2012 Medicare Fee Schedule

and

Hospital Outpatient Prospective Payment System for Audiologists

American Speech-Language-Hearing Association

3rd Edition

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3rd Edition Revisions

- Page 1: Overview (Added information on *Middle Class Tax Relief and Job Creation Act of 2012*)

General Information

This ASHA document provides an overview of both the *2012 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 website at www.asha.org/practice/reimbursement/medicare/feeschedule/ for the most up-to-date information on Congressional action.

For additional information, please contact the Health Care Economics and Advocacy Team by e-mail at reimbursement@asha.org.

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Medicare Physician Fee Schedule

Overview

On November 1, 2011, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the 2012 Medicare Physician Fee Schedule (MPFS) that would have represented a 27.4% reduction from 2011 payments and affected all payments under the physician fee schedule. This reduction was then eliminated by Congress on a temporary basis, the latest and final action being the *Middle Class Tax Relief and Job Creation Act of 2012*, which President Obama signed into law on February 22, 2012. This eliminates the 27.4% reduction and extends the therapy cap exceptions process through December 31, 2012. As a result, the final 2012 conversion factor (CF) that is used as a multiplier of the total relative value units (RVUs) for each procedure remains at $34.0376. It is anticipated that Congress will consider a more long-term solution to Medicare Part B reimbursement. Please continue to monitor ASHA's Billing & Reimbursement website at www.asha.org/practice/reimbursement/medicare/feeschedule/ for further updates on Congressional action.

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.

New Developments

Otoacoustic Emissions (OAE) Codes

Effective January 1, 2012, there is a new OAE Current Procedural Terminology (CPT©AMA) code, **92558**, "Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis." As a screeing procedure, it is not covered by Medicare.

There are revised code descriptors for the current OAE codes, **92587** and **92588**. These descriptors will guide the audiologist on how to file an OAE claim, based on the number of frequencies performed.

CPT 92587: "Distortion product evoked otoacoustic emissions, limited evaluation (to confirm the presence or absence of hearing disorders, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report." The code remains a limited evaluation, but with clear direction regarding the number of frequencies tested, and now requires an interpretation and report.

CPT 92588 remains a comprehensive evoked OAE but has been revised to require a minimum of 12 frequencies. For more information on the use of these codes, go to ASHA's Billing & Reimbursement website at www.asha.org/Practice/reimbursement/coding/New-and-Revised-OAE-CPT-Codes-for-2012/

ASHA joined with other audiology organizations in a survey of typical work time and other work factors for CPT 92587 and 92588. The survey results were presented to the American Medical Association's Relative Value Update Committee Health Care Professionals Advisory Committee (RUC/HCPAC) which recommended 0.45 work RVUs for 92587 and 0.60 work RVUs for 92588 to CMS. CMS disagreed, assigning 0.35 work RVUs for 92587 and 0.55 work RVUs for 92588 because of their interpretation of the amount of work involved with the procedures.

Physician Quality Reporting System (PQRS)

Private practice audiologists enrolled as Medicare suppliers may continue participating in the Medicare Physician Quality Reporting System (PQRS) program, a voluntary program designed to improve the quality of care to Medicare beneficiaries. For 2012, audiologists can report on four measures (one more than in 2011) that call for referral of patients to a physician after an audiological evaluation finds one of four conditions. The new measure in 2012 is for acute or chronic dizziness.

The other qualifying conditions are:

- 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 2012-2014, the incentive payment for satisfactorily reporting on measures is 0.5% of all allowable Medicare charges. Starting in 2015, eligible professionals that do not satisfactorily report on quality measures will be subject to a payment reduction of 1.5%.

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The audiology measures are reported as CPT modifiers on claims. Measures that are claims-reported must represent at least 50% of patients that fit into a measure.

