2023 Coding and Reimbursement Update

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- It's my great pleasure to welcome back Dr. Kim Cavitt. She's going to be presenting to us today on the Coding and Reimbursement Update for 2023. If you'd like to learn more about Dr. Cavitt, you can read about her on the course registration page on AudiologyOnline, at this time, I'll hand the mic over to you.

- Thank you, and thank you to everyone at AudiologyOnline. I always really enjoy this annual event where I update my audiology colleagues on coding and reimbursement issues. So let's just get started. You can see my disclosures here, I'm not gonna focus at all on any specific product or topic. Here are our learning outcomes for today. And let's just jump right in. This is actually, I forgot to remove this slide, this is gonna show you the ADA, Academy of Doctors of Audiology member resources, but I'm gonna jump right in to the No Surprises, Good Faith Estimate. This actually went into effect last year. I do wanna bring it up again in this update, because I'm finding that many audiology practices have still not yet implemented the provisions of the No Surprises Act and the Good Faith Estimate.

So audiologists, if you are unsure about how to create a good faith estimate, what your roles within it are, you can always also consult a healthcare attorney. As you saw in the previous slide, those of you who are Academy of Doctors of Audiology members, they actually hired an attorney, there are resources and templates and webinars from that attorney on the ADA website. Why you might need to consult an attorney in this situation. The No Surprises Act that went into effect on January 1st, 2022 was actually a byproduct of many states, I think it was at one point 33 states who had no surprises, balance billing restrictions on their state books. And what the problem was is, the federal government realized that when that many states have these types of rules, they need to create something federally that will be overreaching to all 50 states in the nine territories.

That's where the No Surprises Act came from. Why you might need to consult an attorney is, that because there are a lot of states who already had these provisions on the books, some of those provisions are more restrictive, or actually more far-reaching, than the Federal No Surprises Act was, and I'll show you a link to a map in a minute so you can see if you might have some provisions in your state, but that's again, if you have state provisions, you may need an attorney to help you navigate them. If you are an independent contractor relationship, that means you are an independent contractor for another entity, where you might be out-of-network and they might be in or vice versa, you really should contact legal counsel, specifically an attorney who specialize in healthcare, because this is one of the big provisions of the No Surprises Act, when both entities of the patient is seen, the facility and the provider are both not in-network or out-of-network.

So again, if you're in some semblance of an independent contractor relationship with another party, again, please consult legal counsel, get some guidance how the No Surprises Act influences you in that situation. In a nutshell, any time a patient is self-paying, that means you are not billing a health plan, self-paying in any way, either that it is they're uninsured, it's a non-covered service, or a service you are not billing, anytime they're in a self-pay relationship, you have to have a good faith estimate in place. They have to receive it prior to the provision of care. Any situation where they are self-paying, your estimate needs to be within $400 of the final bill, or you're gonna need to provide another good faith estimate.

Now, let's talk about this versus you being an in-network provider with a health plan or an out-of-network provider with a health plan. If you are an in-network provider with a health plan, you would need to have a patient sign an advanced beneficiary notice for traditional Medicare or a notice of non-coverage prior to the provision of care for all non-covered or potentially non-covered services. That is separate from the good faith estimate. That is a provision of the health plan. So that's a provision of traditional

Medicare, that's a provision of Medicare Advantage, or that's a provision of a health insurance contract, that if you are going to bill their member, you're an in-network provider here, if you are gonna bill their member for a non-covered service, they need to have notice ahead of time.

Now, then separately, if you are not submitting a claim for those services, you're also going to need a good faith estimate. So you need a notice of non-coverage or an ABN, and you can collect all unmet deductibles, applicable co-insurance and co-payments, and the usual and customary charge of non-covered services at the time of visit. And three days before you see that person, if you are scheduling them out more than three days, more than 72 hours, you will have needed to provide them a good faith estimate, if any of the services that you suspect you're gonna provide on the date of service are not being billed to insurance. So you need a notice of non-coverage or an ABN to meet the health plan requirements, you can collect patient responsibility at the time of visit, or you can submit a claim, if you do not submit a claim, you need a good faith estimate.

If you are an out-of-network provider, I strongly recommend notices of non-coverage. The more you can have a patient acknowledge their financial responsibilities upfront, the less problems you have down the road. So anytime you think it's gonna be non-covered, or potentially non-covered, you're out of network and you're collecting everything upfront, you can have them sign a notice of non-coverage, that's not required, but it's something I recommend. You can collect your usual and customary rate for all items and services provided. Now, if any item or service that you're gonna provide as an out-of-network provider is not being billed to their health plan, you need a good faith estimate. And if you are billing things to their health plan, please do not accept assignment on a claim as an out-of-network provider.

You wouldn't accept assignment, because you're not in-network. And again, that detailed good faith estimate, so if you are not submitting any singular item or service to the insurance for claims processing, you need a good faith estimate if that patient is being scheduled out more than three days. And that means, that applies to hearing aid services, that applies to anything that could be potentially covered by the health plan, that can be billed, that has a code, needs a good faith estimate. Some of you may have office management systems that can automate this for you. Even in the audiology space, some of you may work for hospital or healthcare systems that are automating the good faith estimate.

Try to see how much of this your systems can automate for you based again, upon scheduling. But if you are not submitting something to insurance, you need a good faith estimate. Hearing aid patients who are not being fit with amplification the same day, 'cause you didn't schedule that fitting out, should always be receiving good faith estimates, which outline evaluation fitting and long-term care costs, as well as any non-refundable fees. You also are gonna need your bill of sale, in most states, there's a few that don't require a bill of sales, but if you require a bill of sale, you're going to need that as well to outline the patient's rights and responsibilities. That good faith estimate for hearing aid services can only be avoided if you submit every item and service to the health plan.

Phone triage during a scheduling process is invaluable to determining what needs to be on your good faith estimate. And again, you should have policies and procedures in your practice for providing this estimate when you are scheduling a patient out three or more days. This link is to a map that's been put together by the Commonwealth Fund. It's gonna show you all of the states that have some semblance of state provisions around balance billing and no surprises. So you want, if your state has provisions that it says there are state provisions, you again, might need to do a little more research, and or engage with an attorney to help you meet the requirements of your state, in addition

to the requirements of the federal government, because again, state, some of them, because they preceded the federal government, are more detailed and have more requirements than the federal government provisions have.

