Robert C. Fifer, Ph.D.
University of Miami
Miami, Florida

BILLING AND CODING FOR REIMBURSEMENT

Pitfalls: Solicitation

- Forbidden solicitation scenarios
  - Health fair screenings
  - Quid pro quo
  - Exchange of money
  - Screening a nursing home or rehab center

Pitfall: Billing more than one code per procedure

- Basic principle #1: One procedure, one code
- Basic principle #2: See #1
- Ex: Rotational chair evaluation (inappropriate) recommendations have included
  - 92546 (4 units) Sinusoidal vertical axis rotational testing
  - 92270 Electro-oculography with interpretation and report

Electro-oculography

Ophthalmological diagnosis: The EOG is used to assess the function of the pigment epithelium. During dark adaptation, the resting potential decreases slightly and reaches a minimum ("dark trough") after several minutes. When the light is switched on, a substantial increase of the resting potential occurs ("light peak"), which drops off after a few minutes when the retina adapts to the light. The ratio of the voltages (i.e. *light peak* divided by *dark trough*) is known as the *Arden ratio*.

Electro-oculography

- Electro-Oculography is a procedure in which electrodes placed on the skin adjacent to the eyes measure changes in standing potential between the front and back of the eyeball as the eyes move; a sensitive electrical test for detection of retinal pigment epithelium dysfunction.

Contact/Units/Time for Correct Coding

- 92546 Sinusoidal vertical axis rotational testing
- 92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
- 92620 Evaluation of central auditory function, with report; initial 60 minutes

Pitfall: Inaccurate Guidelines

- Establishing guidelines on the basis of equipment capabilities rather than actual intent of code descriptor
- Ex: otoacoustic emissions
  - 4 frequencies = screening?
  - 6 frequencies = diagnostic?
  - Clinical question – asking if something could be wrong vs. mapping the cochlea

Pitfall: Graduate School Protocols

- Question: "Why did you do that?"
- Answer: "Because that is how I was taught to do it in graduate school. I don't feel comfortable doing it differently."
- Reality: Establish a clinical question and choose your procedures to answer that question.

Pitfall: Accuracy in Code Selection

- Accuracy problems occur when:
  - Code descriptor is translated at the local level
  - An in-house coding system is used rather than CPT, ICD-9, HCPCS
  - Descriptor is abbreviated in such a way that the meaning changes
- Solution: obtain current copy of CPT, ICD-9, and Level II HCPCS manuals (www.ama-assn.org)

Issue: Medicare Supp. Insurance Pays for Hearing Aids but must have denial

- Condition of participation (COP) requirements to have denial from Medicare
- Hearing aids are non-covered by law
- Medicare has provision for this circumstance
  - Report hearing aid code with GY modifier
  - GY means, "I know that you don't cover this, but I need your denial for COP requirements of supplemental insurance." (Fifer's loose paraphrase)

Example 3: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "cough". The chest x-ray reveals 3 cm peripheral pulmonary nodule. The radiologist should report a diagnosis of "pulmonary nodule" and may sequence "cough" as an additional diagnosis.

2. If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

Example 1: A patient is referred to a radiologist for a spine x-ray due to complaints of "back pain". The radiologist performs the x-ray, and the results are normal. The radiologist should report a diagnosis of "back pain" since this was the reason for performing the spine x-ray.

Example 2: A patient is seen in the ER for chest pain. An EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The patient was told to follow-up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for the EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

3. If the results of the diagnostic test are normal or non-diagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather, the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered by the ICD-9-CM Coding Guidelines as unconfirmed and should not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

Example: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "rule out pneumonia." The radiologist performs a chest x-ray, and the results are normal. The radiologist should report the sign(s) or symptom(s) that prompted the test (e.g., cough).

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2009 CPT Revisions

Introduction to Special Otorhinolaryngologic Services no longer includes:

"All services include medical diagnostic evaluation. Technical procedures (which may or may not be performed by the physician personally) are often part of the service but should not be mistaken to constitute the service itself."

2009 CPT Revisions

- The phrase, "With Observation and Evaluation by Physician" no longer precedes the Vestibular Function Tests Without Electrical Recording codes (92531 – 92534)
- The phrase, "and Medical Diagnostic Evaluation" no longer precedes the Vestibular Function Tests With Electrical Recording codes (92541 – 92548). The reference to "PENG" is also deleted
- The phrase, "With Medical Diagnostic Evaluation" no longer precedes the Audiologic Function Tests (92551 – 92596)

2009 CPT Addition

A new procedure code in the Other Procedures section of Neurology/Neurology and Neuromuscular Procedures:

- 95992 Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day

(Do not report 95992 in conjunction with 92531, 92532)

- Medicare payment decision.......

