2016 Hospital Outpatient Prospective Payment System for Audiologists and Speech-Language Pathologists

American Speech-Language-Hearing Association

1st Edition November 10, 2015

General Information

This document, developed by the American Speech-Language-Hearing Association (ASHA), provides an analysis of the 2016 Medicare Hospital Outpatient Prospective Payment System (OPPS), including Ambulatory Payment Classifications (APC) using CPT (Current Procedure Terminology ® American Medical Association) codes. The OPPS is primarily used by audiologists providing services to outpatient Medicare beneficiaries in hospitals, and some speech-language pathologists providing instrumental assessments that are not classified in the Medicare system as therapy services. The CPT codes are listed in their assigned APCs with the national payment rates. Please check ASHA's Billing and Reimbursement website for the most up-to-date information. For additional information or questions, please contact the Health Care Economics and Advocacy Team at reimbursement@asha.org.

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Overview

Payment for hospital-based outpatient audiology services are made under the Outpatient Prospective Payment System (OPPS). Payment is determined by assignment of the CPT code to an Ambulatory Payment Classification (APC).

This document includes regulations and rates for implementation on January 1, 2016, for audiologists providing services to Medicare Part B beneficiaries in the hospital setting under the OPPS. National payment rates for audiology-related services are also included.

Speech-language pathology services performed in hospital outpatient clincis are billed fee-for-service through the Medicare Physician Fee Schedule, with the exception of a few CPT codes not classified as "always" or "sometimes" therapy codes. Services billed through the OPPS do not require the –GN modifier. A complete list of the always therapy codes can be found on the CMS Annual Therapy Update website.

Additional information can be found on ASHA's Outpatient MPFS website. For questions, please contact reimbursement@asha.org.

Analysis of the 2016 Hospital Outpatient Prospective Payment System

The hospital Outpatient Prospective Payment System (OPPS) pays for designated services performed in hospital outpatient departments, including audiology services and select speech-language pathology services. Units of payment are calculated in the Ambulatory Payment Classification (APC), which groups individual services to APCs based on similar characteristics and costs. The reimbursement for each service within the APC is the same. Some APCs are classified as "ancillary," which indicates the services, when performed with other "primary services," are seen as dependent on the primary service and not paid for separately. This method of bundling payment is referred to as "packaging."

In the 2015 final rule, CMS reclassified several APCs as "ancillary" APCs that would result in bundled, packaged payment. In other words, if other services are performed in the hospital on the same day as an ancillary service, the ancillary service will not receive separate payment. Due to this policy, the audiometric CPT codes and the cochlear implant programming and subsequent reprogramming codes were unpaid in 2015 if other services were performed in the hospital on the same date. ASHA requested reconsideration in 2015 comments, met with CMS staff in early 2015, and consulted with external data specialists to provide CMS further justfication for the recognizion of audiology services as primary services. Due to these advocacy efforts, CMS reversed their position for the cochlear implant services. While this decision did not address the audiometric coding issues, it is a significant victory for hospital cochlear implant centers.

See **Table 1** for a listing of APC classifications and rates for vestibular and audiology services, **Table 2** for cochlear implant and osseointegrated implant surgeries, and **Table 3** for related electrophysiological studies, and **Table 4** for speech-language pathology and related services.

How to Read the OPPS Tables

The **APC (Ambulatory Payment Classification)** denotes the classification group with CPT codes based on similar characteristics and costs.

The **national fee** is the remimbursement rate for each code within the APC.

Classification Codes:

J1—*Hospital Part B service paid through a comprehensive APC*
All covered Part B services on the claim are packaged with the primary *J1* service for the claim, except services with classification codes *F*,*G*, *H*, *L* and *U*; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. APCs and CPT codes with those classifications are paid separately and are not packaged with the *J1* service.

Q1—*Packaged APC Payment*
APCs and CPT codes billed on the same date of service as those classified with *S*, *T*, or *V* are packaged and not paid for separately. If billed without the classified *S*, *T*, or *V*, payment is made at the APC rate.

Q3 – *Packaged APC Payment*
Service may be paid for separately if not billed with a composite APC.

S—*Separate APC Payment*
Regardless of the services performed on the same date of service, the CPT code is paid at the APC classification rate.

T – *Separate APC Payment; Multiple Payment Procedure Reduction applies*
Regardless of the services performed on the same date of service, the CPT code is paid. However, services may be reduced if multiple codes subject to the Multiple Payment Procedure Reduction payment policy are billed.

Table 1. Ambulatory Payment Classifications (APCs) and National Fees: Vestibular and Audiology Services

The services listed below are paid under the hospital OPPS. Any audiology CPT codes not in Table 1 may be paid under the Outpatient MPFS when provided in a facility setting, or bundled into the hospital inpatient prospective payment system for patients admitted into a Part A inpatient stay.