Now we're gonna move on to establishing the over-the-counter hearing aid. So here are the links to both the press release and the federal register. I encourage every audiologist to read the register, read the final rule on over-the-counter, because one thing that none of us anticipated, even someone like me who's been involved in OTC for a decade, since the beginning, I did not anticipate the creation of the prescription class, none of us did, and those provisions are something that affects every hearing aid sale, and has no impact on OTC, it's created another class of hearing aid, I really encourage everyone to read the final rule. So in establishing the over-the-counter hearing aid class, they allowed for outcome limits, they lowered the outcome limits to 111 decibels of sound pressure with 117 dB SPL allowable for input that have input-controlled compression, there's no gain limit, there are specific design requirements, specifically around insertion depth.

There's labeling, and you're seeing a lot of quotes here, because I took this directly from the register. They're phasing in labeling requirements, there is no age verification, it is intended for people 18 years and older, but there is no requirement for age verification for purchase. Over-the-counter is for perceived mild to moderate hearing impairment, that was the goal, and the goal of over-the-counter was zero provider involvement. That it would be off the shelf or from behind a pharmacy, it was not intended for provider involvement. And that's gonna have some implications here in a moment. The OTC category and the self-fitting category classifications, so prior to the OTC final rule, there was a air conduction class of hearing aid, and there was a self-fitting class of hearing aid.

They have now lumped things more together, there is an OTC class of hearing aid that cannot have a requirement for an evaluation and can be sold over-the-counter direct to consumer, and then there's a prescription class, where air, and bone, and wireless are now housed. So that second class is, requires a provider prescription, which you're gonna see in a minute. So it's important that everyone realize the OTC class was intended to not have provider involvement, no evaluation requirement, no fitting requirement, it can be self fit. The prescription class requires a prescription from someone who is licensed and eligible to dispense hearing aids. And that's again where air conduction, bone conduction and wireless are now housed.

There's quality requirements, they have to go through some manufacturing specifications of an OTC class to be able to be sold in the United States. Now again, enforcement is starting a little bit, but we're going to see enforcement I'm sure, hopefully ramping up over time to regulate this class so you don't see things that are really poorly manufactured. Now, they also established a prescription class and this was the surprise. Prescription hearing aids, and this is in quotes 'cause I wanna read it exactly, "Prescription hearing aids are prescription devices as subject to the federal rules. It's a device that is either in the possession of a person or his agents or employees, regularly and lawfully engaged in the manufacturer, transportation, storage, or wholesale or retail distribution of such device, or in the profession of a practitioner, such as physicians, dentists, and veterinarians, licensed by law to order and use such a device, and is to be sold only to or on the prescription of or other order of such practitioner for use in the course of his professional practice."

So hearing aids have to be delivered on a prescription. The FDA did not make, nor did the Federal Trade Commission make any federal decisions on what that looks like in terms of the delivery of the prescription class, that is going to fall on, individually, on all 50 states and nine territories. So what's important is, your state is going to define what the rules are around dispensing a prescription class. Now, while a state cannot require

an evaluation or provider for the OTC class, a state can create regulations if a provider is fitting or servicing an OTC class. So the state can't make rules if there's no provider involvement, but a state can make rules if there is provider involvement in distribution of an over-the-counter device.

Complicated, yes, but this is why it's very important that if you want to be, if you wanna make sure in your state the FDA provisions are appropriately addressed, you need to be part of your state audiology association or your state speech and hearing association, if you have no state audiology association. You need to volunteer and donate time or treasure to make sure that this moves in a way that is comfortable for you and your practice. Now we're gonna move on to HIPAA. HIPAA's hallmark was HIPAA privacy and it was introduced in 2003. In 2013, actually January 31st of 2013, they did a major update to HIPAA called HIPAA Omnibus. Because of that trajectory, they have been hinting in the past year or so that we should expect another major HIPAA update in 2023.

This course is being recorded today on, I think today's January 25th, we could see this as early as next week, I do anticipate some HIPAA updates. And those HIPAA updates, if we use 2013 as our guide, required an update to your notice of privacy practices, it required some new disclosures around marketing, you might see this again, I suspect, one thing I will tell you in advance, that I think we're gonna see more policies around telehealth and around email and text communications, I think that's what we should be expecting. And so you need to be prepared, those notices will come through your national associations, there are also some great resources at healthit.com, or through the Office of Civil Rights at Health and Human Services.

But I would prepare for the fact that you are going to need new HIPAA forms and HIPAA training, this is a good time to remind people, technically, all new hires are supposed to be HIPAA trained within 90 days of hire. And this is again, a typical

requirement in a state or a typical requirement of Medicare, and that your staff needs to be trained on HIPAA at least annually. So HIPAA updates, again, I suspect, be on the lookout through your National Audiology Associations that you're a member of about any HIPAA changes that, or it'll be in the news I'm sure too, any HIPAA changes that are ahead. So Medicare is administered by administrative contractors, and I think there are now nine.

And those administrative contractors can make a little bit of their own rules, or we'll call them medical policies, about how they're going to process traditional Medicare claims. This slide is showing you the current medical policies or local coverage determinations in the United States. The one that people, if Novitas is your contractor, Novitas is Texas and part of the Southwest, and parts of the Northeast, if Novitas is your administrative contractor, you really need to read that policy, because it is very restrictive, they interpreted the Medicare rules in chapter 15, section 80.3 distinctly, and they will only cover things if you have certain diagnosis and they put limits on coverage. So again, if you're in Texas or some of the states in the Southeast or in the Northeast, where Novitas is your contractor, you wanna make sure you read this policy.

If you do the stib and you are in Florida or parts of the Southeast that have Palmetto, you wanna read that policy too around vestibular. But these links will take you to the local coverage determinations. Traditional Medicare has a deductible every year. That deductible is not paid by 95% of supplemental health policies, and this is for traditional Medicare, red, white and blue Medicare card, it has a deductible. There is only one supplement that covers, and that's a plan F, and you can't buy into it anymore, you had to have been grandfathered into it, so it's a very small number of people where their supplemental policy will cover the deductible, but most people are gonna be responsible for this $226.

