CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2044	**Date: September 3, 2010**
	Change Request 6447

Transmittal 2007, dated July 23, 2010, is being rescinded and replaced by Transmittal 2044, to correct the RARC number for business requirement 6447.7.1. The Effective and Implementation dates have been changed to allow contractors time to comply with these additional requirements. All other information remains the same.

SUBJECT: Revisions and Re-issuance of Audiology Policies

I. SUMMARY OF CHANGES: This Change Request (CR) modifies policy relevant to audiology services. Changes were made to eliminate reference to "Otograms", clarify the skills of an audiologist, and clarify the contribution of technicians to diagnostic audiological tests.

EFFECTIVE DATE: September 30, 2010
IMPLEMENTATION DATE: September 30, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/10/Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General
R	5/40.3/Applicable Revenue Codes
R	5/40.5/Line Item Date of Service Reporting
R	5/50/CWF and PSandR Requirements - FIs
R	12/Table of Contents
R	12/30.3/Audiology Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2044	Date: September 3, 2010	Change Request: 6447

Transmittal 2007, dated July 23, 2010, is being rescinded and replaced by Transmittal 2044, to correct the RARC number for business requirement 6447.7.1. The Effective and Implementation dates have been changed to allow contractors time to comply with these additional requirements. All other information remains the same.

SUBJECT: Revisions and Re-issuance of Audiology Policies

Effective Date: September 30, 2010
Implementation Date: September 30, 2010

I. GENERAL INFORMATION

A. Background: In February of 2008, CMS issued CR5717, Transmittals 1470 (Pub.100-04) and 84 (Pub. 100-02), with clarifications to policies relative to audiological diagnostic tests. Among the new language was implementation of changes relative to a 2005 policy concerning services incident to physician services that are paid under the Medicare Physician Fee Schedule (MPFS). Under the MPFS, services with their own benefit category must be furnished and billed according to that benefit and may not also be billed incident to physician services. Diagnostic tests were given as an example. Audiology services are "other diagnostic tests." Since that transmittal there have been continuing questions about the policy, and there is a need for further clarification.

B. Policy: Audiology services must be personally furnished by an audiologist or nonphysician practitioner (NPP). Physicians may personally furnish audiology services, and technicians or other qualified staff may furnish those parts of a service that do not require professional skills under the direct supervision of physicians.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6447.1	Contractors shall educate suppliers via the MLN Matters article to conform to the billing policies in Pub. 100-04, chapter 12, section 30.3 when billing for audiology services.	X		X	X						
6447.2	Contractors shall utilize the list of audiology services posted on the Web site at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp to determine payment.	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6447.3	Contractors shall not pay under the MPFS for audiological diagnostic tests furnished by technicians under the direct supervision of a physician if the test requires professional skills.	X			X						
6447.3.1	Contractors shall use Claim Adjustment Reason Code (CARC) 170: "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present".	X			X						
6447.4	Contractors shall not pay for audiological diagnostic tests furnished by technicians unless the service is furnished under the direct supervision of a physician.	X		X	X						
6447.4.1	Contractors shall use CARC 185: "The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present"; and Remittance Advice Remark Code (RARC) M136: "Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician."	X		X	X						
6447.5	Contractors shall pay under the MPFS for services that require professional skills when they are personally furnished by an audiologist, physician, or NPP.	X			X						
6447.6	Contractors shall pay for diagnostic audiological tests under the MPFS when they meet the requirements of audiology services in Pub. 100-02, chapter 15, section 80.3.	X			X						
6447.7	Contractors shall not pay for services performed by audiologists and billed under the NPI of a physician.	X			X						
6447.7.1	Contractors shall use CARC 170: "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present"; and RARC N290 "Missing/incomplete/invalid rendering provider primary identifier."	X			X						
6447.8	Contractors shall pay for diagnostic audiological tests under the MPFS when they are furnished by individuals qualified as in Pub. 100-02, chapter 15, section 80.3.D.	X			X						
6447.9	When reviewing medical records of diagnostic audiological tests for payment under the MPFS, contractors shall review a technician's qualifications and the medical record to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.	X			X						
6447.10	Contractors shall educate suppliers via the MLN Matters	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	article to document audiological diagnostic tests with sufficient information so that contractors may determine that the service qualifies as an audiological diagnostic test.										
6447.11	Contractors shall pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services posted at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp and are not "always" therapy services and the audiologist is qualified to furnish the service.	X			X						
6447.12	Contractors shall pay for the TC of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified to furnish the service.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6447.14	A provider education article related to this instruction will be available at http://www.cms.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6447.1	This requirement does not limit contractors to use of the MLN Matters article to educate suppliers if the contractor finds that other forms of education are needed.
6447.5	The NPI of the audiologist is not required when the service is billed by a hospital or any facility for audiology services that are furnished in the hospital or facility when those services are furnished by an audiologist who is not enrolled in Medicare or for whom a claim is not being submitted for payment under the MPFS. Physicians may not bill for the services of audiologists.
6447.6	The following language was removed from Pub. 100-02, chapter 15, section 80.3: "Computer-administered hearing tests are screening tests, do not require the skilled services of an audiologist and are not covered or payable using codes for diagnostic audiological testing. Examples include, but are not limited to "otograms" and pure tone or immitance screening devices that do not require the skills of an audiologist." Computer-administered tests may or may not be screening tests. Deletion of the example removes reference to the Otogram, a specific manufacturer's device. Contractors continue to have discretion to cover and pay or to deny coverage and payment for services represented by Category III CPT codes or unlisted codes for computer-administered or other tests based on the requirements for audiology tests furnished by qualified personnel.
6447.10	This requirement does not limit contractors to use of the MLN Matters article to educate suppliers to document audiological diagnostic tests with sufficient information so that contractors may determine that the service qualifies as an audiological diagnostic test if the contractor finds that other forms of education are needed. Absence of guidance as to how to document the services should not be construed as absence of a requirement that the service be appropriately documented in a manner that allows the contractor to determine that the requirements for audiological diagnostic tests have been met.

