CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12091	**Date: June 15, 2023**
	Change Request 13055

Transmittal 11935 issued March 30, 2023, is being rescinded and replaced by Transmittal 12091, dated June 15, 2023, to update business requirement 13055.5.2 to replace MSN 90.94 with MSN 20.94. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and may now be posted to the Internet.

SUBJECT: Allowing Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to establish edits to ensure the following: (a) that only one visit to an audiologist without a physician/NPP order is permitted, per beneficiary, once every 12 months, instructing that claims billed more frequently are denied; (b) that the visit may reflect one or more codes on an applicable list of 36 CPT codes, found in APPENDIX A, along with modifier AB, be billed via providers with certain bill types for outpatient hospitals, critical access hospitals, and SNFs; and, (c) that an audiologist's National Provider Identifier (NPI) is the rendering provider on the line of service, with the AB modifier, which is alongside an applicable code found in APPENDIX A.

EFFECTIVE DATE: July 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2023

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 12091	Date: June 15, 2023	Change Request: 13055

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I. GENERAL INFORMATION

A. Background: Audiologists are authorized to furnish diagnostic and balance assessment services under section 1861(ll)(3) of the Social Security Act (the Act). Hearing and balance assessment services, termed audiology services, are generally covered as "other diagnostic tests" under section 1861(s)(3) of the Act. Audiology services may also be provided by physicians and NonPhysician Practitioners (NPPs), including Physician Assistants (PAs), Nurse Practitioners (NPs), and Clinical Nurse Specialists (CNSs) when authorized by state law and scope of practice.

Before 2023, by regulation at 42 CFR 410.32(a), payment for all these diagnostic services furnished by audiologists were required to have an order from physicians or NPPs who are treating the patient. While all services furnished by audiologists must be personally provided, audiologists do not need the supervision of a physician/NPP to do so.

During Calendar Year (CY) 2023 Physician Fee Schedule (PFS) rulemaking, CMS finalized a regulatory provision at §410.32(a)(4) that allows an exception to the treating physician/NPP order requirement to allow audiologists to personally furnish certain diagnostic tests ─ using a finalized list of 36 Current Procedural Terminology (CPT) codes found in Table 36 in the CY 2023 PFS final rule at 87 FR 69662 ─ without an order. These tests are limited to certain non-acute hearing conditions and diagnostic services related to implanted auditory prosthetic devices (including cochlear, osseointegrated, and auditory brainstem implants), but may not include audiology services that are related to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids (outlined at §411.15(d)). These services (include those that are listed as Audiology Services not requiring a physician/NPP order, as applicable, on the PFS website at: https://www.cms.gov/audiology-services) may be performed once every 12 months using modifier AB created for this purpose ─ it's long descriptor follows: *Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary*.

Modifier AB ─

- Is required to be used alongside any of the codes on the finalized list of 36 CPT codes, but only when the beneficiary has directly accessed the audiologist (that is, without a physician/NPP order); although, there will be times that audiologists will bill for these services, as appropriate, when the beneficiary presents with an order/referral from a physician/NPP that will not have the modifier appended.

- Is not applicable to the remainder of the codes on the Audiology Services code list ─ 14 CPT codes for vestibular function tests – for which codes billed with the AB modifier will be rendered unpayable.

For each beneficiary, only one visit to an audiologist without a physician/NPP order is permitted every 12 months. That is, the audiologist may bill using modifier AB once every 12 months – regardless of the number of applicable CPT codes billed with the modifier on that date of service. For example, if one CPT code is billed with the AB modifier on a certain date, none of the codes on the list of 36 applicable CPT codes will be payable under the PFS for another 12 months without a qualifying order.