APC	Descriptor (National Fee)		Bundling Classification
5721	Level I Diagostic Tests and Related Servcies (**$129.75**)		
	92544	Optokinetic nystagmus test	S
	92545	Oscillating tracking test	S
	92546	Sinusoidal rotational test	S
	92584	Electrocochleography	S
	92586	Auditory evoked potential – limited	S
	92601	Cochlear Implant initial <7 years old	S
	92602	Cochlear implant subsequent <7 years	S
	92603	Cochlear implant initial >7 years old	S
	92604	Cochlear implant subsequent >7 years	S
	92640	ABI programming	S
	92550	Tympanometry & reflex threshold	Q1
	92553	Audiometry air & bone	Q1
	92557	Comprehensive hearing test	Q1
	92562	Loudness balance test	Q1
	92570	Acoustic immitance testing	Q1
	92572	Staggered spondaic word test	Q1
	92579	Visual audiometry (VRA)	Q1
	92582	Conditioning play audiometry	Q1
	92620	Auditory function 60 minutes	Q1
	92625	Tinnitus assessment	Q1
	92626	Eval. of auditory rehab status	Q1
5722	Level II Diagnostic Tests and Related Services (**$220.35)**		
	92537	Caloric	S
	92586	Auditory evoked potential (ABR), limited	S
	92540	Vestibular evaluation	S
	92585	Auditory evoked potential (ABR), comprehensive	S
	92587	OAE limited	S
	92588	OAE comprehensive	S
5723	Level III Diagnostic Tests and Related Services (**$396.52)**		
	92577	Stenger speech test	S

APC	Descriptor (National Fee)		Bundling Classification
0364	Level I Minor Procedures (**$12.70**)		
	92700	Miscellaneous ENT procedure/service	Q1
0365	Level II Minor Procedures (**$30.51**)		
	92555	Speech threshold audiometry	Q1
	92556	Speech threshold & discrimination	Q1
	92563	Tone decay hearing test	Q1
	92564	SISI hearing test	Q1
	92565	Stenger pure tone	Q1
	92567	Tympanometry	Q1
	92568	Acoustic reflex threshold	Q1
	92571	Filtered speech test	Q1
	92575	Sensorineural acuity test	Q1
	92576	Synthetic sentence test	Q1
	92583	Select picture audiometry	Q1
	92596	Ear protection measurement	Q1
5734	Level IV Minor Procedures (**$91.18**)		
	92541	Sponteneous nystagmus test	Q1
	92542	Positional nystagmust test	Q1
	92548	Posturography	Q1
	92552	Pone tone audiometry	Q1
	92561	Bekesy audiometry	Q1

Table 2. APCs and National Fees: Cochlear Implant and Osseointegrated Implant Surgeries

The following APCs may be of interest to audiologists in cochlear implant centers. However, the procedures in this table are for informational purposes only and are not for billing by audiologists.

APC	Descriptor (National Fee)		Bundling Classification
5125	Level V Musculoskeletal Procedures (**$10,537.90)**		
	69714	Implant AOI, w/o mastoidectomy	J1
	69715	Implant AOI, w/mastoidectomy	J1
5166	Level VI ENT Procedures (**$30,427.58**)		
	69930	Implant cochlear device	J1

Table 3. APCs and National Fees: Related Electrophysiological Studies

The following APCs may be of interest to audiologists in cochlear implant centers. Audoiolgists will need to confirm with state licening agencies and hospital policies regarding the provision of electrophysiological studies not related to hearing and balance studies. Medicare requires direct (on-site) supervision by a physician.

APC	Descriptor (National Fee)		Bundling Classification
5721	Level I Diagostic Tests and Related Servcies (**$129.75**)		
	95907	Nerve condution 1-2 studies	S
	95937	Neuromuscular junction test	S
5722	Level II Diagnostic Tests and Related Services (**$220.35)**		
	92516	Facial nerve function test	S
	95908	Nerve conduction 3-4 studies	S
	92909	Nerve conduction test 5-6 studies	S
	95910	Nerve conduction 7-8 studies	S
	95925	Somatosentory testing	S
	95926	Somatosentory testing	S
	95927	Somatosentory testing	S
	95930	Visual evoked potential test	S
5723	Level III Diagnostic Tests and Related Services (**$396.52)**		
	95911	Nerve conduction 9-10 studies	S
	95912	Nerve conduction 11-23 studies	S
	95913	Nerve conduction 13+ studies	S
	95938	Somatosensory testing	S

Table 4. APCs and National Fees: Speech-Language Pathology and Related Services

The following APCs include the services of interest to or performed by speech-language pathologists in the outpatient hospital setting that are not billed through the Medicare Physician Fee Schedule. These services are not on "always" or "sometime" therapy codes and therefore do not require the –GN modifier or the functional outcomes with severity modifiers (G-codes). Services not listed are billed fee-for-service and require adherence to the Medicare fee schedule rules.

APC	Descriptor (National Fee)		Bundling Classification
5151	Level I Airway Endoscopy (**$141.31**)		
	92511	Nasopharyngoscopy	T
5152	Level II Airway Endoscopy (**$375.13**)		
	31579	Diagnostic laryngoscopy	T
5721	Level I Diagnostic Tests and Related Services (**$129.75**)		
	96111	Developmental testing	Q3
5722	Level II Diagnostic Services and Related Tests (**$220.35**)		
	92512	Nasal function studies	S
5731	Level I Minor Procedures (**$12.70**)		
	92700	Miscellaneous ENT procedure	Q1
5734	Level IV Minor Procedures (**$91.18**)		
	92520	Laryngeal function studies	Q1