Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
MaineCare Services
Policy Division
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Augusta, Maine 04333-0011
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TTY: Dial 711 (Maine Relay)

DATE: May 14, 2019

TO: Interested Parties

FROM: Michelle Probert, Director, MaineCare Services

SUBJECT: Adopted Rule: Chapter 101, MaineCare Benefits Manual, Chapters II and III, Section 109, Speech and Hearing Services

This letter gives notice of an adopted rule: Chapter 101, MaineCare Benefits Manual, Chapters II and III, Section 109, Speech and Hearing Services.

The Department of Health and Human Services ("the Department") adopts these changes.

Chapter II: The Department adopts changes to the rule which add two new covered services for adult members (members over the age of 21). The added covered adult services are: (1) Hearing Aid Evaluation and Related Procedures, by Audiologist; and (2) Hearing and/or Hearing Aid Periodic Recheck. In the previous rule, these two services were available for child members only. The Department is making these services available to adults because hearing aids and replacement hearing aids are a covered service under Section 60 Medical Supplies and Durable Medical Equipment, and this helps to ensure that adult members received medical evaluations for the hearing aids.

In addition to the changes above, the Department updated the definition for "Hearing Aid Services."

Chapter III: The Department adopts changes to this rule that increase specific rates pursuant to Resolves 2017, ch. 60, Resolve, Regarding Reimbursement for Speech and Language Pathology Services ("Resolves"). The Resolve requires codes to be amended to increase agency rates, independent rates, speech-pathology assistant agency rates, and speech-language pathology assistant independent rates in Chapter 101, MBM, Chapter III, Section 109, Speech and Hearing Services. The Resolve provided funding to increase reimbursement for these increased rates. The Department adopts:

- Adding Agency rates at 69% of Medicare for codes 92507 (GN), 92521 (GN), 92522 (GN), 92523 (GN), 92607 (GN), 92608 (GN), 92609 (GN), and 92610.
- Adding Independent rates at 90% of Agency rates for codes 92507 (GN), 92507 (TF, GN), 92508 (HQ, GN), 92508 (TF, HQ, GN), 92521 (GN), 92522 (GN), 92523 (GN), 92524 (GN), 92526 (GN), 92607 (GN), 92608 (GN), 92609 (GN), and 92610.

The Resolve directed that these increased rates be effective retroactively to January 1, 2019. However, CMS has indicated to the Department that the rates can be increased no earlier than January 12, 2019 because of the notice of change in reimbursement methodology requirement in 42 CFR § 447.205. The retroactive application of these increased rates comports with 22 M.R.S. § 42(8) which authorizes the Department to adopt rules with a retroactive application for a period not to exceed eight calendar quarters if there is no adverse financial impact on any MaineCare member or provider. The Department has submitted a State Plan Amendment to CMS to allow for the rate increases to be effective retroactive to January 12, 2019.

The Resolve directed the Department to increase certain rates to a precise percentage of the federal Medicare rate for the same service. The final adopted rates are slightly lower than the proposed rates because, for the proposed rule rates, the Department inadvertently used the 2018 federal Medicare national reimbursement rates rather than the 2018 federal Medicare local (Maine 99) reimbursement rates (which is the same area/code the Department uses for other MaineCare rates). Upon advice from the Office of the Attorney General, the Department does not believe the change in rates require additional notice and public comment. In each instance, the final rate is higher than the rates in the former Ch. III regulation.

The Department makes additional changes to the rule:

- Removing the requirement of under age 21 only from codes 92592, 92593, and V5264.
- Adding the following codes so they can be billed under Section 109, as they currently can be billed only under the MCBM, Section 90 (Physician Services). The Department is seeking CMS approval for these changes, with a May 19, 2019 effective date. The chart below matches the new codes to the provision of Section 109 policy which authorizes these services:

Billing Code	Description	Section of Policy
92537	Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	109.07-1; E, K, O, and N
92538	Caloric vestibular test with recording, monothermal (ie, one irrigation in each ear for a total of two irrigations)	109.07-1; E, K, O, and N
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	109.07-1; E, K, O, and N
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	109.07-1; E, K, O, and N
92542	Positional nystagmus test, minimum of 4 positions, with recording	109.07-1; E, K, O, and N
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	109.07-1; E, K, O, and N
92545	Oscillating tracking test, with recording	109.07-1; E, K, O, and N
92546	Sinusoidal vertical axis rotational testing	109.07-1; E, K, O, and N
92547	Use of vertical electrodes	109.07-1; E, K, O, and N
92548	Computerized dynamic posturography	109.07-1; E, K, O, and N
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing.	109.07-1; E, K, O, and N
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	109.07-1; A, E, K, O, and N
92612	Flexible endoscopic evaluation of swallowing by cine or video recording	109.07-1; A, E, K, O, and N

V5011	Fitting/orientation/checking of hearing aid	109.07-1; S

Rules and related rulemaking documents may be reviewed at, or printed from, the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or call Maine Relay at 711.

A concise summary of the adopted rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Chapters II and III, Section 109, Speech and Hearing Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY:
The Department of Health and Human Services ("the Department") adopts these two rules.

Chapter II: The Department adopts changes to the rule which add two new covered services for adult Members (Members over the age of 21). The added covered adult services are: (1) Hearing Aid Evaluation and Related Procedures, by Audiologist; and (2) Hearing and/or Hearing Aid Periodic Recheck. In the previous rule, these two services were available for children Members only. The Department is adding them as adult service because hearing aids and replacement hearing aids are a covered service under Section 60 Medical Supplies and Durable Medical Equipment. The Department wanted to ensure that adult members received medical evaluations for the hearing aids.

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  The chart below matches the new codes to the provision of Section 109 policy which authorizes these services:

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See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

HTTP://WWW.MAINE.GOV/DHHS/OMS/RULES/INDEX.SHTML for rules and related rulemaking documents.

EFFECTIVE DATE: 05/19/19

AGENCY CONTACT PERSON: Cari Philbrick, Comprehensive Health Planner
AGENCY NAME: Division of Policy
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109.01 PURPOSE

The purpose of this rule is to provide medically necessary speech-language pathology and audiology services to MaineCare members who are adults (age twenty-one (21) and over) with rehabilitation potential or to those who have demonstrated medical necessity for speech therapy to avoid a significant deterioration in ability to communicate orally/visually, safely swallow or masticate that would result in an extended length in stay or placement in an institutional or hospital setting, and medically necessary speech-language pathology and audiology services to MaineCare members who are under age twenty-one (21).

109.02 DEFINITIONS

109.02-1 **Audiology Services** means those services requiring the application of theories, principles and procedures related to hearing and hearing disorders for the purpose of assessment and treatment.

109.02-2 **Augmentative and Alternative Communication Devices (AACD)** are electronic or non-electronic aids, devices, or systems and related components, accessories and supplies that assist in overcoming or ameliorating the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities.

109.02-3 **Augmentative and Alternative Communication Services (AACS)** are services provided to assist the individual in meeting the full range of his/her communication needs. The goal of AACS is to overcome or ameliorate the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities.

109.02-4 **Hearing Aid Services**: The hearing aid benefit is described in Chapter II, Section 60, "Medical Supplies and Durable Medical Equipment".

109.02-5 **Practitioner of the Healing Arts**: physicians and all others registered or licensed in the healing arts, including, but not limited to, nurse practitioners, podiatrists, optometrists, chiropractors, physical therapists, occupational therapists, speech therapists, dentists, psychologists and physicians' assistants.

109.02-6 **Rehabilitation Potential** is a documented expectation by the member's physician or PCP (Primary Care Provider for members receiving MaineCare Primary Care Case Management Services) that the member's condition will improve significantly in a reasonable predictable period of time as a result of the prescribed treatment plan. The physician or PCP's documentation of rehabilitation potential must include the reasons used to support the physician or PCP's expectation.

109.02 **DEFINITIONS** (cont.)

109.02-7 **Speech and Hearing Agency** is a facility that offers, at a minimum, both speech-language pathology services and audiology services by qualified professional staff who are employees of the speech and hearing agency. Contracted staff are not considered employees.

109.02-8 **Speech-Language Pathology Services** are those services requiring the application of theories, principles and procedures related to the development and disorders of speech, voice, language, and oral pharyngeal and related functions, for purposes of assessment and treatment.

