



---

**2011 Medicare Fee Schedule**  
*and*  
**Hospital Outpatient Prospective Payment System**  
**for Audiologists**

American Speech-Language-Hearing Association

---

## General Information

This ASHA document provides an overview of both the *2011 Medicare Physician Fee Schedule* (MPFS) and the *Hospital Outpatient Prospective Payment System* (OPPS), comments on relevant revisions, and reproduces a listing of all the procedures used by audiologists, the actual national average payment amounts, describes three methods for accessing the exact payment figure based on your geographic location, and includes a convenient link to an ASHA table of Medicare audiology coding rules.

Please check the ASHA Billing and Reimbursement Web site at [www.asha.org/practice/reimbursement/medicare/feeschedule/](http://www.asha.org/practice/reimbursement/medicare/feeschedule/) for the most up-to-date information.

For additional information, please contact the Health Care Economics and Advocacy Team by e-mail at [reimbursement@asha.org](mailto:reimbursement@asha.org).

# Table of Contents

<b>MEDICARE PHYSICIAN FEE SCHEDULE .....</b>	<b>1</b>
OVERVIEW .....	1
NEW DEVELOPMENTS .....	1
Vestibular Function Codes .....	1
Physician Quality Reporting Initiative (PQRI) .....	1
SUMMARY OF TABLES .....	2
PAYMENT RULES OF THE MEDICARE PHYSICIAN FEE SCHEDULE .....	2
Standard 20% Copayment .....	2
Geographic Adjustment of the Fee Schedule .....	2
“Limiting Charge” .....	2
Table 1: Impact of Assignment on Medicare Payments .....	3
Modifiers .....	3
Medicare CPT Coding Rules .....	3
<i>National Correct Coding Initiative (CCI) Edits</i> .....	3
<i>Designation of Time</i> .....	4
Relationship to Non-Medicare Payers .....	4
ASHA Participation in American Medical Association Relative Value Committees.....	4
Table 2: Topical List of Codes.....	4
2011 MEDICARE RELATIVE UNITS (RVU) & FEE CALCULATIONS .....	5
Table 3: 2011 Medicare Physician Fee Schedule♦ .....	6
Geographic Adjustment Calculations .....	11
<b>HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.....</b>	<b>12</b>
APC PAYMENT RATES.....	12
OTHER NEW DEVELOPMENTS .....	12
BUNDLED VESTIBULAR TESTING CODES .....	12
Cochlear Implantation (CPT 69930).....	12
TABLE 4: HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) RATES FOR AUDIOLOGY SERVICES.....	13
TABLE 5: AMBULATORY PAYMENT CLASSIFICATIONS (APCs) FOR AUDIOLOGY SERVICES.....	16

## Medicare Physician Fee Schedule

### OVERVIEW

On November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) issued the *2011 Outpatient Medicare Physician Fee Schedule* (MPFS) for Part B services that would have represented a 30.1% reduction from current payments and affected all payments under the physician fee schedule. However, on December 15, 2010, President Obama signed into law the *Medicare and Medicaid Extenders Act of 2011 (MMEA)*, which eliminates the 30.1% reduction and extends the therapy cap exceptions process through December 31, 2011. The final 2011 conversion factor (CF), which is used as the multiplier of the total relative value units (RVUs) for each procedure, is \$33.9764. This is a 33.1% increase from the initially published 2011 CF. Congress has acted in each of the last eight years to prevent the reductions in the MPFS, which are a consequence of a provision in the Medicare law, known as the sustainable growth rate (SGR), that mandates an adjustment to the conversion factor when total Medicare physician expenditures in the prior year exceed a target.

The MPFS payment rates apply to audiology Medicare Part B services except for those audiology services provided to hospital outpatients under the hospital HOPPS. **Tables 1 – 4** relate to the MPFS and **Table 5** provides the audiology HOPPS payment rates and methodology.

*“Work component” by audiologists:* ASHA, through its Health Care Economics Committee (HCEC), had successfully advocated that services rendered by audiologists should be valued as professional rather than technical by Medicare. ASHA, the American Academy of Audiology (AAA), and the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) surveyed work RVUs for several procedures in 2009 and 2010. This year audiologists can observe how the work values have remained constant.

Because the nonphysician work pool was eliminated in 2008, CMS will continue to transition the nonphysician work codes over the next three years. This will reduce the technical component RVUs.

### NEW DEVELOPMENTS

#### Vestibular Function Codes

There are no new or revised CPT codes related to audiology services. However, on October 1, 2010, erroneous Correct Coding Initiative (CCI) edits related to vestibular testing codes were changed to allow Medicare billing for any combination of up to three of the following codes on the same date of service and without use of a modifier: 92541, 92542, 92544, and 92545. The CCI edits that originally went into effect January 1, 2010, had prevented billing of more than one vestibular testing code on the same day. However, audiologists billing for all of the listed procedures on the same day should continue using 92540 Basic vestibular evaluation.

ASHA received guidance from CMS that any claims for services provided prior to October 1, 2010, that were affected by the original CCI edits (e.g., claims never submitted) can be billed and should be paid by the Medicare Administrative Contractor. However, it is our understanding that any claims that have already been submitted and denied based on the prohibitive CCI edits cannot be appealed.

