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The Fundamentals of the Role of Medicare in Audiology

Presented by:

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Billing, Coding, and Reimbursement Bootcamp

- This course is part of a series of recorded and text courses by Dr. Cavitt
- This series is designed to provide ***all you need to know*** about billing, coding, reimbursement, and legal/ethical compliance issues for audiology practices
- Other courses in the series can be found in the AudiologyOnline course library, under the topic Billing/Coding Bootcamp

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

- Please note: Medicare AND Medicaid
- CMS, for short
- They are part of the Department of Health and Human Services
- They govern the Federal Medicare and Medicaid Programs
- Claims are paid via Medicare Area Contractors

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Medicare Enrollment

- Need enrollment as an individual (855-I) and practice (855-B)
- Must have an NPI, License, and address before proceeding with enrollment
- Can enroll online through http://pecos.hhs.coms.gov
  - Best way to enroll; avoid paper applications

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Medicare Enrollment

- Determined on 855-R
- Options:
  - Participating:
    - Accept Assignment
    - Listed in provider directory
    - Rollovers to secondary
    - Medicare pays 5% more

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Medicare Enrollment

- Non-Participating:
  - Accept assignment on claim by claim basis or charge patient limiting charge (115% of allowed amount)
  - Patient pays provider on date of service
    - Patient receives 95% of Medicare allowed charge from Medicare/secondary payer
  - Typically does not rollover to secondary carrier

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Medicare Enrollment

- Free
  - Audiologists cannot opt out of Medicare
  - If charge X to one, you must charge X to all

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Medicare Enrollment Options

	Par	Non-Par who accepts assignment	Non-Par who do not accept assignment (Limiting Charge)
Billed Amount	$125	$125	$109.25
Medicare Allowed Amount	$100	$95	$95
80% of Medicare Allowed	$80	$76	$76
Beneficiary Co-Insurance	$20	$19	$19
Total Payment to Provider	$100	$95	$109.25 (95 x 1.15 limiting charge); patient paid $14.25 difference

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CMS Audiology Policies

- Update to Audiology Policies
  - October, 2008
- Revision and Re-Issuance of Audiology Policies
  - September, 2010
- ABN
  - January, 2012
- PQRS

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CMS Audiology Policies

- Update to Audiology Policies
  - Effective October, 2008
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads//R84BP.pdf
- Revisions and Re-Issuance of Audiology Policies
  - Effective September, 2010
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//MM6447.pdf

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CMS Audiology Policies

- "Incident to billing"
- Required physician orders
- Treatment services
- Computerized audiometry
- Role of technicians and their supervision requirements
- Role of students, including but not limited to, the final year extern and their supervision requirements
- Medical necessity
- Billing of technical and professional components
- Use of 92700
- Opt out provision
- Billing in comprehensive outpatient rehabilitation facility
- Mandatory claims submission

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Medicare

- Local Coverage Determinations
  - Trailblazer
  - Palmetto
  - First Coast (Vestibular)
- Medicare Area Contractors

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Medical Necessity

- "Examples of appropriate reasons for ordering audiological diagnostic tests that could be covered include, but are not limited to:
  - Evaluation of suspected change in hearing, tinnitus, or balance;
  - Evaluation of the cause of disorders of hearing, tinnitus, or balance;
  - Determination of the effect of medication, surgery, or other treatment;
  - Reevaluation to follow-up changes in hearing, tinnitus, or balance that may be caused by established diagnoses that place the patient at probable risk for a change in status including, but not limited to: otosclerosis, atelectatic tympanic membrane, tympanosclerosis, cholesteatoma, resolving middle ear infection, Menière's disease, sudden idiopathic sensorineural hearing loss, autoimmune inner ear disease, acoustic neuroma, demyelinating diseases, ototoxicity secondary to medications, or genetic vascular and viral conditions;
  - Failure of a screening test (although a screening test is non-covered);
  - Diagnostic analysis of cochlear or brainstem implant and programming; and
  - Audiology diagnostic tests before and periodically after implantation of auditory prosthetic devices'.

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

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Documentation

- "Documentation for Orders (Reasons for Tests).
  - The reason for the test should be documented either on the order, on the audiological evaluation report, or in the patient's medical record. (See subsection C. of this section concerning reasons for tests.)
- Documenting skilled services. When the medical record is subject to medical review, it is necessary that the record contains sufficient information so that the contractor may determine that the service qualifies for payment. For example, documentation should indicate that the test was ordered, that the reason for the test results in coverage, and that the test was furnished to the patient by a qualified individual.
  - Records that support the appropriate provision of an audiological diagnostic test shall be made available to the contractor on request".