109.03 **ELIGIBILITY FOR CARE**

Members must meet the financial eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare, as described in Chapter I, prior to providing services.

109.04 **SPECIFIC ELIGIBILITY FOR CARE**

Services for members of all ages must be medically necessary and ordered by a practitioner of the healing arts as allowed by the respective licensing authority and his or her scope of practice. The Department or its authorized agent has the right to perform medical eligibility determination and/or utilization review to determine if services are medically necessary.

Adult members (age twenty-one (21) and over) must have an initial evaluation by a physician or PCP documenting that the member has experienced a significant decline in his/her ability to communicate orally/visually, safely swallow or masticate, and that the member has rehabilitation potential; or that the member may suffer a significant deterioration in ability to communicate orally/visually, safely swallow or masticate that would result in an extended length in stay or placement in an institutional or hospital setting. This requirement will not apply to members with Medicare coverage or other third party health insurance until the coverage for speech therapy services by the other payer has been exhausted.

109.05 **DURATION OF CARE**

A. Each Title XIX and XXI member is eligible for as many covered services as are medically necessary as determined by the Department of Health & Human Services. The Department reserves the right to request additional information to determine medical necessity; and

B. Members aged twenty-one (21) and older, who receive speech therapy services, must obtain a re-evaluation of their progress in speech therapy by a speech-language pathologist every six (6) months. The report of the speech-language pathologist's progress and prognosis for improved speech, oral/visual communication, swallowing or chewing functioning must be sent to a physician

109.05 **DURATION OF CARE** (cont.)

or PCP, who must in turn, determine if the member meets the criteria described in Section 109.04, "Specific Eligibility for Care". Services will be covered only as long as the member meets the eligibility requirements in 109.04.

109.06 **SETTING**

MaineCare will reimburse speech and hearing services when provided in appropriate settings. Approved settings for these services are the practitioners' office, speech and hearing agencies, members' homes, and schools for members under age 21.

Services may be provided in an alternative setting at the practitioner's discretion when the following conditions are met:

1. The services are medically necessary.

2. The setting is conducive to the services being provided.

For speech and hearing services provided in a nursing facility or an ICF-MR by a speech-language pathologist or audiologist, refer to Chapter II, Section 67, "Nursing Facility Services", or Section 50, "ICF-MR Services".

109.07 **COVERED SERVICES**

A covered service is a service for which the member is eligible and payment can be made by the Department. All covered services provided under this Section must be ordered or requested in writing by a practitioner of the healing arts as allowed by the respective licensing authority and his or her scope of practice. Covered services are also limited to the following:

109.07-1 **Covered Services for All Members**

The following services are covered for all members:

A. **Speech, Voice and Language Evaluation, Diagnosis and Plan of Care by Speech-Language Pathologist**

A direct encounter between a licensed speech-language pathologist and the member to determine the status of both receptive and expressive communication skills.

B. **Speech, Voice and Language Therapy and/or Aural Rehabilitation, Individual**

The process of producing behavioral change in the member with a communication disorder involving a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

109.07 **COVERED SERVICES** (cont.)

C. **Speech, Voice and Language Therapy and/or Aural Rehabilitation, Group**

The process of producing behavioral change in the member with a communication disorder involving other than a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

D. **Speech and Language Periodic Re-Evaluation**

A direct encounter between member and speech-language pathologist to determine current status with periodicity determined by plan of care. At minimum, re-evaluations will occur and plans shall be updated within six (6) months of the date of the plan of care.

E. **Speech Pathology Diagnostic Services at Physician or PCP's Request**

Specialty testing by speech-language-pathologist to assist in diagnosis and development of a medical plan of care. Report will include speech-language pathologist's recommendations. Currently acceptable medical tests and procedures are to be utilized as medically necessary.

F. **Hearing Screening by a Speech-Language Pathologist**

Pure tone air conduction testing by a speech-language pathologist as part of a hearing screening program.

G. **Speech, Voice and/or Language Screening**

Speech, voice and/or language screening performed by a licensed speech-language pathologist or a registered speech-language pathology assistant as part of screening.