**Note:** The October 1, 2010 effective date applies only to services provided in an office setting. Outpatient facilities will not be able to take advantage of the change until January 1, 2011.

#### Physician Quality Reporting Initiative (PQRI)

For 2011, private practice audiologists enrolled as Medicare suppliers will be able to continue participating in the Medicare Physician Quality Reporting Initiative (PQRI) program, a voluntary program designed to improve the quality of care to Medicare beneficiaries. Audiologists can report on three measures that call for referral of patients to a physician after an audiological evaluation finds one of three conditions:

- congenital or traumatic deformity of the ear;
- history of active drainage from the ear within the previous 90 days (for patients who have disease of the ear and mastoid processes); or
- history of sudden or rapidly progressive hearing loss.

For 2010, the incentive payment for satisfactorily reporting on measures is 2% of all allowable Medicare charges. The final rule affirms the incentive payment structure set out in the Affordable Care Act (ACA): an incentive payment of 1% for 2011 and 0.5% for 2012-2014. Starting in 2015, eligible professionals that do not satisfactorily report on quality measures will be subject to a payment adjustment.

The audiology measures are reported via claims. Currently, providers participating in PQRI need to report on 80% of patients that fit into a measure. Effective January 1, 2011, providers reporting on claims-based measures will only need to report on 50% of patients that fit into a measure.

Effective 2011, the Physician Quality Reporting Initiative will instead be known as the Physician Quality Reporting System (PQRS).

## SUMMARY OF TABLES

[Table 1](#) illustrates the impact on payment for audiology services when not accepting Medicare assignment.

[Table 2](#) is a topical list of codes used by audiologists and related health care professionals. The codes are grouped to differentiate the audiology categories.

[Table 3](#) is the complete list of procedures in numerical order with the RVUs and national fee data.

[Table 4](#) is a list of hospital 2011 audiology HOPPS payment rates grouped by ambulatory payment classifications (APCs).

[Table 5](#) lists relevant APCs under hospital HOPPS.

## PAYMENT RULES OF THE MEDICARE PHYSICIAN FEE SCHEDULE

The Medicare Physician Fee Schedule (MPFS), also referred to as the Physician Fee Schedule or Medicare Fee Schedule, is based on Current Procedural Terminology (CPT) codes in the Health Care Common Procedural Coding System (HCPCS).<sup>1</sup> The MPFS has set Medicare Part B<sup>2</sup> prospective payment rates since 1992

<sup>1</sup> HCPCS Level I: CPT Codes  
HCPCS Level II: Alphanumeric codes developed by CMS for equipment, supplies, and procedures not described in CPT Codes.

<sup>2</sup> Medicare Part B covers outpatient services and inpatient physician visits. Rehabilitation and diagnostic services are covered by Part B after depletion of the Part A 100-day skilled

for audiologists, physicians, other private practitioners and medical clinics. Reimbursement for outpatient rehabilitation services in such facilities as hospitals, skilled nursing facilities, and rehabilitation agencies was included in the MPFS in 1999. The MPFS includes both facility and non-facility rates. CMS determined that the higher non-facility rates apply to audiology and speech-language pathology services (as well as to physical therapy and occupational therapy) even when rendered in a facility<sup>3</sup>. Hospital-based outpatient audiology services are paid under the outpatient prospective payment system (OPPS) – see [Table 4](#).

## Standard 20% Copayment

All Part B services require the patient to pay a 20% copayment. The fee schedule does not deduct the copayment amount. Therefore, the actual payment by Medicare is 20% less than shown in this fee schedule.

## Geographic Adjustment of the Fee Schedule

You may request a fee schedule adjusted for your geographic area from the Medicare Administrative Contractor (MAC) that processes your claims. You can also access the rates for geographic areas by going to the CMS Web site at [www.cms.gov/apps/physician-fee-schedule/overview.aspx](http://www.cms.gov/apps/physician-fee-schedule/overview.aspx). See the [Geographic Adjustment Calculations](#) section after Table 3 for further instructions. In general, urban states and areas have payment rates that are 5% to 10% above the national average. Likewise, rural states are lower than the national average.

## “Limiting Charge”

Independent audiologists paid by Medicare as private practitioners under the fee schedule may elect to be “nonparticipating” even though enrolled as a Medicare supplier. This status allows payment at a higher rate than specified in the fee schedule if the audiologist does *not* accept assignment. Medicare payment is made directly to the provider when accepting assignment instead of the patient (except the 20% co-payment for which all Part B patients are responsible).

Nonparticipating audiologists who do not accept assignment can add a *limiting charge* of up to 15% to the total fee schedule amount, as long as the 115%

nursing facility stay or 90-day hospital stay or disqualification of skilled nursing status.

<sup>3</sup> *Federal Register*, July 22, 1999 (p. 39623)

result does not surpass the audiologist’s customary fee for that particular CPT code. The net gain for the audiologist is 9.25% (not 15%) because nonparticipating practitioners are reimbursed at 95% of the fee schedule amount.

The following calculations in [Table 1](#) illustrate fees without and with the limiting charge add-on.

