2018

Hospital Outpatient Prospective Payment System for Audiologists and Speech-Language Pathologists

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

General Information

This document, developed by the American Speech-Language-Hearing Association (ASHA), provides an analysis of the 2018 Medicare Hospital Outpatient Prospective Payment System (OPPS), including Ambulatory Payment Classifications (APCs) using CPT (Current Procedure Terminology ® American Medical Association) codes. The OPPS is primarily used by audiologists providing services to outpatient Medicare beneficiaries in hospitals, and some speech-language pathologists providing instrumental assessments that are not classified in the Medicare system as therapy services. The CPT codes are listed in their assigned APCs with the national payment rates. Please check ASHA's Billing and Reimbursement website for the most up-to-date information. For additional information or questions, please contact the Health Care Economics and Advocacy Team at reimbursement@asha.org.

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Overview

Payment for hospital-based outpatient audiology services are made under the Outpatient Prospective Payment System (OPPS). Payment is determined by assignment of the Current Procedural Terminology (CPT) code to an Ambulatory Payment Classification (APC).

This document includes regulations and rates for implementation on January 1, 2018, for audiologists providing services to Medicare Part B beneficiaries in the hospital setting under the OPPS. National payment rates for audiology-related services are also included.

Speech-language pathology services performed in hospital outpatient clinics are billed fee-for-service through the Medicare Physician Fee Schedule (MPFS), with the exception of a few CPT codes not classified as "always" or "sometimes" therapy codes. Services billed through the OPPS do not require the –GN modifier. A complete list of the "always" therapy codes can be found on the CMS Annual Therapy Update website.

Additional information can be found on ASHA's Outpatient MPFS website. For questions, please contact reimbursement@asha.org.

Analysis of the 2018 Hospital Outpatient Prospective Payment System

The hospital Outpatient Prospective Payment System (OPPS) pays for designated services performed in hospital outpatient departments, including audiology services and select speech-language pathology services. Units of payment are calculated in the Ambulatory Payment Classification (APC), which groups individual services to APCs based on similar characteristics and costs. The reimbursement for each service within the APC is the same. Some APCs are classified as "ancillary," which indicates that those services, when performed with other "primary services," are seen as dependent on the primary service and not paid for separately. This method of bundling payment is referred to as "packaging."

See **Table 1** for a listing of APC classifications and rates for vestibular and audiology services, **Table 2** for cochlear implant and osseointegrated implant surgeries, **Table 3** for related electrophysiological studies, and **Table 4** for speech-language pathology and related services.

2018 Payment Updates

CMS is updating OPPS rates by 1.35% and estimates that hospital outpatient departments will see a 1.4% increase in payments, after the impact of all other policy changes are taken into consideration.

Revised Ambulatory Payment Classifications (APCs)

CMS finalized revisions to the values of several APCs related to audiology services and moved CPT codes among these APCs, as reflected in **Tables 1-4**.

APC Change for Caloric Vestibular Testing

As part of the revision to APCs, CMS has reclassified CPT codes 92537 (caloric vestibular test, bithermal, with recording) and 92538 (caloric vestibular test, monothermal, with recording) to a different APC, which results in a reduced payment of over 40% for each service. Audiologists should be prepared for a decrease in payment for caloric testing when provided in the outpatient hospital setting, as illustrated in the following table.

Year	APC	APC Descriptor	National Rate
2017	5722	Level II Diagnostic Tests and Related Services	$232.21
2018	5721	Level I Diagostic Tests and Related Servcies	$136.31

Site Neutral Payment

Section 603 of the Bipartisan Balanced Budget Act of 2015 authorized the removal of certain items and services from payment through the OPPS when furnished by non-excepted off-campus provider-based departments (PBDs) of hospitals. Instead, these items and services are paid under the MPFS using established rates specific to off-campus PBDs, beginning January 1, 2017. PBDs may not be in the same building or complex, but are still considered part of the hospital and must meet all of the conditions of participation and payment as a hospital. According to CMS, exceptions to this requirement that are eligible to be billed by off-campus PBDs under the OPPS are items and services that are provided:

1. By a dedicated emergency department;
2. By an off-campus PBD that was billing for services prior to November 2, 2015, and has continued to bill from the same address since that time; or
3. In a PBD that is located "on campus" or within 250 yards of the hospital.