And as you know how deductibles work, while it will reduce the cost to the allowable rate, it will not cover the cost until their deductible is met, so the health plan will pay nothing. So I am a huge advocate of collecting unmet deductibles at the time of service, which is absolutely legitimate with any health plan. So Medicare had some significant changes as it pertained to audiology in 2023. These went into effect on January 1st. This is specifically related to the order requirement. So audiologists can provide now non-acute hearing assessment that's unrelated to balance, or hearing aids, or examinations for the fitting, or modification of a hearing aid, once, one date of service, one visit, one incidence of care, every 12 months without an order.

So one date of service, one incidence of care that's not for vestibular, that's not for testing for solely related to the purchase of the hearing aid, and we'll talk about that specifically later, and it's for a non-acute, more of a chronic condition, you can do one date of service of a limited number of testing, one date, without an order. Medicare Advantage plans generally do not require physician orders, unless it's an HMO and it's specified in the agreement, but most advantage plans do not require an order already. So you have unlimited visits without an order, as long as they're medically necessary. But red, white and blue traditional Medicare is now allowing one visit of hearing tests, hearing testing, I'll show you the list, one visit every 12 months.

Vestibular testing always requires an order. Always, you have to have an order in order to bill vestibular testing. Here are the list of audiologic procedures that you can perform once, you can perform one of these or all of them, once every 12 months, one singular date of service, without an order, this is your list. It will be invaluable at scheduling for you to determine your approach to the physician order. You will need to screen the individual for warning signs of ear disease, and any complaint or symptom that is 90 days, has lasted for zero to, last zero to 90 days, because that makes it acute, and you don't want a diagnosis of acute to go out with any of these claims that don't have an order, or anything that involves balance needs an order.

Audiologists at the outset of this need to be very wary of the use of acute diagnosis, such anything sudden, anything sudden needs an order. Any acute otitis media, any vestibular diagnosis, using any of those diagnoses on a claim without an order could get your claim denied. So it's really important to have this triage. We recommend, really recommend you obtain a physician order when you're receiving a referral from a physician, specifically an Otolaryngologist, for assessment of any acute otologic condition. In these situations, it's always better to air on the side of getting an order than not getting an order if you're being referred for testing for an acute condition. When the chief complaint is a non-acute or chronic condition, this is your common sensorineural hearing loss, you can do one up to, I think it's 36 procedures listed in that table.

You can do them once a year, one date to service, without that physician order. When it's not required and not obtained, no ordering physician will be listed on the claim. So if you don't have an order, you don't put the ordering physician on the claim in box 17 of a CMS 1,500 form, you leave it blank. You don't put an ordering physician there. Instead, for all the procedures you provided, you're gonna add the AB modifier. This modifier is specific to audiology services. It means that an audiology service was personally furnished by an audiologist without an order for non-acute hearing assessment unrelated to disequilibrium or hearing aid, and the service can only be performed once every 12 months per beneficiary.

That AB would need to be on every procedure performed that was on from this list. If you did something that is not on this list, you need an order, if it is a diagnostic procedure. Generally the services billed on a traditional Medicare claim will all be physician ordered or all not need to be physician ordered, you don't wanna have, let me use an example, an otoneurologic ABR is not on that list, requires an order, you don't wanna have that in an audio and then not have the order. It's either everything is

ordered or everything doesn't need to be. One exception may be when you're billing some services to obtain that denial and you're adding the GY modifier.

That might be your only exception here, that some of the diagnostic services, the hearing tests, will have an AB, and anything hearing aid related will have the GY. That might be one exception to the rule. It is recommended that you utilize an ABN prior to assessment or secure that physician referral or order if you have no record, you don't know if they've used their AB modifier in the last 12 months, you don't have an order, or you're planning, as a result of the lack of the order, to use the AB modifier. So again, if you are not sure if they have had any procedure in the last 12 months that has been billed, 'cause they saw somebody else, that has been billed without an order, you wanna have that advanced beneficiary notice in place.

You wanna reach out again to your systems vendors to see if they can help automate for you a trigger that will tell you, "Hey, this patient was tested eight months ago without an order," that can give you a tickler, find out what your systems are capable of. You're going to need to obtain a physician order for any medically necessary, on the audiology code list once they've had one procedure without an order in the ear. So let's say you wanna see someone six months later, you need an order, if the first time you saw them, they didn't have an order, the next time you see them within 12 months, you're going to need an order for any subsequent testing.

I am recommending people will be very conservative here, 12 months, let's give an example. If I, my recommendation, if I saw someone on January 2nd for a hearing test without an order, I would not feel comfortable seeing them again without an order until after February 1st, because it's 12 months, it's not 365 calendar days, it's not one year, it's 12 months. So because of that, I would be very conservative here in the beginning and wait until the following month in order to do another procedure without an order. There is going to be a large learning curve, this was not finalized until November, and it

is a huge systems change for many, many entities. Many of you are probably already getting the denials.

Those denials were 100% expected based upon what Medicare said here, that this policy was going to take them about six months to fully implement, because of the very short window they had to work within. So my recommendations to you are, if you are getting denials, here are your options. One, and each option has pros and cons, and well, one option might work well for one practice and not work well for the other, it's really all about efficiencies of your practice, how your practice functions. One option is to appeal the denials. It's fairly straightforward to appeal the denials, you're gonna see a link here at the bottom, which is the audiology services link from Medicare. The very first thing on that page is that this AB modifier is allowed.

You could literally link, all depending on how they accept appeals, you could print it and scan it, you can email it, you can link it, whatever you need to do, you can appeal. Your second option is to just keep getting orders for everybody for six months and get orders for every procedure, just like you have for the last 20 years. The third option is to hold your claims. So Medicare allows a 365 day claims window. You could hold your claims until summer and then submit them all at that point once this is more fully implemented. All three options have pros and cons, but those are your best three options for the situation at hand. I wanna talk about some very, I think there's a lot of misinformation and a lot of, I call them shenanigans out there, around hearing testing and Medicare.

Yes, Medicare is very clear that they do not cover hearing tests for the sole purpose of fitting or modifying a hearing aid. Very clear about that. But they're also, these are all things directly from them, so I wanna make sure that people know this. It is appropriate to pay for audiological services for patients who have sensorineural hearing loss and who wear hearing aids if the reason for the test is anything other than the evaluation of

the hearing aid. That you wanna reprogram the hearing aid. For example, if a patient reports a perceived change in hearing, that test would be covered, just because the outcome is a hearing aid or just because you might reprogram it, if the patient reports a change in hearing, they've had cancer, they've had chemotherapy, they had a perforated ear drum, whatever, they've had a change in history or condition or perceived hearing loss, that test would be covered, even if the outcome is just a hearing aid.