Audiology Services in Settings Qualified for Non-Facility Rates

In general, if services are rendered in one's own office, the Medicare fee is higher (i.e., the non-facility rate) because the practitioner is paying for overhead and equipment costs. The audiologist receives a lower rate when the service is rendered in a facility because the facility incurs overhead/equipment costs. Skilled nursing facilities are the most common applicable facility setting because hospital outpatient departments are not paid under the Medicare Physician Fee Schedule. Therapy services, such as speech-language pathology services, are allowed at non-facility rates in all settings (including facilities) because of a section in the Medicare statute permitting these services to receive nonfacility rates regardless of the setting. ASHA asked CMS for clarification regarding audiology and CMS responded succinctly that the facility rate applied to all facility settings for audiology services. **Table 3** of this document provides both facility and non-facility RVUs and rates.

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 facility and non-facility RVUs and national fee data.

Table 4 is a list of hospital 2012 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).[1] The MPFS has set Medicare Part B[2] prospective payment rates since 1992 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[3]. 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. 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 practice audiologists paid by Medicare as private practitioners under the fee schedule may elect to not accept assignment, that is, be "nonparticipating" even though they are enrolled as

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[1] HCPCS Level I: CPT Codes
HCPCS Level II: Alphanumeric codes developed by CMS for equipment, supplies, and procedures not described in CPT Codes.

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

[3] *Federal Register*, July 22, 1999 (p. 39623)

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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% 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

	Scenario 1: *Participating Provider Accepts Assignment (not entitled to limiting charge add-on)*	**Scenario 2**: *Nonparticipating Provider Accepts Assignment (not entitled to limiting charge add-on)*	**Scenario 3**: *Nonparticipating Provider Does Not Accept Assignment (thus, entitled to limiting charge add-on)*
Fee Schedule Amount	$100	$100	$100
Total Allowed Payment	$100	$100 x 95% = $95	$100 x 95% x 115% = $109.25(total allowed payment)
Medicare Pays	80% x $100 = $80	80% x $95 = $76	Patient reimbursed $76 (80% of $95)
Patient Pays	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 that the work is substantially greater than typically required 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. Note that many third party payers selectively adopt Medicare coding rules.

National Correct Coding Initative (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.

A subset of the CCI edits is the Outpatient Code Editor (OCE), which applies only to hospital outpatient services. Typically, the OCE edits for 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.

The ASHA Web site includes a comprehensive list of CCI edits that apply to audiology. Go to:

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www.asha.org/practice/reimbursement/coding/CCI_edits_AUD.htm.

The CCI also includes a set of edits called Medically Unlikely Edits (MUEs), also for Medicare Part B claims. An MUE for a CPT or HCPCS Level II code is the maximum number of times that the code can be reported for the same patient on the same day. Not all codes have an MUE and/or a CCI edit. See www.asha.org/Practice/reimbursement/coding/Medically-Unlikely-Edits-Audiology/ for a list of audiology-related MUEs.

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 stressed 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.

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 2012 are Faith Akin, Robert Burkard, Leisha Eiten, Robert Fifer (ASHA advisor to the AMA RUC HCPAC Review Board), and Chair, Stuart Trembath. For further information, contact George Lyons, ex officio member of the HCEC and Director of Government Relations and Public Policy, at glyons@asha.org.

Table 2: Topical List of Codes◆

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

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2012 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
- 92550
- 92557
- 92567
- 92568
- 92569
- 92570
- 92587
- 92588
- 92601
- 92602
- 92603
- 92604
- 92621
- 92625
- 92626
- 92627
- 92640

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Table 3: 2012 Medicare Physician Fee Schedule◆

Final Conversion Factor: $34.0376

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	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
69210[5]		Remove impacted ear wax	0.61	0.83	0.28	0.07	1.51	0.96	$51.40	$32.68
92516		Facial nerve function test	0.43	1.64	0.22	0.03	2.10	0.68	$71.48	$23.15
92540		Basic vestibular evaluation	1.50	1.39	0.00	0.05	2.94	1.55	$100.07	$52.76
92540	26	Basic vestibular evaluation	1.50	0.75	0.75	0.04	2.29	2.29	$77.95	$77.95
92540	TC	Basic vestibular evaluation	0.00	0.64	0.00	0.01	0.65	0.01	$22.12	$0.34
92541		Spontaneous nystagmus test	0.40	0.68	0.00	0.02	1.10	0.42	$37.44	$14.30
92541	26	Spontaneous nystagmus test	0.40	0.18	0.18	0.01	0.59	0.59	$20.08	$20.08
92541	TC	Spontaneous nystagmus test	0.00	0.50	0.00	0.01	0.51	0.01	$17.36	$0.34
92542		Positional nystagmus test	0.33	0.71	0.00	0.02	1.06	0.35	$36.08	$11.91

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[4] Facility fees do not apply to hospital outpatient settings.

