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2010 Medicare Fee Schedule *and* Hospital Outpatient Prospective Payment System for Audiologists

This ASHA document provides an overview of both the *2010 Medicare Physician Fee Schedule (MPFS)* and the *Hospital Outpatient Prospective Payment System (OPPS)*, comments on relevant revisions, and reproduces a listing of all the procedures used by audiologists, the actual national average payment amounts, describes three methods for accessing the exact payment figure based on your geographic location, and includes a convenient link to an ASHA table of Medicare audiology coding rules.

Please check the ASHA Billing and Reimbursement Web site at <http://www.asha.org/practice/reimbursement/medicare> for the most up-to-date information. The rates published here, pursuant to legislation enacted in late December, are in effect only for January-February 2010. For additional information, please contact the Health Care Economics and Advocacy Team by e-mail at reimbursement@asha.org.

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Medicare Physician Fee Schedule

OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) issued the 2010 Outpatient Medicare Physician Fee Schedule (MPFS) for Part B services on October 30, 2009 with a 21.2% reduction in the conversion factor that affects all services paid under the physician fee schedule. This reduction was overridden on a temporary basis by a section of the Department of Defense Appropriations Act of 2010, signed into law December 23, 2009. The legislation, maintaining the 2009 conversion factor (\$36.0666), is a temporary fix because it is in effect only for services rendered January-February 2010. Please continue to check for updates to this document at <http://www.asha.org/practice/reimbursement/medicare/feeschedule.htm>.

The MPFS payment rates apply to audiology Medicare Part B services except for those audiology services provided to hospital outpatients under the hospital HOPPS. **Tables 1 – 4** relate to the MPFS and **Table 5** provides the audiology HOPPS payment rates and methodology.

“Work component” by audiologists: ASHA, through its Health Care Economics Committee (HCEC), had successfully advocated that services rendered by audiologists should be valued as professional rather than technical by Medicare. ASHA, the American Academy of Audiology (AAA), and the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) surveyed work RVUs for several procedures last year and additional procedures this year. Some codes with newly assigned work RVUs saw an increase of 30 to 40% in 2009.

Because the nonphysician work pool was eliminated in 2008, CMS will continue to transition the nonphysician work codes over the next three years. This will reduce the technical component RVUs.

NEW DEVELOPMENTS

CPT Codes

Audiologists will be reporting three new Current Procedural Terminology (CPT ©) codes starting January 1, 2009. The codes describe well known procedures that CMS found are usually (over 95% in the Medicare population) billed in combination with one another. The new codes are:

92540 Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording. (Do not report 92540 in conjunction with 92541, 92542, 93544, or 92545)

92550 Tympanometry and reflex threshold measurements (Do not report 92550 in conjunction with 92567, 92568)

92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing (Do not report 92570 in conjunction with 92567, 92568)

92569 Acoustic reflex testing, decay has been deleted. Audiologists should now use CPT 92570, since acoustic reflex decay testing is always done in conjunction with tympanometry and acoustic reflex threshold testing.

Again, ASHA collaborated with AAA and AAO-HNS in the development of and the valuation for the combined procedures. The new codes are the result of a CMS request that the American Medical Association (AMA) CPT Editorial Panel and the AMA Specialty Society Relative Value Scale (RVS) Update Committee (RUC) establish bundled codes and recommend relative values for the new procedures.

Physician Quality Reporting Initiative (PQRI)

For 2010, private practice audiologists enrolled as Medicare suppliers will be able to participate in the Medicare Physician Quality Reporting Initiative (PQRI) program, a voluntary program designed to improve the quality of care to Medicare beneficiaries. Private practice health care professionals who participate in PQRI by reporting on approved quality measures are eligible for a 2% incentive payment. Audiologists will be able to report on three measures that call for referral of patients to a physician after an audiological evaluation finds one of three conditions:

- congenital or traumatic deformity of the ear;
- history of active drainage from the ear within the previous 90 days (for patients who have disease of the ear and mastoid processes); or
- history of sudden or rapidly progressive hearing loss.

Audiology Timed Codes

CMS cautions audiologists on calculating time attributed to the five timed audiology evaluation codes; CMS accepted the professional component RVUs for these codes in the 2009 fee schedule. In the 2010 fee schedule, CMS stresses that activities such as counseling, establishment of interventional goals, or evaluating potential for remediation are not included as diagnostic tests, and that time spent on these activities should not be included in billing for:

- 92620 (evaluation of central auditory function, with report; initial 60 minutes)
- 92621 (evaluation of central auditory function, with report; each additional 15 minutes)
- 92626 (evaluation of auditory rehabilitation status; first hour)
- 92627 (evaluation of auditory rehabilitation status; each additional 15 minutes)
- 92640 (diagnostic analysis with programming of auditory brainstem implant, per hour).

SUMMARY OF TABLES

Table 1 illustrates the impact on payment for audiology services when not accepting Medicare assignment.

Table 2 is a topical list of codes used by audiologists and related health care professionals. The codes are grouped to differentiate the audiology categories.

