
**AGENDA**

- Reimbursement basics –
  - Coding
  - Coverage
  - Payment
- 2013 Medicare Reimbursement rates for bone anchored hearing systems

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**What is Reimbursement….**

- **Coding:**
  - Services, Devices, Drugs, etc
  - Patient's Diagnosis
- **Coverage:**
  - Contract/Policy Provisions – specific exclusions and limitations
  - Medical Necessity – clinical coverage guidelines
- **Payment:**
  - Various Methodologies

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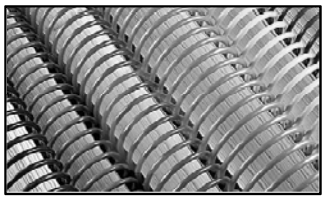
## CODING



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## Applicable Coding Systems

| Coding System | Used to Describe |
|---|---|
| CPT | Describes medical, surgical, and diagnostic services |
| HCPCS | Products, supplies, drugs, and DME |
| ICD-9-CM Diagnosis | Patient's primary, secondary, etc. diagnosis that prompted the treatment/visit |

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## CPT®

- Current Procedural Terminology
- CPT® is registered trademark of the American Medical Association (AMA)
- Listing of codes and descriptive terms for reporting medical services and procedures
- Level I HCPCS codes
- 5 numeric digits

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## Applicable Surgical CPT® Codes

| CPT Code | Description |
|---|---|
| 69714 | Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy |
| 69715 | ... with mastoidectomy |
| 69717 | Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy |
| 69718 | ... with mastoidectomy |
| 69399 | Unlisted procedure external ear |

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## HCPCS

- Healthcare Common Procedure Coding System
- The HCPCS is divided into two sub-systems:
  - Level I (CPT® codes)
  - Level II (commonly referred to as "HCPCS codes")
- HCPCS codes (Level II) are developed and maintained by The Centers for Medicare & Medicaid Services (CMS)
- HCPCS codes (Level II) are used primarily to identify products, supplies, and services not included in the CPT® codes
- Alpha-numeric with one letter followed by four digits

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## Applicable HCPCS

| HCPCS | Description |
|---|---|
| L8690 | Auditory osseointegrated device, includes all internal and external components **(Implant, Abutment and Sound Processor)** |
| L8691 | Auditory osseointegrated device, external sound processor, replacement **(Replacement processor)** |
| L8692 | Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment **(Softband and Sound Processor)** |
| L8693 | Auditory osseointegrated device abutment, any length, replacement only **(Replacement abutment)** |

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L8690

L8691

L8692

L8693

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## ICD

- International Classification of Diseases (ICD) code sets
  - Currently*: International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
    - Based on the World Health Organization's Ninth Revision, International Classification of Diseases
- Used to identify/report patient diagnoses and inpatient procedures
- The National Center for Health Statistics (NCHS) and CMS are the U.S. gov agencies responsible for changes and modifications

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## ICD-9 Diagnosis Codes – sample list of applicable codes

| | |
|---|---|
| 388.2 | Unspecified sudden hearing loss |
| 388.5 | Disorders of acoustic nerve |
| 389.0 | Conductive hearing loss |
| 389.00 | Unspecified conductive hearing loss |
| 389.01 | Conductive hearing loss, external ear |
| 389.05 | Conductive hearing loss, unilateral |
| 389.06 | Conductive hearing loss, bilateral |
| 389.08 | Conductive hearing loss of combined types |
| 744.0 | Congenital anomalies of ear causing impairment of hearing |
| 744.00 | Unspecified congenital anomaly of ear causing impairment of hearing |
| 744.01 | Congenital absence of external ear causing impairment of hearing |
| 744.02 | Other congenital anomaly of external ear causing impairment of hearing |
| 744.03 | Congenital anomaly of middle ear, except ossicles, causing impairment of hearing |
| 744.09 | Other congenital anomalies of ear causing impairment of hearing |
| 744.23 | Microtia |

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## *Transition of ICD-9 to ICD-10

- **ICD-9 codes** *(numeric 3 to 5 digits)* ➡ 17,000 codes
- **ICD-10 codes** (*alpha-numeric 3 to 7 characters)* ➡ 141,000 codes approx.
  - **ICD-10-CM** (diagnosis)
  - **ICD-10-PCS** (inpatient procedure)
- More specific ICD-10 codes means many ICD-9 codes will now map to multiple ICD-10 codes

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## *Transition of ICD-9 to ICD-10

- REQUIRED!! Everyone covered by the Health Insurance Portability Accountability Act (HIPAA)
- CMS set implementation date as October 1, 2014
  - Claims for date of service on or after the compliance deadline must use ICD- 10 diagnosis and inpatient procedure codes
  - General Equivalence Mappings (GEMs) avail on CMS site