[5] 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.

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CPT	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
92542	26	Positional nystagmus test	0.33	0.16	0.16	0.01	0.50	0.50	$17.02	$17.02
92542	TC	Positional nystagmus test	0.00	0.55	0.00	0.01	0.56	0.01	$19.06	$0.34
92543		Caloric vestibular test	0.10	0.45	0.45	0.02	0.57	0.00	$19.40	$0.00
92543	26	Caloric vestibular test	0.10	0.05	0.05	0.01	0.16	0.16	$5.45	$5.45
92543	TC	Caloric vestibular test	0.00	0.40	0.00	0.01	0.41	0.01	$13.96	$0.34
92544		Optokinetic nystagmus test	0.26	0.60	0.00	0.02	0.88	0.28	$29.95	$9.53
92544	26	Optokinetic nystagmus test	0.26	0.12	0.12	0.01	0.39	0.39	$13.27	$13.27
92544	TC	Optokinetic nystagmus test	0.00	0.48	0.00	0.01	0.49	0.01	$16.68	$0.34
92545		Oscillating tracking test	0.23	0.57	0.00	0.02	0.82	0.25	$27.91	$8.51
92545	26	Oscillating tracking test	0.23	0.11	0.11	0.01	0.35	0.35	$11.91	$11.91
92545	TC	Oscillating tracking test	0.00	0.46	0.00	0.01	0.47	0.01	$16.00	$0.34
92546		Sinusoidal rotational test	0.29	2.67	0.00	0.02	2.98	0.31	$101.43	$10.55
92546	26	Sinusoidal rotational test	0.29	0.13	0.13	0.01	0.43	0.43	$14.64	$14.64
92546	TC	Sinusoidal rotational test	0.00	2.54	0.00	0.01	2.55	0.01	$86.80	$0.34
92547		Supplemental electrical test	0.00	0.16	0.16	0.01	0.17	0.17	$5.79	$5.79
92548		Posturography	0.50	2.58	0.00	0.02	3.10	0.52	$105.52	$17.70
92548	26	Posturography	0.50	0.23	0.23	0.01	0.74	0.74	$25.19	$25.19
92548	TC	Posturography	0.00	2.35	0.00	0.01	2.36	0.01	$80.33	$0.34

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CPT	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
92550		Tympanometry & reflex threshold	0.35	0.25	0.00	0.01	0.61	0.36	$20.76	$12.25
92551[6]		Pure tone hearing test, air (screening)	0.00	0.34	0.00	0.01	0.35	0.01	$0.00	$0.00
92552		Pure tone audiometry, air	0.00	0.86	0.00	0.01	0.87	0.01	$29.61	$0.34
92553		Audiometry, air & bone	0.00	1.05	0.00	0.01	1.06	0.01	$36.08	$0.34
92555		Speech threshold audiometry	0.00	0.63	0.00	0.01	0.64	0.01	$21.78	$0.34
92556		Speech audiometry, complete	0.00	0.99	0.00	0.01	1.00	0.01	$34.04	$0.34
92557		Comprehensive hearing test	0.60	0.52	0.38	0.03	1.15	1.01	$39.14	$34.38
92558[7] (new)		Evoked OAE, screening	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
92559[7]		Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
92560[7]		Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
92561		Bekesy audiometry, diagnosis	0.00	1.05	0.00	0.01	1.06	0.01	$36.08	$0.34
92562		Loudness balance test	0.00	1.13	0.00	0.01	1.14	0.01	$38.80	$0.34
92563		Tone decay hearing test	0.00	0.86	0.00	0.01	0.87	0.01	$29.61	$0.34
92564		SISI hearing test	0.00	0.74	0.00	0.01	0.75	0.01	$25.53	$0.34
92565		Stenger test, pure tone	0.00	0.45	0.00	0.01	0.46	0.01	$15.66	$0.34
92567		Tympanometry	0.20	0.23	0.13	0.01	0.44	0.34	$14.98	$11.57

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[6] Medicare does not cover this service under the audiology benefit. RVUs have been assigned for the benefit of non-Medicare payers.
[7] Medicare does not cover these services under the audiology benefit.

