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2024 Coding and Reimbursement Update

Kim Cavitt, AuD

Audiology Resources, Inc.

Kim Cavitt, AuD

Kim Cavitt, AuD was a clinical audiologist and preceptor at The Ohio State University and Northwestern University and has served as an Adjunct Lecturer at Northwestern and Western Michigan Universities. Since 2001, Dr. Cavitt has operated her own Audiology consulting firm, Audiology Resources, Inc. Audiology Resources, Inc. provides comprehensive operational, compliance and reimbursement consulting services to hearing healthcare providers. She is a Past President of the Academy of Doctors of Audiology (ADA), serves as the Chair of the State of Illinois Speech Pathology and Audiology Licensure Board and serves on committees through ADA.

Disclosures

- **Presenter Disclosure**: Financial: Kim Cavitt is the owner of Audiology Resources, Inc. She is a consultant for the Academy of Doctors of Audiology, Michigan Audiology Coalition, Illinois Academy of Audiology, Eargo and an advisor for Tuned. She received an honorarium for this course. Non-financial: Kim Cavitt is chair of the Illinois Board of Speech Pathology and Audiology and a committee member of the Academy of Doctors of Audiology.
- **Content Disclosure**: This learning event does not focus exclusively on any specific product or service.
- **Sponsor Disclosure**: There is no external sponsor for this course.

Learning Outcomes

After this course, participants will be able to:

- List the new CPT codes for 2024 and define their appropriate use.
- List the requirements for coverage for the BCBS Federal Employee Health Benefit Plans for 2024.
- Discuss how to determine potential covered services, out of pocket costs, and hearing aid coverage for different types of Medicare.

Informed Consent

- Audiologists are required, in many instances and in many states, to obtain informed consent prior to the provision of care.
- A patient must be informed, and acknowledge in writing, all of the potential benefits, risks, and alternatives involved in any medical procedure or other course of treatment.
  - May need specific consent for treatment, telehealth, email and/or text (electronic communications).
- You must obtain the patient's written consent to proceed prior to the provision of care
  - https://www.law.cornell.edu/uscode/text/38/7331
  - https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/informed-consent/index.html
  - https://healthcare.findlaw.com/patient-rights/understanding-informed-consent-a-primer.html
  - https://www.ncbi.nlm.nih.gov/books/NBK430827/
- Can vary and be more expansive state by state.

Modifiers

- 59: Distinct Procedural Service
  - Used in situations where you are unbundling parts of a bundled code.
    - 92540
    - 92557
- XE: Separate encounter, a service that is distinct because it occurred during a separate encounter
  - Saw a patient a second time for testing on the same date of service.
- XS: Separate structure, a service that is distinct because it was performed on a separate organ/structure
  - One of the options for bilateral cochlear implant programming on the same date of service.
- XU: Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.
  - Used when performing 92601-92604 and 92626/7 or 92584 or 92568 on the same patient on the same date of service.

The Options for Billing Binaural Implant Services

- There is no ”one size fits all” magic option.
- Options:
  - Two units
    - 92602 with two units
  - Use of -50 modifier
    - 92602 -50
  - Two separate line items
    - 92602 -RT –XS
    - 92602 –LT –XS
  - See patient on separate date of service
    - This is the ONLY way to guarantee payment for binaural visits.

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Cochlear Implant Neurotelemetry

- 92584: Electrocochleography (e.g. ECoG)
  - Intraoperative or post-operative/activation.
  - NCCI coding edit exists if billed on the same date as 92601-92604.
    - TC/PC Split

Why 92584 and Not 92651 CPT® Assistant (OCTOBER 2021 / VOLUME 31 ISSUE 10)

- "Under the heading, "Medicine: Audiologic Function Tests," in the Frequently Asked Questions section (p 17) of the July 2011 issue of CPT® Assistant, a question and answer pertaining to code 92584, Electrocochleography, was published. This article provides an updated question and answer to reflect the development of new Current Procedural Terminology (CPT®) codes for reporting auditory evoked potential (AEP) testing. This information supersedes the previously published information in the July 2011 issue.
- THEN
- The original question and answer:
  - Question: During cochlear implantation procedures, an audiologist is requested to perform neural response telemetry to assess the electrode impedance and to stimulate the internal cochlear implant device. The provider holds an external processor and coil over the internal device. Electrodes are selected for testing with documentation indicating which electrodes were stimulated and the response. May either code 92601-52 or code 92603-52, based on age, be appropriate, or would this procedure be reported with unlisted code 92700?
  - Answer: Code 92584, Electrocochleography, should be reported for neural response telemetry (NRT). NRT is used to detect where to set the initial cochlear implant program. It involves stimulating the cochlea electrically and using adjacent electrodes to record the electrical response from within the cochlea (summating potential and action potential). It is used both intraoperatively and postoperatively. Neither code 92603, Diagnostic analysis of cochlear implant, age 7 years or older; with programming, nor code 92604, Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming, should be reported to describe neural response telemetry, even with Modifier 52, Reduced Services, appended.