**Table 1: Impact of Assignment on Medicare Payments**

	<b>Scenario 1:</b> <i>Participating Provider Accepts Assignment (not entitled to limiting charge add-on)</i>	<b>Scenario 2:</b> <i>Nonparticipating Provider Accepts Assignment (not entitled to limiting charge add-on)</i>	<b>Scenario 3:</b> <i>Nonparticipating Provider Does <u>Not</u> Accept Assignment (thus, entitled to limiting charge add-on)</i>
<b>Fee Schedule Amount</b>	\$100	\$100	\$100
<b>Total Allowed Payment</b>	\$100	\$100 x 95% = \$95	\$100 x 95% x 115% = \$109.25( total allowed payment)
<b>Medicare Pays</b>	80% x \$100 = \$80	80% x \$95 = \$76	Patient reimbursed \$76 (80% of \$95)
<b>Patient Pays</b>	20% x \$100 = \$20	20% x \$95 = \$19	\$109.25 - \$76.00 = \$33.25 (out-of-pocket)

**Modifiers**

Most CPT codes represent “typical” visit lengths or times to conduct a typical test, unless time is specified in the CPT descriptor. For significantly atypical procedures, a **modifier “-22”** can be used to indicate much longer than normal procedures and a **“-52” modifier** for an abbreviated procedure. For modifier “-22” claims, a full description of the procedure rendered should be submitted with the claim. Modifier “-22” should not be used frequently because a MAC could make the determination that the procedure reflects typical service delivery. **Modifier “-59”** is used to establish one procedure as distinct from another billed on the same day.

**Medicare CPT Coding Rules**

Medicare and the AMA have established rules for using specific CPT codes. The Medicare rule always supersedes the AMA rule when billing Medicare. ASHA’s Billing & Reimbursement Web site includes the full CPT descriptors and rules for their appropriate usage at: [www.asha.org/practice/reimbursement/medicare/Aud\\_coding\\_rules.htm](http://www.asha.org/practice/reimbursement/medicare/Aud_coding_rules.htm). Note that many third party payers selectively adopt Medicare coding rules.

*National Correct Coding Initiative (CCI) Edits*

CMS uses an automated edit system to control specific code pairs that can be reported on the same day. CCI has been in place since January 1, 1996, and is updated quarterly. The goal of the National Correct Coding Initiative (NCCI or, more commonly, CCI) is to prevent payment of “mutually exclusive” code pairings or otherwise inappropriate pairs to be delivered to the same patient on the same day. The edits apply to all Part B settings, not just physician and audiologist offices and hospitals.

The ASHA Web site includes a comprehensive list of CCI edits that apply to audiology. Go to: [www.asha.org/practice/reimbursement/coding/CCI\\_edits\\_AUD.htm](http://www.asha.org/practice/reimbursement/coding/CCI_edits_AUD.htm). A complete list of code edits for Part B services other than those billed by hospitals is found at [www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp](http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp).

The Outpatient Code Editor (OCE) applies only to hospital outpatient services. Typically, the OCE edits for audiology and speech-language pathology are similar to those in the CCI system. The OCE revisions also occur quarterly but one quarter after the revised CCI edits are implemented. See [www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHHOPPS/list.asp](http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHHOPPS/list.asp) for the full OCE edits.

\*All CPT codes and descriptors are copyright 2010 American Medical Association

*Designation of Time*

The CPT/HCPCS procedures for audiology do not include time designations except for the five codes listed below. Other procedures have been valued based on the typical time for performing the test.

CMS cautions audiologists on calculating time attributed to the five timed audiology evaluation codes; CMS accepted the professional component RVUs for these codes in the 2009 fee schedule. In the 2010 fee schedule, CMS stresses that activities such as counseling, establishment of interventional goals, or evaluating potential for remediation are not included as diagnostic tests, and that time spent on these activities should not be included in billing for:

- 92620 (evaluation of central auditory function, with report; initial 60 minutes)
- 92621 (evaluation of central auditory function, with report; each additional 15 minutes)
- 92626 (evaluation of auditory rehabilitation status; first hour)
- 92627 (evaluation of auditory rehabilitation status; each additional 15 minutes)
- 92640 (diagnostic analysis with programming of auditory brainstem implant, per hour).

**Note:** A timed code is billed only if testing is at least 51% of the time designated in the code’s descriptor.

**Relationship to Non-Medicare Payers**

Many state Medicaid programs and private health plans, including HMOs and PPOs, have adopted the MPFS while designating their own conversion factor. ASHA members may wish to negotiate with non-Medicare payers. Audiologists may request that payers negotiate their rates using such resources as

the ASHA publication, *Negotiating Health Care Contracts and Calculating Fees: A Guide for Speech-Language Pathologists and Audiologists*, rather than adopt the MPFS rankings. This publication (Item #0112450) can be ordered from ASHA Product Sales at 1-888-498-6699 or online at [www.asha.org/shop](http://www.asha.org/shop).

