Centers for Disease Control and Prevention
EARLY HEARING DETECTION AND INTERVENTION
Ad Hoc Group - Teleconference

Agenda for January 2, 2001

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JUNE HOLSTRUM: Happy New Year, everybody. I hope you had a great holiday. I'm June Holstrum from the Centers for Disease Control and Prevention. Welcome to our January teleconference on Early Hearing Detection and Intervention. Thank you for joining us. Please remember to mute your microphone when you're not talking. Today's conference is being recorded and will be available on the Internet.

Before we begin our scheduled program, are there any announcements or comments from any of our listeners? None

JUNE HOLSTRUM: We have a couple of announcements here. The first one is that the CDC EHDI team is seeking a senior epidemiologist with expertise in planning, designing, implementing state-based tracking and surveillance systems. The applicant would be responsible for epidemiological component of the national program to promote the health and development of children through early detection of hearing loss and appropriate follow-up. If anyone is interested they can give me a call, or send a CV. The e-mail is jholstrum@cdc.gov; or give me a call at 770-488-7401.

Our other announcement is that we will soon be releasing the new 2001 EHDI RFP. It will be essentially the same as the 2000 RFP. The narrative from some of the successful applications from last year are available on the www.infanthearing.org Web site, so you can get a little help through those to see how successful applicants wrote their proposals. We're not sure how soon that will be out. It will probably be at least a couple more months, and we'll give you some updates as we progress on that.

Today's conference is a special issue dealing with funding and billing mechanisms, and our first speaker is Steve White from ASHA talking about billing for screening.
Go ahead, Steve.

STEVEN WHITE: Good afternoon, everyone. It's a pleasure to be here this afternoon.
And I just thought I'd let you know that the purpose of this presentation is to serve as a stimulus for discussion later during the conference call. I've learned over the years is that the more you speak in general about a reimbursement topic, the greater your chances are to hear that there are more exceptions than rules. There is an old axiom about HMOs: Once you've seen one HMO, you've seen one HMO. That can be converted to, “Once you've seen how one newborn infant hearing screening program is reimbursed, you've seen how one screening program is reimbursed,” because everybody is paid in a different way. And so what I'll describe this afternoon is some of the obvious reimbursement rules.

The first rule is that reimbursement is dependent on the site of service. Principally here we can discuss inpatient care, that is, those services performed with inpatients in hospitals; and outpatient care, and that would be in an audiologist's office, a physician's office, or an outpatient clinic in a hospital or other setting. The second rule is that reimbursement methodology is dependent on the individual payer. Attention can be given to three specific payers this afternoon.

The first payer is Medicare. Even though Medicare is known for paying for services rendered to people 65 and older and other Americans with severe disabilities, the program sets the standard for how different procedures are paid. The second payer is actually a group of payers – state Medicaid programs. The descriptions of the Medicaid programs indicate that they pay for some, if not all, of the services in early hearing loss detection and intervention (EHDI) programs. Payment for services would be required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) federal regulations.

The third classification payers are the private health plans. Here we can include fee-for-service plans such as Blue Cross and Blue Shield. There are also managed care organizations such as

health maintenance organizations (HMOs) and preferred provider organizations (PPOs). There are other ways that EHDI services receive reimbursement because of state grants and other state initiatives. I've asked Charlie Diggs to address those programs and state laws at the conclusion of my presentation.

All right, let's start with the inpatient setting, depending on the payer, whether that is Medicare, Medicaid, or a private plan. Medicare uses the diagnosis-related groups, or DRGs, for their prospective payment system (PPS). The hospital inpatient PPS went into effect in 1983 so it has a considerable history. I imagine that those of you who have services reimbursed in hospitals know the DRG system well. Medicare adjusts the DRGs on an annual basis based on information received regarding new costs for services rendered to patients for the principle diagnosis.