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CPT	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
92568		Acoustic reflex testing	0.29	0.17	0.17	0.01	0.47	0.47	$16.00	$16.00
92570		Acoustic immittance testing	0.55	0.36	0.29	0.03	0.94	0.87	$32.00	$29.61
92571		Filtered speech hearing test	0.00	0.71	0.00	0.01	0.72	0.01	$24.51	$0.34
92572		Staggered spondaic word test	0.00	0.92	0.00	0.01	0.93	0.01	$31.65	$0.34
92575		Sensorineural acuity test	0.00	1.91	0.00	0.01	1.92	0.01	$65.35	$0.34
92576		Synthetic sentence test	0.00	0.99	0.00	0.01	1.00	0.01	$34.04	$0.34
92577		Stenger test, speech	0.00	0.51	0.00	0.01	0.52	0.01	$17.70	$0.34
92579		Visual audiometry (VRA)	0.70	0.53	0.39	0.03	1.26	1.12	$42.89	$38.12
92582		Conditioning play audiometry	0.00	1.86	0.00	0.01	1.87	0.01	$63.65	$0.34
92583		Select picture audiometry	0.00	1.36	0.00	0.01	1.37	0.01	$46.63	$0.34
92584		Electrocochleography	0.00	2.08	0.00	0.01	2.09	0.01	$71.14	$0.34
92585		Auditory evoked potentials, comprehensive	0.50	3.13	0.00	0.02	3.65	0.52	$124.24	$17.70
92585	26	Auditory evoked potentials, comprehensive	0.50	0.24	0.24	0.01	0.75	0.75	$25.53	$25.53
92585	TC	Auditory evoked potentials, comprehensive	0.00	2.89	0.00	0.01	2.90	0.01	$98.71	$0.34

Final 2012 Rates

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CPT	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
92586		Auditory evoked potentials, limit	0.00	2.35	0.00	0.01	2.36	0.01	$80.33	$0.34
92587		Evoked otoacoustic emiss, limited	0.35	0.44	0.00	0.04	0.83	0.39	$28.25	$13.27
92587	26	Evoked otoacoustic emiss, limited	0.35	0.15	0.15	0.03	0.53	0.53	$18.04	$18.04
92587	TC	Evoked otoacoustic emiss, limited	0.00	0.29	0.00	0.01	0.30	0.01	$10.21	$0.34
92588		Evoked otoacoustic emiss, comp.	0.55	0.68	0.00	0.03	1.26	0.58	$42.89	$19.74
92588	26	Evoked otoacoustic emiss, comp.	0.55	0.26	0.26	0.02	0.83	0.83	$28.25	$28.25
92588	TC	Evoked otoacoustic emiss, comp.	0.00	0.42	0.00	0.01	0.43	0.01	$14.64	$0.34
92596		Ear protector eval	0.00	1.26	0.00	0.01	1.27	0.01	$43.23	$0.34
92601		Cochlear implant follow-up exam, pt < 7 yrs of age	2.30	1.82	1.26	0.11	4.23	3.67	$143.98	$124.92
92602		Reprogram cochlear implant, pt < 7 yrs of age	1.30	1.32	0.74	0.07	2.69	2.11	$91.56	$71.82
92603		Cochlear implant follow-up exam, pt ≥ 7 yrs of age	2.25	1.92	1.25	0.11	4.28	3.61	$145.68	$122.88