Why 92584 and Not 92651 CPT® Assistant (OCTOBER 2021 / VOLUME 31 ISSUE 10)

- NOW
- The updated question and answer:
  - Question: An audiologist may perform an evoked compound action potential (eCAP) during or after cochlear device implantation, such as neural response telemetry (NRT), neural response imaging (NRI), auditory nerve response telemetry (ART), or other electrically evoked procedures to assess electrode impedance and stimulate the internal cochlear implant device. What is the appropriate code(s) to report for these procedures? May one of the new codes for auditory evoked potential (AEP) testing (92651-92653) be reported? Or may one of the cochlear implant programming or reprogramming codes (92601-92604) be reported with modifier 52 appended?
  - Answer: It is not appropriate to report codes 92651-92653 for the procedures described in the question. Code 92584, Electrocochleography, should be reported for eCAP, including NRT, NRI, ART, or other procedures that may be performed to electrically stimulate the cochlea and record a response, both intraoperatively and postoperatively. These procedures measure compound action potentials (CAPs) and are recorded by stimulating one or more implanted electrodes. The measurement of CAPs is the same measurement made during electrocochleography (92584), rather than the additional early AEP responses that are measured during auditory brainstem response procedures. In addition, codes 92601-92604 should not be reported to describe eCAP procedures, even with modifier 52 Reduced Services, appended."

Auditory Osseointegrated Device Programming Codes

- **Went into effect January 1, 2024.**
- 92622: Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
  - Does not require implantation.
  - Must spend at least 31 minutes without a 52 modifier. (reduced service)
  - Document minutes in medical record.
- 92623: Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (list separately in addition to code for primary procedure
  - Must spend at least 8 minutes.
  - Must document minutes in medical record.
- **These codes ARE NOT FOR COCHLEAR IMPLANT SERVICES!**
- Neither code can be reported with 92626 or 92627.
  - Evaluation of auditory function for surgically implanted device(s), candidacy or post-operative status of a surgically implanted device(s)
- **These are post fitting/activation codes ONLY.**
- Can be billed with AB modifier.

92700

- To classify procedures that do not have CPT codes.
- Could be replaced by an E/M code.
- **Must be submitted to health plan for claims processing.**
- **A physician order is required for traditional Medicare.**
- Coverage is limited.
- Individually reviewed.
- Advanced Beneficiary Notice (ABN) required for traditional Medicare beneficiaries.
  - Patient should pay usual and customary rate at date of service.
  - It will ALWAYS require a physician order.
- Notices of non-coverage required for other payers.
  - Patient should pay usual and customary rate at date of service.
- Initially can be submitted electronically, but most payers request additional information on initial denial.

92700

- If reporting 92700, submit report with:
  - Copy of Patient Report documenting medical necessity.
  - One page info sheet specific to procedure
    - Description of procedure
    - Clinical utility of the procedure
    - Procedure it is similar to.
    - Time required to perform.
    - Skills of tester
    - Equipment used
    - Peer reviewed research links
    - Usual and customary fee

92700

- Communication and Functional Needs Assessment (if E/M not an option)
- High-frequency audiometry
- Behavioral observation audiometry
- Eustachian tube function testing
- Use of goggles
- Saccade testing
- Sensory organization test
- Speech in noise testing
- Removal of incidental cerumen, independent of audiometric testing
- Fistula testing
- VHit
- Vestibular Autorotation Test (VAT)
- Fukada
- Acceptable noise level
- Auditory prosthetic device evaluation and selection

Hearing Protection/Hearing Aid

- When the individual has normal hearing (for hearing protection)
  - V5274
    - Bill as units or as separate line items with RT and LT modifiers.
- When the individual has an aidable hearing loss (for hearing protection and amplification)
  - V5298
    - Bill as units or as separate line items with RT and LT modifiers.

Use of Evaluation and Management Coding in Audiology

- These are the codes physicians and non-physician practitioners (such as nurse practitioners and physician assistants) utilize to bill for office visits.
  - Must be billed consistently across all patients for the same visit type, regardless of payer.
  - These codes are for EVALUATIONS not for hearing aid patient follow-up.
  - Code selection based upon new or established patient, time, and **complexity**.
    - Avoid 99204, 99205, 99214, and 99215 because of this (as we lack complexity).
  - Per the American Medical Association (who owns the CPT code set and can dictate its use), “A physician or other qualified healthcare professional” is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service”.
  - So, can an audiologist in your state “evaluate” and ”manage”?
    - You want this determination in writing for your state licensure board or a healthcare attorney.

Why it Needs to be in Your Scope of Practice?

- Code set, and AMA guidance, requires it.
- Malpractice coverage is null and void if practicing outside your scope of practice.
- If a payer denies the E/M code AND transfers payment to provider responsibility, you need this documentation for your appeal so that they will either cover the service or transfer the financial responsibility to the patient.
  - When in-network, you must follow the remittance.

Evaluation and Management Time Changes

- 2024 MIMIMUM total time on the date of service to meet or exceed
  - 99202: 15 minutes (versus 15-29)
  - 99203: 30 minutes (versus 30-44)
  - 99212: 10 minutes (versus 10-19)
  - 99213: 20 minutes (versus 20-29)
  - Need to document state and end time.