And again, when a test reveals information that is not known to the physician prior to the test, that information cannot be used to deny a payment. So again, if the test was ordered for reported change in hearing, may not be denied when the results reveal that there was no change in hearing, but the audiologist finds the hearing aid malfunction, that doesn't mean the test will be denied. Medicare pays for tests for the reason for the test, as long as you, the reason, has not been completely ruled out, what I mean the reason, that they're referring you for a hearing loss and they don't have a hearing loss at all, then you can't use a hearing loss diagnosis, you can't use a diagnosis you know they don't have.

But Medicare pays for the reason for the test, not necessarily the outcome. So again, if a patient has a change in hearing, Medicare would cover that test now, once a year without an order, subsequent with an order. Once every 12 months, I need to stop saying here, once every 12 months without an order. Now we're gonna move on to coding changes. CPT and HCPCS, so there were no audiology-specific, far-reaching CPT HCPCS or ICD 10 changes that were significant to audiology for the new year. There were some codes that have been deleted and I wanna give reminders that these codes no longer exist. That's audiometric testing of groups, Bekesy, and short increment sensitivity index, those codes have been deleted.

Let's talk a little bit about some modifier changes, or some new modifier changes or new approaches or new modifier. The AB modifier is our modifier specific to audiology, it needs to go on every procedure where you do not have an order on a singular claim, 'cause it's remember, one visit every 12 calendar months without an order. So the AB would be on every medically necessary procedure you performed. Please, please make sure you are documenting medical necessity, health plans, Medicare included, do not pay for routine or just a protocol, you have to be able to document that the reason for the test results in payment, that is Medicare's verbiage, why did you need to do what you did?

And so if you have a patient who doesn't, it will tell you nothing diagnostically really to do a temp that you didn't already know, then I wouldn't do a temp. You have to be able to document medical necessity, so everything, the AB will go on a claim where you have no physician order, and the physician order section of that claim will not be populated. An XU modifier is similar to a 59 modifier, which is a distinct procedural service. So an XU now is being recommended for situations where you have an Unusual Non-Overlapping Service, that the service is distinct because it does not overlap with the usual components of the main service. So I would be using this modifier around implant programming instead of the 59 now, I would be using, so if I did 92601-92604 plus 92584, 92568, 92627 on the same patient on the same date of service, I would be adding the XU modifier to all the procedures performed.

MIPS or the Merit Based Incentive Payment System, there has been no changes to MIPS as it pertains to audiology, no significant changes, they made in addition of a measure, but no real significant change, especially as it pertains to your participation status, the low volume threshold is still the same for 2023 as it was for 2022. Are you required to participate in MIPS? It is really, really important that you go in to this link and put in the NPIs of all your individual audiology providers and see if they are required to report or if their reporting is merely voluntary. If you are required to report

and you are not reporting, you will be penalized. So you wanna make sure that you rule out what your reporting responsibilities are for each of your individual audiology providers, and you can do this from this link.

The 2023 MIPS measures are documentation of current medications in the medical record, preventative care and screening of depression with a follow-up plan, a falls plan of care, referral for otologic evaluation for patients with acute or chronic dizziness, preventative care and screening around tobacco cessation, elder maltreatment, which is very also common in our licensure laws, a functional outcome assessment, which is around the stib. A falls screening, a future falls risk, this is a measure that cannot be reported on claims, it has to be only reported through a registry, screening for the social drivers of health, and preventative care and screening for alcohol use, unhealthy alcohol use. If you want to know more about MIPS and how to implement it in your practice, which I am a huge advocate of, but I had to have a real realization in 2022 that audiologists are only gonna do this if they're forced to.

If you would like to be on the forefront of illustrating your quality and your outcomes and your value to the healthcare system, I recommend you go to the page that I've linked before, QPP page, and go to a page that is maintained by the audiology groups, and the name of the webpage is audiology quality, all one word, .org. And that is where you can get a lot of information about the merit based incentive payment system. Now let's talk a little bit about OTC and Insurance. Over-the-counter means over-the-counter, and I wanna give an analogy here. Aleve, I love Aleve, Aleve is an over-the-counter medication. When it is purchased over-the-counter as Aleve, it is not covered by most health plans, you might be able to use a health savings account for it, or a flexible savings account, but is not covered by your health insurer.

When it is classified as Naproxen, which is its pharmaceutical name, it would be covered by your health insurance or by your prescription benefit. That's the difference,

same with over-the-counter hearing aids. When it is an over-the-counter hearing aid, that's its classification, that's how it's being delivered off the shelf, it is not covered by most health plans, I'm gonna show a few exceptions, is not covered by most health plans. Again, might be covered by a health savings account, might be covered by flexible spending, but not covered by a health insurer. Patients were intended to purchase OTC from an OTC vendor, not from an audiologist or a hearing aid dispenser. My recommendation, if you and your company want to have distribution of sale of OTC, I think that's awesome, but I would set that up as a separate business that has no providers and that they're purchasing it through an e-commerce or off the shelf in your office, and that nobody has anything to do with it, except, nobody has anything to do with it in your office other than the sale, but nobody's fitting it to them, because the minute you fit it, you might then be subject to state dispensing laws around fitting an OTC device.

Aetna covers FDA approved over-the-counter hearing aids. My recommendation is that patients purchase the OTC from an OTC vendor, and that could be you, but as a separate business entity, and that they submit things to their insurance themselves. Right now, today, in my opinion, the only appropriate code for over-the-counter hearing aids is V5298, which is hearing aid not otherwise classified. It is, in my opinion, because I have a deep respect for the code set and its intent, it is not a digital V5257. It would be a hearing aid not otherwise classified. Will we someday see a code for OTC? Maybe, but that code is gonna be driven by industry, because to create a hardware code, you need evidence from peer reviewed journals in the United States, and you need sales data, and the only way you're gonna get sales data is from a vendor.