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

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Post-Implementation Contact(s): Dorothy Shannon: Dorothy.Shannon@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs)*****, include the following statement:**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

(Rev. 2044, 09-03-10)

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev.2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

Language in this section is defined or described in Pub. 100-02, chapter 15, sections 220 and 230.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required that all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- Comprehensive outpatient rehabilitation facilities (CORFs);
- Outpatient physical therapy providers (OPTs);
- Other rehabilitation facilities (ORFs);
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

NOTE: No provider or supplier other than the SNF will be paid for therapy services during the time the beneficiary is in a covered SNF Part A stay. For information regarding SNF consolidated billing see chapter 6, section 10 of this manual.

Similarly, under the HH prospective payment system, HHAs are responsible to provide, either directly or under arrangements, all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health POC. No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay. For information regarding HH consolidated billing see chapter10, section 20 of this manual.

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language

pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

In Chapter 23, as part of the CY 2009 Medicare Physician Fee Schedule Database, the descriptor for PC/TC indicator "7", as applied to certain HCPCS/CPT codes, is described as specific to the services of privately practicing therapists. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for CORF services identified by the HCPCS codes in §20. Assignment is mandatory.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does **not** apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are to be paid on a reasonable cost basis.

Contractors process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, HHAs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. These provider types submit their claims to the contractors using the 837 Institutional electronic claim format or the UB-04 paper form when permissible. Contractors also process claims from physicians, certain nonphysician practitioners (NPPs), therapists in private practices (TPPs), (which are limited to physical and occupational therapists, and speech-language pathologists in private practices), and physician-directed clinics that bill for services furnished incident to a physician's service (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to"). These provider types submit their claims to the contractor using the 837 Professional electronic claim format or the CMS-1500 paper form when permissible.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described). Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that is paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

Contractors pay the nonfacility rate on institutional claims for services performed in the provider's facility. Contractors may pay professional claims using the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Contractors pay the codes in §20 under the MPFS on professional claims regardless of whether they may be considered rehabilitation services. However, contractors must use this list for institutional claims to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for any rehabilitation service.