No Charge Items

Do not charge a health plan for an item or service your received at no charge.

Audiology Compact

- https://aslpcompact.com/
- **Still not operationalized and functional.**
- Need to be licensed in the state in which the patient is currently housed/living to provide remote care.
  - Unless the state allows for limited allowances.

FDA: Establishing OTC

- https://www.fda.gov/news-events/press-announcements/fda-finalizes-historic-rule-enabling-access-over-counter-hearing-aids-millions-americans
- https://www.federalregister.gov/documents/2022/08/17/2022-17230/medical-devices-ear-nose-and-throat-devices-establishing-over-the-counter-hearing-aids

FDA Requirements

- Requirements:
  - Receive a User Brochure
  - Medical Clearance
    - Medical clearance needed for each fitting of a child under the age of 18 years of age.
    - Needs to be in FDA language.

FDA and State Dispensing Laws

- It is IMPORTANT that, before you discontinue use of the medical clearance, medical waiver, and red flags for adults, that you contact your state dispensing and/or audiology licensure boards, in writing, and determine if the requirement remains in your state.
  - Your state would have to have changed the law or rules to remove these types of requirements.

OTC and Prescription Class

- OTC Class
  - Cannot be restricted by state laws UNLESS dispensed by licensed provider (then state can impose restrictions).
  - No requirements of licensed provider.
  - No requirements for evaluation.
  - Self-fitting.
    - Must be able to be adjusted by the purchaser.
  - Manufacturing and label requirements.
  - Returns and receipts determined by seller.
  - Do not know, at this time, what products will make up this class.

- Prescription Class
  - Air conduction, bone conduction, wireless and legacy make up this class.
  - Manufacturing and labeling requirements.
  - Requires a prescription.
    - “They be sold only to or on the prescription or other order of a practitioner licensed by law to use or order the use of (prescribe) the devices (which is as proposed)”.
  - Requires medical clearance for children.
  - Can be regulated by the State for sale and distribution.
  - https://www.fda.gov/news-events/press-announcements/fda-finalizes-historic-rule-enabling-access-over-counter-hearing-aids-millions-americans

Prescription Hearing Aids

- “Prescription hearing aids are prescription devices and as such, they are subject to § 801.109. Under § 801.109(a), a prescription device is a device that is:
  - (1) either in the possession of a person, or his agents or employees, regularly and lawfully engaged in the manufacture, transportation, storage, or wholesale or retail distribution of such device or in the possession of a practitioner, such as physicians, dentists, and veterinarians, licensed by law to use or order the use of such device and
  - (2) is to be sold only to or on the prescription or other order of such practitioner for use in the course of his professional practice”.
- Will be defined by the State.
- Who can prescribe and what is required for prescription.

Prescription for Hearing Aid

- Your state determines:
  - Whether or not you have the legal authority (through licensure) to prescribe a hearing aid.
  - What constitutes or is required for a prescription for hearing aids.
- The health plan determines if they require a prescription.
  - They HAVE to do this because the prescription is required by the FDA.
  - Health plans may begin not covering hearing aids without a prescription.
    - You may need to produce the prescription.

Prescription for Hearing Aid

- **You each need to be a member of your state association and donate time and treasure to:**
  - Creating prescriptive language.
  - Combatting scope creep.
  - Expanding scope of practice.