The diagnostic service(s) may reflect one or several codes that is typically used for that particular encounter with the beneficiary. Diagnostic tests provided can include those that are split into a Professional Component (PC) and a Technical Component (TC) and those that are not. As with all services, the actual tests provided and their results must be documented in the medical record, for purposes of medical review. We note that modifier AB shall be billed with the designated code(s) for medically necessary non-acute conditions furnished by an audiologist without the order of the treating physician or nonphysician practitioner (NPP). In the event of the unexpected discovery of an acute condition during a visit with an audiologist without the order of the treating physician or NPP, modifier AB shall be billed with each of the services furnished, and the presence of the acute condition will not be cause to deny the claim, provided that good faith efforts were made, as documented in the medical record, to avoid furnishing audiology services for acute conditions without the order of the treating physician or NPP. During this interim period and at all other times, however, the beneficiary may seek care from his or her treating physician (or NPP) in order to receive medical care that could potentially result in a referral to an audiologist for further diagnostic testing.

B. Policy: This instruction is to establish the billing requirements needed to process claims for diagnostic tests with modifier AB when directly accessed by beneficiaries and personally provided by audiologists. In order to be paid, the professional claim requires that the NPI of an audiologist is on the detail line as the rendering provider when the service/code is billed with modifier AB; that the use of modifier AB, along with the applicable code(s), be limited to a frequency of one visit, once every 12 months per beneficiary; and, to ensure that if modifier AB is billed more frequently than that, it is denied. We also developed new Medicare Summary Notifications (MSNs) for use in the business requirements to notify beneficiaries regarding when they are eligible to see the audiologist again without a physician/NPP referral; and when claims are denied because (a) services with the modifier AB were not provided by an audiologist and (b) modifier AB was billed more frequently than once every 12 months. Further, claims will be returned when the AB modifier is billed alongside a CPT code for which it is not applicable.

NOTE: CMS will annually provide the AB modifier code list update on the CMS website at: https://www.cms.gov/audiology-services. An update to the Appendix A CPT code list will be provided through a CR when needed. Since new CPT codes may not be added every calendar year, a CR would only be written when the APPENDIX A code list is revised/updated. The Part A and Part B Medicare Administrative Contractors may access the website for these updates.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility

		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13055.1	Effective for dates of service (DOS) on or after July 1, 2023, contractors shall process and pay for audiology services when submitted on type of bill 12x, 13x, 22x, 23x, and 85x with the AB modifier and one of the CPT codes provided in the list of applicable 36 CPT codes.	X				X				
13055.1.1	Contractors shall post SNF claims where the services are billed with a TC modifier as Tech, all other SNF services as PROF. For the other type of bills 12x and 13x, if billed with a TC modifier, CWF shall post as Tech. If billed with a 26 modifier post as PROF, and for all other CPT codes (listed in Appendix A) if billed post as TECH. CWF shall post type of bill 85x based on the REV codes.								X	
13055.2	Effective for DOS July 1, 2023 or after, contractors shall process and pay the CPT codes listed in Appendix A when claims are submitted with the AB modifier and the rendering NPI of an audiologist (specialty code 64) is present on the detail line.		X							
13055.2.1	Contractor shall process and pay detail lines submitted with the rendering NPI of an audiologist when one or more of the CPT codes listed in Appendix A, with the 'AB' modifier, are present on the same detail line and an ordering/referring physician or nonphysician practitioner is not present on the claim.		X							
13055.2.2	Contractor shall process and pay detail lines submitted with the rendering NPI of an audiologist when one or more of the CPT codes listed in Appendix A, with the AB modifier, are present on the same detail line and an ordering/referring physician or nonphysician practitioner is present on the claim.		X							
13055.2.3	Contractor shall deny detail lines submitted when one or more of the CPT codes listed in Appendix A, with the AB modifier, are present on the same detail line, and the rendering NPI is not an audiologist. Contractor shall use the following messages:		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• CARC: 8 – "The procedure code is inconsistent with the provider type/specialty (taxonomy)." • RARC: N95 – "This provider type/provider specialty may not bill this service." • Group Code: CO (Contractual Obligation) • MSN Message: 20.93 - This service was denied because the provider is not an Audiologist. • MSN Spanish Translation - Este servicio fue denegado porque el proveedor no es audiólogo.									
13055.2.4	The contractor shall post Part B services (36 CPT codes) as full component when received with AB modifier. Note: The contractor shall post CPT 92587/92588 appropriately, based upon any modifier that may be submitted for any submission of 92587 or 92588 with a TC and/or 26 modifier.								X	
13055.2.4.1	The contractor shall allow outpatient claims (TOB 22x, 23x, 12x, 13x and 85x w/rev 096x 097x or 098x) for the 36 CPT codes without the TC/26 component and Part B claims billing for the same date of service and same CPT code. The contractor shall consider this as one service for that date of service.								X	
13055.2.4.2	For professional claims, contractors shall return as unprocessable detail lines submitted with the rendering NPI of an audiologist when one or more of the applicable 36 CPT codes listed in Appendix A with the AB modifier are present on the same detail line with a TC or 26 modifier, except those codes that can be split into professional and technical components, 92587 and 92588. The contractor shall use the following messages: • Claims Adjustment Reason Code (CARC): 16- (Claim/service lacks information or has submission/billing error(s)) • Remittance Advice Remark Code (RARC):		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	N519- (Invalid combination of HCPCS modifiers) • Group Code: CO									
13055.3	Contractors shall return as unprocessable details lines when submitted with the AB modifier and any other CPT not on the list of applicable 36 CPT codes (see Appendix A). The contractor shall use the following messages: • Claims Adjustment Reason Code (CARC): 16- (Claim/service lacks information or has submission/billing error(s)) • Remittance Advice Remark Code (RARC): N519- (Invalid combination of HCPCS modifiers) • Group Code: CO		X							
13055.4	Contractors shall generate the following message on all paid detail lines/claims (per Business Requirements (BRs) 13055.1, 13055.2, 13055.2.1 and 13055.2.2): • Medicare Summary Notice (MSN) Message: 20.92 -Your Audiologist visit has been approved. You will qualify for another service 12 months after the date of this visit. • MSN Spanish Translation - Su visita al audiólogo ha sido aprobada. Usted calificará para otro servicio 12 meses después de la fecha de esta visita.	X	X			X	X			
13055.5	Contractors shall create a frequency edit to allow no more than one occurrence/visit on a treatment day (may include multiple services on the same date) per beneficiary for audiologist claims submitted with the AB modifier within 12 months.	X	X						X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: For example, if service(s) is provided with the "AB" modifier present on the claims with DOS on March 17, 2023, the beneficiary is not eligible again until March 17, 2024. The edit shall be overridable. Instructions will be provided in a TDL on the override conditions if/when needed.									
13055.5.1	The contractor shall process the new CWF error code that will be triggered based on the 12-month limitation for the new audiology modifier AB for the beneficiary.					X				
13055.5.2	Contractors shall deny claims/detail lines submitted with the AB modifier and applicable CPT codes that exceed the maximum limit of one occurrence/visit (may include multiple services on the same date) per beneficiary within 12 months. Contractors shall use the following messages: • CARC: 119 - "Benefit maximum for this time period or occurrence has been reached." • RARC: N362 - "The number of days or units of service exceeds out acceptable maximum." • Group Code: CO (Contractual Obligation) • MSN Message: 20.94 - This service was denied because it was too soon after your last Audiologist visit without a referral. Medicare covers one Audiologist visit without a referral once every 12 months. • MSN Spanish Translation - Este servicio fue denegado porque fue demasiado pronto después de su última visita al audiólogo sin un referido. Medicare cubre una visita al audiólogo sin referido una vez cada 12 meses.	X	X							
13055.6	Contractors shall use normal processing logic for audiologist claims submitted without the AB modifier.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13055.7	The contractor shall create a new reason code to assign when the new AB modifier is billed with a CPT code other than the allowed 36 CPT codes.					X				
13055.7.1	The contractor shall return the claim to provider with the reason code when submitted with the AB modifier and any other CPT not on the list of applicable 36 CPT codes.					X				
13055.7.2	The contractor shall modify existing reason codes to allow for the processing of claims with the 36 CPT codes accompanied by the new AB modifier.					X				
13055.8	Contractors shall display the frequency limitation data on all the Common Working File (CWF) provider query screens, including the next eligible date for the CPT codes listed in appendix A on PRVN screen, HUQA, MBD and NGD.								X	HETS, MBD, NGD
13055.9	Contractor shall create a new Auxiliary File in Health Insurance Master Record (HIMR) to maintain Appendix A CPT codes.								X	
13055.10	Contractor shall display audiology service information, in a format equivalent to the CWF HIMR Screens, using the MCS Desktop Tool (MCSDT).						X			
13055.11	The contractor shall display the new audiology service information on the DDE screens, in a format equivalent to the CWF HIMR screens.					X				
13055.12	The contractor shall create a bypass to edit 7257, for Outpatient and Part B claims when AB modifier is present on Audiological Services.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13055.13	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Pamela West, 410-786-2302 or Pamela.West@cms.hhs.gov (For background and policy information) , Carla Douglas, 410-786-4799 or Carla.Douglas@cms.hhs.gov (For institutional claims processing issues) , Dennis Savedge, 410-786-0140 or Dennis.Savedge@cms.hhs.gov (For professional claims processing issues)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 1