Payment for rehabilitation therapy services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the TPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the contractor on a professional claim.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by TPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to, therapist, therapy and related instructions.") Such services are billed to the contractor on the professional claim format. Assignment is mandatory.

The following table identifies the provider and supplier types, and identifies which claim format they may use to submit bills to the contractor.

"Provider/Supplier Service" Type	**Format**	**Bill Type**	**Comment**
Inpatient hospital Part A	Institutional	11X	Included in PPS
Inpatient SNF Part A	Institutional	21X	Included in PPS
Inpatient hospital Part B	Institutional	12X	Hospital may obtain services

"Provider/Supplier Service" Type	Format	Bill Type	Comment
			under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B (audiology tests *are not included)*	Institutional	22X	SNF must provide and bill, or obtain under arrangements and bill.
Outpatient hospital	Institutional	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill.
Outpatient SNF	Institutional	23X	SNF must provide and bill or obtain under arrangements and bill.
HHA billing for services rendered under a Part A or Part B home health plan of care.	Institutional	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	Institutional	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF)	Institutional	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Institutional	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.
Physician, NPPs, TPPs, (service in hospital or SNF)	Professional	See Chapter 26 for place of service, and type of	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents.

"Provider/Supplier Service" Type	Format	Bill Type	Comment
		service coding.	Otherwise, suppliers bill to the contractor using the professional claim format. Note that services of a physician/ NPP/TPP employee of a facility may be billed by the facility to a contractor.
Physician/NPP/TPPs office, independent clinic or patient's home	Professional	See Chapter 26 for place of service, and type of service coding.	Paid via Physician fee schedule.
Critical Access Hospital - inpatient Part A	Institutional	11X	Rehabilitation services are paid *at* cost.
Critical Access Hospital - inpatient Part B	Institutional	85X	Rehabilitation services are paid *at* cost.
Critical Access Hospital – outpatient Part B	Institutional	85X	Rehabilitation services are paid *at* cost.

Complete Claim form completion requirements are contained in chapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If a contractor receives an institutional claim for one of these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its professional claims area to obtain the non-facility price in order to pay the claim.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. Contractors may consider other codes on institutional claims for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and could be performed within the scope of practice of the therapist providing the service.

40.3 - Applicable Revenue Codes

(Rev.2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

The appropriate revenue codes for reporting outpatient rehabilitation services are

0420 - Physical Therapy Services
0430 - Occupational Therapy Services
0440 – Speech-language pathology services

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the FI should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

40.5 - Line Item Date of Service Reporting

(Rev.2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

Contractors will return claims that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting became effective for claims with dates of service on or after October 1, 1998.

Services that do not require line item date of service reporting may be reported before or after those services that require line item reporting.

50 - CWF and PS&R Requirements - FIs

(Rev.2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

The FI reports the procedure codes in the financial data section (field 65a-65j) of the PS&R record. It includes revenue code, HCPCS, units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a separate line. The FI reports the payment amount before adjustment for beneficiary liability in field 65g “Rate” and the actual charge in field 65h “Covered Charges.” The PS&R system includes outpatient rehabilitation, and CORF services listed in subsections E and F on a separate report from cost based payments. See the PS&R guidelines for specific information.

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 2044, 09-03-10)

30.3 - *Audiology Sevices*

30.3 – *Audiology Services*

(Rev.2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

Section 1861(ll)(3)of the Social Security Act (the Act) defines "audiology services" as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise by covered if furnished by a physician. In this section, these hearing and balance assessment services are termed "audiology services," regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable State laws.

References to technicians apply also to other qualified clinical staff. See Pub. 100-02, chapter 15, section 80.3.D.

A - Correct *Reporting*

1. General. Contact the contractor for guidance if the CPT codebook changes the description of codes mentioned in this section.

Other policies concerning audiological services are found in Pub. 100-02, chapter 15, section 80.3.

See chapter 26 of this manual for place of service and type of service coding.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added section 1834(k)(5) to (the Act), required that all claims for certain audiology services be reported using a uniform coding system. CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system for the reporting of these services. This coding requirement is effective for all claims for audiology services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for audiology services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for audiology services furnished in the office setting and for the associated professional services furnished in physician's office and hospital outpatient settings.