The two groups that I'll just mention today are DRG 373 (vaginal delivery without complication), and DRG 370 (cesarean section with complications). Medicare sets specific rates for these two DRGs, and may revise the DRGs annually if there are new data available to reflect costs for procedures related to these DRGs. State officials at Medicaid programs always observe Medicare payment methodology. If your state Medicaid agency uses the DRGs, it will be interesting for me to find out what your experience is. What we've heard is that most state Medicaid programs adapt their payment system to the federal DRGs. They modify the Medicare DRGs and determine the state's reimbursement rate. However, we do know that there are some states that may not be willing to revise their DRG rates when they are apprised that new technologies or new procedures are available and being used. We know at least one audiologist who is not very pleased with the fact that his state has mandated newborn infant hearing screening, while his state Medicaid program will not revise the DRG rate to reflect that requirement.

Now private plans -- we've moved from Medicare to Medicaid to private plans on the inpatient level -- private plans may also adopt a modified DRG system or some other per diem rate. Hospitals can usually negotiate with a private payer for new rates using the cost of new procedures or technologies as reason for a higher reimbursement rate.
To summarize - for reimbursement for inpatient services, especially as they relate to newborn infant hearing screening, the DRG system or other per diem system is probably used. Now an interesting part of this whole discussion is what happens at the outpatient setting. Medicare again is the trendsetter for outpatient services, and probably all of you know about the Medicare Physician Fee Schedule, which uses a resource-based relative value scale, or RBRVS.

The RBRVS uses three components for each outpatient procedure. The first component is physician work; the next component is practice expense, and this includes supplies, equipment, and non-physician labor costs; and the third component is the malpractice expense. The Health Care Financing Administration (HCFA) examines these three components, and then determines a reimbursement rate depending on the resources used for each of those three components.
The Medicare fee schedule uses procedures listed in the American Medical Association's Current Procedural Terminology or CPT. The codes are also included in the Level I HCFA common procedural coding system, or HCPCS.

When you take review the Federal Register wherein HCFA has issued the annual update of the Physician Fee Schedule, you'll find an extensive tabular listing. The table includes a list of CPT codes/HCPCS, a description of the individual procedures, the physician work relative value, the practice expense relative value, and, lastly, the malpractice expense relative value. HCFA sums the relative values for each procedure, that is, gives each CPT code a total value, and then provides a conversion factor by which that relative value is multiplied, and you the product is a reimbursement rate.

There are four relevant procedures to discuss this afternoon. One is 92585, or CPT 92585, (auditory evoked potentials, comprehensive); 92586, (auditory evoked potentials, limited); 92587 (evoked acoustic emissions, limited); and last, 92588 (comprehensive or diagnostic evaluation using evoked acoustic emissions). These procedure codes are probably well known by all

listening in this afternoon. The two limited procedures -- 92586, auditory evoked potentials, and 92587, evoked acoustic emissions limited -- are used for the outpatient hearing screening reimbursement rate for hearing screening. Outpatient infant hearing screening occurs for a number of reasons: a hospital doesn't have a screening program and therefore refers the baby to an outpatient setting such as an audiologist's office, physician's office; the baby is born at a birthing center; or the baby needs a rescreen and returns to the hospital as an outpatient. If you look at the ASHA Web site, we have the Medicare fee schedule posted. The national rate for the auditory evoked potential, limited (92586), is $79.58; and for evoked otoacoustic emissions (92587), limited, is $61.98.

For each state or urban area within a state, the Health Care Financing Administration provides geographic adjusters. In order to determine what the reimbursement rate is for a particular procedure, each rate must be adjusted according to geographic area. You should be aware that ASHA requested and received a new procedure designation, 92586, for the ABR limited code just last year. When the AMA Relative Value Update Committee discussed the value of the new procedure, they did not accept ASHA's recommendation for a practice expense because the committee was advised that the procedure was only performed as an inpatient procedure. The AMA recommendation to the Health Care Financing Administration was that there be no practice expense associated with the outpatient service. Subsequently, ASHA recommended to HCFA that practice expense be assigned to 92586, with the argument that the procedure is performed on an outpatient basis. HCFA accepted ASHA's recommendation for the 2001 Medicare Fee Schedule.