CMS website:
http://cms.gov/Medicare/Coding/ICD10/index.html

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**Coding** ✓

**Coverage** ☐

**Payment** ☐

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**COVERAGE**


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**Coverage**

- The circumstances under which a payer will reimburse a provider for services, procedures, devices, drugs etc…
- Coverage decisions are based on:
  - Contract Provisions
  - Medical Necessity

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## Coverage

- Outlined in the member's Certificate of Coverage
- Specific exclusions from benefits – i.e. cosmetic surgery
- Specific riders for additional benefits – i.e. hearing aid coverage
- Coverage Policies - meet certain clinical/medical requirements
- Can vary by payer and by the plans offered by the same payer (employer plans, individual plans, HMOs, PPOs, etc.)

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## Coverage

**What is Medical Necessity?**

- Coverage Policies - meet certain clinical/medical requirements for either diagnosis or treatment of a medical condition
  - Particular diagnosis
  - Test Results
- Must meet accepted standards of medical practice
  - Not considered experimental or investigational
- "Reasonable & necessary"

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## Coverage – Medicare

- **Benefit Policy Manual - Chapter 16 - General Exclusions From Coverage**
  - No payment may be made for expenses incurred for hearing aids
- November 2005: CMS modified the "hearing aid" definition to exclude certain implanted devices from the category of "hearing aid"
- Osseointegrated implants are prosthetics

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## Coverage – Medicare

Defined in Medicare's hearing aid definition:

- *"….Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve are payable by Medicare as prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss, or surgery…."*

Found at: **Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage**
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf

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## Coverage - Medicare

*"…The following are prosthetic devices:*

- *Cochlear implants and auditory brainstem implants; that is, devices that replace the function of cochlear structures or auditory nerves and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays.*
- *Osseointegrated implants; that is, devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer."*

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## Replacement Sound Processor Coverage - Medicare

- Loss
- Irreparable damage
  - Specific accident or natural disaster (like a flood)
- Irreparable wear
  - Deterioration sustained from day-to-day usage over time
  - Reasonable Useful Lifetime - 5 yrs
  - During the reasonable lifetime Medicare will cover the repair of the device
- Change in the patient's condition
  - Medical documentation

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## Coverage - Medicaid

- Funded jointly by the state & federal gov.
- Managed by the states
- Variations in coverage


## Coverage - Medicaid

Medicaid Coverage Scenarios:

- Surgery & device
- Surgery, not device (confusing!)
- Softband and sound processor as a hearing aid
  - Sometimes due to state mandates for ha coverage
- Age restrictions for both treatment methods

## Coding ✓
## Coverage ✓
## Payment ☐

## PAYMENT

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## Payment

- The $$$ amount paid to health care professionals or facilities for the provision of services
- Methodologies vary
- Like contract terms & conditions – payment is negotiable w/ private payers

- Importance of evaluating costs v. reimbursement rates during contract negotiation

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## Payment - Medicare

- **Fee Schedule:**
  - Listing of fees used by Medicare to pay doctors or other providers/suppliers
  - Fee for Service
- **Prospective Payment System:**
  - Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount
  - Payment amount is based on the classification system of that service - - like APC or DRG

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## Payment - Medicare Payment Methodologies

| | |
|---|---|
| Physician | Medicare Physician Fee Schedule |
| Hospital Outpt | Outpatient Prospective Payment System or OPPS<br>Ambulatory Payment Classifications or APCs |
| Ambulatory Surgery Ctr | Ambulatory Surgical Center System |
| Hospital Inpt | Inpatient Prospective Payment System or IPPS<br>Diagnosis Related Groupings or DRGs |

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## Medicare Physician Fee Schedule

| | 2013 Nat'l Payment Amount |
|---|---|
| 69714 | $ 1,109.15 |
| 69715 | $ 1,362.62 |
| 69717 | $ 1,161.89 |
| 69718 | $ 1,376.57 |

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## Medicare Physician Fee Schedule

Fee Schedule Look-Up:

Found at: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

- Search:
  - Pricing
  - National payment amount
  - Specific Carrier/Medicare Administrative Contractor (MAC)
  - Specific Carrier/Medicare Administrative Carrier (MAC) locality
  - Single, List or Range of codes
  - Modifiers

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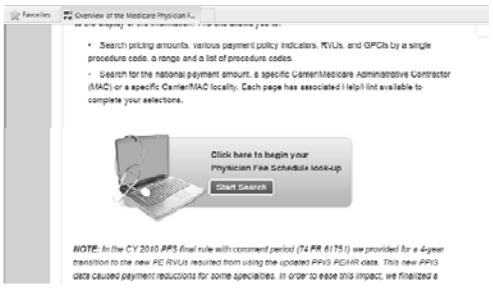
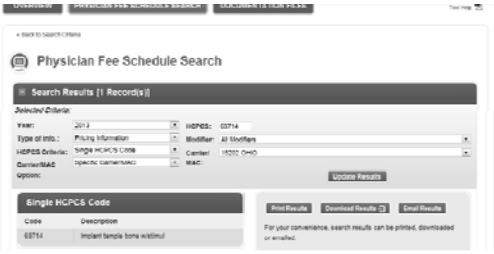
## Medicare Physician Fee Schedule