Third-party Coverage

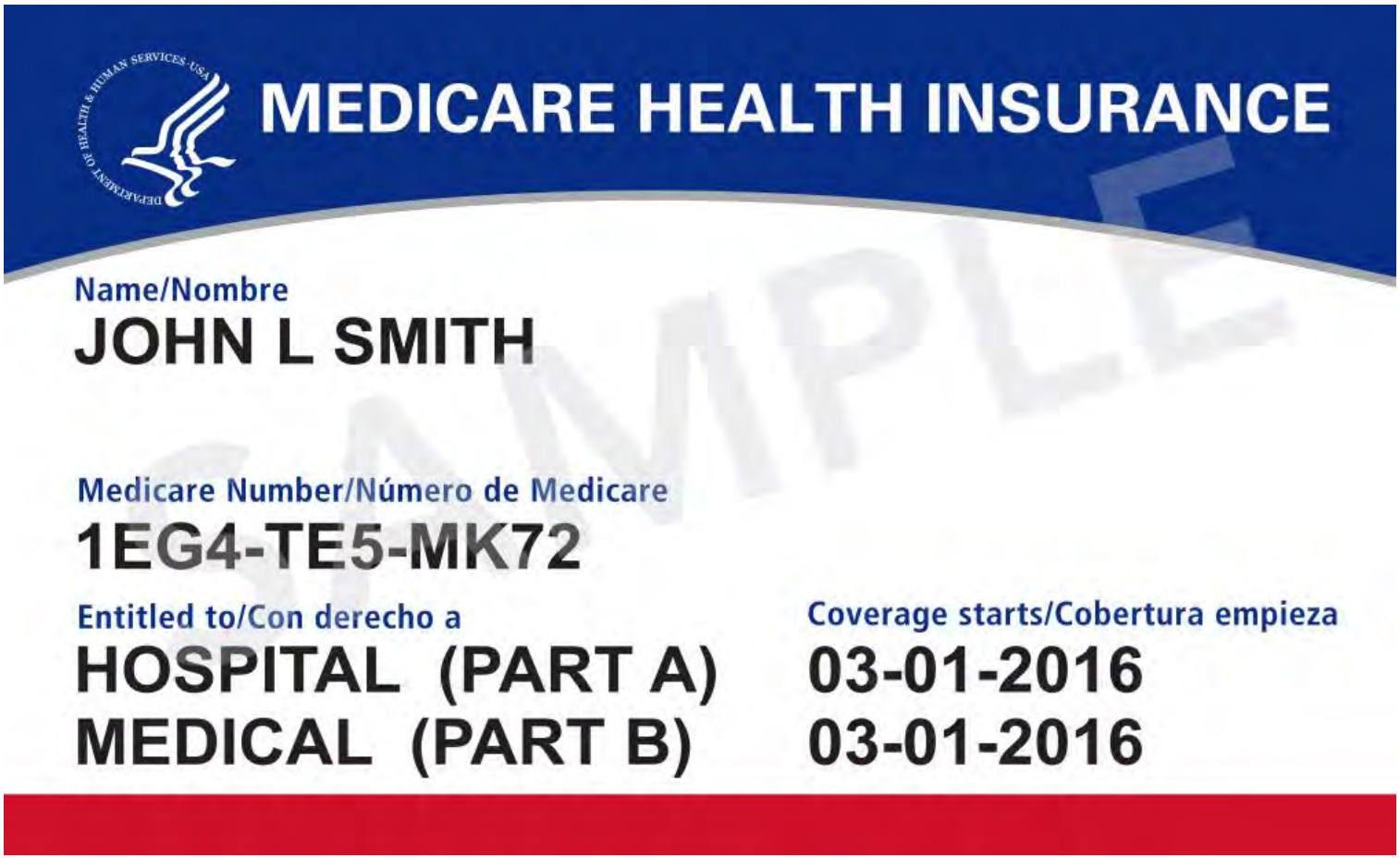
Medical Necessity = Coverage

Document, document, document.

Why did you do what you did?

Why do that need that make, model, and style of hearing aid and its associated features?

Insurance Card Examples – Traditional Medicare



Traditional Medicare

- Advanced Beneficiary Notices can apply here.
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ABN-Tutorial/formCMSR131tutorial111915f.html
- Ask about Medicare Supplement (Medi-Gap).
  - Covers 20% co-insurance.

Medicare Fee Schedule

- https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

Medicare has a Deductible

- Traditional Medicare deductible for 2024 is $240.
  - Who is responsible for the deductible (supplement, secondary, or beneficiary) varies patient to patient.
- Some Medicare Part C plans have deductibles and some do not.
  - Can find out if go online or call to check eligibility and benefits.

The List of Audiologic Procedures That Can Be Provided for Non-acute Conditions Without a Physician Order Once Every 12 Months

https://www.cms.gov/files/zip/audiology-code-list-updated-7522.zip

Medicare Physician Order Changes

- Effective January 1, 2023
- Technically, audiologists can provide non-acute hearing assessment unrelated to disequilibrium or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids once every 12 months without a physician order.
- This applies to traditional Medicare beneficiaries. Medicare Advantage plans, generally, do not require a physician order (unless specified in your agreement).
- Vestibular services (92517-92519 and 92537-92549) and 92700 will always require a physician order for traditional Medicare coverage.

Medicare Physician Order Changes

- It is recommended that practices either utilize an Advanced Beneficiary Notice, prior to assessment, or secure a physician referral If their practice has:
  1. no record of the use of the AB code (and associated testing), by their or another practice within the past 12 months,
  2. does not have a physician order AND
  3. are planning, as a result of the lack of a physician order, to utilize the AB modifier.

Again, this is another example where triage at scheduling can be invaluable. We also encourage audiologists to reach out to their Electronic Health Record/Electronic Medical Record (EHR/EMR) vendors to determine what internal verification processes might exist.

Medicare Physician Order Claim Information

- If you do not have an order:
  - Leave qualifier, name of referring provider and referring provider NPI fields blank.
  - Add an AB modifier to every Medicare covered service line item on the claim.
  - Vestibular services, 92700 and the services associated with an acute diagnosis ALWAYS requires an order.
  - Do not put services that were not ordered on the same claim as services that require an order.
    - Everything on the claim should either be ordered or not ordered.

Insurance Card Examples – Medicare Supplement (Medi-gap)

Medicare Supplement

- Its primary role is to cover the Medicare 20% co-insurance.
  - Most do not cover the deductible (except Plan F).
- Its associated hearing aid “benefits” are discount, unfunded benefits through hearing benefit plans/third-party networks.