Payment occurs for early hearing loss detection procedures in both inpatient and outpatient settings. It may not be reflected in the DRG or inpatient per diem, but it should be. The procedure codes in the Medicare fee schedule demonstrate that HCFA has understood the need for reimbursement for these early identification procedures. I'll conclude with Medicare because most Medicaid programs -- and I'm sure I'll find out for sure this afternoon -- and private health plans model their payment systems on either the DRGs or the Medicare Physician Fee Schedule. Moreover, private health plans tend to use the Medicare relative values, or they establish reimbursement rates using negotiated rates on the CPT procedures.

And now I'll ask Dr. Charlie Diggs, the Director of State to Consumer Advocacy here at ASHA, to speak for a few minutes on how state laws address payment for infant hearing screening.

CHARLIE DIGGS: Good afternoon.
To paraphrase one of Steve's comments, once you find out what happens in one state, you've found out what's happened in one state. Although we now have 32 states plus the District of Columbia that mandates universal newborn hearing screening, there are only eight or nine of them, depending how you count, that actually address the reimbursement for the cost of screening.

The most comprehensive of the laws is the one in Missouri, which includes not only the initial screening, the rescreening, follow-up audiologic evaluation, but also includes purchase of the first hearing aids for the child. Now that's the good news. There's also a very comprehensive law in Florida which was passed recently and took effect in 2000. And it's good because it took a look at some of the problems other states that have reimbursement laws were having, and actually put some language in the statute to take care of those exceptions.

For example, in the six to nine states that talk about the reimbursement of infant hearing screening, some of their language was very general, and it said that the initial procedure for screening should be covered by anyone who offers a health insurance policy in the state. Well, the insurers came back and they said, well, it's already covered in the normal per diem rate that's provided for a normal delivery in the hospital. So having heard some of that, Florida added some specific language that said that it should be reimbursable and compensated supplemental to this

per diem rate.

Of the states that do reimburse for the initial screening, there are about three or four that only reimburse under the Medicaid program. And my favorite of all the laws is the one in Oregon that simply states that parents and children have the right to this procedure irrespective of their ability to pay, and they end right there.

So they don't say who's going to pay for it, whether the hospital absorbs it, whether the state absorbs it, as is the case in Massachusetts, although the model law that ASHA and other organizations have promoted has included an insurance coverage.

The reality is that in order to get the laws passed and to avoid some of the protests from the health insurance industry, they basically dropped that kind of phraseology. So that's sort of a snapshot picture of what reimbursement by statute is under the various state laws.

STEVEN WHITE: Paul, what I said is when the test is done as an outpatient procedure, if it is a screen then you would use the 92586 if it is indeed a screening procedure.

JUNE HOLSTRUM: Thank you, Steve and Charlie.
I think since we're doing things a little bit different we're going to hold questions until the end, keep all your questions and we'll have time for questions for discussion. Our next speakers are Peggy McManus and Margaret Hayden from the MCH Policy Research Center to talk about Medicaid managed care and Medicaid billing. Peggy.

PEGGY MCMANUS: Thank you very much. Just briefly, we operate in the Maternal and Child Health Policy Research Center in Washington, D.C. And over the years we've been funded by the Federal Maternal and Child Health Bureau to look at a lot of health care financing issues affecting children. This is the first time, however, we've been doing a study on hearing. And we have received a small grant from the Maternal and Child Health Bureau, and are working with Karl White at the National Center for Hearing Assessment and Management. And if our dreams could come true, our session today would be like two months from now, but this was on your agenda. So briefly what we're going to do is describe to you what information we're collecting on two studies. One of them is Medicaid managed care contract analysis, where we've been looking at the language in the Medicaid contract to see what newborn hearing screening provisions are there, and Margaret will explain that further. And the second study is a study of all the state Medicaid agencies to look at payment rates. And we intend to finish both of these studies in the spring of this year, so we're here today to describe those but not to give you findings. I'm going to turn it over to Margaret, who's going to give you a little more detail about what information we're collecting.