**ASHA Participation in American Medical Association Relative Value Committees**

ASHA represents the audiology profession at both the AMA Relative Value Update Committee (RUC) and the AMA CPT Editorial Panel. The ASHA Health Care Economics Committee coordinates recommendations from ASHA members and related audiology organizations in developing new procedures for adoption by the CPT Editorial Panel. The Committee also conducts surveys and holds consensus panel meetings to develop data that are presented to the AMA and CMS to develop fees. Audiology members of the HCEC in 2011 are Robert Burkard, Leisha Eiten, Robert Fifer (ASHA advisor to the AMA RUC HCPAC Review Board), Richard Hogan, and Chair, Stuart Trembath. For further information, contact Steven White, ex officio member of the HCEC and Director of the Health Care Economics & Advocacy Team, at [swhite@asha.org](mailto:swhite@asha.org).

**Table 2: Topical List of Codes\***

Vestibular Function Studies	Audiometric Tests			Electrophysiology/Audio-metric Tests	Audiology Related	Aural Rehabilitation	Implant Services
92540	92550	92562	92575	92584	69210	92626	92601
92541	92551	92563	92576	92585		92627	92602
92542	92552	92564	92577	92586			92603
92543	92553	92565	92579	92587			92604
92544	92555	92567	92582	92588			92640
92545	92556	92568	92583				
92546	92557	92569	92596				
92547	92559	92570	92620				
92548	92560	92571	92621				
	92561	92572	92625				

\*All CPT codes and descriptors are copyright 2010 American Medical Association

## 2011 MEDICARE RELATIVE UNITS (RVU) & FEE CALCULATIONS

The MPFS uses a resource-based relative value scale (RBRVS) that assigns a relative value to each current procedural terminology (CPT) procedure. The relative weighting factor (relative value unit or RVU) is derived from a resource-based relative value scale (see [Table 3](#)).

The RBRVS divides each procedure into three RVU components:

- The professional component also known as physician work that encompasses time, technical skill, physical effort, stress, and judgment on the part of the physician or other qualified health care professional;
- The technical component also known as practice expense that includes overhead costs and non-physician medical staff time costs; and
- The professional liability component or malpractice costs

The RVUs for the three components are summed for the CPT procedure total RVUs and then multiplied by the annual conversion factor.

Except for those codes assigned a Professional and Technical component (vestibular and OAE), historically, most audiology codes were not assigned a professional work value. Rather, the audiologist's time was compensated through the practice expense component of the fee schedule. In the last few years, professional work values have been systematically assigned for the audiologist's time and effort and transferred out of the practice expense component. This effort is not yet complete and there are still some codes with only a practice expense and malpractice component.

The following procedures are now valued primarily for professional work:

- |         |         |
|---------|---------|
| • 92540 | • 92602 |
| • 92550 | • 92603 |
| • 92557 | • 92604 |
| • 92567 | • 92621 |
| • 92568 | • 92625 |
| • 92569 | • 92626 |
| • 92570 | • 92627 |
| • 92601 | • 92640 |

**Table 3: 2011 Medicare Physician Fee Schedule\***

**Conversion Factor: \$33.9764**

**Modifiers:**  
**26** = “Professional component,” the portion of diagnostic test that involves a physician’s work and allocation of the practice expense.  
**TC** = “Technical component,” for diagnostic tests, the portion of a procedure that does not include a physician’s participation. The TC value is the difference between the global values and the professional component (26).  
**No Modifier** = “Global value,” includes both professional and technical components.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see <a href="#">geographic adjustors</a> section)
69210 <sup>4</sup>		Remove impacted ear wax	0.61	0.79	0.07	1.47	\$49.95
92506 <sup>5</sup>		Speech, lang., aud. process evaluation	0.86	2.26	0.05	3.17	\$107.71
92507 <sup>5</sup>		Speech, lang., aud process treatment	1.30	1.05	0.07	2.42	\$82.22
92508 <sup>5</sup>		Speech/hearing treatment, group	0.33	0.45	0.01	0.79	\$26.84
92516		Facial nerve function test	0.43	1.54	0.03	2.00	\$67.95
92540		Basic vestibular evaluation	1.50	1.31	0.05	2.86	\$97.17
92540	26	Basic vestibular evaluation	1.50	0.77	0.04	2.31	\$78.49
92540	TC	Basic vestibular evaluation	0.00	0.54	0.01	0.55	\$18.69
92541		Spontaneous nystagmus test	0.40	0.92	0.02	1.34	\$45.53
92541	26	Spontaneous nystagmus test	0.40	0.19	0.01	0.60	\$20.39
92541	TC	Spontaneous nystagmus test	0.00	0.73	0.01	0.74	\$25.14
92542		Positional nystagmus test	0.33	0.99	0.02	1.34	\$45.53
92542	26	Positional nystagmus test	0.33	0.16	0.01	0.50	\$16.99
92542	TC	Positional nystagmus test	0.00	0.83	0.01	0.84	\$28.54

<sup>4</sup>CPT 69210: Current CMS policy considers removal of cerumen a component of audiologic diagnostic testing and not paid separately. Under Medicare, CPT 69210, “Removal of impacted cerumen, one or both ears,” is not recognized.