Insurance Card Examples – Medicare Part C (Advantage)

UHC

BCBS

Medicare Advantage

- Also known as Medicare Part C
- Encompasses Medicare Part A, Part B, Part D (typically) and Medi-Gap under a single plan.
- They are not all created equal.
  - Some mimic premier commercial insurance and others mimic Medicaid.

Medicare Advantage (Part C)

- General Rule of Thumb:
  - If in-network with the Advantage plan
    - Do not collect anything on the date of service but applicable unmet deductibles, applicable co-insurance, applicable co-payments, and usual and customary costs of prior notified non-covered services.
    - Complete an organization predetermination for non-covered services that are not listed on the non-covered or exclusion list (when using 92700).
  - If out of network with the Advantage plan
    - Have patient complete notice of non-coverage prior to provision of care.
    - Collect unmet deductibles, applicable co-insurance, applicable co-payments, Medicare Limiting Charge on the date of service for covered services (anything medically necessary and meeting coverage allowances) and and usual and customary costs of prior notified non-covered services.
    - Reimburse the patient in accordance with remittance.

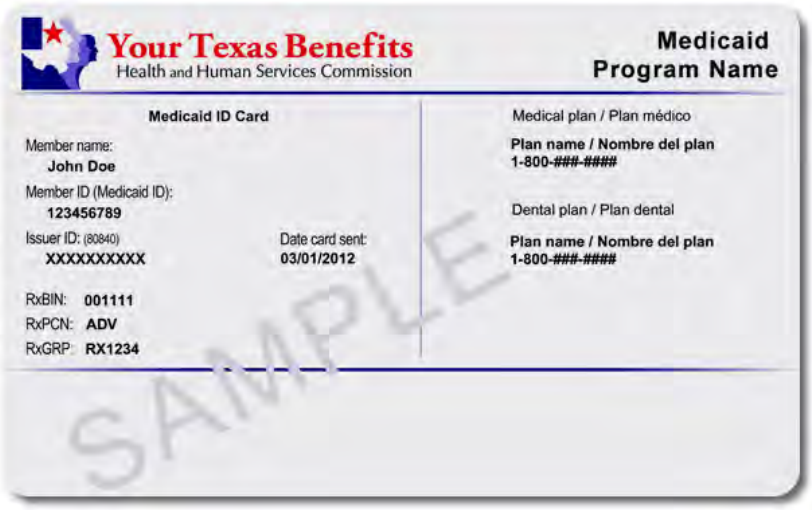
Medicare Advantage (Part C)

- Hearing Aid ”Benefit” Tips:
  - These are typically discount programs, unless union/employee/retiree Advantage plan or a state coverage mandate exists.
  - Hearing aid “benefits” are typically ONLY available through Hearing Benefit Plans/Third-Party Networks.
    - Most will not have any access to out of network benefits.
  - Calling to verify benefits may trigger the plan contacting the member.

Routine Hearing Tests

- Medicare Advantage may cover routine testing.
- There is no code specific to routine testing.
- ”Routine” in healthcare typically refers to screenings or basic testing.
  - Hearing Screening (92551 or V5008)
  - Pure-tone, air (92552)
  - Audiometry for hearing aid evaluation to determine the level and degree of hearing loss (S0618)

Medicaid


Your Texas Benefits
Health and Human Services Commission
Medicaid
Program Name
Medicaid ID Card
Member name:
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Member ID (Medicaid ID):
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Issuer ID: (80840)
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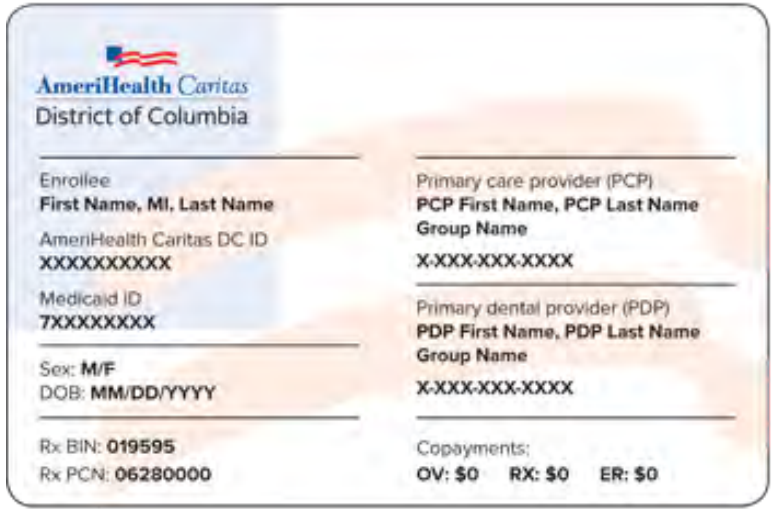
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District of Columbia
Enrollee
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AmeriHealth Caritas DC ID
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Medicaid ID
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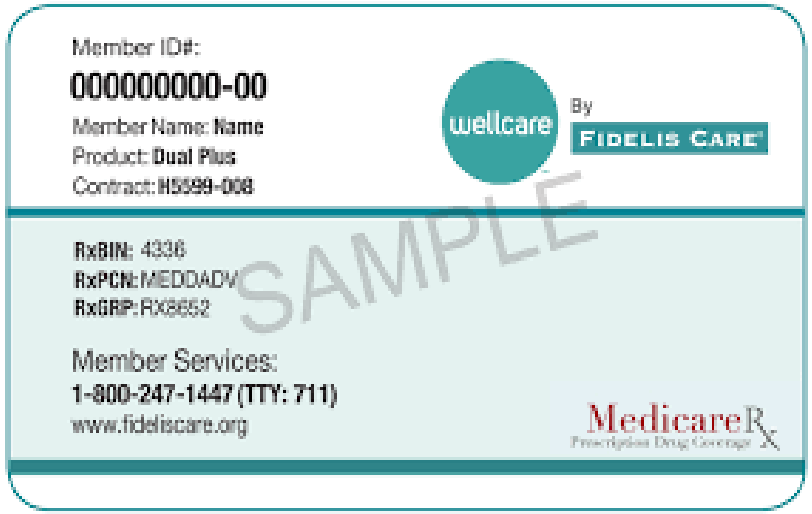
DOB: MM/DD/YYYY
Rx BIN: 019595
Rx PCN: 06280000
Primary care provider (PCP)
PCP First Name, PCP Last Name
Group Name
X-XXX-XXX-XXXX
Primary dental provider (PDP)
PDP First Name, PDP Last Name
Group Name
X-XXX-XXX-XXXX
Copayments:
OV: $0 RX: $0 ER: $0