MARGARET HAYDEN: The first study, as Peggy explained, was an analysis of Medicaid managed care contracts. We looked at contracts used by the 42 state agencies that were enrolling children into managed care in June of 2000 -- looking for provisions that related to hearing screenings for newborns and adolescents, with attention to: what types of screening were specified for what ages, whether these were for all or just for at-risk children, and also whether plans were required or recommended to perform these screenings. Additionally, we looked at some provisions related to speech and language development in children. Our goal was to determine the extent to which these contract provisions were consistent with current medical standards on hearing screening that have been issued by the AAP and the Joint Committee on Infant Hearing.

And the second study that we're doing -- it's currently underway -- is to learn about how Medicaid is financing hearing screening and intervention services for these children enrolled in managed care organizations, but we're also looking at children in primary care case management programs and fee-for-service arrangements. For this study, we are interviewing state EPSDT coordinators (the Early and Periodic Screening, Diagnosis, and Treatment program coordinators) to learn

about what specific services are carved out of managed care contracts and what fees are paid for hearing services such as screens, evaluations, tests and equipment. We're also asking these coordinators some general questions on reimbursement, getting at some of the issues around hospital payment policy adjustments in response to recent medical guidelines on hearing screens, and just to find out really whether there have been any particular concerns in the states regarding reimbursement for these hearing services..

PEGGY MCMANUS: That's a quick summary of our two studies, which again we plan to have completed in spring of this year, and they will be coming out from Karl White's organization. Any questions, or June, how do you want to proceed?

JUNE HOLSTRUM: Thank you for that report, and we'll look forward to hearing about your results in a couple of months. We do have one more speaker that was not on your agenda.
Carri Brewer from the Pediatric Research Unit at the Medical College of Wisconsin is going to be talking about a survey of hospital reimbursement.

CARRI BREWER: Hi, June. Thank you.
Just a quick review on some of the research we've done on our universal newborn hearing screening in Wisconsin. In 1999 the Wisconsin legislature established a statute that is by August 5th, 2003, fewer than 88 percent of all deliveries in the state are performed in hospitals that have newborn hearing screening programs. Every hospital would be mandated to establish a newborn hearing screening program. With that established statute we, along with the Wisconsin Association for Perinatal Care, wanted to look at the prevalence of newborn hearing screening at Wisconsin hospitals and to estimate the prevalence in 2000 and 2001. We also wanted to look at follow-up procedures and programs for newborns with abnormal tests.

In January 2000 we sent a 16-question survey to 102 hospitals asking a variety of questions about testing referrals, data management systems, referral systems, and education and technical assistance needed, including financial assistance needed to implement or improve their program. We had a 93 percent response rate to our survey, and we found that the number of programs increased from 2 in 1997 to 33 in 1999, and the number of newborns tested increased from 10 percent in '97 to 31 percent in 1999. We had some interesting findings from our survey. One in particular was that with each additional 100 births per hospital, the likelihood of establishing a program increased by 21 percent. We also found that hospitals who had a program coordinator or a registered nurse performing the testing were 11 and 14 times more likely to establish a follow-up procedure for diagnostic and intervention services.

Lastly, we found that hospitals in Wisconsin are basically voluntarily implementing UNH programs, and we estimate that by late 2001 approximately 73 percent of all newborns will be tested in Wisconsin for their hearing. With that said and with our results, we decided to look at reimbursement and follow-up procedures for these hospitals who have established newborn hearing screening programs. So we just sent out a follow-up survey this past Tuesday, it was January 2nd, and we sent it to the 33 hospitals with current programs. And we hope to be sharing those results with you in March, and we're hoping to find out reimbursement information as well as referral and follow-up type procedures. So with that, June, thank you.

JUNE HOLSTRUM: Thank you, Carri.
For the rest of our time today we would like to open it up to discussion and questions, either for our speakers, or anyone else that might be listening is also free to answer. And also we'd like to hear from programs that have developed unique ways or mechanisms to reimburse. So anyone that has a question, feel free to lead off.

PENNY HATCHER: This is Penny Hatcher in Minnesota. Margaret Hayden, with the MCH Policy Research Center, I'd like to ask you a question on your survey of EPSDT coordinators. How many states were you doing?

MARGARET HAYDEN: We're doing all the states.

PENNY HATCHER: Okay. And then the second question is are you looking at a question related to whether they have newborn hearing screening on their periodicity schedule?