H. **Augmentative and Alternative Communication Evaluation Services**

The scope of augmentative and alternative communication evaluation services including: diagnostic, screening, preventive, and corrective services provided by a licensed speech-language pathologist or, as appropriate, a registered speech-language pathology assistant. Specific activities include: evaluation for, recommendations of, design, set-up, customization, reprogramming, maintenance, and training related to the use of an AACD. Refer to Chapter II, Section 60, “Durable Medical Equipment”, of the *MaineCare Benefits Manual* for criteria for augmentative communication devices.

109.07 **COVERED SERVICES** (cont.)

I. **Therapeutic Adaptations and Set-Up for Assistive/Adaptive Equipment**

This shall include customizing the operational characteristics of an AACD in order to meet the needs of the individual member and to maximize the use and effectiveness of the device.

This service shall be performed by a licensed speech-language pathologist who is familiar and has experience with augmentative communication devices.

J. **Reprogramming**

This shall include any necessary reprogramming of AACD equipment when performed by a licensed speech-language pathologist or registered speech-language pathology assistant who is familiar and has experience with augmentative communication devices.

K. **Audiologic Evaluation, Diagnosis and Plan of Care, by Audiologist**

A direct encounter between a member and an audiologist to determine the member's hearing status.

L. **Audiologic Evaluation for Persons Difficult to Test**

Based on a written plan of care serial evaluation for persons difficult to test in order to obtain reliable audiologic information necessary for case management.

M. **Audiologic Evaluation for Site of Lesion**

A direct encounter between a member and an audiologist which determines site of lesion; this may include, but is not limited to, the following tests: pure tone air, pure tone bone, speech audiometry, Bekesy, tonedecay, short increment sensitivity index (SISI), impedance, alternate binaural loudness balance tests (ABLB).

N. **Audiologic Evaluation as a Result of Change in Hearing Status Because of Disease, or Trauma**

Audiologic evaluation necessitated by an observed or suspected change in a member's hearing status because of disease or injury, on referral from a physician or PCP.

109.07 **COVERED SERVICES** (cont.)

O. **Audiologic Diagnostic Services at Physician or PCP's Request**

Specialty testing performed by an audiologist to assist in diagnosis and developing a medical plan of care. The report shall include audiologist's recommendations.

P. **Aural or Language Rehabilitation (including speech reading), Individual, by Audiologist**

The process of producing behavioral change in the member presenting communication disorders related to auditory function, involving a one-to-one relationship, and following a plan of care. This includes cochlear implant follow-up aural rehabilitation services.

Q. **Aural or Language Rehabilitation (including speech reading), Group, by Audiologist**

The process of producing behavioral change in the member presenting a communication disorder related to auditory function involving other than a one-to-one relationship and following a plan of care.

R. * **Hearing Aid Evaluation and Related Procedures, by Audiologist**

Covered services must be provided by an audiologist, and include evaluating members for hearing aid and demonstrating the basic features of hearing aids to the member. For each evaluation of a member, the audiologist will write a written report.

Members are eligible for one hearing aid or one replacement hearing aid every five years, through Section 60 (Medical Supplies and Durable Medical Equipment). Providers must submit prior authorization request and documentation for hearing aids, as required in Section 60.

S. *** Hearing and/or Hearing Aid Periodic Recheck**

Covered services must be provided by an audiologist and include re-evaluating members in accordance with a written plan of care.

T. *** Ear Molds**

NOTE: "Group" is defined as two to four individuals with one clinician. When services are provided, a brief notation must be made for each individual in his/her medical record.

*The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services of these changes.

109.07 **COVERED SERVICES** (cont.)

109.07-2 **Covered Services for Members under the Age of Twenty-One (21)**

Coverage of the following services is limited to members under the age of twenty–one (21):

A. **Hearing Screening for Children up to Age Five (5) by an Audiologist**

109.08 **LIMITATIONS**

109.08-1 **Audiology Evaluation**

If such an evaluation has already been performed by another audiologist within the previous four (4) months, prior authorization (PA) by the Department is required. Refer to Section 109.09-5, below, for procedure to request PA.