Medicaid

- **The rules and fee schedules are published and vary greatly state by state and plan by plan.**
  - The plan must offer, at a minimum, what the state dictates and allows.
- The insurance card will typically say Medicaid somewhere on the card.
- They do not cover routine testing.
- Prior authorization is common.
  - Cannot be retroactively obtained.
- Itemization is typical.
  - They often cover many items and services that are medically necessary and performed, such as auditory rehabilitation, electroacoustic analysis and real-ear measurement.
- If out of network:
  - There are not typically out of network benefits. They must see an in-network provider to access their benefits.
  - Can typically see a Medicaid patient (state dependent) as a cash pay patient once they receive a good faith estimate (if scheduled over 3 days in advance) AND a notice of non-coverage.

Insurance Card Examples – Dual Eligibility MCO



Medicare Dual Plan

- **Individual has Medicare and Medicaid.**
- Even if Non-Par Medicare Provider or Out of Network, you must accept assignment on these claims.
- Cannot collect Medicare payment upfront when an ABN is utilized.
- Many programs (QMB) do not allow providers to collect unmet deductibles or co-insurance from the patient.
- Out of network coverage and benefits may vary.
  - Complicated.
  - Please verify benefits.
  - Many services, especially hearing aids, require prior authorization.
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf
- **Recommend referring these individuals to in-network, participating providers.**

Insurance Card Examples – Commercial Insurance

BSBS

UHC

Commercial Insurance

- Employer or private coverage for those under 65 years of age or for retiree benefits of those over 65 years of age.
- May cover routine hearing testing.
- Hearing aid coverage is typically directly through the health plan.
  - Some exceptions:
    - Cigna uses Amplifon for their hearing aid benefits.
    - UHC uses UHC Hearing for some of their benefits (specifically for unfunded, discount “benefits”).

Payer Guidance and Medical and Coverage Policies

- Many third-party payers do not cover amplification for the treatment of tinnitus in the absence of hearing loss.
- Aetna: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#
- BCBS:
  - Google “BCBS Medical Policies (add you state here).
- Cigna: https://www.cigna.com/health-care-providers/coverage-and-claims/policies/
- Humana: http://apps.humana.com/tad/tad_new/home.aspx?type=provider
- UHC
  - https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html
  - Also search subsidiaries, such as Optum and Oxford, separately.
- VA Community Care
  - https://vacommunitycare.com/provider

Third-party Medical Policies – UHC Commercial 2024

- https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/hearing-aids-devices-including-wearable-bone-anchored-semi-implantable.pdf
- Removed the requirement for a written recommendation from a physician.
- “Refer to the member specific benefit plan document to determine if coverage applies.
- Standard plans include coverage for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- Benefits are provided for the Hearing Aid and for charges for the associated fitting and testing.
- The wearable Hearing Aids benefit does not include batteries, accessories, or dispensing fees.

Third-party Medical Policies – UHC Commercial 2024

- For certain plans, benefits are also provided for certain U.S. Food and Drug Administration (FDA) approved over-the-counter Hearing Aids for Covered Persons aged 18 and older who have mild to moderate hearing loss.
  - Benefits for over-the-counter Hearing Aids do not require any of the following:
    - A medical exam.
    - A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
    - A written prescription or other order.
- If more than one type of Hearing Aid can meet the member's functional needs, benefits are available only for the Hearing Aid that meets the minimum specifications for the member's needs. If the member purchases a Hearing Aid that exceeds these minimum specifications, UnitedHealthcare will pay only the amount that it would have paid for the Hearing Aid that meets the minimum specifications, and the member will be responsible for paying any difference in cost".
  - I would recommend a waiver that clearly reflects this fact.