MARGARET HAYDEN: We actually have looked at that through the contracts analysis piece, the first study that we did, and we're actually confirming those findings when we go through and make these calls.

PEGGY MCMANUS: But we anticipate -- this is Peggy McManus talking -- that there will probably be a lot of follow-up needed by the state EHDI coordinators based on some of the preliminary findings. There's a lot of work to be done, I think.

PENNY HATCHER: Peggy, this is Penny Hatcher again. Can you clarify that statement? I'm getting the feeling that you're finding some things that coordinators are going to need to follow-up.

PEGGY MCMANUS: This will be laid out in the report, but essentially I think we were surprised to see that the compliance with the recommended standards wasn't as high as we thought it might be. So the periodicity schedules, I think, need to be updated to be consistent with the current standards. But we'll have all that information on a state-by-state basis for you.

VINCE CAMPBELL: This is Vince Campbell at CDC. I wanted to ask about your survey of hospitals, number of live births and increasing likelihood of universal newborn hearing screening.

CARRI BREWER: Yes, we did track the number of births, and total number of births. Are you wondering how that relates to actual reporting?

VINCE CAMPBELL: Well, I was wondering if there seemed to be some sort of critical threshold that they cross that would put them over into reporting.

CARRI BREWER: No, that was not an issue

PAT RICE: This is Pat Rice calling from Minnesota. I'm curious if anybody has any information about hospitals that have looked to renegotiate their rate after implementing a program, and to what extent they were successful in getting the payers to pay.
[No response]

JUNE HOLSTRUM: Must have been a tough question.

PAT RICE: I guess so.

JUNE HOLSTRUM: Maybe somebody will think about it and come up with an answer.

FRAN STEVENS: This is Fran Stevens from New York. I've got just some food for thought, and I don't know -- I guess the answer might be it depends on every state's legislation. But my question is, if the outpatient reimbursement is higher than what ends up as a negotiated increase in DRGs for inpatients, is this going to serve as a disincentive to hospitals to screen in hospital and rather to wait for outpatient?
I know it's kind of a [inaudible] issue, but if you double the reimbursement for outpatient are we setting up some disincentives for inpatient screening?

CHARLIE DIGGS: This is Charlie Diggs.
I think in New York -- your law's a little different, since it does allow for screening within the first 30 days of birth.

FRAN STEVENS: Right.

CHARLIE DIGGS: Most of the other states require the screening before the dismissal from the hospital. So what you might be seeing is exactly what you talked about, a disincentive [inaudible] New York to do the inpatient and to go with the outpatient if that's a greater reimbursement rate. I don't see that occurring throughout the rest of the country.

FRAN STEVENS: We haven't actually begun yet, but I raise the issue anyway.

PAUL KILENY: This is Paul Kileny from Michigan. I have a couple of comments, and then a question to Steve White, I believe.

First of all, I was not surprised but not quite happy by the silence to the question regarding adjusting DRGs, which means that that hasn't happened. And that has been our experience here in the state of Michigan, too. One thing that everybody should know and understand and remember, that a covered benefit doesn't necessarily mean reimbursement, or certainly doesn't necessarily mean realistic reimbursement for any kind of service, especially for a service that is mandated by the state.

Now if you forego inpatient testing in a state for, let's say, a Medicaid-covered baby and the Medicaid policy is that this service is covered by DRG 373, even if you bill it as an outpatient procedure you will not be reimbursed. That is pretty clear because it's part of the DRG, and the fact that you have not done it as an inpatient, that really doesn't matter as far as the reimbursement is concerned.

Now the question that I had with Steve, and maybe I didn't hear it correctly, his comment correctly, is did you say, Steve, that for a follow-up test in an outpatient setting you recommend using the ABR limited, 92586?

STEVE WHITE: Paul, what I said is when the test is done as an outpatient procedure, if it is a screen then you would use the 92586 if it is indeed a screening procedure.

PAUL KILENY: Okay, so you did not say that for a follow-up for an infant, for a newborn that has failed the screening, bringing him back for an outpatient testing you should use 92585, which is the standard ABR DRG, correct?