So right now, my recommendation is that patients submit claims themselves for over-the-counter hearing aids, and the code would be V5298. I build these updates really around, I keep track all year of the questions that people ask me a lot about, and what I'm finding is that a lot of people are thrown by the insurance card. And so I really

wanna talk a little bit about some tips around how to look at an insurance card, which is the very kind of first step in learning about a health plan. So if someone gives you a Traditional red, white and blue Medicare card, that card, I can't remember if I have cards here, I don't, 'cause their images aren't very good.

So if you have a red, white and blue Medicare card, if that card has their social on it, that card is not valid. That's the first thing I wanna tell you about that. That card is gonna have a member number. If a patient gives you a card that's red, white and blue Medicare, and they give you a card that says Advantage anywhere on it, only one of those two cards is valid. You can't have Traditional Medicare and have Medicare Advantage both valid at the same time. I'm gonna defend patients a little bit, because they've been told to keep their, seniors can come in and out of Medicare every year, so they can be in Medicare Advantage one year and be back to Traditional Medicare the next, they can switch Medicare Advantage plans.

They can change once a year, so Medicare encourages them to keep their Traditional Medicare card. So even if they have switched to an Advantage for this year, they still may have a Traditional Medicare card with them. But if anything says Advantage on it, anywhere on the card, they can't both be valid, you're going to need to determine, and what I would start with is determining if the Advantage card is valid. I wouldn't always trust the dates, I would actually go in to a portal or into Availity to check the validity, only one of those cards can be valid. So if they have Traditional red, white and blue Medicare, they have no hearing aid coverage through that Traditional red, white and blue Medicare.

If they have Advantage, that is privatized Medicare, it's also known as Medicare Part C, that is Medicare Part A, hospitalization skilled nursing, Part B, outpatient care, and Supplemental, Supplemental is only there to cover the Medicare 20% co-insurance, that's all of it combined together into one health plan called Medicare Advantage, they

follow Medicare guidelines, although they've never required an order except for an HMO. So you can do vestibular with a Medicare Advantage plan without an order. They typically, this is not 100%, because like in my state, we have a mandate, so they cover hearing aids, but typically, if they have an Advantage plan, that is a discount plan, and they have hearing aid coverage, it's typically a discount plan through a third party network.

TruHearing, United Hearing, Nations, Amplifon, of the like. Now there are some exceptions, in Illinois there's a mandate, so they can have Medicare Advantage and have a funded hearing aid benefit. There are retiree plans, state teachers, unionized plans, that can be an Advantage plan, but has a funded hearing aid benefit, so there are some exceptions, but a general rule of thumb is, most Medicare Advantage plans, except for retiree and in the state of Illinois, are discount hearing aids through a third party network. That's Advantage. Now you're gonna have the Medicare Supplement, the Medicare Supplement is only there to cover the Medicare co-insurance. That's its only purpose. It covers the Medicare co-insurance. So if Medicare covers it, they cover it, Medicare doesn't cover it, they don't cover it.

They offer discount hearing aids, discounted options through a third party network. And the biggest of these is the ARP plan. If a card says dual, the word dual is anywhere, it could be Molina duel, it could be AmeriCorps dual, AmeriHealth dual, whatever the card, if it has dual on it, that means a patient is Medicare Medicaid. And if you are out-of-network to that health plan, the maximum you can collect for covered services is the Medicare limiting charge, less any co-insurance or unmet deductible that applies if you're out-of-network. Then there's Medicaid. Medicaid is state administered or managed by a managed care organization. It often covers hearing aids, it also often covers hearing screenings and auditory rehabilitation.

It's governed by very specific policies, and most hearing aids, and even sometimes some coverage of diagnostic services requires a prior authorization. Medicaid, if you were out-of-network with Medicaid, and they are straight Medicaid, they are not dual, straight Medicaid, they can take on the financial responsibility of the cost of out-of-network care. Now, one other thing I wanna add about Medicaid, Medicaid eligibility can actually change monthly. Also, some Medicaid beneficiaries have something called a spend down where they have to spend so much money until Medicaid fully kicks in each month. So that's what makes Medicaid a little more complicated. Then there are the commercial health plans, PPO, POS, HMO, are you contracted in your office with all types of commercial plans?

There are plans where they only will contract audiology to the PPO and they will not contract to them to the HMO. You might have decided to not be in the HMO. What product in a commercial plan are you contracted for? And again, commercial plans are governed by medical policies. Medical policies is what guides their coverage. It is very important that for all the types of services you provide, tinnitus, auditory processing, vestibular, cochlear implants, hearing aids, whatever that is that you provide, intraoperative monitoring from the management, do they have medical policies that govern it? Many third party payers do not cover amplification for the treatment of auditory processing or tinnitus in the absence of hearing loss. Non-covered.

You don't have legitimate coverage if you don't follow the medical policies. So at any point they can come back, even if they paid it, just because a plan paid it doesn't make it legit, and they can come back, depends on what's in your contract, 3, 5, 7 years from now and ask for the money back, if you did not follow the policies. And again, look up the potential policies for every item or service you offer. Here are the links for Aetna, Cigna, Humana, UnitedHealthcare, and VA Community Care. Blue Cross Blue Shield is harder because they function under a lot of different names and they're all individually administered separately in the district, wait, I mean in the territory or in the state, so

you will Google Blue Cross Blue Shield medical policy, your state, it may be under Anthem, it may be under Empire, it could be under Wellmark, it could be under Excellus, it could be under other names, but the blues exist, but the policies are very, very state driven.

It's a good time to talk about Blue Cross Blue Shield a bit for a second, I'm gonna come to their defense. While UnitedHealthcare has the great portal that has medical, that has all of their allowable rates and that's all published, they can do that because they've operated for years under primarily a national contract for things. This is our allowable rates, this is how we do things, these are our policies. Blue Cross Blue Shield, because they've traditionally represented so many states and municipalities, they've represented many unions, they allow for that contract to be very individually negotiated by the employer. And so that means they don't have, it'd be impossible for them to have a one-stop-shop of this is the hearing aid benefit for everybody, 'cause it can change, it can change by employee at times.

So that's why you're not gonna see a singular benefit or policy that just overreaches all the Blue Cross Blue Shield health plans. Here is the medical policy for UnitedHealthcare for hearing aids, you have to follow this medical policy to legitimately receive coverage. United has a maximum amount that is usually 5,000 to 2,500 an ear, and the benefits are for charges associated with fitting and testing. The benefit, that benefit, whatever that is, does not include batteries, accessories, or dispensing fees, those would be the separate responsibility of the patient. United allows for the upgrade, because they say, if more than one type of hearing aid can meet the members' functional needs, benefits are only available for the hearing aid that meets the minimum specifications for the member's needs.