Table 3 is the complete list of procedures in numerical order with the RVUs and national fee data.

Table 4 lists the geographic adjustments indices for the MPFS.

Table 5 is a list of hospital 2010 audiology HOPPS payment rates grouped by ambulatory payment classifications (APCs).

Table 6 lists relevant APCs under hospital HOPPS.

PAYMENT RULES OF THE MEDICARE PHYSICIAN FEE SCHEDULE

The Medicare Physician Fee Schedule (MPFS), also referred to as the Physician Fee Schedule or Medicare Fee Schedule, is based on Current Procedural Terminology (CPT) codes in the Health Care Common Procedural Coding System (HCPCS).¹ The MPFS has set

¹ HCPCS Level I: CPT Codes

Medicare Part B² prospective payment rates since 1992 for audiologists, physicians, other private practitioners and medical clinics. Reimbursement for outpatient rehabilitation services in such facilities as hospitals, skilled nursing facilities, and rehabilitation agencies was included in the MPFS in 1999. The MPFS includes both facility and non-facility rates. CMS determined that the higher non-facility rates apply to audiology and speech-language pathology services (as well as to physical therapy and occupational therapy) even when rendered in a facility³. Hospital-based outpatient audiology services are paid under the outpatient prospective payment system (OPPS) – see **Table 5**.

Standard 20% Copayment

All Part B services require the patient to pay a 20% copayment. The fee schedule does not deduct the copayment amount. Therefore, the actual payment by Medicare is 20% less than shown in this fee schedule.

Geographic Adjustment of the Fee Schedule

You may request a fee schedule adjusted for your geographic area from the Medicare carrier or fiscal intermediary that processes your claims. You may also calculate your rate using the example at **Table 4**. The CMS web site provides another method for determining your rate at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp. Click “accept” at the bottom of the page. From there you select HCPCS (CPT) codes and your locality for a list of your precise payment rates.

In general, specific urban areas with high labor costs will have payment rates 5% to 10% above the national average. Conversely, rural states and rural areas have rates lower than the national average. (See **Table 4 – Geographic Practice Cost Indices**)

HCPCS Level II: Alphanumeric codes developed by CMS for equipment, supplies, and procedures not described in CPT Codes.

² Medicare Part B covers outpatient services and inpatient physician visits. Rehabilitation and diagnostic services are covered by Part B after depletion of the Part A 100-day skilled nursing facility stay or 90-day hospital stay or disqualification of skilled nursing status.

³ *Federal Register*, July 22, 1999 (p. 39623)

“Limiting Charge”

Independent audiologists paid by Medicare as private practitioners under the fee schedule may elect to be “nonparticipating” even though enrolled as a Medicare supplier. This status allows payment at a higher rate than specified in the fee schedule if the audiologist does *not* accept assignment. Medicare payment is made directly to the provider when accepting assignment instead of the patient (except the 20% co-payment for which all Part B patients are responsible).

Nonparticipating audiologists who do not accept assignment can add a *limiting charge* of up to 15% to the total fee schedule amount, as long as the 115% result does not surpass the audiologist’s customary fee for that particular CPT code. The net gain for the audiologist is 9.25% (not 15%) because nonparticipating practitioners are reimbursed at 95% of the fee schedule amount.

The following calculations in **Table 1** illustrate fees without and with the limiting charge add-on.

Table 1: Impact of Assignment on Medicare Payments

	Scenario 1: <i>Participating Provider Accepts Assignment (not entitled to limiting charge add-on)</i>	Scenario 2: <i>Nonparticipating Provider Accepts Assignment (not entitled to limiting charge add-on)</i>	Scenario 3: <i>Nonparticipating Provider Does Not Accept Assignment (thus, entitled to limiting charge add-on)</i>
Fee Schedule Amount	\$100	\$100	\$100
Total Allowed Payment	\$100	\$100 x 95% = \$95	\$100 x 95% x 115% = \$109.25 total allowed payment
Medicare Pays	80% x \$100 = \$80	80% x \$95 = \$76	Not applicable
Patient Pays	20% x \$100 = \$20	20% x \$95 = \$19	\$76 + \$19 (20% co-pay x \$95) + \$14.25 limiting charge add-on = \$109.25

Modifiers

Most CPT codes represent “typical” visit lengths or times to conduct a typical test, unless time is specified in the CPT descriptor. For significantly atypical procedures, a **modifier “-22”** can be used to indicate much longer than normal procedures and a **“-52” modifier** for an abbreviated procedure. For modifier “-22” claims, a full description of the procedure rendered should be submitted with the claim. Modifier “-22” should not be used frequently because a fiscal intermediary or carrier could make the determination that the procedure reflects typical service delivery. **Modifier “-59”** is used to establish one procedure as distinct from another billed on the same day.

Medicare CPT Coding Rules

Medicare and the AMA have established rules for using specific CPT codes. The Medicare rule always supersedes the AMA rule when billing Medicare. ASHA’s Billing & Reimbursement Web site includes the

full CPT descriptors and rules for their appropriate usage at:

http://www.asha.org/practice/reimbursement/medicare/Aud_coding_rules.htm. Note that many third party payers selectively adopt Medicare coding rules.