109.08-2 **Adult Speech-Language Pathology Services**

The member must also receive an initial evaluation by a speech-language pathologist that supports the physician or PCP's determination that the member meets the eligibility criteria described in Section 109.04, "Specific Eligibility for Care". If speech-language pathology services are to be continued beyond a period of six (6) months, a re-evaluation by a speech-language pathologist must be completed every sixth month from the initial determination of rehabilitation potential, in order to determine that eligibility continues to exist. A report of the results of the speech-language pathologist's six-month re-evaluation must be sent to the member's physician or PCP, who will use that information to decide if eligibility continues to exist. If the physician or PCP agrees in writing that eligibility continues to exist, the member may continue to receive speech-language pathology services for an additional six (6) month period.

109.09 **POLICIES AND PROCEDURES**

109.09-1 **Records**

The provider will maintain an individual record for each member eligible for MaineCare reimbursement, including but not limited to:

A. Name, birthdate, MaineCare ID Number.

B. Referral from a practitioner of the healing arts as allowed by the respective licensing authority and his or her scope of practice, made in writing or by telephone prior to the delivery of service. Written referral confirming a telephone referral must be included in the record within thirty (30) days of the original order.

C. Pertinent medical information, as available, regarding the member's condition.

109.09 **POLICIES AND PROCEDURES** (cont.)

D. Appropriate hearing and/or speech-language evaluation and diagnosis.

E. A plan of care which includes identified problems, treatment in relation to the problems, and obtainable goals. This plan shall be updated in relation to the member's progress in reaching the goals.

F. Documentation of each visit, showing the date of service, the service performed, the start time and stop time of the service, indicating the total time spent in delivering the service, and the signature of the individual performing the service.

G. Progress notes written regularly (at least quarterly), which state the progress which the member has made in relation to the plan of care.

H. A discharge summary with a copy sent to the referring practitioner of the healing arts.

I. Copies of prior authorization or any other pertinent information concerning the member.

Members' records will be kept current and available to the Department as documentation of services included on invoices.

109.09-2 **Audiology Reports and Plan of Care**

The report of hearing evaluation or specific audiology procedures will include a plan of care based on audiologic and other data obtained. The plan of care is a prerequisite to aural rehabilitation and speech-language therapy, and should include but not be limited to: Diagnosis with severity rating, short and long-term goals(s) and objectives, method of evaluating member change, estimated time to achieve goal(s) and objectives, frequency and duration of therapy contacts, and periodicity of review.

109.09-3 **Qualified Professional Staff**

A. A speech-language pathologist must hold a valid license from the State or Province in which the services are provided in order to receive reimbursement.

B. Audiologists must hold a valid license for the State or Province in which the services are provided in order to receive reimbursement.

C. A speech-language pathology assistant must be registered as a speech-language pathology assistant by the Maine Board of Examiners on Speech-Language Pathology and Audiology, as documented by written evidence from such Board, or be registered in accordance with the licensure of the State or Province in which services are provided.

109.09 **POLICIES AND PROCEDURES** (cont.)

A speech-language pathology assistant must be supervised by a licensed speech-language pathologist.

D. A speech and language clinician must be a licensed speech-language pathologist.

109.09-4 **Division of Program Integrity**

Members under the age of twenty-one (21) may get the speech and hearing services for which they qualify, and which are covered in the *MaineCare Benefits Manual*. However, the Department or its authorized agent will review speech and hearing services for children under the age of twenty-one (21) for medical necessity as outlined in Chapter I of this Manual.

See Chapter I of this Manual for additional information on Division of Program Integrity activities.

109.09-5 **Procedure to Request Prior Authorization**

To request prior authorization of adult services, the request must be made in writing to:

Prior Authorization Unit
Division of Health Care Management
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011

109.10 **REIMBURSEMENT**

The maximum amount of payment for services rendered is the lowest of the following:

A. The provider's usual and customary charge,

B. The amount listed in Chapter III, Section 109 of the *MaineCare Benefits Manual*,

C. The lowest amount allowed by Medicare Part B, when applicable.

In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

109.11 COPAYMENTS

109.11-1 Copayment Amount

A. A copayment will be charged to each MaineCare member receiving speech pathology services, with the exception of those exempt, as specified in the *MaineCare Eligibility* Manual, such as children. The amount of the copayment shall not exceed $2.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	**Member Copayment**
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 or more	$2.00

B. The member shall be responsible for copayments up to $20.00 per month whether the copayment has been paid or not. After the $20.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

C. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the copayment. A member's inability to pay a copayment does not, however, relieve his/her liability for a copayment.