If the member purchases a hearing aid that exceeds the minimum specs, United will only pay for what meets the minimum specs, and the patient is responsible for any

difference in cost. That is their policy. They also require, and I can't, oh here it is, I skipped over that first one, they also require that you have a written recommendation for hearing aids, this is not a medical clearance. This form needs to be written recommendation for hearing aids from a physician, not a nurse practitioner, not a physician's assistant, it has to be an MD or DO physician needs to sign off on a written recommendation form for hearing aids, you need to keep that in your file. Many times they will deny the first time and they're gonna want that written recommendation for hearing aids, it's also important to tell you that they can ask for the invoice at any time.

Hearing aid invoices are not a secret to them anymore, they all buy hearing aids, all these health plans buy hearing aids through administrators, they know what the invoice costs are now, and so if they ask you for an invoice, you must produce the legitimate invoice. A good time to give some advice, don't fit stock hearing aids on people, you need to have an invoice that you're billing to insurance, because you need to have an invoice, if they request it, that was dated after the evaluation and that actually has the patient's name on it. They wanna make sure that these devices were ordered specifically for this patient and that they are the latest technology. This is Aetna's medical policy.

Aetna only covers hearing aids if you meet this criteria. I actually just reviewed a case in the last week around this. The patient did not meet the Aetna coverage policies for hearing aids, her hearing loss wasn't great enough to meet these requirements. This is what Aetna requires to cover hearing aids. TRICARE's is exactly the same as this. Aetna considered the Bose and other FDA-cleared hearing aids available over-the-counter without a prescription as medically necessary, again, and that they will cover them. For plans that do not include hearing aids, either OTC prescription hearing aids are eligible for coverage if they're cleared by the FDA and prescribed by a qualified healthcare provider and medical necessity has been met.

So for Aetna to cover hearing aids, you have to have a hearing loss that meets these criteria, the device has to be FDA approved, and has to be prescribed by a physician, an audiologist or dispenser. Anthem has very, very specific policies around coverage, they are very specific. Here is what they require. You have to have audiometry of greater than 26 decibels. You have to have a hearing loss of greater than 26. And I would be conservative, I would consider that your pure tone average needs to be greater than 26 decibels, or you're not meeting the coverage criteria. Binaural hearing aids are medically necessary when binaural testing shows improved speech recognition. So I would be, we do word rack, we do speech noise, and a monaural, and in monaural conditions, and then do it in a binaural condition to show improvement, that their speech understanding improves when we use both ears, and have that documented.

They only cover air conduction hearing aids with advanced technology when you have documented medical necessity, that they need this, you have to have documentation why this make, model and style is the most appropriate for the hearing loss. I wanna remind people that there is no research evidence that's conducted by independent labs to date that performance improves with premium technology over mid-level technology with certain features. So you need to make sure your documentation clearly indicates why what you're recommending is medically necessary. Replacement, Anthem doesn't cover replacement just because someone's eligible. And this is a misnomer for Medicaid, this is a misnomer for any health plan, they do not cover replacement hearing aid just because they're due.

They cover replacement, especially Medicaid plans, when they're out of warranty and no longer functioning to support the daily activities of life, that you can't repair them, that you can't make them appropriate. That's when replacement hearing aids are covered, not just because a timeframe has been reached, and you need to make sure your documentation illustrates that. Air conduction devices when they're not medically

necessary. And this is important, replacement of a functional air conduction hearing device that's still under warranty for the sole purpose of obtaining a device with updated technology is considered not medically necessary unless the new updated device will provide a significant functional advantage over the device that was originally used. Your documentation is gonna tell you that.

Health plans also don't care if a hearing aid can stream, that's for personal comfort, or if it's rechargeable. You need to make sure you are documenting the necessity of these features. This is the Federal Employee Health Plan. If you click on this link, this is going to take you, actually I think I can click, and I'm not sure I can, 'cause it's gonna take me to another screen, if you click on this link, it's gonna take you to a map. You can click on your state, it's gonna show you the plan documents of every Federal health plan that's available in your state. The plan documents, the Blue Cross Blue Shield plan document will tell you the specific hearing aid benefit.

The others will tell you whether hearing aids are covered or not covered. All Federal health plans do not cover hearing aids. Most do, but not all of them. Blue Cross Blue Shield standard plan versus basic. If they have in the Federal Employee Health Plan, if the federal employee health plan's standard plan, and that'll be on their card, that means the deductible will not apply for the hearing aid purchase. If they have, it says basic, the deductible will apply. So that's what the distinction is there. FEHP is still $2,500 every five years, for anyone that is 23 years, 22 years or older. If they are under 22 years of age, it is 2,500 a year. This is why if you are fitting Federal employees' children, that delivery should be unbundled, because they get access to 2,500 every year and it will cover repairs.

Let's talk a little bit about verifying hearing aid benefits. So hearing aid benefits should be verified prior to the visit, prior to the hearing aid examine, selection, or communication needs assessment, you should be verifying coverage and benefits, you

should be capturing that information and scheduling. So they're going to tell you, the only thing they can tell you in a verification is about the benefit, they cannot tell you about your contract, they can't tell you if you can upgrade, they can't tell you what the allowable rates are, they can't tell you anything about your contract, they can only tell you about the patient's benefit. If you wanna know about your contract, you need to go to provider relations or the contracting department.

When you're calling the number on the back of the card, that is a number that is specific to that patient's benefits. So here are your options that you'll see around hearing aid benefits. An allowance, common in retiree plans, that's dollars towards, allowances are typically in this 3 to $800 range. They were never intended to cover the entire costs, they're just dollars towards. You don't have to fit within an allowance benefit. Fixed dollar amount, that is the FEHP, 2,500, UnitedHealthcare 2,500 an ear, those are fixed benefits, they're telling you a fixed dollar amount. And a fixed benefit amount, anything around, well, they typically have medical policies that will tell you what's included in the fixed dollar amount, and then anything outside the inclusive part of the fixed, what's inclusive to it, like for example, with UnitedHealthcare dispensing fees, batteries, and accessories, can be the responsibility of the patient.

