Coding and Reimbursement Daily Challenges: A Case Study of Scenarios and Solutions

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eAudiology
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How to ask a Question

To ask a question, please type your question into the chat box in the lower left corner of the screen and click on the "Send" button located right below the box.

Course Objectives

- Address common, everyday coding dilemmas
- Describe *"incident to"* and its impact on the profession of audiology
- Identify timely issues faced by audiologists
- Identify available resources

Coding Pearl

- **Coding is not driven by reimbursement!**

Coding Mantra

- **Purchase coding manuals annually**
- **Read the introduction section of the manuals…they can be very useful**

Basic Coding Guidelines

- Code: Signs & Symptoms
  - Reason for the referral
    - Hearing loss?
    - Tinnitus?
    - Disequilibrium?
  - Can not use rule/out

Patient Scenario:

- 21 year old male, Tim Panic, presents with fullness in his right ear, dizziness for 4 weeks and a noted decrease in his hearing acuity in his right ear.

Test Battery Results:

- Otoscopy = abnormal tympanic membrane, right ear
- CPT 92557/pure tone air & bone conduction= mild to moderate conductive hearing loss
- Speech recognition studies = excellent
- CPT 92567/tympanometry = Type B tympanogram, AD, with low compliance values
- Absent acoustic reflexes, AD
- All test results are within normal limits, AS

How to Code for this Scenario:

Code test results, in addition, the patient's signs and symptoms may be coded using ICD-9 code 389.03

»Conductive hearing loss, middle ear

Coding Pearls:

- Utilizing the most specific, five digit codes results in fewer denials
- Avoid unspecified codes
  - End in "zero"
  - 4 digit codes such as 389.1
    - Likely to be denied

Diagnostic "V" Codes

- V72.11: Encounter for Hearing Examination Following Failed Hearing Screening

  Is Commonly Utilized…& Is Commonly Denied

MEDICARE: National v Local Coverage Determinations

- **Medicare Policy**: Coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury…and within the scope of a Medicare benefit category.

National v Local Coverage (cont'd)

- **National Coverage Determinations**, or **NCD**s are made through an evidence-based process, with opportunities for public participation, which may be supplemented by outside technology assessment or consultation, such as Medicare Coverage Advisory Committee (MCAC).

National v Local Coverage (cont'd)

- In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a **Local Coverage Determination**, or **LCD**.

Medicare: Local Coverage Determinations

- Become Familiar with your Medicare Carrier's Local Coverage Determinations. They:
  - Identify the circumstances under which a particular service will…or, will not be, covered and correctly coded as related to the issue of medically reasonable and necessary
  - Define other parameters:
    - Test suite
    - Testing protocols
    - Documentation protocols
    - Medical necessity protocols
- May be obtained at: www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp

MEDICARE: Other Considerations

Medicare Beneficiary Notices Initiative (BNI)

Purpose:

- To wed consumer rights & protections with effective beneficiary communication so that beneficiaries are given the opportunity to exercise their rights and protections in a timely and well-informed manner
- These rights and protections are both statutorily & regulatorily mandated

BNI (cont'd)

- Promotes beneficiary education and health promotion
- Facilitates access to, and exercise of, individual rights and protections
- Notices are given to beneficiaries by:
  - Providers, suppliers, & health plans

Advance Beneficiary Notice (ABN)

- Informs patient that certain procedures may be denied by Medicare as not being "*medically reasonable and necessary*" and that the patient will be expected to pay for these services

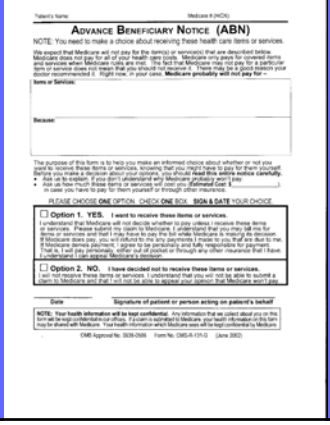
ABN (cont'd)

- Criteria:
  - Notification must be given prior to a service being rendered
  - Must be in writing on CMS-R-131 form
    - Patient Name
    - Date
    - Description of service
    - Reason service may be denied or reduced

ABN (cont'd)

- Applies whether Medicare is primary or secondary
- Utilization:
  - *Possibly* for periodic testing of patient with ototoxicity
  - *Possibly* for cerumen removal

Contact your Medicare Carrier since policy implementation has been inconsistent among the regions



ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

Medicare ABN

- **ADVANCE BENEFICIARY NOTICE (ABN)**NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item (s) or service s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**
- **Items or Services: Because:**
- The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**
- • Ask us to explain, if you don't understand why Medicare probably won't pay.
- • Ask us how much these items or services will cost you (**Estimated Cost: $**_____),in case you have to pay for them yourself or through other insurance.

