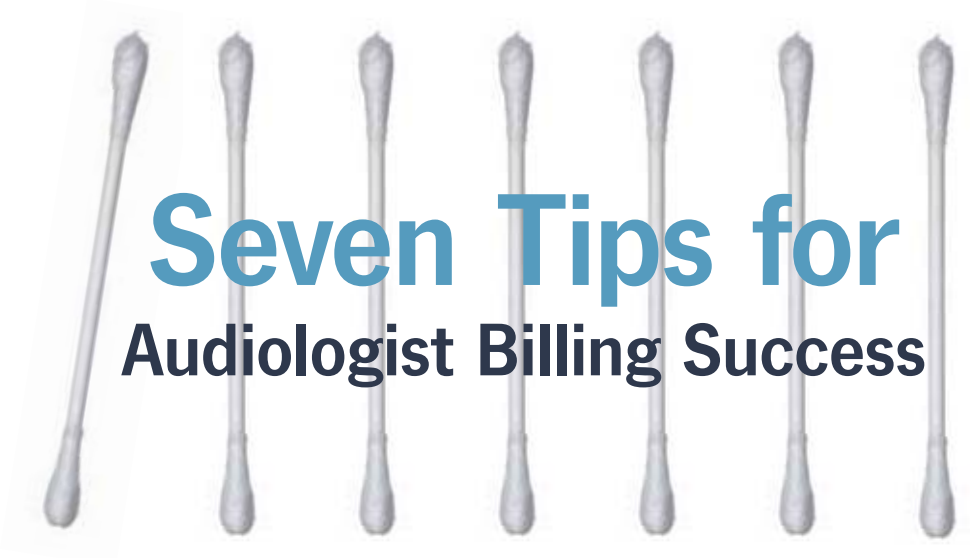

Seven Tips for Audiologist Billing Success

Listen to what Medicare rules your provider should follow.

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Medicare requirements for billing audiology services depend on the provider. What's good for an audiologist may not be good for a physician or non-physician, for example. Here are seven must-know tips for audiologists reporting services under Centers for Medicare & Medicaid Services (CMS) guidelines.

1. Audiologists Must Bill Medicare Directly

Audiologists may no longer bill Medicare for services incident-to a physician's services. Medicare now requires an audiologist to bill under his or her own National Provider Identifier (NPI) for all claims for services rendered as of Oct. 1, 2008 (*Medlearn Matters*, 2008). Audiologists must register an NPI prior to billing Medicare.

Resource tip: View *Medlearn Matters* July 18, 2008 article MM6061 at: www.cms.hhs.gov/MLNMattersArticles/downloads/MM6061.pdf.

Note: Private payers may allow for billing of an audiologist's services incident-to physician services. The information throughout this article is specific for Medicare payers. Consult individual private payer policies and contracts for guidance.

2. Audiologists Must Be Qualified

The Social Security Act (the Act) requires audiology services be provided by a "qualified audiologist." Section 1861(ll)(3) of the Act provides that a qualified audiologist is an individual with a master's or doctoral degree in audiology, according to CMS (Transmittal 84, 2008). "A Doctor of Audiology (AuD) 4th year student with a provisional license from a state does not qualify unless he or she also holds a master's or doctoral degree in audiology," reiterates CMS.

Transmittal 84 (sec. 80.3.1) defines a qualified audiologist as an individual who:

- Is licensed as an audiologist by the state in which the individual furnishes such services, or
- In the case of an individual who furnishes services in a state not licensing audiologists has:
  - completed successfully 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), and;
  - performed not less than nine months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and;
  - completed successfully a national examination in audiology approved by the secretary.

Transmittal 84 provides payers with direction to validate qualifications, and allows that audiology services also may be performed, "where it is allowed by state and local laws, by a physician or non-physician practitioner."

Different billing and coding guidelines apply for audiological aides, assistants, technicians, or others who do not meet the above qualifications.

Resource tip: View CMS Transmittal 84, issued Feb. 28, 2008 at: www.cms.hhs.gov/Transmittals/Downloads/R84BP.pdf.

3. Audiology Services Must Be Diagnostic

Chapter 15, section 80.3 of the *Medicare Benefits Policy Manual*, as updated by Transmittal 84, states, "Diagnostic services performed by a qualified audiologist and meeting the requirements at section 1861(ll)(3)(B) are payable as 'other diagnostic tests.'"

In contrast, "There is no provision in the law for Medicare to pay audiologists for therapeutic services." The policy manual continues, "For example, vestibular treatment, auditory rehabilitation and auditory processing treatment, while they are within the scope of practice of audiologists, are not diagnostic tests, and therefore, shall not be billed by audiologists to Medicare." In particular, audiologists may not bill Medicare for an Epley maneuver or canalith repositioning procedure (95992 *Canalith, repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*).