STEVEN WHITE: You're correct. What I understand is that some hospitals have the baby go see an audiologist or return to the hospital for a follow-up, and they just perform a rescreen, not a comprehensive assessment.

PAUL KILENY: Well, this is all semantic, but the moment you do a second test -- a screening is a one-shot snapshot, is a one single procedure. That's by definition, in medical terms, that's what screening is. The moment that you do a second or a third test that is not screening, regardless of what specific techniques you use to perform the second or third test.

KARL WHITE: Paul, this is Karl White, and I need some clarification about your comment. It seems to me there are a number of other screening procedures, such as cystic fibrosis, that are explicitly two-stage screening protocols, and both stages are recognized as a part of the screening protocol. That's certainly the case in many newborn hearing screening programs. They have an inpatient component and an outpatient component even though it's still considered screening. Am I wrong on that?

PAUL KILENY: Well, I think that in the case of hearing evaluation the second procedure should not be considered a screening.

KARL WHITE: For example, here in Utah a part of the state rule that accompanies the legislation is that when the hospital chooses to use otoacoustic emissions as the in-hospital procedure, they

are then required to do an outpatient screening, and the rule states that it is a part of the screening procedure.

PAUL KILENY: Well, that's because that's how the rule was set in this particular state. However, one could also argue that anything that follows an initial screen -- and the purpose of the screen is to divide the population into a proportion that is very likely to have normal function, in this case hearing, and into another component that is at risk for hearing loss because of the screening result. And the next step really should be to establish whether this patient does or doesn't have the hearing loss, in which case it's not a screening anymore.

KARL WHITE: I guess I disagree with that. It depends on how you define screening. I don't see anything in medical literature I read that says screening has to be a single procedure. As I noted earlier, cystic fibrosis, for example, is clearly a two-stage procedure. And I think with hearing screening it could be as well.

PAUL KILENY: Well, I obviously disagree with that. I think that any subsequent test, when you test hearing, should be considered a comprehensive or a diagnostic procedure. And indeed you do have the opportunity for the second test to do a diagnostic procedure. Now if you choose to just stop at a single level ABR test, that's clearly overloading the system because then you may have to bring back that infant again, and thus escalate costs which are already poorly reimbursed.

KARL WHITE: I think there's another way to look at that, that second stage B

PAUL KILENY: No, that's -- I think that's a more economic debate, view. Now I have just another comment regarding how to bill for an outpatient procedure. There's certain hospitals or birthing centers who, because of the numbers, are exempt from performing UNHS, and those then refer to another institution.

Now the only way or the only realistic way to be reimbursed for the test by the other institution is to bill the institution that has made the referral. Because again, if you're in a state where, for instance, Medicare or Medicaid has declared newborn hearing screening to be part of a DRG like 373, then by billing an outpatient procedure to Medicaid or Medicare you will not be reimbursed. So the only way to be reimbursed under those circumstances is if you bill the institution where this baby was born. And I don't know if anybody has any contrary knowledge or opinion about this, but this is an important issue because smaller institutions with small numbers of deliveries are really exempt of doing screening and are exempt of the expenses, while the larger institutions need to carry all of the burden, especially given that reimbursement is virtually non-existent.

STEVE WHITE: This is Steve. So in essence what you're doing is subcontracting with the referral institution?

PAUL KILENY: Correct.

STEVE WHITE: That's a fairly common practice in a number of other areas I'm aware of, so I'm not surprised by it.

KARL WHITE: This is Karl White again from NCHAM. It depends on the state whether those smaller institutions are exempt or not. Every state has a different cutoff. Some require all birthing facilities, some all with more than 50 births, some all with more than 200 births. So that varies widely across the country.

MIKE ADAMS: This is Mike Adams at CDC.
I was wondering if anybody from the Georgia program is on the call. Adam Roache or anybody?

ELANA MORRIS: Yes, I'm from the Georgia program.

MIKE ADAMS: Yes, I was wondering, I think you have a rather innovative way to use some of your monies, your tobacco monies, to provide incentives to get your hospitals to screen.