Medicare ABN

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- PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.
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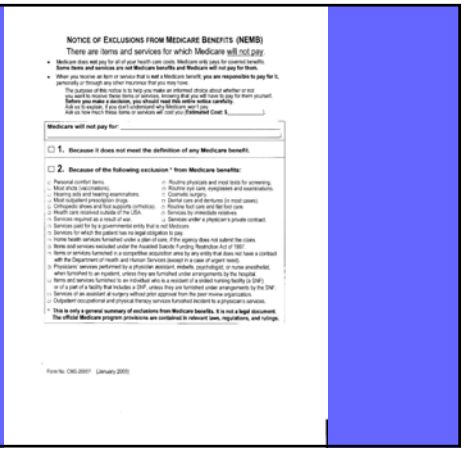
- ☐☐ **Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.
- _____ **Date Signature of patient or person acting on patient's behalf**
- **NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.
- OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

Notice of Exclusions From Medicare Benefits (NEMB)

- Document provided to the Medicare patient for services that are *excluded* by Medicare, regardless of the provider of service:
  - **Hearing aids and routine hearing exams**
- You do not bill Medicare; patient responsibility applies
- Utilizes form CMS-20007; no signature needed
  http://cms.hhs.gov/medlearn/refabn.asp



NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.** Ask us to explain, if you don't understand why Medicare won't pay. Ask us how much these items or services will cost you (**Estimated Cost: $_____**).

Medicare will not pay for: _____

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- Personal comfort items.
- Most shots (vaccinations).
- Hearing aids and hearing examinations.
- Most outpatient prescription drugs.
- Orthopedic shoes and foot supports (orthotics).
- Cosmetic surgery (unless needed for the SSA).
- Services required as a result of war.
- Services paid for by a governmental entity that is not Medicare.
- Services for which the patient has no legal obligation to pay.
- Home health services furnished under a plan of care, if the agency does not submit the plan.
- Items and services excluded under the Ticket to Work and Self-Sufficiency Program.
- Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- Services of an assistant at surgery without prior approval from the peer review organization.
- Outpatient occupational and physical therapy services furnished incident to a physician's services.
- Routine physicals and most tests for screening.
- Routine eye care, eyeglasses and examinations.
- Cosmetic surgery.
- Dental care and dentures (in most cases).
- Routine foot care and flat foot care.
- Services by immediate relatives.
- Services under a physician's private contract.

* **This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Form No. CMS-20007 (January 2005)

Medicare NEMB

- **NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)**
- There are items and services for which Medicare will not pay.
- • Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits.
- **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- • When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,**
- personally or through any other insurance that you may have.
- The purpose of this notice is to help you make an informed choice about whether or not
- you want to receive these items or services, knowing that you will have to pay for them yourself.
- **Before you make a decision, you should read this entire notice carefully.**
- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $_____**).
- **Medicare will not pay for:** _____
- _____;

Medicare NEMB

- □ **1. Because it does not meet the definition of any Medicare benefit.**
- □ **2. Because of the following exclusion * from Medicare benefits:**
- □ Personal comfort items. □ Routine physicals and most tests for screening.
- □ Most shots (vaccinations). □ Routine eye care, eyeglasses and examinations.
- □ Hearing aids and hearing examinations. □ Cosmetic surgery.
- □ Most outpatient prescription drugs. □ Dental care and dentures (in most cases).
- □ Orthopedic shoes and foot supports (orthotics). □ Routine foot care and flat foot care.
- □ Health care received outside of the USA. □ Services by immediate relatives.
- □ Services required as a result of war. □ Services under a physician's private contract.
- □ Services paid for by a governmental entity that is not Medicare.
- □ Services for which the patient has no legal obligation to pay.
- □ Home health services furnished under a plan of care, if the agency does not submit the claim.
- □ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- □ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- □ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- □ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- □ Services of an assistant at surgery without prior approval from the peer review organization.
- □ Outpatient occupational and physical therapy services furnished incident to a physician's services.
- *** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**
- Form No. CMS-20007 (January 2003)

"Incident To" Billing

- Definition: **Separate, but related, services provided to a Medicare patient subsequent to a physician's evaluation**
- There ***first*** must be a service furnished by a physician to initiate the course of treatment
- The service is billed secondary to the medical visit, or ***"incident to"***