<sup>5</sup> Medicare does not cover these services under the audiology benefit.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see <a href="#">geographic adjustors</a> section)
92543		Caloric vestibular test	0.10	0.54	0.02	0.66	\$22.42
92543	26	Caloric vestibular test	0.10	0.05	0.01	0.16	\$5.44
92543	TC	Caloric vestibular test	0.00	0.49	0.01	0.50	\$16.99
92544		Optokinetic nystagmus test	0.26	0.81	0.02	1.09	\$37.03
92544	26	Optokinetic nystagmus test	0.26	0.12	0.01	0.39	\$13.25
92544	TC	Optokinetic nystagmus test	0.00	0.69	0.01	0.70	\$23.78
92545		Oscillating tracking test	0.23	0.77	0.02	1.02	\$34.66
92545	26	Oscillating tracking test	0.23	0.11	0.01	0.35	\$11.89
92545	TC	Oscillating tracking test	0.00	0.66	0.01	0.67	\$22.76
92546		Sinusoidal rotational test	0.29	2.47	0.02	2.78	\$94.45
92546	26	Sinusoidal rotational test	0.29	0.13	0.01	0.43	\$14.61
92546	TC	Sinusoidal rotational test	0.00	2.34	0.01	2.35	\$79.84
92547		Supplemental electrical test	0.00	0.14	0.01	0.15	\$5.10
92548		Posturography	0.50	2.50	0.02	3.02	\$102.61
92548	26	Posturography	0.50	0.24	0.01	0.75	\$25.48
92548	TC	Posturography	0.00	2.26	0.01	2.27	\$77.13
92550		Tympanometry & reflex threshold	0.35	0.25	0.01	0.61	\$20.73
92551 <sup>6</sup>		Pure tone hearing test, air (screening)	0.00	0.33	0.01	0.34	\$11.55
92552		Pure tone audiometry, air	0.00	0.75	0.01	0.76	\$25.82
92553		Audiometry, air & bone	0.00	0.94	0.01	0.95	\$32.28
92555		Speech threshold audiometry	0.00	0.54	0.01	0.55	\$18.69
92556		Speech audiometry, complete	0.00	0.85	0.01	0.86	\$29.22
92557		Comprehensive hearing test	0.60	0.56	0.03	1.19	\$40.43

<sup>6</sup> Medicare does not cover this service under the audiology benefit. RVUs have been assigned for the benefit of non-Medicare payers.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see <a href="#">geographic adjustors</a> section)
92559 <sup>7</sup>		Group audiometric testing	0.00	0.00	0.00	0.00	\$0.00
92560 <sup>7</sup>		Bekesy audiometry, screen	0.00	0.00	0.00	0.00	\$0.00
92561		Bekesy audiometry, diagnosis	0.00	0.96	0.01	0.97	\$32.96
92562		Loudness balance test	0.00	0.93	0.01	0.94	\$31.94
92563		Tone decay hearing test	0.00	0.72	0.01	0.73	\$24.80
92564		SISI hearing test	0.00	0.65	0.01	0.66	\$22.42
92565		Stenger test, pure tone	0.00	0.38	0.01	0.39	\$13.25
92567		Tympanometry	0.20	0.24	0.01	0.45	\$15.29
92568		Acoustic reflex testing	0.29	0.19	0.01	0.49	\$16.65
92570		Acoustic immittance testing	0.55	0.36	0.03	0.94	\$31.94
92571		Filtered speech hearing test	0.00	0.58	0.01	0.59	\$20.05
92572		Staggered spondaic word test	0.00	0.93	0.01	0.94	\$31.94
92575		Sensorineural acuity test	0.00	1.45	0.01	1.46	\$49.61
92576		Synthetic sentence test	0.00	0.78	0.01	0.79	\$26.84
92577		Stenger test, speech	0.00	0.47	0.01	0.48	\$16.31
92579		Visual audiometry (VRA)	0.70	0.56	0.03	1.29	\$43.83
92582		Conditioning play audiometry	0.00	1.50	0.01	1.51	\$51.30
92583		Select picture audiometry	0.00	1.04	0.01	1.05	\$35.68
92584		Electrocochleography	0.00	1.96	0.01	1.97	\$66.93
92585		Auditory evoked potentials, comprehensive	0.50	2.82	0.02	3.34	\$113.48
92585	26	Auditory evoked potentials, comprehensive	0.50	0.24	0.01	0.75	\$25.48
92585	TC	Auditory evoked potentials, comprehensive	0.00	2.58	0.01	2.59	\$88.00
92586		Auditory evoked potentials, limit	0.00	2.07	0.01	2.08	\$70.67