CCI Edits

CMS uses an automated edit system to control specific code pairs that can be reported on the same day. CCI has been in place since January 1, 1996, and is updated quarterly. The goal of the National Correct Coding Initiative (NCCI or, more commonly, CCI) is to prevent payment of “mutually exclusive” code pairings or otherwise inappropriate pairs to be delivered to the same patient on the same day. As of 2006, the edits apply to all Part B settings, not just physician offices and hospitals.

Prior to 2006, CCI edits were limited to services reimbursed by carriers (e.g., physician offices and private practice audiologists). Now, all provider settings are affected.

The ASHA Web site includes a comprehensive list of CCI edits that apply to audiology. Go to: http://www.asha.org/practice/reimbursement/coding/CCI_edits_AUD.htm

A complete list of code edits for Part B services other than those billed by hospitals is found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIIEP/list.asp>. The Outpatient Code Editor (OCE) applies only to hospital outpatient services. Typically, the OCE edits for audiology and speech-language pathology are similar to those in the CCI system. The OCE revisions also occur quarterly but one quarter after the revised CCI edits are implemented. See <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIIEHOPPS/list.asp> for the full OCE edits. See box following the table below for assistance in deciphering the list of code edits on the CMS Web site.

Designation of Time

The CPT/HCPCS procedures for audiology do not include time designations except for evaluation of central auditory function (92620 and 92621), evaluation of auditory rehabilitation status (92626 and 92627), and programming of auditory brainstem implants (92640). Other procedures represent the generally typical time for performing the test.

Relationship to Non-Medicare Payers

Many state Medicaid programs and private health plans, including HMOs and PPOs, have adopted the

MPFS while designating their own conversion factor. ASHA members may wish to negotiate with non-Medicare payers. Audiologists may request that payers negotiate their rates using such resources as the ASHA publication, *Negotiating Health Care Contracts and Calculating Fees: A Guide for Speech-Language Pathologists and Audiologists*, rather than adopt the MPFS rankings. This publication (Item #0112450) can be ordered from ASHA Product Sales at 1-888-498-6699 or online at <http://www.asha.org/shop>.

ASHA Participation in American Medical Association Relative Value Committees

ASHA represents the audiology profession at both the AMA Relative Value Update Committee (RUC) and the AMA CPT Editorial Panel. The ASHA Health Care Economics Committee coordinates recommendations from ASHA members and related audiology organizations in developing new procedures for adoption by the CPT Editorial Panel. The Committee also conducts surveys and holds consensus panel meetings to develop data that are presented to the AMA and CMS to develop fees. Audiology members of the HCEC in 2010 are Leisha Eiten, Robert Fifer (ASHA advisor to the AMA RUC HCPAC Review Board), Richard Hogan, Neil Shepard, and Chair, Stuart Trembath. For further information, contact Steven White, ex officio member of the HCEC and Director of the Health Care Economics & Advocacy Team, at swhite@asha.org.

Table 2: Topical List of Codes[♦]

Vestibular Function Studies	Audiometric Tests			Electrophysiology/Audio-metric Tests	Audiology Related	Aural Rehabilitation	Implant Services
92540	92550	92562	92575	92584	69210 ⁴	92626	92601
92541	92551	92563	92576	92585		92627	92602
92542	92552	92564	92577	92586			92603
92543	92553	92565	92579	92587			92604
92544	92555	92567	92582	92588			92640
92545	92556	92568	92583				
92546	92557	92569	92596				
92547	92559	92570	92620				
92548	92560	92571	92621				
	92561	92572	92625				

⁴ CPT 69210: Current CMS policy considers removal of cerumen a component of audiologic diagnostic testing and not paid separately. Under Medicare, CPT 69210, "Removal of impacted cerumen, one or both ears," is not recognized.

2010 MEDICARE RELATIVE UNITS (RVU) & FEE CALCULATIONS

The MPFS uses a resource-based relative value scale (RBRVS) that assigns a relative value to each current procedural terminology (CPT) procedure. The relative weighting factor (relative value unit or RVU) is derived from a resource-based relative value scale (see **Table 3**).

The RBRVS divides each procedure into three RVU components:

- The professional component also known as physician work that encompasses time, technical skill, physical effort, stress, and judgment on the part of the physician or other qualified health care professional;
- The technical component also known as practice expense that includes overhead costs and non-physician medical staff time costs; and
- The professional liability component or malpractice costs

The RVUs for the three components are summed for the CPT procedure total RVU and then multiplied by the annual conversion factor.