Note: Although CMS national policy does not allow Medicare payment to audiologists who perform therapeutic procedures, other payers may cover such services when performed by a qualified audiologist.

Transmittal 84 identifies payable audiological diagnostic tests as "tests of the audiological and vestibular systems, including hearing, balance, central auditory processing, tinnitus, and tests of certain prosthetic devices such as cochlear implants, osseointegrated auditory prosthetic devices and auditory brainstem implant devices, performed by qualified audiologists."

More specifically, covered tests include:

- Vestibular function (92541-92546, 92548)
- Audiologic tests (92552-92557, 92561-92585, 92587-92588, 92596)
- Cochlear implant (re)programming (92601-92604)
- Auditory processing, tinnitus (92620-92627, 92640)

Watch for exceptions: According to the policy manual, Medicare payment for audiological diagnostic tests is not allowed when:

- The type and severity of the current hearing, tinnitus, or balance status needed to determine the appropriate medical or surgical treatment is known to the physician before the test; or
- The test was ordered for the specific purpose of fitting or modifying a hearing aid.

On the latter point, Transmittal 84 qualifies, "It is appropriate to pay for audiological services for patients who have sensorineural hearing loss and who wear hearing aids if the reason for the test is anything other than evaluation of the hearing aid." As an example, a perceived change in hearing or tinnitus may be covered to rule out other causes (auditory nerve lesions, middle ear infections) and result in subsequent evaluation of the hearing aid (not covered) or aural rehabilitation by a speech-language pathologist.

4. Testing Must Be Ordered

A physician must order audiologic testing "for the purpose of obtaining information necessary for the physician's diagnostic medical evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem," according to the policy manual. The ordering physician would be identified in box 17 of the CMS-1500 claim form. A nonphysician practitioner (NPP) also may order testing "when the nonphysician practitioner orders diagnostic tests within their scope of practice, state and local laws and any policies applicable to the setting."

If a physician (or qualified NPP) orders a specific audiologic test, only that test may be provided on that order. An additional order is required if further testing is required.

For example, an otolaryngologist may want all patients with ear problems to have audiologic function testing before the patient sees the physician. This standing order is not allowed; a specific order for diagnostic testing must be provided by the physician prior to the performance of any audiologic testing.

When the physician orders diagnostic audiologic tests by an audiologist without naming specific tests, however, the audiologist may select the appropriate battery of tests, according to the policy manual, section 80.3.

If a beneficiary undergoes diagnostic testing performed by an audiologist without a physician (or qualified NPP) order, the tests are not covered, even if the audiologist discovers a pathologic condition.

5. Computer-administered Tests Don't Qualify

Computer-administered hearing tests do not require the skilled services of an audiologist, physician, or NPP, and are not coded as diagnostic audiologic testing. Specifically, codes 92557 *Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)*, 92567 *Tympanometry (impedance testing)*, 92568 *Acoustic reflex testing; threshold*, and 92587 *Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)* have been valued to include professional delivery not present in automated tests.

Examples of computer-administered tests include "otograms" and pure tone or immitance screening devices. The correct code to report computer-administered tests is 92700 *Unlisted otorhinolaryngological service or procedure.*

6. Provide Complete Service Documentation

The policy manual makes clear, "The reason for the test should be documented either on the order, on the audiological evaluation report, or in the patient's medical record." Reasons for testing may include evaluation of suspected change in hearing, tinnitus, or balance; evaluation of the cause of hearing, tinnitus, or balance disorders; determination of medication, surgery, or other treatment effects; and others.

Ideally, documentation for audiologic testing explains why the procedure was done, the equipment and work involved, outcomes, and any benefit provided to the patient. CMS guidelines require the medical record "identify the name and professional identity of the person who ordered and the person who actually performed the service."

7. Pay Attention to PC and TC Modifiers

Some audiology test codes include both a technical and a professional component. Such codes are identified readily in the National Physician Fee Schedule Relative Value File by the separate line item listings for modifiers TC *Technical component* and 26 *Professional component* under the primary code entry.

If the qualified audiologist performs the testing only using his or her own equipment, without interpreting the results, report the appropriate CPT® code with modifier TC. For example, an independent audiologist performs a positional nystagmus test for which an otolaryngologist provides the interpretation. The audiologist would report 92542-TC *Positional nystagmus test, minimum of 4 positions, with recording*, while the otolaryngologist would report 92542-26.

If the qualified audiologist both performs the testing and interprets the results using his or her own equipment, report the appropriate CPT® code with no modifier for the audiologist's service.

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