ELANA MORRIS: Yes. What Georgia has done is through the tobacco settlement funds through the Medicaid agency they've given the public health agency, which is our agency, money for an incentive program. And what will happen is that those hospitals that provide 85 percent screening universally for newborns will receive, I think it's about $40, for any screening of a Medicaid client. It's not through the Medicaid program; it will be -- they will get that reimbursement from the state health department. But the money is coming through the Medicaid program. And I think long-term Medicaid will be looking at adding the screening to the DRG. And that would be really a better long-term approach.

JUNE HOLSTRUM: Are there other states out there or other programs that have some innovative ways or incentives for paying for screening and evaluation expenses? If each state and each program has a different way of doing it, we'd like to hear about some of them.

BEPPIE SHAPIRO: This is Beppie in Hawaii, and I'll just tell you why I'm not giving you the way we do it. I don't know that. It's done hospital by hospital. And if you [inaudible] she might have a better clue about it. But as far as I know, we have not collected any information on how or whether each hospital is getting reimbursement.

PENNY HATCHER: We don't have a solution either, and we are a voluntary state. But we're fortunate right now that we're in the process of revising our EPSDT periodicity schedule. And we're going to use the Academy of Pediatrics well child schedule, and they do have newborn hearing screening there. And we're trying to sell it like it’s done for metabolic screen, and it seems like that might go through. Unfortunately that's only the Medicaid kids, and it will be outpatient reimbursement. But we find once that standard is set, then the private sector looks at that and feels, gee, why are we giving the Medicaid kids better service than the commercial children? And we go, well, then fine, give the commercial kids the same standard of care. And that's a little bit of peer pressure there. We hope it works.

MIKE ADAMS: Colorado, I understand -- this is sort of second-hand information, and perhaps someone who's a little closer might speak to it -- but I understand that Colorado, in the health department, they have authority to say what kind of procedures are done in newborn care, and that in fact they just added screening to that list. Someone there who could clarify that?

[No response]

MIKE ADAMS: Sounds like not, but it was also my understanding that not many states had that regulatory authority. It would be another route to go, however.

PAUL KILENY: Hi. This is Paul Kileny again. I just have a question. Has anyone else listening in whose institution and state DRG 373 is being used, and supposedly a portion is for newborn hearing screening, has anyone in an audiology or [inaudible] setting actually can account for any amount of funds have come in from the DRG specifically for newborn hearing screening?

BETTY VOHR: This is Betty Vohr from Rhode Island. The hospitals in Rhode Island contract for DRGs, but no one can ever give us feedback on what component is specifically for newborn hearing screening. That's essentially where we stand.

JUNE HOLSTRUM: Do we have any other questions before we sign off today?

EVEY CHEROW: I'm wondering if I could just make a plea, that for people who are still interested in signing up for ASHA’s Pediatric Audiology conference February 8th to 11th in St. Pete, Florida, that they can find the registration materials on our Web site. Just wanted to mention that again.?

Peggy, I'm wondering if you stated that you're reviewing hearing screening through adolescence, is that correct? And do you say that you're using AAP's hearing screening periodicity schedule?

PEGGY MCMANUS: I got a few beeps, and I didn't get the last part of the question.

EVEY CHEROW: Okay. I just wasn't sure if you've reviewed ASHA's guidelines on audiologic screening for the pediatric population and if that would be helpful to you.

PEGGY MCMANUS: Yes.

EVEY CHEROW: We don't have a screening schedule in chart form. It's in manual form, chapter by chapter, by age range across the pediatric population. I just didn't know if it would be helpful for your data analysis to make some comparisons in that regard.

PEGGY MCMANUS: What we've done so far is for the newborn period to follow what the Joint Committee on Infant Health and the AAP standards were, and then for the later age group to follow the AAP standards. That's how we've handled it so far.

EVEY CHEROW: Okay. If you need further information, we'd be happy to provide it.

PEGGY MCMANUS: Okay.

EVEY CHEROW: Thank you.

MELINDA PEET: This is Melinda Peet [phonetic] with the Office of Public Health in Louisiana. Could Steve please repeat the CPT codes he gave us earlier?