New code surveys

- About to complete surveys on new codes:
  - Combined vestibular code
  - Tymp, reflex threshold, reflex decay
  - Tymp, reflex threshold
- Need volunteers
  - nswanson@asha.org

Finally! Professional Work for SLPs

- Passage of MIPPA
- Independent provider status for SLPs
- Will be able to bill Medicare for services July 1, 2009
  - Special session on this Saturday noon – 1:00 PM in S105B/C, McCormick South
  - CMS and the AMA RUC have agreed we can now survey SLP codes for 'work'

Audiology and Work

- Audiology is now revising most procedures so that their values are in the professional component rather than the technical component
- 2008 saw work component RVUs accepted for
  - 92620 Central auditory function eval; initial 60 min
  - +92621 ...; each additional 15 minutes
  - 92625 Tinnitus assessment
  - 92626 AR eval; first hour
  - +92627 ...; each additional 15 minutes
  - 92640 Diagnostic analysis auditory brainstem implant, per hour

Professional Component (*"Work"*)

- Major element of reimbursement
- Core element of RBRVS
- Permits scaling of RVUs based on skill, effort, risk, and time
- Some AUD and SLP codes have work by virtue of "physician supervision"
  - Todd Klemp

Professional Component (*"Work"*)

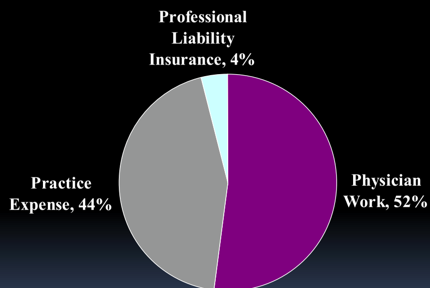
- Neither AUD nor SLP specifically authorized work RVUs in statute
- Previous payment for most AUD codes and some SLP codes via Non-Physician Work Pool
  - Considered practice expense and included some indirect costs plus malpractice RVUs

Professional Component (*"Work"*)

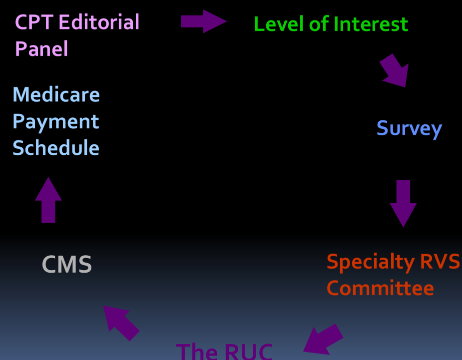
- Timing is good to be recognized for 'work' because:
  - Non-physician work pool being abolished
  - New formula for calculation of practice expense RVUs
  - Possibility / probability of reduction in reimbursement
- However, any SLP codes surveyed for work will not appear on fee schedule with revised values until 2010 at earliest

Components of the RBRVS

Percent of Total Relative Value



RUC Cycle



Audiology, SLP and the Medicare RBRVS

- Medicare differentiates between audiologists and speech-language-hearing pathologists (SLPs)
- Audiologists are recognized by Medicare as independent practitioners who can independently bill for diagnostic audiologic tests
  - diagnostic tests have to be performed with a physician referral and there is no provision for direct payment to audiologists for therapeutic services.
  - "Incident-to" does not apply to diagnostic audiologic tests and audiologists do not require physician supervision.
- SLPs are now recognized to bill as private practitioners

Medicare Payment

Non-Physician Work Pool (zero work pool)

- Pool created as an interim solution, to limit the significant reductions in PE RVUs for technical component codes and other codes that with zero physician work RVUs that would have occurred under the originally proposed top-down methodology
- Methodology was not resource-based
- Most codes have their costs allocated by a combination of the work RVU and the direct inputs

2009 Medicare Fee Schedule

Speech-Language Pathology

- How some SLP codes are impacted by the conversion factor ($36.0666):

CPT Code	Description	2008 Rate	2009 Rate
92506	Speech & language evaluation	$146.25	$147.15
92507	Speech & language treatment	$62.84	$61.31
92610	Dysphagia clinical evaluation	$100.93	$77.90
92526	Dysphagia treatment	$82.65	$78.26

2009 Medicare Fee Schedule

Speech-Language Pathology

- RVU changes in SLP procedures of note are:
  - **CPT 92506 -** Speech and Language Evaluation total RVU increases to 4.08 from 3.84, and payment increases to $147.15 from $146.25
  - **CPT 92507 -** Speech and Language Treatment RVU has modest increase to 1.70 from 1.65, but payment will decrease to $61.31 from $62.85
  - **CPT 92610 –** Dysphagia clinical evaluation RVU decreases to 2.16 from 2.65 and the rate decreases from $100.93 to $77.90
  - **CPT 92526 –** Dysphagia treatment RVU remains 2.17 and the rate decreases from $82.65 to $78.26

2009 Medicare Fee Schedule

Audiology

- How some audiology codes are impacted by the conversion factor ($36.0666):

CPT Code	Description	2008 Rate	2009 Rate
92557	Comprehensive audiometry	$52.88	$45.08
92569	Acoustic reflex decay	$17.52	$14.43
92620	Central auditory function (first hour)	$60.94	$85.98
92626	Evaluation of auditory rehabilitation status (first hour)	$82.27	$91.61

2009 Medicare Fee Schedule

Audiology

- RVU changes in audiology procedures of note are:
  - **CPT 92557 –** Comprehensive audiometry total RVU decreases to 1.25 from 1.39 and payment decreases to $45.08 from $52.88
  - **CPT 92569 –** Acoustic reflex decay total RVU decreases to 0.40 from 0.46 and payment decreases to $14.43 from $17.52
  - **CPT 92620 –** Central auditory function (1st hour) total RVU increases to 2.38 from 1.60 and payment increases to $85.98 from $60.94
  - **CPT 92626 –** Auditory rehabilitation status (1st hour) to RVU increases to 2.54 from 2.16 and payment increases to $91.61 from $82.27