For calendar year (CY) 2018, CMS is finalizing a reduction to the current PFS payment rates for these items and services by 10%. CMS currently pays for these services under the PFS based on a percentage of the OPPS payment rate. Specifically, the final policy will change the PFS payment rates for these services from 50% of the OPPS rate to 40% of the OPPS rate. CMS believes that this adjustment will provide a more level playing field for competition between hospitals and physician practices by promoting greater payment alignment.

2018 OPPS Ambulatory Payment Classifications and National Fees

How to Read the OPPS Tables

The **APC (Ambulatory Payment Classification)** denotes the classification group with CPT codes based on similar characteristics and costs.

The **national fee** is the remimbursement rate for each code within the APC.

Classification Codes:

J1—*Hospital Part B service paid through a comprehensive APC*
All covered Part B services on the claim are packaged with the primary *J1* service for the claim, except services with classification codes *F*,*G*, *H*, *L* and *U*; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. APCs and CPT codes with those classifications are paid separately and are not packaged with the *J1* service.

Q1—*Packaged APC Payment*
APCs and CPT codes billed on the same date of service as those classified with *S*, *T*, or *V* are packaged and not paid for separately. If billed without the classified *S*, *T*, or *V*, payment is made at the APC rate.

Q3 – *Packaged APC Payment*
Service may be paid for separately if not billed with a composite APC.

S—*Separate APC Payment*
Regardless of the services performed on the same date of service, the CPT code is paid at the APC classification rate.

T – *Separate APC Payment; Multiple Payment Procedure Reduction applies*
Regardless of the services performed on the same date of service, the CPT code is paid. However, services may be reduced if multiple codes subject to the Multiple Payment Procedure Reduction payment policy are billed.

Table 1. Ambulatory Payment Classifications (APCs) and National Fees: Vestibular and Audiology Services

The services listed below are paid under the hospital OPPS. Any audiology CPT codes not in Table 1 may be paid under the Outpatient MPFS when provided in a facility setting, or bundled into the hospital inpatient prospective payment system for patients admitted into a Part A inpatient stay.

APC	Descriptor (2018 National Rate)		Bundling Classification	Notes
5721	*Level I Diagostic Tests and Related Servcies* (**$136.31**)			*2017 Rate:* $127.05
	92540	Vestibular evaluation	S	
	92544	Optokinetic nystagmus test	S	
	92545	Oscillating tracking test	S	
	92546	Sinusoidal rotational test	S	
	92584	Electrocochleography	S	
	92586	Auditory evoked potential – limited	S	
	92601	Cochlear Implant initial <7 years old	S	
	92602	Cochlear implant subsequent <7 years	S	
	92603	Cochlear implant initial >7 years old	S	
	92604	Cochlear implant subsequent >7 years	S	
	92640	ABI programming	S	
	92550	Tympanometry & reflex threshold	Q1	
	92553	Audiometry air & bone	Q1	
	92557	Comprehensive hearing test	Q1	
	92562	Loudness balance test	Q1	
	92570	Acoustic immitance testing	Q1	
	92572	Staggered spondaic word test	Q1	
	92579	Visual audiometry (VRA)	Q1	
	92582	Conditioning play audiometry	Q1	
	92620	Auditory function 60 minutes	Q1	
	92625	Tinnitus assessment	Q1	
	92626	Eval. of auditory rehab status	Q1	
	92537	Caloric vestibular test, bithermal, w/rec	S	Moved from APC 5722
	92538	Caloric vestibular test, monothermal, w/rec	S	Moved from APC 5722
5722	*Level II Diagnostic Tests and Related Services* (**$248.81**)			*2017 Rate:* $232.21
	92585	Auditory evoked potential (ABR), comprehensive	S	
	92587	OAE limited	S	
	92588	OAE comprehensive	S	

