literature).

2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease.

3. Not primarily for the convenience of the patient, physician, or other health-care provider, and not costlier than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

In all cases, documentation in the patient's medical record must be consistent with and support the reason that the procedures were performed. Visit www.audiology.org and search keywords "Medicare Frequently Asked Questions" for more information.

How Does Medical Necessity Factor into My Billing Practices?

Beyond the earlier-mentioned principles, many payers—including Medicaid and private insurance—have specific guidelines for what is considered medically necessary for certain items, procedures, and/or services. These policies will be found in the payers' payment policies or clinical guidelines. For example, the Medicare Benefit Policy Manual, Chapter 15, section 80.3 sections (A–I), outlines when coverage for audiology services is considered medically necessary, and therefore a covered Medicare benefit (CMS, 2016). Medicare Administrative Contractors may also publish Local Coverage Determinations (LCDs) to more specifically define coverage guidelines for specific procedures.

What if There Is a Service That I Feel Is in the Patient's Best Interest that the Insurance Company Does Not Consider to Be Medically Necessary?

It is important to keep in mind that insurance does not always pay for everything that a provider may believe is necessary. An example would be routine annual hearing testing to monitor hearing (and hearing aid) status for Medicare beneficiaries. Medicare does not prevent a provider from billing a patient directly for this service. Make sure that any specific notice

of non-coverage guidelines for the patient's insurance are followed (including use of appropriate CPT modifiers).

What Are the Specific Requirements When Performing and Billing for OAEs?

Otoacoustic emissions (OAEs) are not warranted in every test scenario. The documentation must substantiate the need for service.

CPT code 92587, distortion product OAEs (DPOAEs) or transient evoked OAEs (TEOAEs), limited evaluation (to confirm the presence or absence of hearing disorder, 3–6 frequencies), with interpretation and report, is to be utilized when testing TEOAEs and/or DPOAEs. The procedure involves testing 3–11 discrete frequencies, i.e., 3–11 frequencies per ear, in both the right and left ears. The interpretation cannot be merely a "pass/fail" but, instead, must clearly document the ear and frequency-specific test results. The reduced service modifier is indicated if only testing one ear.

CPT code 92588, Comprehensive diagnostic evaluation (cochlear mapping, minimum of 12 frequencies), with report, is a more extensive OAE test that involves at least 12 frequencies in the right ear and 12 in the left, and the interpretation of the test and the report in the patient's record. Higher-frequency resolution testing is recommended in applications requiring greater sensitivity to subtle changes in cochlear function. This includes, but is not limited to, ototoxicity evaluation (baseline and monitoring), hearing conservation, tinnitus evaluation, hereditary hearing-loss evaluation, monitoring recovery from sudden hearing loss, and site-of-lesion evaluation.

Must Both Ipsilateral and Contralateral Acoustic Reflex Thresholds Be Obtained to Bill CPT Codes 92568, 92550 and 92570?

Yes. To appropriately bill for acoustic reflex testing, the audiologist must perform both contralateral and ipsilateral reflexes. If you are only performing ipsilateral reflexes, you must append the -52 modifier to indicate reduced services. A reduced services modifier is not required for incomplete stimulus frequencies, as long as there is a combination of the four test conditions that are necessary to obtain the complete diagnostic information. However, if one or more of the test conditions is not performed (e.g., two contralateral stimulations and one ipsilateral stimulation, or two contralateral stimulations only), then use of modifier 52, Reduced services, would be appropriate to signify that the basic protocol for the procedure has not been altered, but the entire procedure has not been performed (*CPT Assistant*, June 2009).

An ipsilateral acoustic reflex screening at 1000 Hz does not meet the coding criteria for 92568, because the protocol for this procedure requires obtaining the threshold level for the acoustic reflex, and not simply observing the presence or absence of an acoustic reflex at a single intensity level.

What Code Can I Use to Bill for Speech-in-Noise Testing (e.g., QuickSIN, HINT, BKB-SIN)?

Speech-in-noise testing could be included in Comprehensive Audiological Evaluation (92557) or as part of Speech Audiometry with Speech Recognition (92556) evaluation. Alternatively, it could be billed as an unlisted otorhinolaryngological procedure code 92700, with documentation and explanation of the procedure. Audiologists should consult payer guidelines for submitting the unlisted code.

CPT code 92700 should not be filed to Medicare if utilized as a predictor of hearing aid performance in noise.

Speech-in-noise testing should not be billed as a Filtered Speech Test (92571), as this code is one component of a comprehensive central auditory processing evaluation, and because filtered speech is NOT a speech-in-noise test.

If you have additional questions related to coding, reimbursement, or compliance, please e-mail your question to reimbursement@audiology.org.

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References

Centers for Medicare & Medicaid Services (CMS). (2016) Medicare Benefit Policy Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf (Accessed April 12, 2017).

Medicare. (2016) www.medicare.gov. (Accessed April 12, 2017).