<sup>7</sup> Medicare does not cover these services under the audiology benefit.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see <a href="#">geographic adjustors</a> section)
92587		Evoked otoacoustic emiss, limited	0.13	0.94	0.02	1.09	\$37.03
92587	26	Evoked otoacoustic emiss, limited	0.13	0.07	0.01	0.21	\$7.14
92587	TC	Evoked otoacoustic emiss, limited	0.00	0.87	0.01	0.88	\$29.90
92588		Evoked otoacoustic emiss, comp.	0.36	1.57	0.02	1.95	\$66.25
92588	26	Evoked otoacoustic emiss, comp.	0.36	0.18	0.01	0.55	\$18.69
92588	TC	Evoked otoacoustic emiss, comp.	0.00	1.39	0.01	1.40	\$47.57
92596		Ear protector eval	0.00	1.16	0.01	1.17	\$39.75
92601		Cochlear implant follow-up exam, pt < 7 yrs of age	2.30	1.89	0.11	4.30	\$146.10
92602		Reprogram cochlear implant, pt < 7 yrs of age	1.30	1.29	0.07	2.66	\$90.38
92603		Cochlear implant follow-up exam, pt ≥ 7 yrs of age	2.25	1.84	0.11	4.20	\$142.70
92604		Reprogram cochlear implant, pt ≥ 7 yrs of age	1.25	1.19	0.05	2.49	\$84.60
92620		Auditory function, 60 min	1.50	0.86	0.07	2.43	\$82.56
92621		Auditory function, + 15 min	0.35	0.20	0.01	0.56	\$19.03
92625		Tinnitus assessment	1.15	0.66	0.05	1.86	\$63.20
92626 <sup>8</sup>		Evaluation of auditory rehab status, 1 <sup>st</sup> hr	1.40	1.01	0.07	2.48	\$84.26
92627 <sup>8</sup>		Evaluation of auditory rehab status, each 15 min	0.33	0.26	0.01	0.60	\$20.39
92630 <sup>9</sup>		Auditory rehab, pre-lingual hearing loss	0.00	0.00	0.00	0.00	\$0.00
92633 <sup>9</sup>		Auditory rehab, post-lingual hearing loss	0.00	0.00	0.00	0.00	\$0.00
92640		Brainstem implant programming, per hr.	1.76	0.78	0.37	2.91	\$98.87

<sup>8</sup> Audiologists may use these evaluation codes.

<sup>9</sup> Medicare does not cover these services under the audiology benefit.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see <a href="#">geographic adjustors</a> section)
95920		Intraop nerve test add-on, per hr.	2.11	2.47	0.09	4.67	\$158.67
95920	26	Intraop nerve test add-on	2.11	0.95	0.08	3.14	\$106.69
95920	TC	Intraop nerve test add-on	0.00	1.52	0.01	1.53	\$51.98
95925		Somatosensory testing	0.54	4.07	0.02	4.63	\$157.31
95925	26	Somatosensory testing	0.54	0.24	0.01	0.79	\$26.84
95925	TC	Somatosensory testing	0.00	3.83	0.01	3.84	\$130.47
95926		Somatosensory testing	0.54	3.90	0.04	4.48	\$152.21
95926	26	Somatosensory testing	0.54	0.24	0.03	0.81	\$27.52
95926	TC	Somatosensory testing	0.00	3.66	0.01	3.67	\$124.69
95927		Somatosensory testing	0.54	3.64	0.02	4.20	\$142.70
95927	26	Somatosensory testing in the trunk or head	0.54	0.25	0.01	0.80	\$27.18
95927	TC	Somatosensory testing in the trunk or head	0.00	3.39	0.01	3.40	\$115.52
95930		Visual evoked potential test	0.35	3.56	0.02	3.93	\$133.53
95930	26	Visual evoked potential test	0.35	0.16	0.01	0.52	\$17.67
95930	TC	Visual evoked potential test	0.00	3.40	0.01	3.41	\$115.86
95934		H-reflex test	0.51	1.13	0.02	1.66	\$56.40
95934	26	H-reflex test	0.51	0.24	0.01	0.76	\$25.82
95934	TC	H-reflex test	0.00	0.89	0.01	0.90	\$30.58
95936		H-reflex test, not g/s muscle	0.55	0.80	0.02	1.37	\$46.55
95936	26	H-reflex test, not g/s muscle	0.55	0.25	0.01	0.81	\$27.52
95936	TC	H-reflex test, not g/s muscle	0.00	0.55	0.01	0.56	\$19.03
95937		Neuromuscular junction test	0.65	1.20	0.05	1.90	\$64.56
95937	26	Neuromuscular junction test	0.65	0.29	0.04	0.98	\$33.30
95937	TC	Neuromuscular junction test	0.00	0.91	0.01	0.92	\$31.26

## Geographic Adjustment Calculations

Precise payment rates by locality are available at: [www.cms.gov/apps/physician-fee-schedule/overview.aspx](http://www.cms.gov/apps/physician-fee-schedule/overview.aspx).

Local rates are also available on your payer's Website (Medicare Administrative Contractor – MAC).

### *To See Payment Rates:*

- ✓ Click "Start Search" and "Accept" the terms of agreement, if asked
- ✓ Select the year
- ✓ Select "Pricing Information"
- ✓ Choose your "HCPCS (CPT code) criteria"
- ✓ Select "Specific Locality"
- ✓ Enter the code or codes you are looking for, choose "All modifiers"
- ✓ Select your locality
- ✓ The first column of results, "Non-facility price", applies to *all* SLP services, whether in a facility or not
- ✓ The results can be printed, downloaded and saved, or e-mailed

### *To See Geographic Practice Cost Index (GPCI):*

- ✓ Click "Start Search" and "Accept" the terms of agreement, if asked
- ✓ Select the year
- ✓ Select "Geographic Practice Cost Index"
- ✓ Choose your "Carrier/Medicare Administrative Contractor Option"
  - ✓ Select "Specific Locality" if you want to see only the GPCI in your area
  - ✓ Select your locality
- ✓ Click "Submit"
- ✓ In the table, PE = Practice Expense and MP = Malpractice
- ✓ The results can be printed, downloaded and saved, or e-mailed.