There are some diagnostic tests for which the main payment is composed of all three parts, the professional/physician component, technical component and malpractice component. Starting in 2008 all audiometric procedures will no longer be composed of the technical and malpractice components only. The following procedures now are valued primarily for professional work:

- | | |
|---------|---------|
| • 92540 | • 92602 |
| • 92550 | • 92603 |
| • 92557 | • 92604 |
| • 92567 | • 92621 |
| • 92568 | • 92625 |
| • 92569 | • 92626 |
| • 92570 | • 92627 |
| • 92601 | • 92640 |

**Jan. – Feb. 2010 Temporary Conversion Factor:
\$36.0666**

Table 3: 2010 Medicare Physician Fee Schedule*

**Jan. – Feb. 2010 Temporary Conversion Factor:
\$36.0666**

Modifiers:
26 = “Professional component,” the portion of diagnostic test that involves a physician’s work and allocation of the practice expense.
TC = “Technical component,” for diagnostic tests, the portion of a procedure that does not include a physician’s participation. The TC value is the difference between the global values and the professional component (26).
No Modifier = “Global value,” includes both professional and technical components.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in table 5)
69210 ⁵		Remove impacted ear wax(See note in Table 2)	0.61	0.63	0.06	1.30	\$46.89
92506 ⁵		Speech, lang., aud. process evaluation	0.86	3.37	0.05	4.28	\$154.37
92507 ⁵		Speech, lang., aud process treatment	0.52	1.23	0.02	1.77	\$63.84
92508 ⁵		Speech/hearing treatment, group	0.26	0.60	0.01	0.87	\$31.38
92516		Facial nerve function test	0.43	1.24	0.02	1.69	\$60.95
92540		Basic vestibular evaluation	1.50	1.09	0.04	2.63	\$94.86
92540	26	Basic vestibular evaluation	1.50	0.64	0.03	2.17	\$78.26
92540	TC	Basic vestibular evaluation	0.00	0.45	0.01	0.46	\$16.59
92541		Spontaneous nystagmus test	0.40	0.97	0.02	1.39	\$50.13
92541	26	Spontaneous nystagmus test	0.40	0.15	0.01	0.56	\$20.20
92541	TC	Spontaneous nystagmus test	0.00	0.82	0.01	0.83	\$29.94
92542		Positional nystagmus test	0.33	1.07	0.02	1.42	\$51.21
92542	26	Positional nystagmus test	0.33	0.13	0.01	0.47	\$16.95
92542	TC	Positional nystagmus test	0.00	0.94	0.01	0.95	\$34.26
92543		Caloric vestibular test	0.10	0.55	0.02	0.67	\$24.16

⁵ Medicare does not cover these services under the audiology benefit.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in table 5)
92543	26	Caloric vestibular test	0.10	0.04	0.01	0.15	\$5.41
92543	TC	Caloric vestibular test	0.00	0.51	0.01	0.52	\$18.75
92544		Optokinetic nystagmus test	0.26	0.87	0.02	1.15	\$41.48
92544	26	Optokinetic nystagmus test	0.26	0.10	0.01	0.37	\$13.34
92544	TC	Optokinetic nystagmus test	0.00	0.77	0.01	0.78	\$28.13
92545		Oscillating tracking test	0.23	0.83	0.02	1.08	\$38.95
92545	26	Oscillating tracking test	0.23	0.09	0.01	0.33	\$11.90
92545	TC	Oscillating tracking test	0.00	0.74	0.01	0.75	\$27.05
92546		Sinusoidal rotational test	0.29	2.01	0.02	2.32	\$83.67
92546	26	Sinusoidal rotational test	0.29	0.11	0.01	0.41	\$14.79
92546	TC	Sinusoidal rotational test	0.00	1.90	0.01	1.91	\$68.89
92547		Supplemental electrical test	0.00	0.11	0.01	0.12	\$4.33
92548		Posturography	0.50	2.01	0.02	2.53	\$91.25
92548	26	Posturography	0.50	0.19	0.01	0.70	\$25.25
92548	TC	Posturography	0.00	1.82	0.01	1.83	\$66.00
92550		Tympanometry & reflex threshold	0.35	0.21	0.01	0.57	\$20.56
92551 ⁶		Pure tone hearing test, air (screening)	0.00	0.28	0.01	0.29	\$10.46
92552		Pure tone audiometry, air	0.00	0.59	0.01	0.60	\$21.64
92553		Audiometry, air & bone	0.00	0.76	0.01	0.77	\$27.77
92555		Speech threshold audiometry	0.00	0.42	0.01	0.43	\$15.51
92556		Speech audiometry, complete	0.00	0.65	0.01	0.66	\$23.80
92557		Comprehensive hearing test	0.60	0.50	0.02	1.12	\$40.39
92559		Group audiometric testing	0.00	0.00	0.00	0.00	0.00
92560		Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00