## Medicare Physician Fee Schedule



## Medicare Physician Fee Schedule

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## Medicare Physician Fee Schedule

Look up carrier via the Zip Code to Carrier Locality File found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html

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## Medicare – Hospital Outpt

### Ambulatory Payment Classifications or APCs

- Hospital Outpatient Prospective Payment System (HOPPS)
- Services in each APC are similar clinically and in terms of the resources they require
- A payment rate is established for each APC
- CPT codes map to APC

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## Medicare – Hospital Outpt

**APC includes:**

- Inexpensive drugs
- Med/Surg supplies
- Recovery Room
- Costs to procure donor tissue (execpt corneal tissue)
- Anesthesia
- IV Therapy
- Facilities are required to bill for services (above) but receive no payment

CMS may make changes to APCs and OPPS quarterly. Significant changes made at the start of each calendar year.

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## Medicare – Hospital Outpt

**69714 - 69718** map to APC 425

Effective 2013 National Average Payment for APC 425 is **$9,601.88***

Surgery and Device

*Found at: Addendum A.-Final OPPS APCs for CY 2013 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/January-2013-addendum-A.html

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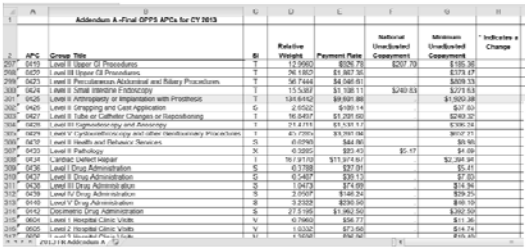
## Medicare – Hospital Outpt



| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 1 | Addendum A.-Final OPPS APCs for CY 2013 | | | | | | | |
| 2 | APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment | * Indicates a Change |
| 207 | 0419 | Level II Upper GI Procedures | T | 12.9660 | $926.73 | $207.70 | $185.36 | |
| 208 | 0420 | Level III Upper GI Procedures | T | 56.1803 | $4,017.35 | | $373.47 | |
| 209 | 0421 | Level II Percutaneous Abdominal and Biliary Procedures | T | 56.7444 | $4,057.81 | | $809.53 | |
| 338 | 0424 | Level II Small Intestine Endoscopy | T | 15.5387 | $1,108.11 | $240.83 | $273.63 | |
| 301 | 0425 | Level II Arthroplasty or Implantation with Prosthesis | T | 134.6452 | $9,601.88 | | $1,920.38 | |
| 302 | 0426 | Level II Grepping and Cast Application | G | 2.0522 | $180.14 | | $37.50 | |
| 303 | 0427 | Level II Tube or Catheter Changes or Repositioning | T | 16.8497 | $1,201.60 | | $240.32 | |
| 304 | 0428 | Level III Cystourethroscopy and Urodynamics | T | 21.4715 | $1,531.17 | | $306.24 | |
| 305 | 0429 | Level V Cystourethroscopy and other Genitourinary Procedures | T | 45.7395 | $3,261.94 | | $652.31 | |
| 306 | 0430 | Level II Health and Behavior Services | S | 0.0795 | $44.06 | | $8.96 | |
| 307 | 0433 | Level II Pathology | X | 0.5665 | $23.43 | $5.17 | $4.69 | |
| 308 | 0434 | Cardiac Defect Repair | T | 76.7170 | $11,974.67 | | $2,394.94 | |
| 309 | 0436 | Level I Drug Administration | S | 0.1788 | $27.91 | | $5.61 | |
| 310 | 0437 | Level II Drug Administration | S | 0.1457 | $39.13 | | $7.83 | |
| 311 | 0438 | Level III Drug Administration | S | 1.0473 | $74.69 | | $14.94 | |
| 312 | 0439 | Level IV Drug Administration | S | 3.0907 | $146.24 | | $29.25 | |
| 313 | 0440 | Level V Drug Administration | S | 3.3325 | $230.90 | | $46.18 | |
| 314 | 0442 | Osteomeng Drug Administration | S | 27.5195 | $1,962.50 | | $392.50 | |
| 315 | 0604 | Level 1 Hospital Clinic Visits | V | 0.7960 | $56.77 | | $11.36 | |
| 316 | 0605 | Level 2 Hospital Clinic Visits | V | 1.0332 | $73.66 | | $14.74 | |
| 317 | 0606 | Level 3 Hospital Clinic Visits | V | 1.5058 | $107.37 | | $21.48 | |
| 318 | | 2013 FR Addendum A | | | | | | |

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## Medicare – Ambulatory Surgery Ctr

- **ASC:**
  - A distinct entity established exclusively for outpatient surgical services
  - Certified to be a Medicare provider
  - Expanded list of services that can be done in an ASC (safety risks and medical monitoring)
- Payment
  - Based on the cpt code
  - Less than outpatient hospital site of service

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## Medicare – Ambulatory Surgery Ctr

Effective 2013 **69714 - 69718** are reimbursed $**7,888.90***
in an ASC.