Providers are responsible for documenting the amount of copayments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

109.11-2 Copayment Exemptions and Dispute Resolutions

See Chapter I of this Manual for information on copayment exemptions and dispute resolutions.

109.12 BILLING INFORMATION

Providers must bill in accordance with the Department's “Billing Instructions for the CMS1500 Claim Form.”

SECTION 109 SPEECH AND HEARING SERVICES Last Updated:05/19/19

MaineCare coverage of Speech and Hearing Services is limited. Refer to Chapter II, Section 109.08 for specific limitations. Use the following modifiers whenever appropriate, as well as any other HIPAA compliant billing modifiers not listed below that apply to the service. The Modifier(s) column below is for reference only. Professional judgment of Qualified Professional Staffing in accordance with 109-09.3 should make the final determination.
Modifier GN if services are delivered under an outpatient speech-language pathology plan of care.
Modifier TF applicable for Assistant services.
Modifier HQ for group services (two (2) to four (4) members with one clinician).
Modifier 52 if the service is reduced, or applied to one ear and not both.
Modifier TL for services performed under an Individualized Family Service Plan (IFSP).
Modifier TM if performed under an Individualized Education Plan (IEP) with MaineCare Addendum.
Modifier 22 if the work required to provide a service is substantially greater than typically required. (Documentation must be submitted with the provider claim that supports the substantial additional work and the reason for that additional work. If so, after manual clinical review by the Department or authorized agent, the provider will receive an additional twenty-percent (20%) reimbursement for the service.

The Independent Rate applies to organizations with either one or more Speech Language Pathologist or Audiologist.

Billing Code	Modifier(s)	Description	Agency Rate	Independent Rate	HIPAA compliant unit defined as
92507	GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	$53.05*	$47.74*	per session
92507	TF,GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual intermediate level of care (Assistant)	$44.55	$40.10*	per session
92508	HQ,GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	$19.80	$17.82*	per member per session

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Billing Code	Modifier(s)	Description	Agency Rate	Independent Rate	HIPAA compliant unit defined as
92508	TF,HQ,GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals (Assistant)	$19.80	$17.82*	per member per session
92521	GN	Evaluation of speech fluency (eg, stuttering, cluttering)	$76.93*	$69.24*	per session
92522	GN	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	$62.33	$56.10*	per session
92523	GN	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)with evaluation of language comprehension and expression (eg, receptive and expressive language)	$133.38*	$120.04*	per session
92524	GN	Behavioral and qualitative analysis of voice and resonance	$64.52	$58.07*	per session
92526	GN	Treatment of swallowing dysfunction and/or oral function for feeding	$69.35	$62.42*	per session
92537**		Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	$27.26	$19.69	per session
92538**		Caloric vestibular test with recording, monothermal (ie, one irrigation in each ear for a total of two irrigations)	$13.83	$9.98	per session
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	$65.87	$47.57	per session
92541**		Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	$36.30	$26.21	per session

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Billing Code	Modifier(s)	Description	Agency Rate	Independent Rate	HIPAA compliant unit defined as
92542**		Positional nystagmus test, minimum of 4 positions, with recording	$37.56	$27.13	per session
92544**		Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	$30.16	$21.78	per session
92545**		Oscillating tracking test, with recording	$28.27	$20.42	per session
92546**		Sinusoidal vertical axis rotational testing	$50.53	$36.49	per session
92547**		Use of vertical electrodes	$3.00	$2.17	per session
92548**		Computerized dynamic posturography	$57.32	$41.40	per session
92550		Tympanometry and reflex threshold measurements	$20.13	$20.13	per session
92551		Screening test, pure tone, air only	$12.12	$8.76	per session
92552		Pure tone audiometry (threshold); air only	$18.36	$13.26	per session
92553		Pure tone audiometry (threshold); air and bone	$23.28	$16.81	per session
92555		Speech audiometry threshold;	$13.43	$9.70	per session
92556		Speech audiometry threshold; with speech recognition	$20.83	$15.04	per session
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	$29.83	$21.54	per session
92561		Bekesy audiometry; diagnostic	$23.53	$16.99	per session
92562		Loudness balance test, alternate binaural or monaural	$22.79	$16.46	per session
92564		Short increment sensitivity index (SISI)	$16.14	$11.66	per session
92565		Stenger test, pure tone	$9.26	$6.69	per session
92567		Tympanometry (impedance testing)	$9.28	$6.70	per session
92568		Acoustic reflex testing, threshold	$11.65	$11.65	per session
92570**		Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing.	$21.78	$15.73	per session