⁶ Medicare does not cover these services under the audiology benefit.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in table 5)
92561		Bekesy audiometry, diagnosis	0.00	0.76	0.01	0.77	\$27.77
92562		Loudness balance test	0.00	0.69	0.01	0.70	\$25.25
92563		Tone decay hearing test	0.00	0.57	0.01	0.58	\$20.92
92564		SISI hearing test	0.00	0.53	0.01	0.54	\$19.48
92565		Stenger test, pure tone	0.00	0.32	0.01	0.33	\$11.90
92567		Tympanometry	0.20	0.22	0.01	0.43	\$15.51
92568		Acoustic reflex testing	0.29	0.16	0.01	0.46	\$16.59
92570		Acoustic immittance testing	0.55	0.30	0.02	0.87	\$31.38
92571		Filtered speech hearing test	0.00	0.44	0.01	0.45	\$16.23
92572		Staggered spondaic word test	0.00	0.62	0.01	0.63	\$22.72
92575		Sensorineural acuity test	0.00	1.06	0.01	1.07	\$38.59
92576		Synthetic sentence test	0.00	0.59	0.01	0.60	\$21.64
92577		Stenger test, speech	0.00	0.40	0.01	0.41	\$14.79
92579		Visual audiometry (VRA)	0.70	0.47	0.03	1.20	\$43.28
92582		Conditioning play audiometry	0.00	1.15	0.01	1.16	\$41.84
92583		Select picture audiometry	0.00	0.88	0.01	0.89	\$32.10
92584		Electrocochleography	0.00	1.64	0.01	1.65	\$59.51
92585		Auditory evoked potentials, comprehensive	0.50	2.22	0.02	2.74	\$98.82
92585	26	Auditory evoked potentials, comprehensive	0.50	0.19	0.01	0.70	\$25.25
92585	TC	Auditory evoked potentials, comprehensive	0.00	2.03	0.01	2.04	\$73.58
92586		Auditory evoked potentials, limit	0.00	1.65	0.01	1.66	\$59.87
92587		Evoked autoacoustic emiss, limited	0.13	0.81	0.02	0.96	\$34.62
92587	26	Evoked autoacoustic emiss, limited	0.13	0.05	0.01	0.19	\$6.85
92587	TC	Evoked autoacoustic emiss, limited	0.00	0.76	0.01	0.77	\$27.77
92588		Evoked autoacoustic emiss, comp.	0.36	1.28	0.02	1.66	\$59.87

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in table 5)
92588	26	Evoked autoacoustic emiss, comp.	0.36	0.14	0.01	0.51	\$18.39
92588	TC	Evoked autoacoustic emiss, comp.	0.00	1.14	0.01	1.15	\$41.48
92596		Ear protector evaluation	0.00	1.03	0.01	1.04	\$37.51
92601		Cochlear implant follow-up exam, pt under 7 yrs of age	2.30	1.79	0.09	4.18	\$150.76
92602		Reprogram cochlear implant, pt under 7 yrs of age	1.30	1.27	0.05	2.62	\$94.49
92603		Cochlear implant follow-up exam, pt 7 yrs of age or older	2.25	1.51	0.09	3.85	\$138.86
92604		Reprogram cochlear implant, pt 7 yrs of age or older	1.25	0.97	0.05	2.27	\$81.87
92620		Auditory function, 60 min	1.50	0.58	0.06	2.14	\$77.18
92621		Auditory function, + 15 min	0.35	0.13	0.01	0.49	\$17.67
92625		Tinnitus assessment	1.15	0.47	0.04	1.66	\$59.87
92626 ⁷		Evaluation of auditory rehab status, 1 st hr	1.40	0.79	0.05	2.24	\$80.79
92627 ⁷		Evaluation of auditory rehab status add-on, each 15 min	0.33	0.20	0.01	0.54	\$19.48
92630 ⁸		Auditory rehab, pre-lingual hearing loss	0.00	0.00	0.00	0.00	0.00
92633 ⁸		Auditory rehab, post-lingual hearing loss	0.00	0.00	0.00	0.00	0.00
92640		Brainstem implant programming, per hr.	1.76	0.44	0.27	2.47	\$89.08
95920		Intraop nerve test add-on, per hr.	2.11	1.95	0.07	4.13	\$148.96
95920	26	Intraop nerve test add-on	2.11	0.75	0.06	2.92	\$105.31
95920	TC	Intraop nerve test add-on	0.00	1.20	0.01	1.21	\$43.64

⁷ New in 2006. Audiologists may use these evaluation codes.

⁸ Medicare does not cover these services under the audiology benefit.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in table 5)
95925		Somatosensory testing	0.54	3.00	0.03	3.57	\$128.76
95925	26	Somatosensory testing	0.54	0.19	0.01	0.74	\$26.69
95925	TC	Somatosensory testing	0.00	2.81	0.02	2.83	\$102.07
95926		Somatosensory testing	0.54	2.92	0.03	3.49	\$125.87
95926	26	Somatosensory testing	0.54	0.19	0.01	0.74	\$26.69
95926	TC	Somatosensory testing	0.00	2.73	0.02	2.75	\$99.18
95927		Somatosensory testing	0.54	2.84	0.03	3.41	\$122.99
95927	26	Somatosensory testing in the trunk or head	0.54	0.20	0.01	0.75	\$27.05
95927	TC	Somatosensory testing in the trunk or head	0.00	2.64	0.02	2.66	\$95.94
95930		Visual evoked potential test	0.35	2.74	0.02	3.11	\$112.17
95930	26	Visual evoked potential test	0.35	0.13	0.01	0.49	\$17.67
95930	TC	Visual evoked potential test	0.00	2.61	0.01	2.62	\$94.49
95934		H-reflex test	0.51	0.86	0.02	1.39	\$50.13
95934	26	H-reflex test	0.51	0.19	0.01	0.71	\$25.61
95934	TC	H-reflex test	0.00	0.67	0.01	0.68	\$24.53
95936		H-reflex test, not g/s muscle	0.55	0.62	0.02	1.19	\$42.92
95936	26	H-reflex test, not g/s muscle	0.55	0.20	0.01	0.76	\$27.41
95936	TC	H-reflex test, not g/s muscle	0.00	0.42	0.01	0.43	\$15.51
95937		Neuromuscular junction test	0.65	0.91	0.04	1.60	\$57.71
95937	26	Neuromuscular junction test	0.65	0.23	0.03	0.91	\$32.82
95937	TC	Neuromuscular junction test	0.00	0.68	0.01	0.69	\$24.89