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Physician Order Requirements

- Needed for each incident of care
- Does not guarantee medical necessity
- Should state "audiologic and/or vestibular evaluation"
  - Should avoid the term "hearing aid"
- Delivery methods:
  - Hand delivered, faxed or mailed
  - E-mailed
  - Telephone
    - Avoid this option

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Advanced Beneficiary Notice (ABN)

- The Advanced Beneficiary Notice of Noncoverage (ABN) is a Medicare defined and regulated document that is used to notify Medicare beneficiaries of their potential financial responsibilities prior to the rendering of a service or the dispensing of an item.
- The current ABN form (effective March 2011) and its accompanying guidance can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//ABN_Booklet_ICN006266.pdf and http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/02_ABN.asp.
- This document is appropriate for Medicare beneficiaries only.
- Please consult your Medicare Advantage (Part C) guidance to determine if this form is allowed and applicable for Medicare Advantage members.

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Advanced Beneficiary Notice

- The ABN, the alerting notice to the patient on their fiscal responsibility for Medicare diagnostic services, has two roles:
  - As a **required** notification that informs the beneficiary that the item or service may not meet the definition of medical necessity in this incidence of care.
  - As a **voluntary** notification or a notification of non-coverage that informs the beneficiary that the item or service is statutorily excluded or does not meet the definition of a Medicare benefit.

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Advanced Beneficiary Notice (ABN)

-Required ABN uses:

- Order in place but medical necessity not met
- Testing frequency outside the norm
- Use of 92700
- Local coverage determination in place

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Advanced Beneficiary Notice

- Some common situations where the use of a required ABN would be warranted:
  - The audiologist has a physician order but there is evidence that medical necessity may have not been met in this instance of care.
  - The code 92700 (unlisted otorhinological item or service) is used.
  - An LCD is in place and the provider is performing a procedure that appears to be not covered by the LCD.
- If a required ABN is completed and the beneficiary wants the claim submitted to Medicare for a coverage decision (they selected option 1 in section G), the provider should add the –GA modifier to the item(s) or service(s) that were listed on the ABN.

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Advanced Beneficiary Notice

- A physician orders an annual hearing test on a Medicare beneficiary. The beneficiary has been previously diagnosed with a sensorineural hearing loss. When the patient arrives in your clinic, they do not report a change in history or medical condition and do not have a medical condition that requires audiologic monitoring. Instead, the patient is interested in amplification.
- A Medicare beneficiary is undergoing vestibular evoked myogenic potential (VEMP) testing. As this procedure does not have a CPT code, the use of 92700 is warranted.
- A local coverage determination is in place in Texas. A Medicare Beneficiary in Texas is about to undergo audiologic testing. As the coverage of the audiologic testing in this case is dependent on the beneficiary having one of the approved diagnoses, the use of a required ABN is warranted. This is the due to the fact that the resulting diagnosis is not one the diagnoses approved for payment by the LCD.

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Advanced Beneficiary Notice (ABN)

- Voluntary ABN uses
  - Routine or annual audiologic testing where medical necessity was not met
  - Hearing aids or testing for the sole purpose of obtaining a hearing aid
  - Treatment services such as cerumen removal, canalith repositioning, tinnitus management and aural rehabilitation
  - Tinnitus maskers and devices
  - Evaluation and Management codes
  - Audiologic and/or vestibular testing where a physician order was not obtained prior to testing
  - Audiologic evaluations that were the result of solicitation (i.e. reminder cards, marketing events)
  - Audiologic and/or vestibular testing that was completed by a student in the absence of 100% personal supervision by an audiologist or physician
  - Audiologic testing that requires the skills of an audiologist or physician but was completed by a technician
  - Screenings

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Advanced Beneficiary Notice

- Use of Voluntary ABN
  - The provider should add the –GY (item or service statutorily excluded or does not meet the definition of a Medicare benefit) and -GX modifiers to the item(s) or service(s) that were listed on the ABN.

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PQRS

- http://www.asha.org/advocacy/audiologypqri/
- PQRS is a voluntary program designed to improve the quality of care to Medicare beneficiaries. Beginning January 1, 2012 audiologists that bill Medicare Part B and who participate in PQRS by reporting on approved quality measures are eligible for a .50% incentive payment.
- Audiologists have the opportunity to improve both the profession of audiology and quality of care provided to patients by participating in the Medicare Physician Quality Reporting System (PQRS) program.
- The audiologist must be a Medicare provider. This means that in addition to having one's own NPI number, the audiologist must have completed the Medicare form 855I for formally registering with Medicare as a provider and, if necessary, an 855R form to inform Medicare where regular payments should be directed.
- It is reported on a HCFA 1500 form
- PQRS is a program that will apply to non-Medicare situations as well (for example, procedures or situations involving children). But to be eligible to receive the .5% bonus at year end, the PQRS participant must be a Medicare provider.
- Will be mandatory by 2015

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PQRS

- The measures are:
  - Congenital or traumatic deformity of the ear
  - A history of active drainage from the ear within the previous 90 days (for patients who have disease of the ear and mastoid processes)
  - A history of sudden or rapidly progressive hearing loss
  - Acute or chronic dizziness

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Medical Records Retention

- HIPAA is 6 years
- Consult state laws
- Consult your third-party contracts
- Pediatrics and hospitals often have different policies
- http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_012547.pdf

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