## Hospital Outpatient Prospective Payment System

Payment for hospital-based outpatient audiology services are made under the Hospital Outpatient Prospective Payment System (OPPS). Under OPPS, payment is determined by assignment of the CPT code to an Ambulatory Payment Classification (APC). For each of the over 450 non-pharmaceutical APCs, the payment rate reflects costs (2008 data) gathered from all acute care hospitals. Note that speech-language pathology services are paid using the Medicare Physician Fee Schedule in the hospital outpatient setting.

### APC PAYMENT RATES

- APC 215 (Level I Nerve and Muscle Tests)
  - **+8.6%** \$44.89
  - Includes H-reflex test
- APC 216 (Level III Nerve and Muscle Tests)
  - **+2.9%** \$186.17
  - Includes Intraoperative neurophysiology testing; Visual evoked potential test
- APC 218 (Level II Nerve and Muscle Tests)
  - **+0%** \$80.78
  - Includes Auditory evoked potentials, limited; Neuromuscular junction test
- APC 363 (Level I Otorhinolaryngologic Function Tests)
  - **+3.5%** \$63.24
  - Includes most vestibular function tests; Evoked otoacoustic emissions, limited
- APC 364 (Level I Audiometry)
  - **+3.2%** \$32.70
  - Includes Speech threshold; Loudness balance; Tympanometry
- APC 365 (Level II Audiometry)
  - **+2.4%** \$87.47
  - Includes Comprehensive hearing test; Visual audiometry, Air & bone
- APC 366 (Level III Audiometry)
  - **+13.7%** \$124.51
  - Includes Stenger test; Cochlear implant follow-up
- APC 660 (Level II Otorhinolaryngologic Function Tests)
  - **+0%** \$101.20
  - Includes Posturography; Electrocochleography; Evoked otoacoustic emissions, comprehensive

### OTHER NEW DEVELOPMENTS

#### Bundled Vestibular Testing Codes

On January 1, 2011 (for facilities), erroneous Correct Coding Initiative (CCI) edits related to vestibular testing codes were changed to allow Medicare billing for any combination of up to three of the following codes on the same date of service and without use of a modifier: 92541, 92542, 92544, and 92545. The CCI edits that originally went into effect January 1, 2010, had prevented billing of more than one vestibular testing code on the same day. However, audiologists billing for all of the listed procedures on the same day should continue using 92540 Basic vestibular evaluation.

ASHA has received guidance from CMS that any claims for services provided prior to October 1, 2010, that were affected by the original CCI edits (e.g., claims never submitted) can be billed and should be paid by the Medicare Administrative Contractor. However, it is our understanding that any claims that have already been submitted and denied based on the prohibitive CCI edits will not be appealable.

#### Cochlear Implantation (CPT 69930)

The cochlear implant payment is increased by 7.4% to \$31,060. This significant increase comes after a 2010 increase of 9.1%. The payment now covers most costs of the procedure and is no longer a disincentive to hospitals concerned about maintaining this specialty program.

**TABLE 4: HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) RATES FOR AUDIOLOGY SERVICES\*****HOSPITAL OPPS**

<b>CPT/HCPCS</b>	<b>Description</b>	<b>Ambulatory Payment Classification</b>	<b>Payment Rate</b> subject to geographic adjustors	<b>Copayment</b>
<b>G0268</b>	Removal of impacted wax on same day as audiologic testing (physician only code)	Packaged into payment for other tests as of 2009		
<b>69210</b>	Removal of impacted wax (physician only code)	0340	\$46.23	\$9.25
<b>69930</b>	Cochlear implantation	0259	\$31,060.00	\$6212.00
<b>92516</b>	Facial nerve function test	0660	\$101.20	\$20.24
<b>92540</b>	Basic vestibular evaluation	0660	\$101.20	\$20.24
<b>92541</b>	Spontaneous nystagmus test	0363	\$63.24	\$12.65
<b>92542</b>	Positional nystagmus test	0363	\$63.24	\$12.65
<b>92543</b>	Caloric vestibular test	0660	\$101.20	\$20.24
<b>92544</b>	Optokinetic nystagmus test	0363	\$63.24	\$12.65
<b>92545</b>	Oscillating tracking test	0363	\$63.24	\$12.65
<b>92546</b>	Sinusoidal rotational test	0660	\$101.20	\$20.24
<b>92547</b>	Supplemental electrical test	Not separately billed; bundled with CPT 92541 as of 2008.		
<b>92548</b>	Posturography	0660	\$101.20	\$20.24
<b>92550</b>	Tympanometry & reflex thresh	0364	\$32.70	\$6.54
<b>92551</b>	Pure tone hearing test, air (screening)	Not covered		
<b>92552</b>	Pure tone audiometry, air	0364	\$32.70	\$6.54
<b>92553</b>	Audiometry, air & bone	0365	\$87.47	\$17.50
<b>92555</b>	Speech threshold audiometry	0364	\$32.70	\$6.54
<b>92556</b>	Speech audiometry, complete	0364	\$32.70	\$6.54
<b>92557</b>	Comprehensive hearing test	0365	\$87.47	\$17.50