	A	B	C
1	**Appendix A - Effective 01/01/2023 - "AB" Modifier Allowed**		
2		Editing for CR 13055 Effective 07/01/2023	
3	**CPT Code**	**Short Descriptor**	**Modifier AB Allowed**
4	**92550**	Tympanometry & reflex thresh	**YES**
5	**92552**	Pure tone audiometry air	**YES**
6	**92553**	Audiometry air & bone	**YES**
7	**92555**	Speech threshold audiometry	**YES**
8	**92556**	Speech audiometry complete	**YES**
9	**92557**	Comprehensive hearing test	**YES**
10	**92562**	Loudness balance test	**YES**
11	**92563**	Tone decay hearing test	**YES**
12	**92565**	Stenger test pure tone	**YES**
13	**92567**	Tympanometry	**YES**
14	**92568**	Acoustic refl threshold tst	**YES**
15	**92570**	Acoustic immitance testing	**YES**
16	**92571**	Filtered speech hearing test	**YES**
17	**92572**	Staggered spondaic word test	**YES**
18	**92575**	Sensorineural acuity test	**YES**
19	**92576**	Synthetic sentence test	**YES**
20	**92577**	Stenger test speech	**YES**
21	**92579**	Visual audiometry (vra)	**YES**
22	**92582**	Conditioning play audiometry	**YES**
23	**92583**	Select picture audiometry	**YES**
24	**92584**	Electrocochleography	**YES**
25			
26	**92587**	Evoked auditory test limited	**YES**
27	92587 – TC		**YES**
28	92587 – 26		**YES**
29			
30	**92588**	Evoked auditory tst complete	**YES**
31	92588 – TC		**YES**
32	92588 – 26		**YES**
33			
34	**92601**	Cochlear implt f/up exam <7	**YES**
35	**92602**	Reprogram cochlear implt <7	**YES**
36	**92603**	Cochlear implt f/up exam 7/>	**YES**
37	**92604**	Reprogram cochlear implt 7/>	**YES**
38	**92620**	Auditory function 60 min	**YES**
39	**92621**	Auditory function + 15 min	**YES**
40	**92625**	Tinnitus assessment	**YES**
41	**92626**	Eval aud funcj 1st hour	**YES**
42	**92627**	Eval aud funcj ea addl 15	**YES**
43	**92640**	Aud brainstem implt programg	**YES**
44	**92651**	Aep hearing status deter i&r	**YES**
45	**92652**	Aep thrshld est mlt freq i&r	**YES**
46	**92653**	Aep neurodiagnostic i&r	**YES**
47			