But the fixed typically means that all the items or services, even if you itemize them, they're only gonna pay a maximum of X. Fixed dollar amount benefits, if it is UnitedHealthcare and Blue Cross Blue Shield, they will allow for the upgrade, if you have an upgrade waiver in place. Percentage of allowable, we pay 80% of the allowable rate. That allowable is your contracted rate, yours that is in your agreement. That is all around what you've negotiated. That is the percentage of allowable. In those scenarios, you should be billing all the services itemized, because there's gonna be a percentage of allowable on all the services for the codes that they recognize and allow. This is important to know what codes in the delivery they recognize and allow and you should bill that in an itemized manner in that percentage of allowable.

The patient's gonna have responsibilities there that you should collect on the date of service. Percentage of dollars billed. That is a contract that I would renegotiate, because that's a very slippery slope, because you always need to bill everyone the same. So that itemization is absolutely not gonna help you in a percentage of dollars billed arrangement. In a percentage of dollars billed arrangement, if we're talking about a Blue Cross Blue Shield health plan, they typically do not allow for the upgrade, and because it's a percentage of dollars billed. So you need to find out through contracting is there a cap on what that they'll allow for that. There is an 'Up to', where a health plan will say we pay up to 3,000, that does not mean they pay 3,000.

That means that for all the codes you bill, the maximum they will pay for that hearing aid delivery is 3,000, so it would have to be itemized, because they're all gonna be paid based upon your allowable. Again, an up to dollar amount typically, if it's a Blue Cross Blue Shield plan, will allow for the upgrade. Good time to remind, if you haven't been to my boot camps or heard this before, Aetna, Humana, Cigna, they don't allow for upgrades. The only health plans that allow for upgrades, UnitedHealthcare Commercial Plans and Blue Cross Blue Shield Association Plans that are not invoice plus and not percentages of dollars billed. Invoice plus, is they pay invoice plus something, those claims should always be itemized, if you are not itemizing the invoice plus relationship, you are leaving significant money on the table.

And you always wanna know what is inclusive to a hearing aid benefit. Like I showed you the UnitedHealthcare benefit, they include everything around evaluation and fitting, notice I didn't say repairs, or care, or follow-up. And they don't cover batteries, or accessories, or dispensing fees, so that's what's inclusive and what is not. You can have different types of hearing aid benefits, you can have Medicaid, you can have state funded plans for special populations, for children, for the handicapped, you can have VA community care, you can have voc rehab, you can have workers' comp,

commercial health plans. They can all have different ways they approach the hearing aid benefit. And this is when itemization is going to help, billing this not in the single bundled code.

Itemizing out from evaluation through fitting, the services you provided by individual code. Sometimes you need to re-verify benefits, and this is a perfect time to give this reminder. You need to verify Medicaid benefits every month. Every single month Medicaid benefits need to be re-verified and it's typically easily done within their Medicaid portal. At the beginning of each year. If you've verified hearing aid benefits in December and you've not fit those hearing aids yet, you need to re-verify the benefits to make sure they still have a hearing aid benefit. Always need to re-verify a benefit at the beginning of a new year, and any time in change of employment. So your schedulers, your front office people, need to be asking, "Have you had any change in employment?

Are you now retired?" Very common thing to happen as a change of a year, are you now retired, where this is no longer your health plan? Are you on COBRA? When is your COBRA expired? 'Cause it's 18 months, then they don't have the same health insurance again, any type of change in employment or change of insurance, you need to re-verify benefits. I wanna go through some things about what not to do. I take on average about 100, 150 questions a month from audiologists all over the country, and I hear a lot of things, I saw this on Facebook, I went to this talk and this is what they said. I wanna focus on what not to do, and I'm gonna document why you don't do it.

So let's go through some of this. 92557 includes pure tone air, bone, SRT, and speech recognition. If you bill any entity, and I'm not just talking about Medicare, if you bill any entity for any aspect of that, you can't then turn around and give any aspect of that away for free to someone else, because the payer, whether it's Blue Cross Blue Shield, whether it's Medicare, whether it's Medicaid, whoever it is, they don't understand why

are you billing me for something that you're giving away to someone else for free. So you can't provide free hearing testing to some patients and then bill a health plan for the same procedures. If the service is free to one individual, it needs to be free to all individuals.

This has been clearly documented. I'm gonna give you documentation as to, this has been clearly documented, the attorneys for ADA, AAA and ASHA, we all looked into this, it's been clearly documented that this could be deemed problematic. The only exceptions are if a patient's indigent or if your practice only bills insured patients, that's all you bill, and here is a link to the exceptions. So the solution here is you bill the patient or their health plan for all services rendered and items dispensed and stop providing free care. If we all stopped providing free care, then patients would expect to pay for care. You don't bill a health plan for hearing aids that you haven't fit yet.

That's actually a false claim, you've billed for services that have not been rendered. There are no loopholes around this. Fitting a patient with a loaner or a demo, no, you do not fit someone with hearing aids, you do not bill for their hearing aids until you are fitting them with their hearing aids that is invoiced to them. The solution, you verify coverage and benefits, you fit within the hearing aid benefit, and applicable medical policies, and coverage allowances, and bill the hearing aids and any related services on the date of dispensing. Do not fit stock hearing aids on a patient and bill the hearing aids to a health plan. They oftentimes want invoices now, and I'm gonna defend the health plans here.

There have been many massive cases that they lost, one case in Texas, they lost $28 million. One in New York, I think was 11 million. People were fitting them with either really, really old hearing aids, or devices that weren't actually an FDA approved hearing aid, and billing the health plan. So this is why United has put the written recommendation in, 'cause they got horribly burned in one of these cases, millions and

millions of dollars. And again, I wanna stress, these were audiologists that were doing this, these were not dispensers or companies, there were audiologists involved in this as well. They wanna know that the product you've ordered is for this patient and that the dates line up with the evaluation.

They want their members to get the latest technology that was ordered specifically for them, and it's all about what's the medical necessity of the device. Some plans pay based upon the invoice. Some plans you might need the invoice and appeal, but in your contract is someone who reads these, they can ask for the invoice at any time. So my solution is to select and order hearing aids for each specific patient from the manufacturer following the communication needs assessment or hearing aid evaluation when the health plan is paying in whole or in part for the cost of an item. Don't bill a health plan for something you've received at no charge. If a manufacturer is giving you something away for free, you can't bill the health plan for it.