Geographic Adjustment Calculations

The method for calculating geographic adjustments is illustrated below. Precise payment rates by locality are also available at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp.

- ✓ Click “Accept” at bottom of page.
- ✓ Choose your “HCPC (CPT code) criteria” and select “Pricing Information”
- ✓ Select specific LOCALITY
- ✓ Enter the code or codes you are looking for, choose “All modifiers”, and select locality

In the results, the “Non-Facility Price” is for services rendered in a private office setting. The “Facility Price” is for services in a facility *except* for hospital outpatient departments where payments are determined by the HOPPS as shown in **Table 5** below.

Example: Calculating geographic adjustments

CPT Description and Geographic Index	Work RVUs	Practice RVUs	Malpractice RVUs	Total RVUs	2010 Conversion Factor	Adjusted Fee
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CPT 92567

Tympanometry →

0.20 0.22 0.01

Alabama index →

$\frac{x0.982}{\quad}$ $\frac{x0.853}{\quad}$ $\frac{x0.496}{\quad}$

Alabama RVUs →

0.1964 + 0.18766 + 0.00496 = 0.38902 x \$36.0666 = **\$14.03**

Table 4: 2010 Geographic Cost Indices

Carrier No.	Locality No.	Locality Name	Work ^{**}	Practice Expense	Malpractice
10102	00	Alabama	0.982	0.853	0.496
00831	01	Alaska	1.500	1.090	0.646
03102	00	Arizona	0.988	0.957	0.822
00520	13	Arkansas	0.961	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California [*]	1.007	1.058	0.549
01192	99	Rest of California [*]	1.007	1.058	0.549

** CY 2010 work GPCI does not reflect the 1.000 floor established by the MIPPA which expires 01/01/10 and reflects 1.500 floor in Alaska established by the MIPPA.

* Indicates multiple contractors.

Carrier No.	Locality No.	Locality Name	Work**	Practice Expense	Malpractice
04102	01	Colorado	0.986	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
09102	03	Fort Lauderdale, FL	0.989	1.018	2.250
09102	04	Miami, FL	1.000	1.069	3.167
09102	99	Rest of Florida	0.973	0.939	1.724
10202	01	Atlanta, GA	1.009	1.014	0.836
10202	99	Rest of Georgia	0.979	0.883	0.829
01202	01	Hawaii/Guam	0.998	1.161	0.665
05130	00	Idaho	0.967	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	0.989	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	0.975	0.880	1.219
00630	00	Indiana	0.986	0.918	0.599
05102	00	Iowa	0.965	0.870	0.434
05202	00	Kansas	0.969	0.882	0.557
00660	00	Kentucky	0.969	0.860	0.652
00528	01	New Orleans, LA	0.986	1.044	0.956
00528	99	Rest of Louisiana	0.970	0.878	0.892
14102	03	Southern Maine	0.980	1.025	0.492
14102	99	Rest of Maine	0.962	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	0.994	0.982	0.874
14202	01	Metropolitan Boston	1.029	1.291	0.764
14202	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	0.998	0.923	1.083
00954	00	Minnesota	0.992	0.983	0.245
00512	00	Mississippi	0.959	0.854	0.808
05302	02	Metropolitan Kansas City, MO	0.990	0.945	1.188
05302	01	Metropolitan St Louis, MO	0.993	0.931	1.075
05302	99	Rest of Missouri*	0.949	0.821	0.997
03202	01	Montana	0.950	0.847	0.673
05402	00	Nebraska	0.959	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
14302	40	New Hampshire	0.982	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116

* Indicates multiple contractors.