Surgery and Device

*Found at: Addendum AA -- Final ASC Covered Surgical Procedures for CY 2013 (Including Surgical Procedures for Which Payment is Packaged) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html

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## Medicare – Ambulatory Surgery Ctr

**Addendum AA -- Final ASC Covered Surgical Procedures for CY 2013 (Including Surgical Procedures for Which Payment is Packaged) to Reflect Revised Payment Rates Based on Changes to the Medicare Physician Fee Schedule Created by the American Taxpayer Relief Act of 2012**

*CPT codes and descriptions only are copyright 2011 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2011/12 American Dental Association. All Rights Reserved.*

| | HCPCS Code | Short Descriptor | Subject to Multiple Procedure Discounting | Jan 2013 Payment Indicator | Jan 2013 Payment Weight | Jan 2013 Payment Rate |
|---|---|---|---|---|---|---|
| 3601 | 69714 | Implant temple bone w/stimul | Y | J8 | 183.8176 | $7,888.90 |
| 3602 | 69715 | Temple bne implnt w/stimulat | Y | J8 | 183.8176 | $7,888.90 |
| 3603 | 69717 | Temple bone implant revision | Y | J8 | 183.8176 | $7,888.90 |
| 3604 | 69718 | Revisc temple bone implant | Y | J8 | 183.8176 | $7,888.90 |
| 3605 | 69720 | Release facial nerve | Y | A2 | 42.8706 | $1,839.88 |
| 3606 | 69740 | Repair facial nerve | Y | A2 | 42.8706 | $1,839.88 |
| 3607 | 69745 | Renair facial nerve | Y | A2 | 42.8706 | $1,839.88 |

Jan 2013 ASC AA | Jan 2013 ASC 00 | Jan 2013 ASC 0108 | Jan 2013 ASC 0102 | Jan 2013 ASC EE

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## Medicare – Durable Medical Equipment

- CMS publishes Floor and Ceiling Rates and State rates

| | Floor | Ceiling |
|---|---|---|
| L8691 | $2,229.00 | $2,972.00 |
| L8692 | Non-Covered by Medicare | |
| L8693 | $1,267.52 | $1,690.03 |

Found at: DMEPOS Fee Schedules http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

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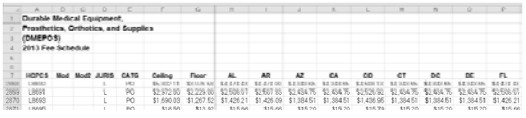
## Medicare – Durable Medical Equipment


Durable Medical Equipment,
Prosthetics, Orthotics, and Supplies
(DMEPOS)
2013 Fee Schedule

| HCPCS | Mod | Mod2 | JURIS | CATG | Ceiling | Floor |
|---|---|---|---|---|---|---|
| L8691 | | | L | PO | $2,972.00 | $2,229.00 |
| L8692 | | | L | PO | $1,690.03 | $1,267.52 |

*Jurisdiction: "L" = Local Part B Carrier jurisdiction*
*Category: "PO" = Prosthetics & Orthotics*

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## Medicare – find your local contacts

**Provider Compliance Group Interactive Map**

- Allows you to access state-specific CMS contractor contact information

Found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html#ks

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## Coding
## Coverage
## Payment

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### We've identified a patient – what next?

- Request benefit/coverage for specific codes
  - Benefits can vary for in-network v. out-of-network providers
- Provide required medical necessity documentation and verify coverage
- Understand the payment methodology and amount
- Is an pre-authorization or pre-certification required?
  - Clarify that procedure
- Document! Document! Document!
  - Contact person
  - Date/time
  - Summary of the conversation
  - Any reference numbers specific to the call

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### Oticon Medical Insurance Support

Assistance with the process of determining coverage and obtaining necessary pre-authorizations

Oticon Medical Insurance Support specialists

Oticon Medical
580 Howard Avenue
Somerset, New Jersey 08873
Phone: 1-888-277-8014
Fax: 1-732-868-6949

- Oticon Medical is now a Medicare Durable Medical Equipment provider

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# QUESTIONS?

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