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Billing Code	Modifier(s)	Description	Agency Rate	Independent Rate	HIPAA compliant unit defined as
92579		Visual reinforcement audiometry (VRA)	$32.19	$23.25	per session
92582		Conditioning play audiometry	$37.07	$26.77	per session
92583		Select picture audiometry	$25.75	$18.59	per session
92585		Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	$75.46	$54.34	per session
92586		Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	$37.14	$26.82	per session
92587		Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked optoacoustic emissions, with interpretation and report	$20.88	$19.37	per session
92588		Distortion product evoked otoacoustic emissions; comprehensive or diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	$31.98	$31.98	per session
92592		Hearing aid check; monaural	$25.79	$18.62	per session
92593		Hearing aid check; binaural	$25.79	$18.62	per session
92601		Diagnostic analysis of cochlear implant, patient younger than 7 years of age, with programming	$107.70	$77.78	per session
92602		Diagnostic analysis of cochlear implant, patient younger than 7 years of age, subsequent reprogramming	$66.33	$47.90	per session
92603		Diagnostic analysis of cochlear implant, age 7 years or older, with programming	$105.15	$75.94	per session
92604		Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	$62.27	$44.97	per session

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Billing Code	Modifier(s)	Description	Agency Rate	Independent Rate	HIPAA compliant unit defined as
92607	GN	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	$88.11*	$79.30*	60 mins
92608	GN	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	$35.36*	$31.82*	30 mins
92609	GN	Therapeutic services for the use of speech-generating device, including programming and modification	$73.85	$66.47*	per session
92610		Evaluation of oral and pharyngeal swallowing function	$57.79*	$52.01*	per session
92611**		Motion fluoroscopic evaluation of swallowing function by cine or video recording	$58.89	$53.00	per session
92612**		Flexible endoscopic evaluation of swallowing by cine or video recording	$125.93	$113.33	per session
92620		Evaluation of central auditory function, with report; initial 60 minutes	$34.11	$29.20	60 mins
92621		Evaluation of central auditory function, with report; each additional 15 minutes	$8.62	$7.38	15 mins
92630	GN	Auditory rehabilitation; prelingual hearing loss	$55.50	$40.08	per session
92630	HQ,GN	Auditory rehabilitation; prelingual hearing loss (Group)	$36.63	$26.45	per member per session
92633	GN	Auditory rehabilitation; postlingual hearing loss	$55.50	$40.08	per session
92633	HQ,GN	Auditory rehabilitation; postlingual hearing loss (Group)	$36.63	$26.45	per member per session

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Billing Code	Modifier(s)	Description	Agency Rate	Independent Rate	HIPAA compliant unit defined as
96110	GN	Developmental screening (eg, developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument	$5.32	$3.85	per session
V5008		Hearing screening	$17.02	$12.86	15 mins
V5008	TF	Hearing screening (Assistant)	15.32	$11.57	15 mins
V5010		Assessment for hearing aid	$17.75	$12.78	15 mins
V5011**		Fitting/orientation/checking of hearing aid	$56.85	$51.17	per session
V5264		Ear mold/insert, not disposable, any type	$45.50	$32.86	per unit
V5362		Speech screening	$17.76	$12.87	15 mins
V5362	TF	Speech screening (Assistant)	$14.65	$10.58	15 mins
V5363		Language screening	$17.76	$12.87	15 mins
V5363	TF	Language screening (Assistant)	$14.65	$10.58	15 mins
V5364		Dysphagia screening	$17.76	$12.87	15 mins
V5364	TF	Dysphagia screening (Assistant)	$14.65	$10.58	15 mins

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