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CPT	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
92604		Reprogram cochlear implant, pt ≥7 yrs of age	1.25	1.26	0.70	0.05	2.56	2.00	$87.14	$68.08
92620		Auditory function, 60 min	1.50	1.02	0.77	0.07	2.59	2.34	$88.16	$79.65
92621		Auditory function, + 15 min	0.35	0.26	0.17	0.01	0.62	0.53	$21.10	$18.04
92625		Tinnitus assessment	1.15	0.76	0.58	0.05	1.96	1.78	$66.71	$60.59
92626[8]		Evaluation of auditory rehab status, 1st hr	1.40	1.11	0.78	0.07	2.58	2.25	$87.82	$76.58
92627[8]		Evaluation of auditory rehab status, each 15 min	0.33	0.30	0.19	0.01	0.64	0.53	$21.78	$18.04
92630[9]		Auditory rehab, pre-lingual hearing loss	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
92633[9]		Auditory rehab, post-lingual hearing loss	0.00	0.00	0.00	0.00	0.00	0.00	$0.00	$0.00
92640		Brainstem implant programmin g, per hr.	1.76	1.2	0.78	0.37	3.33	2.91	$113.35	$99.05
95920		Intraop nerve test add-on, per hr.	2.11	2.69	0.00	0.09	4.89	2.20	$166.44	$74.88
95920	26	Intraop nerve test add-on	2.11	0.94	0.94	0.08	3.13	3.13	$106.54	$106.54
95920	TC	Intraop nerve test add-on	0.00	1.75	0.00	0.01	1.76	0.01	$59.91	$0.34

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[8] Audiologists may use these evaluation codes.
[9] Medicare does not cover these services under the audiology benefit.

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CPT	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
95925		Somatosensory testing	0.54	4.33	0.00	0.02	4.89	0.56	$166.44	$19.06
95925	26	Somatosensory testing	0.54	0.24	0.24	0.01	0.79	0.79	$26.89	$26.89
95925	TC	Somatosensory testing	0.00	4.09	0.00	0.01	4.10	0.01	$139.55	$0.34
95926		Somatosensory testing	0.54	4.16	0.00	0.04	4.74	0.58	$161.34	$19.74
95926	26	Somatosensory testing	0.54	0.23	0.23	0.03	0.80	0.80	$27.23	$27.23
95926	TC	Somatosensory testing	0.00	3.93	0.00	0.01	3.94	0.01	$134.11	$0.34
95927		Somatosensory testing	0.54	4.24	0.00	0.02	4.80	0.56	$163.38	$19.06
95927	26	Somatosensory testing in the trunk or head	0.54	0.24	0.24	0.01	0.79	0.79	$26.89	$26.89
95927	TC	Somatosensory testing in the trunk or head	0.00	4.00	0.00	0.01	4.01	0.01	$136.49	$0.34
95930		Visual evoked potential test	0.35	4.07	0.00	0.02	4.44	0.37	$151.13	$12.59
95930	26	Visual evoked potential test	0.35	0.16	0.16	0.01	0.52	0.52	$17.70	$17.70
95930	TC	Visual evoked potential test	0.00	3.91	0.00	0.01	3.92	0.01	$133.43	$0.34
95934		H-reflex test	0.51	1.28	0.00	0.02	1.81	0.53	$61.61	$18.04
95934	26	H-reflex test	0.51	0.23	0.23	0.01	0.75	0.75	$25.53	$25.53
95934	TC	H-reflex test	0.00	1.05	0.00	0.01	1.06	0.01	$36.08	$0.34
95936		H-reflex test, not g/s muscle	0.55	0.89	0.00	0.02	1.46	0.57	$49.69	$19.40
95936	26	H-reflex test, not g/s muscle	0.55	0.25	0.25	0.01	0.81	0.81	$27.57	$27.57
95936	TC	H-reflex test, not g/s muscle	0.00	0.64	0.00	0.01	0.65	0.01	$22.12	$0.34

Final 2012 Rates

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CPT	Mod	Description	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Malprac-tice RVUs	Non-Facility Total RVUs	Facility Total RVUs	Non-Facility Fee (see geographic adjustors section)	Facility Fee (see geographic adjustors section)[4]
95937		Neuromuscular junction test	0.65	1.34	0.00	0.05	2.04	0.70	$69.44	$23.83
95937	26	Neuromuscular junction test	0.65	0.28	0.28	0.04	0.97	0.97	$33.02	$33.02
95937	TC	Neuromuscular junction test	0.00	1.06	0.00	0.01	1.07	0.01	$36.42	$0.34

Geographic Adjustment Calculations

Precise payment rates by locality are available at: **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.