2. Use of the NPI. For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims *they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the carrier or Medicare administrative contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital Outpatient Prospective Payment System (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.*

Audiologists must be enrolled and use their NPI on claims for services they render *in office settings* on or after October 1, 2008 (for additional information about enrollment, refer to Pub. 100-08, *Medicare* Program Integrity Manual, chapter *15*). Before October 1, 2008, *the services of* audiologists who *were* not yet enrolled *in Medicare were* billed by a physician or group who employ*ed* the audiologist. Audiologists shall use the billing instructions in the Medicare manuals; for example, see this manual, *c*hapter 1, *section* 30.

See the most recent *MPFS* for pricing and *physician* supervision levels for audiology services: http://www.cms.hhs.gov/PFSlookup/01_Overview.asp#TopOfPage. *The NPI of the supervising physician shall be used to bill audiology services when supervision is appropriate.*

The most recent OPPS pricing for audiology services is available in Addendum B at: http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage.

B. Billing for Audiology Services

See the CMS Web site at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp *for a listing of all CPT codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The Physician Fee Schedule at http://www.cms.gov/PFSlookup/01_Overview.asp#TopOfPage allows you to search pricing amounts, various payment policy indicators, RVUs, and GPCIs.*

Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.

Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.

The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision.

Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component if the audiology service has a professional component/technical component split.

1. Billing under the MPFS for Audiology Services Outside the Facility Setting

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable are appropriate to the test.

a. Professional Skills.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to:

- *Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test;*
- *Development and modification of the test battery and test protocols;*
- *Clinical judgment, assessment, evaluation, and decision-making;*
- *Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes;*
- *Tests related to implantation of auditory prosthetic devices, central auditory processing, contralateral masking; and/or*

- *Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss.*

Audiology codes may be billed under the MPFS by audiologists, physicians, and NPPs using their own NPI in the rendering loop when those professionals personally furnish the test. Physicians and NPPs may not bill for these codes when an audiologist has furnished the service.

b. Technician Skills.

There may be subtests, or parts of a battery of tests, that may be appropriately furnished by an educated and experienced technician using a specific protocol under the direction of a supervising physician. These services are identified by local contractor determination as services that do not require professional skills. They may be furnished by a qualified technician under the direct supervision of a physician, but not under the supervision of an audiologist or an NPP. The supervising physician is responsible for rendering and documenting all clinical judgment and for the appropriate provision of the service by the technician.

A technician may not perform any part of a service that requires professional skills. A technician also may not perform a global service. For example, a technician may not interpret test results or engage in clinical decision-making.

c. Professional Component (PC)/Technical Component (TC) Split Codes.

- *The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.*

- *The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.*

- *The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.*

d. Tests that are Not Described by Specific CPT Codes. Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure).

e. Tests that are Contractor-Priced. For codes valued by contractors, the contractor determines whether and how much, if applicable, to pay for the service. The contractor sets the requirements for personnel furnishing the tests.

2. Billing for Audiology Services Furnished to Hospital Outpatients.

All codes may be reported for audiology services furnished in the hospital outpatient setting and, in such cases, the code represents the facility service for the diagnostic test. All audiology services furnished to hospital outpatients must be billed and paid to the hospital under the OPPS or other applicable hospital payment system. The hospital bills its fiscal intermediary or Medicare administrative contractor (A/B MAC) and is paid for the facility resources required to furnish the services, regardless of whether the service is furnished by a physician, NPP, audiologist, or technician.

Physicians, NPPs, and audiologists cannot bill and be paid for the TC of PC/TC split codes when these services are furnished to hospital outpatients. The associated professional services (represented by the PC or the CPT code for the audiology test which has no PC/TC split) of an enrolled audiologist, physician, or NPP who has reassigned benefits may be billed by the hospital to the carrier or A/B MAC, as appropriate. Alternatively, if the physician, NPP, or audiologist has not assigned benefits, the professional would bill his/her carrier or A/B MAC for the professional services furnished.

The appropriate revenue code for reporting audiology services is 0470 (Audiology; General Classification). Providers are required to report a line-item date of service per revenue code line for audiology services.