"*Incident To*" Billing (cont'd)

- Medicare regulations stipulate that ***"incident to"*** services be:
  - Furnished in a non-institutional setting to non-institutional patients (i.e., only applies to outpatient care)
  - Only for services that ***do not have their own benefit category***

"*Incident To*" Billing (cont'd)

- Of a type commonly furnished in the office of a physician
- Furnished under the "direct supervision" of the physician AND
- Furnished by a physician, other practitioner, or "auxiliary personnel"

Medicare states that "incident to" services can be rendered if the services are within the person's scope of practice

"Incident To" Billing (cont'd)

- **Note:** Commonly furnished without charge or included in the physician's or other practitioner's bill
- **Note:** Physician must be on the premises, not off-site

"Incident To" Billing (cont'd)

- **With *"incident to"*** billing, the physician bills for services that ***he or she did not personally perform*** (i.e., certain services which the physician supervised)

So, should audiologic testing be able to be billed to Medicare as "incident to"?

- **In A Word……NO!**

WHY???

Medicare Guidance:

- Medicare Program Memorandum AB-02-80 states that “diagnostic testing performed by a qualified audiologist is covered as ‘other diagnostic tests’ under §1861 (s) (3) of the Act when a physician orders such testing for the purpose of obtaining information necessary for appropriate medical or surgical treatment.” (CMS, 2003)

"*Incident To*" Billing

- Many audiologists employed by ENTs are having their claims for Medicare sevices billed under their physician employer
- This is in appropriate and flies in the face of HIPAA and CMS regulations
- WHY???.....

CMS & HIPAA: Each provider who bills Medicare for health care services is required to have their own Provider Identifier Number (PIN)* for Medicare and their National Provider Identifier (NPI) to meet CMS and HIPAA regulations…audiologists included!

EACH AUDIOLOGIST MUST BILL WITH THEIR OWN PINs AND NPIs

Note: If an employee, assign your Medicare benefits to your employer by completing an 855-R form

"Incident To" Requirements
(cont'd)

- Furnished under the "direct supervision" of the physician or other practitioner
  - Audiologists, as defined by CMS, require no physician supervision!!

Effects of "Incident To" Billing:

- All CPT codes are tracked by the entity that values them, the Relative Value Update Committee, or the **RUC …**and by **CMS**

Effects of "Incident To"

Do you know:

- Otolaryngologists bill 79% of 92557, our core codes
- These could be performed by an audiologist
  - Secretary,
  - Nurse
  - Janitor

But, there is no way to discern just who performs the service!

AUDIOLOGISTS ARE INVISIBLE IN THIS PROCESS

AUDIOLOGISTS ARE INVISIBLE IN THIS PROCESS

Rules of "Incident To" (cont'd)

Do You Know:

- Audiologists can not bill "incident to" to another audiologist

Reimbursement Myth

- Audiologists are not reimbursed from the same Medicare Physician Fee Schedule (MPFS) as physicians, we are reimbursed from a lower fee schedule.

Reimbursement Myth (cont'd)

- **Fact:** Reimbursement for audiologists and physicians is based on the MPFS. The only differences in reimbursement between audiologists and physicians are those based on provider participation…

How Can We Change "Incident To" Billing?

- Obtain your National Provider Identifier, or NPI
  - www.nppes.cms.hhs.gov
- Obtain your own Provider Identifier Number (PIN) by completing an 855-I
  - www.cms.hhs.gov
- If an employee of a physician or of another audiologist: assign your benefits to your employer by completing an 855-R
  - www.cms.hhs.gov

Scenario 1

- Situation:
  - A 5 year old is referred by his pediatrician because of middle ear effusion. The outcome of diagnostic testing is normal hearing acuity and normal middle ear studies.
- Question:
  - What ICD-9 code should we use?

Scenario 1 (cont'd)

- Scenario 1 Resolution:
  - 389.9 Unspecified hearing loss?
  - 388.44 Abnormal auditory perception?
  - 389.03 Conductive hearing loss, middle ear?

Scenario 2

- Situation: A patient's insurance company requires un-bundled hearing aid fees.
  - What does "un-bundle" mean and how do we accomplish this?