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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)
  - **-1.2%** $44.89
  - Includes H-reflex test
- APC 216 (Level III Nerve and Muscle Tests)
  - **-0.4%** $185.46
  - Includes Intraoperative neurophysiology testing; Visual evoked potential test
- APC 218 (Level II Nerve and Muscle Tests)
  - **+4.2%** $84.19
  - Includes Auditory evoked potentials, limited; Neuromuscular junction test
- APC 363 (Level I Otorhinolaryngologic Function Tests)
  - **+6.7%** $67.48
  - Includes most vestibular function tests; Evoked otoacoustic emissions, limited
- APC 364 (Level I Audiometry)
  - **+5.1%** $34.38
  - Includes Speech threshold; Loudness balance; Tympanometry
- APC 365 (Level II Audiometry)
  - **-2.6%** $85.24
  - Includes Comprehensive hearing test; Visual audiometry, Air & bone
- APC 366 (Level III Audiometry)
  - **-5.2%** $118.07
  - Includes Stenger test; Cochlear implant follow-up
- APC 660 (Level II Otorhinolaryngologic Function Tests)
  - **+25.8%** $127.35
  - Includes Posturography; Electrocochleo-graphy;

Other New Developments

Codes Transferred from APC 660 to APC 363

Transfer from Level II to Level I Otorhinolaryngologic Function Tests results in a fee reduction of 34%.

- **CPT 92516** Facial nerve function test
- **CPT 92588** Comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies) **This descriptor was revised in 2012 from**: ". . .comparison of. . . otoacoustic emissions at multiple levels and frequencies."

Codes Transferred from APC 364 to APC 365

Transfer from Level I to Level II Audiometry results in a fee increase of approximately 250%.

- **CPT 92561** Bekesy audiometry, diagnostic
- **CPT 92570** Acoustic immitance testing

Cochlear Implantation (CPT 69930)

The cochlear implant payment is reduced by 7.0% to $28,897. This reduction comes after increases of 7.4% and 9.1% in 2011 and 2010, respectively. For many hospitals, the payment does not cover all costs of the procedure but does not appear to be a disincentive to maintaining this specialty program compared to the lower rates of three or more years ago.

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TABLE 4: HOSPITAL OUTPATIENTPROSPECTIVE PAYMENT SYSTEM (OPPS) RATES FOR AUDIOLOGY SERVICES◆

HOSPITAL OPPS

CPT/HCPCS	Description	Ambulatory Payment Classification	Payment Rate subject to geographic adjustors	Copayment
G0268	Removal of impacted wax on same day as audiologic testing (physician only code)	Packaged into payment for other tests as of 2009		
69210	Removal of impacted wax (physician only code)	0340	$45.50	$9.10
69930	Cochlear implantation	0259	$28,897.00	$5779.00
92516	Facial nerve function test	0363 Revised APC – 2012	$67.48	$13.50
92540	Basic vestibular evaluation	0660	$127.35	$20.24
92541	Spontaneous nystagmus test	0363	$67.48	$13.50
92542	Positional nystagmus test	0363	$67.48	$13.50
92543	Caloric vestibular test	0660	$127.35	$20.24
92544	Optokinetic nystagmus test	0363	$67.48	$13.50
92545	Oscillating tracking test	0363	$67.48	$13.50
92546	Sinusoidal rotational test	0660	$127.35	$20.24
92547	Supplemental electrical test	Not separately billed; bundled with CPT 92541 as of 2008.		
92548	Posturography	0660	$127.35	$20.24
92550	Tympanometry & reflex thresh	0364	$34.38	$6.88
92551	Pure tone hearing test, air (screening)	Not covered		
92552	Pure tone audiometry, air	0364	$34.38	$6.88
92553	Audiometry, air & bone	0365	$85.24	$17.05
92555	Speech threshold audiometry	0364	$34.38	$6.88
92556	Speech audiometry, complete	0364	$34.38	$6.88
92557	Comprehensive hearing test	0365	$85.24	$17.05
92559	Group audiometric testing	Not covered		