Third-party Medical Policies 2024 – Aetna

http://www.aetna.com/cpb/medical/data/600_699/0612.html

- "Air conduction hearing aids are considered medically necessary when the following criteria are met:
  - hearing thresholds 40 decibels (dB) HL or greater at 500, 1000, 2000, 3000, or 4000 hertz (Hz); or
  - hearing thresholds 26 dB HL or greater at three of these frequencies; or
  - speech recognition less than 94 percent".
- "Aetna considers the following procedures experimental and investigational because the effectiveness of these approaches has not been established:
  - Air conduction hearing aids for improvement of balance
  - Hearing aids and semi-implantable hearing aids for all other indications (including for improvement of depression and cognitive decline in the elderly)
  - Use of free-floating piezoelectric microphone in an implantable hearing aid".

Third-party Medical Policies 2024 – Aetna

- ”Aetna considers the Bose Hearing Aid and other FDA-cleared hearing aids available over the counter without a prescription as medically necessary equally effective alternatives to hearing aids available only by prescription for persons whose hearing has been evaluated and meet medical necessity criteria for air conduction hearing aids, and the member has a prescription for the hearing aid from a physician or provider licensed to prescribe hearing aids.
  - State dispensing laws will matter here.
- For plans that do not exclude hearing aids, either OTC and prescription hearing aids are eligible for coverage if they are cleared by the FDA and prescribed by a qualified healthcare provider and medical necessity criteria for hearing aids above are met”.

Third-party Medical Policies – Anthem Commercial 2024

https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html

- "Air conduction hearing aid devices are considered **medically necessary** for the treatment of hearing loss when **ALL** of the following criteria are met (A and B):
- The hearing loss is due to one of the following etiologies:
  - Sensorineural hearing loss; **or**
  - Mixed hearing loss; **or**
  - Conductive hearing loss which has been:
    - unresponsive to medical interventions; **and**
    - unresponsive to surgical interventions or not amenable to surgical correction; **and**
- The degree of hearing loss is confirmed by audiometry or other age-appropriate testing to be greater than or equal to 26 decibels (dB)".

Third-party Medical Policies – Anthem Commercial 2024

- "Binaural air conduction hearing aids are considered **medically necessary** when BOTH of the following criteria are met (A and B):
  - Both ears meet the criteria listed above in A and B; **and**
  - Binaural testing shows improved speech recognition using bilateral devices.
- Air conduction hearing aid devices with advanced technology models and features (for example, in-the-ear and in-the-ear-canal models with digital signal processing, directional microphones, multiple channels/memories) are considered **medically necessary** when the technology enhancement is needed to improve the hearing quality for the wearer.
- Replacement of an air conduction hearing aid device that is out of warranty and no longer functioning adequately to support activities of daily living is considered **medically necessary** when the device is malfunctioning and cannot be refurbished or repaired sufficiently to resume its original functionality".

Third-party Medical Policies – Anthem Commercial 2024

- “Air conduction hearing aid devices are considered not **medically necessary** when the above criteria are not met.
  - Air conduction hearing aid devices with advanced technology models and feature enhancements (for example, in-the-ear and in-the-ear-canal models with digital signal processing, directional microphones, multiple channels/memories) are considered **not medically necessary** when provided solely for the convenience of the wearer or to improve his/her cosmetic appearance.
- Replacement of a currently functional air conduction hearing aid device that is still under warranty for the sole purpose of obtaining a device with updated technology, (commonly referred to as an "upgrade"), is considered **not medically necessary** unless the new updated device will provide a significant functional advantage over the device that was originally issued”.
- Upgrade Example: https://providernews.anthem.com/maine/article/billing-for-deluxe-hearing-aids

Third-party Medical Policies 2024 – TRICARE

- TRICARE only covers hearing aids and hearing aid services if you have hearing loss that meets specific criteria.
  - Adults with: Hearing threshold of at least 40 dB HL in one or both ears when tested at 500, 1,000, 1,500, 2,000, 3,000, or 4,000Hz; or hearing threshold of at least 26 dB HL in one or both ears at any three or more of those frequencies; or speech recognition score less than 94%.
  - Children with: hearing threshold level of at least 26dB HL in one or both ears when tested at 500, 1,000, 2,000, 3,000, or 4,000Hz.
- https://www.tricare.mil/CoveredServices/IsItCovered/HearingAids
- https://www.military.com/benefits/veteran-benefits/hearing-aids-for-military-retirees.html

Third-party Medical Policies 2024 – FEHP

- https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/
- FEHP hearing aid benefits are not “one size fits all”.
- Allowable rates are payer dependent.

Third-party Medical Policies 2024 – BCBS FEHP

- https://www.fepblue.org/our-plans/medicare/compare-plans#:~:text=Hearing%20Aids&text=Prior%20approval%20will%20be%20required,aids%20and%20hearing%20aid%20supplies.
- FEP Hearing Aid 005
- FEP Standard plan beneficiaries can received covered services at out of network providers. FEP Basic and Blue Focus beneficiaries have no out of network coverage.