Scenario 2 (cont'd)

- Unbundling is charging for all services, products, or procedures that are provided such as:
  - Hearing Testing
  - Hearing Aid Acquisition Fees
  - Dispensing Fees
  - Earmold Fees, if applicable
  - Earmold impression fees, if applicable
  - Real Ear Measurements
  - Sound Field Testing
  - Hearing Aid Evaluations
  - Conformity Evaluation
  - Rechecks, post warranty
  - Batteries

Bundling

- One fee for all services
- May be a huge loss of revenue
  - Insurance may only pay you the acquisition fee on the full amount if it is not unbundled

Advantages of Unbundling

- Better or fair reimbursement for the services you are providing
- Professional stance in demonstrating what we perform and provide vs what commercial hearing aid providers provide
- Opportunity to educate our patients and insurance carriers as to what audiology is

Scenario 3

- Situation: How do I bill for the QuickSIN or HINT?

Scenario 3 (cont'd)

- Resolution:
  - CPT code 92700 since, at this time, there are no specific codes for these tests:
  - Documentation of test needs to accompany the claim
    - What was done, what was gleaned from the test, how the results impact the patient and the resulting recommendations
      - May need to include professional evidence based literature addressing the particular test/s performed

Scenario 4

- Situation:
  - My Medicare patient is wondering if she should consider a hearing aid. Can I submit CPT code 92626 to Medicare?

Scenario 4 (cont'd)

- Resolution:
  - CPT code 92626 is the evaluation of auditory rehabilitation status and is for the purpose of determining the patient's use of their residual hearing
    - Primarily used to determine cochlear implant candidacy
    - May also be utilized
      - To determine residual hearing post therapy intervention of hearing aids or an implant
      - Create strategies for that patient based on their residual hearing
    - Would not suggest billing Medicare if 92626 was utilized for hearing aid candidacy in a non-implant Medicare beneficiary…WHY???

- Hearing Aid Services are Statutorily Excluded from Medicare Benefit

Scenario 5

- Situation:
  - We see a lot of pediatric patients. How can I bill CPT code 92579?

Scenario 5 (cont'd)

- Resolution:
  - When a code is presented for consideration, a vignette, a detailed description of how that procedure is to be performed, is written and should be followed.
  - This vignette includes performing the procedure "from 500 to 4000 Hz," in the **sound field**, assessing the child's responses to a toy and the conditioning of the response
    - Speech detection threshold is also included
    - Warble tones, narrow bands of noise and ongoing speech are also included in the vignette

Scenario 6

- Situation:
  - We use VNG in our office. Can we bill for CPT 92547 (vertical electrodes)?

Scenario 6 (cont'd)

- Resolution:
  - There is varying guidance on this.
  - The AMA and CMS specify that 92547 should NOT be reported with the use of goggles due to how the code was valued and the technology required.

Scenario 7

- Situation:
  - I have a large tinnitus practice. I often spend an hour conducting a case history. How can I get paid for this?

Scenario 7 (cont'd)

- Resolution:
  - If it is not a Medicare patient, you could use an Evaluation and Management (E & M) code, with the requirements of the code being met. The CPT manual lists these for each code
    - Time dependent
    - Review of Systems (18) need to be met as well in order to bill the code appropriately
    - Complexity of visit
    - New vs established patient criteria

Scenario 8

- Situation:
  - We do Epley maneuvers in our office. How can an audiologist get paid for these?

Scenario 8 (cont'd)

- Resolution:
  - If the patient is not a Medicare beneficiary, you can bill the patient's insurance company, but you will want them to sign an insurance waiver stating that if it is not a reimbursable procedure, the patient will then pay you.
  - Medicare statutorily excludes treatment being performed by an audiologist. If it is a Medicare patient, you will want to provide the patient with an NEMB, the insurance waiver, and have the patient pay you at the time of service.

Scenario 9

- Situation:
  - I receive many physician referrals for Medicare patients. What should these say?

Scenario 9 (cont'd)

- Resolution:
  - The reason for the medical necessity of the referral should be included, for example: "decreased hearing, tinnitus, dizziness."
    - Evaluate and treat is often utilized by physicians, but more detail as to why the patient presented to them needs to be cited.
  - Referral on physician letterhead

Scenario 10

- Situation:
  - Can I provide my best referral sources with notepads or referral pads in order to make it easy for them to refer?

Scenario 10 (cont'd)

- Resolution:
  - As much as you'd like to do this for ease of use for your referral sources, Medicare considers this to be a solicitation of that referral.
  - Therefore, we would suggest the physician's office fax the referral or have the patient bring it with them.
  - Complete the referral loop by writing the referring physician a detail of your findings

Scenario 11

- Situation:
  - I just bought a practice from a retiring audiologist. How long should I retain their clinical records?