STEVE WHITE: Sure I can. There's 92585, which is auditory evoked potentials, comprehensive; and there's 92586, auditory evoked potentials, limited; 92587 evoked acoustic emissions, limited; and 92588, evoked otoacoustic emissions, comprehensive. And I just wanted to add this, especially for Paul, we'll look into what the Health Care Financing Administration is doing relative to newborn infant hearing screening programs as they relate to these DRGs when they rebase them.

KARL WHITE: Steve, this is Karl White from Utah. You said earlier that the 586 to 588 were just for outpatient screening? Was that right?

STEVE WHITE: Well, they're used for outpatient screening, but probably when the hospital does the inpatient report they will use the same procedure codes.

KARL WHITE: And so if a hospital were doing just inpatient screening, would they use the 586 code or the 588 code?
STEVE WHITE: They would use the same codes, yes.

KARL WHITE: And the figures you gave were $117.45 for 586 and $79.58 for 588.

STEVE WHITE: Let me repeat what I said.
For 92586, auditory evoked potentials, limited, it's $79.58. And then for evoked otoacoustic emissions, limited -- I think I did give a wrong number, so I'm glad you asked me again -- it's $61.98 (this is corrected for the transcript).

KARL WHITE: Okay.

STEVE WHITE: So I apologize for that.

KARL WHITE: Okay. So now say those again.

STEVE WHITE: Okay. 92586, auditory evoked potentials, limited, is $79.58. And 92587, evoked otoacoustic emissions, limited, is $61.98. And again, the whole Medicare outpatient fee schedule is on our Web site, so you can download the whole document in PDF format. But it's all there.
UNIDENTIFIED: And what's the Web site for that?

STEVE WHITE: That's www.asha.org.

SCOTT GROSSE: This is Scott Grosse at CDC.
Just to clarify, the Medicare codes are not related to Medicaid. The state Medicaid agencies are not required to follow the Medicare codes for reimbursement. They can choose any CPT they want.

STEVE WHITE: Well, as far as the codes themselves go, to describe the procedures the procedure's described and then the CPT code is given. And it's my understanding that for Medicaid programs if there's a CPT code, the Medicaid program should be using the CPT code.

SCOTT GROSSE: At least in Virginia, when I looked into this a couple of year ago, they were not.

STEVE WHITE: Well, they should be now. Well, for example, with the ABR limited there wasn't a code until 2001.

FRAN STEVENS: This is Fran Stevens. I just would like to clarify. You're actually saying that the CPT codes can be used for an inpatient procedure?
STEVE WHITE: Right. Remember the code itself only describes -- it only relates to the procedure. So if you're doing a specific procedure and there's a current procedural terminology for that, you can use that code. And I would imagine that the hospital has to fill out a form describing what procedures were done at the inpatient level, and if they call for CPT codes these would be the codes that you would use.
Now the use of a code for an inpatient does not mean that you're going to get a reimbursement related to the fee schedule.

FRAN STEVENS: Right. Okay. But you can try.

STEVE WHITE: You could try, I guess, and especially when you're negotiating with a private payer.

FRAN STEVENS: Okay, thank you.

UNIDENTIFIED: June, this is Janet Ferrell. I wanted to make one quick comment.
In Massachusetts there's a large percentage of -- that have insurance policies that are not subject to Mass. state law because they're self-insured, and there's a federal ERISA mandate that makes the insurance not have to pay even though the law says in Massachusetts that they're required to pay.
So last year we paid hospitals using an accommodation rate that we came up with based on a projection of the number of babies that we thought had self-insured policies. But I think people just need to be mindful that just because a law says that insurance pays, it doesn't necessarily mean it pays for all insurances.

STEVE WHITE: This is Steve. That's a very good point. You've probably read this for quite a while on Capitol Hill that a patient's bill of rights that relates to managed care organizations, but also relates to a number of other private health insurance matters. And what it would do, there was a provision in this last Congress in that legislation that would have eliminated ERISA preemptions from state laws. So you bring up a very good point on this.

JUNE HOLSTRUM: I want to thank you all for dialing in today. That's our program, and our next meeting will be on March 6, 2001. Again, thank you for joining us, and we'll talk to you in March.