APC	Descriptor (2018 National Rate)		Bundling Classification	Notes
5723	*Level III Diagnostic Tests and Related Services* (**$444.36**)			*2017 Rate:* $415.69
	92577	Stenger speech test	S	
5731	*Level I Minor Procedures* (**$17.47**)			*2017 Rate:* $12.61
	92700	Miscellaneous ENT procedure/service	Q1	
	92564	SISI hearing test	Q1	Moved from APC 5732
5732	*Level II Minor Procedures* (**$31.80**)			*2017 Rate:* $28.37
	92555	Speech threshold audiometry	Q1	
	92556	Speech threshold & discrimination	Q1	
	92563	Tone decay hearing test	Q1	
	92565	Stenger pure tone	Q1	
	92567	Tympanometry	Q1	
	92568	Acoustic reflex threshold	Q1	
	92571	Filtered speech test	Q1	
	92575	Sensorineural acuity test	Q1	
	92576	Synthetic sentence test	Q1	
	92583	Select picture audiometry	Q1	
	92596	Ear protection measurement	Q1	
5733	*Level III Minor Procedures* (**$54.53**)			*2017 Rate:* $55.94
5734	*Level IV Minor Procedures* (**$105.03**)			*2017 Rate:* $99.98
	92541	Sponteneous nystagmus test	Q1	
	92542	Positional nystagmust test	Q1	
	92548	Posturography	Q1	
	92552	Pure tone audiometry	Q1	Moved from APC 5733
	92561	Bekesy audiometry	Q1	

Table 2. APCs and National Fees: Cochlear Implant and Osseointegrated Implant Surgeries

The following APCs may be of interest to audiologists in cochlear implant centers. However, the procedures in this table are for informational purposes only and are not for billing by audiologists.

APC	Descriptor (2018 National Rate)		Bundling Classification	Notes
5115	*Level V Musculoskeletal Procedures* (**$10,122.22**)			*2017 Rate:* $9,557.20
	69714	Implant AOI, w/o mastoidectomy	J1	
5116	*Level VI Musculoskeletal Procedures* (**$15,369.94**)			*2017 Rate:* $14,697.92
	69715	Implant AOI, w/mastoidectomy	J1	
5166	*Cochlear Implant Procedure* (**$31,823.55**)			*2017 Rate:* $31,823.55
	69930	Implant cochlear device	J1	

Table 3. APCs and National Fees: Related Electrophysiological Studies

The following APCs may be of interest to audiologists in cochlear implant centers. Audoiolgists will need to confirm with state licening agencies and hospital policies regarding the provision of electrophysiological studies not related to hearing and balance studies. Medicare requires direct (on-site) supervision by a physician.

APC	Descriptor (2018 National Rate)		Bundling Classification	Notes
5721	*Level I Diagostic Tests and Related Servcies* (**$136.31**)			*2017 Rate:* $127.05
	92516	Facial nerve function test	S	
	95907	Nerve condution 1-2 studies	S	
	95927	Somatosentory testing	S	
	95930	Visual evoked potential test	S	
	95937	Neuromuscular junction test	S	
5722	*Level II Diagnostic Tests and Related Services* (**$248.81**)			*2017 Rate:* $232.21
	95908	Nerve conduction 3-4 studies	S	
	92909	Nerve conduction test 5-6 studies	S	
	95910	Nerve conduction 7-8 studies	S	
	95925	Somatosentory testing	S	
	95926	Somatosentory testing	S	
5723	*Level III Diagnostic Tests and Related Services* (**$444.36**)			*2017 Rate:* $415.69
	95911	Nerve conduction 9-10 studies	S	
	95912	Nerve conduction 11-23 studies	S	
	95913	Nerve conduction 13+ studies	S	
	95938	Somatosensory testing	S	

Table 4. APCs and National Fees: Speech-Language Pathology and Related Services

The following APCs include the services of interest to or performed by speech-language pathologists in the outpatient hospital setting that are not billed through the Medicare Physician Fee Schedule. These services are not on "always" or "sometimes" therapy codes and therefore do not require the –GN modifier or the functional outcomes with severity modifiers (G-codes). Services not listed are billed fee-for-service and require adherence to the Medicare fee schedule rules.

APC	Descriptor (2018 National Rate)		Bundling Classification	Notes
5151	*Level I Airway Endoscopy* (**$157.07**)			*2017 Rate:* $146.14
	92511	Nasopharyngoscopy	T	
5152	Level II Airway Endoscopy (**$375.44**)			*2017 Rate:* $361.77
	31579	Diagnostic laryngoscopy	T	
5721	Level I Diagnostic Tests and Related Services (**$136.31**)			*2017 Rate:* $127.05
	96111	Developmental testing	Q3	
5722	Level II Diagnostic Services and Related Tests (**$248.81**)			*2017 Rate:* $232.21
	92512	Nasal function studies	S	
5731	Level I Minor Procedures (**$17.47**)			*2017 Rate:* $12.61
	92700	Miscellaneous ENT procedure	Q1	
5734	Level IV Minor Procedures (**$105.03**)			*2017 Rate:* $99.98
	92520	Laryngeal function studies	Q1	


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