Scenario 11 (cont'd)

- Resolution:
  - Your state insurance commission may have requirements that need to be followed and may be posted on their website. If not, the rule of thumb is:
    - 7 years post last date of service for anyone over the age of majority (21 yrs)
    - Pediatric patients, 3 years over the age of majority (21 yrs)
    - HIPAA forms must be retained for 6 years
    - Deceased patient files must be retained for 3 years after death

Scenario 12

- Situation:
  - We received an Explanation of Benefits (EOB) from a patient's insurance company. It stated that the patient could not be billed for the amount not paid.
    - How do we know when we can balance bill?
    - How much is a write-off?

Scenario 12 (cont'd)

- Resolution: Your ability to balance bill is dependent upon your provider status with the insurer.
  - The EOB will state the patient's responsibility.
  - If the pt is not responsible for payment, then that is what will need to be written off.
    - If the EOB states the patient owes $XXX.XX, the patient may then be billed for this amount

Know what is contractually allowable and what is required to be written off in the way of discounts, fees, etc.

Your patient has a contract with their insurance company for specific benefits. You also likely have a contract with that insurance carrier. The benefit is what exists between the patient's contract and their carrier.

Scenario 13

- A Medicare patient presents to my office "to check his or her hearing?" Am I able to bill Medicare for this service?

Scenario 13 (cont'd)

- Remember: In order to meet the threshold of medical necessity that there must be a physician contact with the patient prior to any diagnostic testing. This contact and the reason for the referral must be written in the physician's chart for the patient.

Scenario 13 (cont'd)

- Resolution:
  - If the patient presents with a medical reason such as tinnitus, hearing loss and/or dysequilibrium concerns, and has recently seen his or her physician, contact to that physician's office and request that a referral be faxed to you prior to conducting any diagnostic testing.
  - Request that the referral be made on the practice letterhead or prescription pad and that the referral be written in the patient chart.

Scenario 13 (cont'd)

- Resolution:
  - If the patient has not had contact with his or her physician, refer the patient to the physician for evaluation prior to testing
  - If the patient refuses to seek medical evaluation prior to testing, then the services you provide are excluded from Medicare benefit and the patient becomes financially responsible at the time of service.

Timely Issues of Concern

Recovery Audit Contractors (RAC)

- **RAC's:**
  - Given authority by CMS to recover overpayments and underpayments per the Medicare Prescription and Drug Modernization Act of 2003
  - Pilot program began in CA, NY, FL
  - Over $400,000,000 in overpayments identified
  - Over $144,000,000 in collections
    - Contractors receive a percentage of what they recover
      - Interest rate of payments: 12.125%
  - Tax Relief and Recovery Act of 2006 mandates:
  - Implementation in all 50 states by 2010
  - Implementation to begin 2008
  - Audiology is at risk for 92547
    - Moratorium issued between 5/04 to 2/05
    - Guidance was one unit per date of service (no multiples)

Recovery Audit Contractors: How to Resolve

- Academy is in discussion with other organizations whose members will be affected
- Working with other associations and CMS
  - CMS timeline and guidance was faulty and not well publicized

Medicare Physician Fee Schedule

- For 2008, were to sustain a 10.1% cut in the conversion factor, part of the valuation formula of a code's valuation:
  - Now there's a .5% increase until June 30, 2008
  - Conversion Factor is now $38.0870
    - If no action taken, the 10.1% decrease will be in effect on July 1, 2008

Get Ready…Strap on Your Boots

- We will enjoy a 2% increase in 2008
- By 2010, we will be suffering a potential 17% decrease
  - Academy is working on a prevention plan
  - Dictated by budget neutrality
  - Good news is that we have work values, but we will suffer the same cuts as physicians
  - 2008 GPCIs may be impacted

Resources

- "Capturing Reimbursement: A Guide for Audiologists"
  - www.audiology.org
- Centers for Medicare and Medicaid Services
  - www.cms.hhs.gov
- CPT Manual
  - catalog.ama-assn.org
  - www.ingenix.com
- ICD-9-CM Manual
  - atalog.ama-assn.org
  - www.ingenix.org

Resources (cont'd)

- Healthcare Common Procedure Coding System (HCPCS) Manual
  - catalog.ama-assn.org
  - www.ingenix.com
- Majors Scientific Books
  - www.majorsbooks.com
- National Plan & Provider Enumerator System
- www.nppes.cms.hhs.gov

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THANK YOU!