Carrier No.	Locality No.	Locality Name	Work**	Practice Expense	Malpractice
04202	05	New Mexico	0.973	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	0.997	0.921	0.425
05535	00	North Carolina	0.972	0.925	0.634
03302	01	North Dakota	0.947	0.844	0.387
00883	00	Ohio	0.993	0.927	1.232
04302	00	Oklahoma	0.964	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	0.968	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	0.993	0.925	1.081
09202	20	Puerto Rico	0.904	0.694	0.250
14402	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	0.975	0.906	0.446
03402	02	South Dakota	0.942	0.864	0.420
10302	35	Tennessee	0.978	0.889	0.608
04402	31	Austin, TX	0.992	0.984	0.969
04402	20	Beaumont, TX	0.984	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	0.998	0.953	1.110
04402	15	Galveston, TX	0.991	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	0.968	0.879	1.065
03502	09	Utah	0.977	0.907	1.026
14502	50	Vermont	0.968	0.983	0.489
00904	00	Virginia	0.982	0.942	0.657
09202	50	Virgin Islands	0.997	0.978	1.009
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	0.987	0.974	0.693
00884	16	West Virginia	0.973	0.827	1.353
00951	00	Wisconsin	0.988	0.921	0.409
03602	21	Wyoming	0.956	0.842	0.889
04402	28	Fort Worth, TX	0.998	0.953	1.110

Hospital Outpatient Prospective Payment System

Payment for hospital-based outpatient audiology services are made under the Hospital Outpatient Prospective Payment System (OPPS). Under OPPS, payment is determined by assignment of the CPT code to an Ambulatory Payment Classification (APC). For each of the over 450 non-pharmaceutical APCs, the payment rate reflects costs (2006 data) gathered from all acute care hospitals. Note that speech-language pathology services are paid using the Medicare Physician Fee Schedule in the hospital outpatient setting.

APC PAYMENT RATES

- APC 215 (Level I Nerve and Muscle Tests)
 - **+4.4%** \$41.35
 - Includes H-reflex test
- APC 216 (Level III Nerve and Muscle Tests)
 - **+2.7%** \$180.86
 - Includes Intraoperative neurophysiology testing; Visual evoked potential test
- APC 218 (Level II Nerve and Muscle Tests)
 - **+3.0%** \$80.65
 - Includes Auditory evoked potentials, limited; Neuromuscular junction test
- APC 363 (Level I Otorhinolaryngologic Function Tests)
 - **+2.3%** \$61.08
 - Includes most vestibular function tests; Evoked otoacoustic emissions, limited
- APC 364 (Level I Audiometry)
 - **+1.4%** \$31.68
 - Includes Speech threshold; Loudness balance; Tympanometry
- APC 365 (Level II Audiometry)
 - **+1.2%** \$85.44
 - Includes Comprehensive hearing test; Visual audiometry, Air & bone
- APC 366 (Level III Audiometry)
 - **-3.1%** \$109.49
- Includes Stenger test; Cochlear implant follow-up
- APC 660 (Level II Otorhinolaryngologic Function Tests)
 - **-3.2%** \$101.24
 - Includes Posturography; Electrocochleography; Evoked otoacoustic emissions, comprehensive

OTHER NEW DEVELOPMENTS

Three New Bundled CPT Codes

As described under New Developments in the Medicare Physician Fee Schedule (MPFS), the following three CPT codes are effective 2010. The codes describe procedures that are usually billed in combination with one another.

- **92540 Basic vestibular evaluation** \$101.24
Compares with the MPFS fee of \$74.71
- **92550 Tympanometry and reflex threshold** \$31.68
Compares with MPFS fee of \$16.19
- **92570 Acoustic immitance testing** \$31.68
Compares with MPFS fee of \$24.71

Evoked Otoacoustic Emissions, Comp. (CPT 92588)

This procedure has been shifted from APC 660 to 363. This results in a 42% decrease to \$61.08.

Acoustic Reflex Decay Test (CPT 92569)

This procedure has been deleted, replaced by the new CPT 92570, Acoustic immitance testing.

Cochlear Implantation (CPT 69930)

The cochlear implant payment is increased by 9.1% to \$28,906.

ASHA continues to argue that although the OPPS payment amount covers the cost of the device, it does not cover associated surgical expenses. The inadequate payment is a disincentive to hospitals concerned about maintaining this specialty program.

TABLE 5: HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) RATES FOR AUDIOLOGY SERVICES[♦]**HOSPITAL OPPS**

CPT/HCPCS	Description	Ambulatory Payment Classification	Payment Rate subject to geographic adjustors	Copayment * indicates no geographic adjustor is applicable
G0268	Removal of impacted wax on same day as audiologic testing (physician only code)	Packaged into payment for other tests as of 2009		
69210	Removal of impacted wax (physician only code)	0340	\$45.11	*\$9.03
69930	Cochlear implantation	0259	\$28,906	\$5781
92516	Facial nerve function test	0660	\$101.24	\$20.25
92540	Basic vestibular evaluation	0660	\$101.24	\$20.25
92541	Spontaneous nystagmus test	0363	\$61.08	\$12.22
92542	Positional nystagmus test	0363	\$61.08	\$12.22
92543	Caloric vestibular test	0660	\$101.24	\$20.25
92544	Optokinetic nystagmus test	0363	\$61.08	\$12.22
92545	Oscillating tracking test	0363	\$61.08	\$12.22
92546	Sinusoidal rotational test	0660	\$101.24	\$20.25
92547	Supplemental electrical test	Not separately billed; bundled with CPT 92541 as of 2008.		
92548	Posturography	0660	\$101.24	\$20.25
92550	Tympanometry & reflex thresh	0364	\$31.68	\$6.34
92551	Pure tone hearing test, air (screening)	Not covered		
92552	Pure tone audiometry, air	0364	\$31.68	\$6.34
92553	Audiometry, air & bone	0365	\$85.44	\$17.09
92555	Speech threshold audiometry	0364	\$31.68	\$6.34
92556	Speech audiometry, complete	0364	\$31.68	\$6.34
92557	Comprehensive hearing test	0365	\$85.44	\$17.09
92559	Group audiometric testing	Not covered		