\*All CPT codes and descriptors are copyright 2010 American Medical Association

**HOSPITAL OPPTS**

<b>CPT/HCPCS</b>	<b>Description</b>	<b>Ambulatory Payment Classification</b>	<b>Payment Rate subject to geographic adjustors</b>	<b>Copayment</b>
<b>92559</b>	Group audiometric testing	Not covered		
<b>92560</b>	Bekesy audiometry, screen	Not covered		
<b>92561</b>	Bekesy audiometry, diagnosis	0364	\$32.70	\$6.54
<b>92562</b>	Loudness balance test	0364	\$32.70	\$6.54
<b>92563</b>	Tone decay hearing test	0364	\$32.70	\$6.54
<b>92564</b>	SISI	0364	\$32.70	\$6.54
<b>92565</b>	Stenger test, pure tone	0364	\$32.70	\$6.54
<b>92567</b>	Tympanometry	0364	\$32.70	\$6.54
<b>92568</b>	Acoustic reflex testing; threshold	0364	\$32.70	\$6.54
<b>92570</b>	Acoustic immitance testing	0364	\$32.70	\$6.54
<b>92571</b>	Filtered speech hearing test	0364	\$32.70	\$6.54
<b>92572</b>	Staggered spondaic word test	0366	\$124.51	\$24.91
<b>92575</b>	Sensorineural acuity test	0364	\$32.70	\$6.54
<b>92576</b>	Synthetic sentence test	0364	\$32.70	\$6.54
<b>92577</b>	Stenger test, speech	0366	\$124.51	\$24.91
<b>92579</b>	Visual audiometry (VRA)	0365	\$87.47	\$17.50
<b>92582</b>	Conditioning play audiometry	0365	\$87.47	\$17.50
<b>92583</b>	Select picture audiometry	0364	\$32.70	\$6.54
<b>92584</b>	Electrocochleography	0216	\$186.17	\$37.24
<b>92585</b>	Auditor evoke potentials, comprehensive	0216	\$186.17	\$37.24
<b>92586</b>	Auditory evoke potentials, limited	0218	\$80.78	\$16.16
<b>92587</b>	Evoked otoacoustic emiss, limited	0363	\$63.24	\$12.65

**HOSPITAL OPPS**

<b>CPT/HCPCS</b>	<b>Description</b>	<b>Ambulatory Payment Classification</b>	<b>Payment Rate</b> subject to geographic adjustors	<b>Copayment</b>
<b>92588</b>	Evoked otoacoustic emiss, comp.	0660	\$101.20	\$20.24
<b>92596</b>	Ear protector evaluation	0364	\$32.70	\$6.54
<b>92601</b>	Cochlear implant follow-up exam, pt under 7 yrs of age	0366	\$124.51	\$24.91
<b>92602</b>	Reprogram cochlear implant, pt under 7 yrs of age	0366	\$124.51	\$24.91
<b>92603</b>	Cochlear implant follow-up exam, pt 7 yrs of age or older	0366	\$124.51	\$24.91
<b>92604</b>	Reprogram cochlear implant, pt 7 yrs of age or older	0366	\$124.51	\$24.91
<b>92620</b>	Central auditory function	0365	\$87.47	\$17.50
<b>92621</b>	Central auditory function, add-on	(Under OPPS, 92620 considered full session)		
<b>92625</b>	Tinnitus assessment	0365	\$87.47	\$17.50
<b>92626</b>	Eval of auditory rehab status	0366	\$124.51	\$24.91
<b>92627</b>	Eval of auditory rehab status, add-on	(Under OPPS, 92626 considered full session)		
<b>92630</b>	Auditory rehab; pre-lingual hearing loss	Not covered		
<b>92633</b>	Auditory rehab; post-lingual hearing loss	Not covered		
<b>92640</b>	Auditory brainstem implant programming	0365	\$87.47	\$17.50
<b>95920</b>	Intraop neurophysiology testing, per hour	Not separately billed; bundled with CPT 92541 as of 2008.		
<b>95925</b>	Somatosensory testing; in upper limbs	0216	\$186.17	\$37.24
<b>95926</b>	Somatosensory testing; in lower limbs	0216	\$186.17	\$37.24
<b>95927</b>	Somatosensory testing; in the trunk or head	0216	\$186.17	\$37.24
<b>95930</b>	Visual evoked potential test	0216	\$186.17	\$37.24
<b>95934</b>	H-reflex test	0215	\$44.89	\$8.98
<b>95936</b>	H-reflex test, not g/s muscle	0215	\$44.89	\$8.98
<b>95937</b>	Neuromuscular junction test	0218	\$80.78	\$16.16

**TABLE 5: AMBULATORY PAYMENT CLASSIFICATIONS (APCs) FOR AUDIOLOGY SERVICES**

APC	Group Title
0215	Level I Nerve and Muscle Tests
0216	Level III Nerve and Muscle Tests
0218	Level II Nerve and Muscle Tests
0259	Level VI ENT Procedures
0340	Minor Ancillary Procedures
0363	Level I Otorhinolaryngologic Function Tests
0364	Level I Audiometry
0365	Level II Audiometry
0366	Level III Audiometry
0660	Level II Otorhinolaryngologic Function Tests