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HOSPITAL OPPS

CPT/HCPCS	Description	Ambulatory Payment Classification	Payment Rate subject to geographic adjustors	Copayment
92560	Bekesy audiometry, screen	Not covered		
92561	Bekesy audiometry, diagnostic	0365 Revised APC – 2012	$84.24	$17.05
92562	Loudness balance test	0364	$34.38	$6.88
92563	Tone decay hearing test	0364	$34.38	$6.88
92564	SISI	0364	$34.38	$6.88
92565	Stenger test, pure tone	0364	$34.38	$6.88
92567	Tympanometry	0364	$34.38	$6.88
92568	Acoustic reflex testing; threshold	0364	$34.38	$6.88
92570	Acoustic immitance testing	0365 Revised APC – 2012	$84.24	$17.05
92571	Filtered speech hearing test	0364	$34.38	$6.88
92572	Staggered spondaic word test	0366	$118.07	$23.62
92575	Sensorineural acuity test	0364	$34.38	$6.88
92576	Synthetic sentence test	0364	$34.38	$6.88
92577	Stenger test, speech	0366	$118.07	$23.62
92579	Visual audiometry (VRA)	0365	$85.24	$17.05
92582	Conditioning play audiometry	0365	$85.24	$17.05
92583	Select picture audiometry	0364	$34.38	$6.88
92584	Electrocochleography	0216	$185.46	$37.10
92585	Auditor evoke potentials, comprehensive	0216	$185.46	$37.10
92586	Auditory evoke potentials, limited	0218	$80.78	$16.16
92587	Evoked otoacoustic emiss, limited	0363	$67.48	$13.50
92588	Evoked otoacoustic emiss, comp.	0363 Revised APC – 2012	$67.48	$13.50

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HOSPITAL OPPS

CPT/HCPCS	Description	Ambulatory Payment Classification	Payment Rate subject to geographic adjustors	Copayment
92596	Ear protector evaluation	0364	$34.38	$6.88
92601	Cochlear implant follow-up exam, pt under 7 yrs of age	0366	$118.07	$23.62
92602	Reprogram cochlear implant, pt under 7 yrs of age	0366	$118.07	$23.62
92603	Cochlear implant follow-up exam, pt 7 yrs of age or older	0366	$118.07	$23.62
92604	Reprogram cochlear implant, pt 7 yrs of age or older	0366	$118.07	$23.62
92620	Central auditory function	0365	$85.24	$17.05
92621	Central auditory function, add-on	(Under OPPS, 92620 considered full session)		
92625	Tinnitus assessment	0365	$85.24	$17.05
92626	Eval of auditory rehab status	0366	$118.07	$23.62
92627	Eval of auditory rehab status, add-on	(Under OPPS, 92626 considered full session)		
92630	Auditory rehab; pre-lingual hearing loss	Not covered		
92633	Auditory rehab; post-lingual hearing loss	Not covered		
92640	Auditory brainstem implant programming	0365	$85.24	$17.05
95920	Intraop neurophysiology testing, per hour	Not separately billed; bundled with CPT 92541 as of 2008.		
95925	Somatosensory testing; in upper limbs	0216	$185.46	$37.10
95926	Somatosensory testing; in lower limbs	0216	$185.46	$37.10
95927	Somatosensory testing; in the trunk or head	0216	$185.46	$37.10
95930	Visual evoked potential test	0216	$185.46	$37.10
95934	H-reflex test	0215	$44.89	$8.98
95936	H-reflex test, not g/s muscle	0215	$44.89	$8.98
95937	Neuromuscular junction test	0218	$80.78	$16.16

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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

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