Third-party Medical Policies 2024 – BCBS FEHP

- **Prior authorization is required in 2024.**
- **Documentation of medical necessity has ALWAYS been required.**
- All state FEP plans have a different process.
- There will typically be prior authorization/approval options available through the local BCBS provider, FEB Blue or Availity portal.
- There is a phone option (the number differs state by state).

Third-party Medical Policies 2024 – BCBS FEHP

- Minimum test battery:
  - Air conduction testing
  - Bone conduction testing
  - Speech reception threshold
  - Speech recognition testing

Third-party Medical Policies 2024 – BCBS FEHP

- Recommended documentation for hearing aid prior authorizations:
  - All audiometric test results required by the State.
    - Three and four frequency pure-tone average.
    - Results of medically necessary audiometric testing and otoscopy.
  - Results from a standardized inventory (i.e. HHI, COSI, SAC, etc.)
  - Speech in noise results.
  - Unaided real ear (to illustrate that the aided ear cannot meet NAL targets)
  - Results of any screenings (i.e. cognitive, APD, dexterity, mobile proficiency, speech/language).
  - Findings from patient interview regarding audiologic and communication needs.
  - Copies of any medical referrals/orders/findings/evaluations.
  - Medical clearance/waiver, if required by a State.
  - Prescription for make, model and style of hearing aid being prescribed (as allowed).
  - Documentation of medical necessity for the type, style, and features of hearing aid being prescribed, including peer reviewed research supporting necessity.

Third-party Medical Policies 2024 – BCBS FEHP

- BCBS FEHP plan:
  - This is an allowance benefit.
  - “Hearing aids for children up to age 22, limited to $2,500 per calendar year.
    - Here is a rationale for an unbundled delivery.
  - Hearing aids for adults aged 22 and over, limited to $2,500 every 5 calendar years. Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.”
  - The patient is responsible for all costs which exceed $2500.

Third-party Medical Policies 2024 – BCBS FEHP

BCBS FEHP medical necessity:

- "**Medical necessity** shall mean healthcare services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:
  - In accordance with generally accepted standards of medical practice in the United States; and
  - Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
  - Not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and
  - Not part of or associated with scholastic education or vocational training of the patient; and
  - In the case of inpatient care, able to be provided safely only in the inpatient setting".

Third-party Medical Policies 2024 – BCBS FEHP

- BCBS FEHP plan requires documentation of medical necessity for all hearing aids, including initial fittings:
  - “Must be FDA-approved
  - Dispensed by prescription from a licensed healthcare provider..
  - Hearing aid purchase within 6 months of the date of prescription.
  - Hearing loss determined and documented by audiometric testing (hearing test) completed in the 6 months prior to hearing aid purchase.
  - Moderate hearing loss of 40 dB or greater (based on pure tone average tone-conduction detection threshold) for:
    a) conductive hearing loss unresponsive to medical or surgical interventions
    b) sensorineural hearing loss
    c) mixed hearing loss (combination of conduction hearing loss and sensorineural hearing loss)”

Third-party Medical Policies 2024 – BCBS FEHP

BCBS FEHP plan replacement device, whether in years three to five or after five years of age:

- "Documentation of medical necessity for replacement hearing aid to include:
  - Member's past history of hearing aid use
  - Pertinent medical history, description of functional status, relevant prior treatment
  - Comprehensive audiometric testing: date, type of testing and results that demonstrates the hearing loss and need for a replacement hearing aid
  - The currently used device is no longer functioning adequately and has been determined to be non-repairable and is not under warranty, OR
  - Significant change in the person's hearing that requires a different hearing aid (at least a 15 dB change in at least one frequency between 500 and 4000 Hz)
  - Recommendation for type of replacement device
  - Follow-up plan for assessing effectiveness/outcome of use of the replacement hearing aid
    1. Trial period
    2. Warranty information

Third-party Medical Policies 2024 – BCBS FEHP

BCBS FEHP non-covered items and services list:

- “Accessories which are for convenience and not medically necessary
  - While many hearing aids are now Bluetooth compatible, below are examples of additional tools that are considered not medically necessary (this list is not all inclusive:
    - Streamer remote/TV adapter (for connection to multiple audio sources such as a home theater system or smartphone)
    - Phone clip (allow hearing aid to become a wireless stereo headset)
    - Remote control (change volume/programs and control other accessories)
    - Remote microphone
    - Apps
- Hearing aids that have been returned for a refund during the trial/adjustment period
- Repair of hearing aid performed under warranty
- Repair or replacement of hearing aids due to loss, misuse or abuse
- Over-the-counter hearing aids/ hearing assistive devices/ personal sound amplification products (PSAPs) available without a prescription”.

Health Plans May Ask You For

- Prescription
- Prior authorization or prior authorization number
- Medical clearance, possibly even from an ENT
- Documentation of medical necessity
- Invoice
  - They have the contractual right to this.

These requests will be outlined on denial remittance.

Thank You!

Kim Cavitt, AuD

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