[♦]All CPT codes and descriptors are copyright 2009 American Medical Association

HOSPITAL OPPS

CPT/HCPCS	Description	Ambulatory Payment Classification	Payment Rate subject to geographic adjustors	Copayment * indicates no geographic adjustor is applicable
92560	Bekesy audiometry, screen	Not covered		
92561	Bekesy audiometry, diagnosis	0364	\$31.68	\$6.34
92562	Loudness balance test	0364	\$31.68	\$6.34
92563	Tone decay hearing test	0364	\$31.68	\$6.34
92564	SISI	0364	\$31.68	\$6.34
92565	Stenger test, pure tone	0364	\$31.68	\$6.34
92567	Tympanometry	0364	\$31.68	\$6.34
92568	Acoustic reflex testing; threshold	0364	\$31.68	\$6.34
92570	Acoustic immitance testing	0364	\$31.68	\$6.34
92571	Filtered speech hearing test	0364	\$31.68	\$6.34
92572	Staggered spondaic word test	0366	\$109.49	\$21.90
92575	Sensorineural acuity test	0364	\$31.68	\$6.34
92576	Synthetic sentence test	0364	\$31.68	\$6.34
92577	Stenger test, speech	0366	\$109.49	\$21.90
92579	Visual audiometry (VRA)	0365	\$85.44	\$17.09
92582	Conditioning play audiometry	0365	\$85.44	\$17.09
92583	Select picture audiometry	0364	\$31.68	\$6.34
92584	Electrocochleography	0216	\$180.86	*\$34.20
92585	Auditor evoke potentials, comprehensive	0216	\$180.86	\$34.20
92586	Auditory evoke potentials, limited	0218	\$80.65	*\$14.71
92587	Evoked otoacoustic emiss, limited	0363	\$61.08	\$12.22

HOSPITAL OPPS

CPT/HCPCS	Description	Ambulatory Payment Classification	Payment Rate subject to geographic adjustors	Copayment * indicates no geographic adjustor is applicable
92588	Evoked otoacoustic emiss, comp.	0660	\$101.24	*\$20.25
92596	Ear protector evaluation	0364	\$31.68	\$6.34
92601	Cochlear implant follow-up exam, pt under 7 yrs of age	0366	\$109.49	\$21.90
92602	Reprogram cochlear implant, pt under 7 yrs of age	0366	\$109.49	\$21.90
92603	Cochlear implant follow-up exam, pt 7 yrs of age or older	0366	\$109.49	\$21.90
92604	Reprogram cochlear implant, pt 7 yrs of age or older	0366	\$109.49	\$21.90
92620	Central auditory function	0365	\$85.44	\$17.09
92621	Central auditory function, add-on	(Under OPPS, 92620 considered full session)		
92625	Tinnitus assessment	0365	\$85.44	\$17.09
92626	Eval of auditory rehab status	0366	\$109.49	\$21.90
92627	Eval of auditory rehab status, add-on	(Under OPPS, 92626 considered full session)		
92630	Auditory rehab; pre-lingual hearing loss	Not covered		
92633	Auditory rehab; post-lingual hearing loss	Not covered		
92640	Auditory brainstem implant programming	0365	\$85.44	\$17.09
95920	Intraop neurophysiology testing, per hour	Not separately billed; bundled with CPT 92541 as of 2008.		
95925	Somatosensory testing; in upper limbs	0216	\$180.86	*\$34.20
95926	Somatosensory testing; in lower limbs	0216	\$180.86	*\$34.20
95927	Somatosensory testing; in the trunk or head	0216	\$180.86	*\$34.20
95930	Visual evoked potential test	0216	\$180.86	*\$34.20
95934	H-reflex test	0215	\$39.60	\$7.39
95936	H-reflex test, not g/s muscle	0215	\$39.60	\$7.39
95937	Neuromuscular junction test	0218	\$80.65	*\$14.71

TABLE 6: AMBULATORY PAYMENT CLASSIFICATIONS (APCs) FOR AUDIOLOGY SERVICES

APC	Group Title
0215	Level I Nerve and Muscle Tests
0216	Level III Nerve and Muscle Tests
0218	Level II Nerve and Muscle Tests
0259	Level VI ENT Procedures
0340	Minor Ancillary Procedures
0363	Level I Otorhinolaryngologic Function Tests
0364	Level I Audiometry
0365	Level II Audiometry
0366	Level III Audiometry
0660	Level II Otorhinolaryngologic Function Tests