3. Billing for Audiology Services Furnished to Skilled Nursing Facility (SNF) Patients.

Payment for the facility resources (including the TC of PC/TC split codes) of audiology services provided to Part A inpatients of SNFs is included in the PPS rate. For SNFs, if the beneficiary has Part B but not Part A coverage (e.g., Part A benefits are exhausted), the SNF may elect to bill for audiology services but is not required to do so. As explained in Pub. 100-04, chapter 7, section 40.1, since audiology services furnished during a noncovered SNF stay are not bundled with speech-language pathology services, payment can be made either to the SNF or to the audiology service provider/supplier.

Audiologists, physicians, and NPPs enrolled in Medicare may bill directly for services rendered to Medicare beneficiaries who are in a SNF stay that is not covered by Part A but who have Part B eligibility. Payment is made based on the MPFS, whether on an institutional or professional claim. For beneficiaries in a noncovered SNF stay, audiology services are payable under Part B when billed by the SNF on an institutional claim as type of bill 22X, or when billed directly by the provider or supplier of the service (the audiologist, physician, or NPP who personally

furnishes the test) on a professional claim. For PC/TC split codes, the SNF may elect to bill for the TC of the test on an institutional claim but is not required to bill for the service.

C **- Implant Processing**

Payment for diagnostic testing of implants, such as cochlear, osseointegrated or brainstem implants, including programming or reprogramming following implantation surgery is not included in the global fee for the surgery.

The diagnostic analysis of a cochlear implant shall be billed using CPT codes 92601 through 92604.

Osseointegrated prosthetic devices should be billed and paid for under provisions of the applicable payment system. For example, payment may differ depending upon whether the device is furnished on an inpatient or outpatient basis, and by a hospital subject to the OPPS, or by a Critical Access Hospital, physician's clinic, or a Federally Qualified Health Center.

D **- Aural Rehabilitation Services**

General policy for evaluation and treatment of conditions related to the auditory system.

For evaluation of auditory processing disorders and speech-reading or lip-reading by a speech-language pathologist, use the untimed code 92506 with "1" as the unit of service, regardless of the duration of the service on a given day. This "always therapy" evaluation code must be provided by speech-language pathologists according to the policies in Pub. 100-02, chapter 15, sections 220 and 230. The codes 92620 and 92621 are diagnostic audiological tests and may not be used for SLP services.

For treatment of auditory processing disorders or auditory rehabilitation/auditory training (including speech-reading or lip-reading), 92507, and 92508 are used to report a single encounter with "1" as the unit of service, regardless of the duration of the service on a given day. These codes always represent SLP services. See Pub. 100-02, chapter 15, sections 220 and 230 for SLP policies. These SLP evaluation and treatment services are not covered when performed or billed by audiologists, even if they are supervised by physicians or *qualified NPPs.*

For evaluation of auditory rehabilitation to instruct the use of residual hearing provided by an implant or hearing aid related to hearing loss, the timed codes 92626 and 92627 are used. These are not "always therapy" codes. Evaluation of auditory rehabilitation shall be appropriately provided *and billed* by an audiologist or speech-language pathologist. Also, these services may be provided incident to a physician*'s* or *qualified NPP's* service by a speech-language pathologist, or personally by a physician or *qualified NPP* within their scope of practice. Evaluation of auditory rehabilitation is a covered diagnostic test when performed and billed by an audiologist and is a*n* SLP evaluation service covered under the SLP benefit when performed by a speech-language pathologist.

General policies for post implant services.

The services of a speech-language pathologist may be covered for SLP services provided after implantation of auditory devices. For example, a speech-language pathologist may provide evaluation and treatment of speech, language, cognition, voice, and auditory processing using code 92506 and 92507. Use 92626 and 92627 for auditory (aural) rehabilitation evaluation following cochlear implantation or for other hearing impairments.

For diagnostic testing of cochlear implants, audiologists use codes 92601, 92602, 92603 and 92604. These services may not be provided by speech-language pathologists or others, with the exception of physicians and *NPPs* who may personally provide the services that are within their scope of practice.