You really shouldn't even to be billing the patient for it because it was free. You can't bill separately for anything that you haven't been invoiced for. So you can't bill separately for a battery charger if you haven't been invoiced for it. You can only bill for things separately where you were charged for them. This is a potential false claim and a violation and a kickback and it's been well documented. I'm giving you some cases here, well documented in other aspects of healthcare where this has been found to be problematic. If the item was free, you provide it free to the patient. Don't bill services that were provided by unlicensed, non-credentialed provider to a health plan under another provider's national identifier.

Recent audiology grads, even though they have a diploma are unlicensed. They can't see any patient, except if they're, like my state we have some exceptions that they can practice for a window while their license is being processed, if it's been put forth, but you can't bill a health plan for services they've rendered, because nothing can be billed

incident to an audiologist. That is a general rule of thumb, we do not have a status within healthcare for people to bill incident to us. So they can't provide services that you're billing to a health plan, because they're not credentialed, they're not contracted providers. It would be a false claim, and this is actually one of the paramount examples of a false claim.

So my recommendation is don't begin employment as an audiologist until licensure is conferred, or don't allow audiologists to see patients where insurance claims are being submitted for covered services until they've been credentialed by the health plan. Don't market to existing patients that they're due or eligible for new hearing aids. There is a lot of evidence that this can be deemed, can be caught in audit and you'll be giving the money back. This can be seen as a solicitation or potential fraud abuse or waste. Some health plans, including most state Medicaid programs, have medical policies that say they clearly want documentation of the need of the replacement. The solution is you recommend, and you fit, and bill health plans for replacement hearing aids when it's medically necessary and reasonable to replace the existing hearing aids.

Don't assume a service is non-covered just because the treatment plan includes hearing aids and as a result, charge the beneficiary privately for the service. As we talked earlier, just because the outcome is a hearing aid doesn't mean that Medicare wouldn't cover it. Medicare is going to cover any testing, first of all, when we see a patient, we don't know that they're hearing aid candidate, they can say, "I'm here to get a hearing aid," but you don't know if they're a hearing aid candidate until you test them, 'cause somewhere between 8 and 12% are not gonna be hearing aid candidates at that moment in time. Might be even greater than that as we start to see more people who with normal hearing.

So the moral of the story is that, is what is the reason for the test? Are you trying to find causality? Do they have a change? What is the reason? That is what drives medical

necessity, 'cause you wanna allow people to access their health plan benefits by reviewing their case history, documenting medical necessity for the service provided, and billing the health plan for things that meet the coverage criteria of the health plan. I'm seeing a lot of audiologists think they have a loophole that they can charge people for hearing tests privately at their usual and customary rate just because they called, they said they wanted a hearing aid. That is not necessarily correct for every patient.

Do not uniformly upgrade technology from basic to standard without documentation of medical necessity for that deluxe item, without the patient acknowledging, in writing, their rights and responsibilities that they could have gotten something within their benefit and they've chosen to upgrade, and most importantly, that the payer allows you to contractually upgrade. Aetna, Cigna, Humana do not allow the contractual upgrade. Every health plan does not allow for an upgrade. They just don't, the allowable rate is considered payment in full. And the patient is gonna get an EOB that's gonna show the responsibility of zero, and as some people who have tried to test this over the last many years, you will be giving the money back. The solution is you need to educate yourselves on your payer agreement and the medical payment policies, create a verification process, and you need to have upgrade forms and processes in place.

Don't fit hearing aids on normal hearing individuals and bill the health plan unless explicitly allowed by medical policies. There are vendors out there telling you that you can bill ear protection devices to a health plan as a hearing aid and the person doesn't have hearing loss. There are entities out there telling that you can bill hearing aids for the treatment of tinnitus and they don't have a hearing loss. It's really important, the rule of thumb is, health plans only cover hearing aids if the patient has a hearing loss that can't be medically or surgically treated. So when you are an in-network provider, you should educate yourself on your contracts and the applicable medical policies, and be fitting within those policies.

Don't bill differently to private pay patients for the same items or services. Billing in excess of your usual and customary to a health plan can be perceived as abuse, I've given you some documentation of that, and you wanna bill everybody the same price for the same item or service, regardless of age, or payer, or situation. This one I had to add today, if you're fitting a patient with a CROSS, BICROS system, two devices, do not bill the devices as a hearing aid plus a monaural contralateral device either on a single date of service or on separate dates of service, that's actually a false claim, because you are not using the most appropriate code, and you are submitting things to try to inappropriately get payment.

Just because it's processed and paid by the health plan doesn't mean that they could not come back to retract the monies later. Your solutions are to bill the CROSS, BICROS in the same date of service using the contralateral routing system binaural codes that are most appropriate, it's a system, there is a code for both pieces, that represent both pieces, if you don't like that reimbursement, you need to try to renegotiate that reimbursement. Again, health plans were never out there to pay your bundled cost for three years of care. Health plans pay in an unbundled manner, and long-term care is something they don't pay for upfront. As a general rule of thumb. So itemization and unbundling would help in this situation.

You can appeal the coverage of decision, also with an invoice and a description of how those products actually work. And finally, in close before I go to the questions, do not get your coding, billing and managed care advice from social media, solely from social media. There's lots that goes on in the world, your national associations and audiology both at the state and national level, spend, and meet, and study, and dig, and get information to actually educate their members. That's where you should be getting your information, or from people who work in the consulting space. AAPC, which is the professional coders, or APC, which is again, professional coders, a consulting firm like Zupko and Associates, you want to get information from people who know, a lot of this,

almost all this what not to do is something that someone heard at a random private talk or manufacturer event, or that they read on social media.

Please, that is not the place to get your coding information or managed care information, get it from the health plan, get it from your national or state associations in this space, because that's where you're going to have the most protections and where you're going to have the best information. Well, I hope I answered everyone's questions. If you have questions moving forward, I really suggest you reach out to associations that you are a member of either at the state or national level to help you address your billing reimbursement concerns. I have more courses in my AudiologyOnline Catalog that you can look for to answer and may address some of these larger topics. And I wanna thank my friends and colleagues at AO and all of you out there for attending today, and have a great 2023.