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2024 Coding and Reimbursement Update

Presenter: Kim Cavitt, AuD

It's my pleasure to welcome back Doctor Kim Cavitt. Today she's going to be giving us an update on coding and reimbursement for 2024. I'll go ahead and hand the mic over to you, Doctor Cavitt. Thank you. Thank you to audiology online for having me back for my annual update.

You will see my disclosures here, my financial and non financial disclosures, and here are your learning outcomes. And we're just going to jump right in. First, I always want to stress some things that I don't always see people highlighting. And the first is informed consent. Audiologists in many states and in many instances are required to obtain written informed consent prior to the provision of care.

In informed consent, a patient must be informed in writing of all the potential benefits, risks and alternatives involved in any medical procedure or course of treatment. And it needs. In some states, it has to be specific to telehealth or specific to treatment, specific to email or text. Electronic communications, informed consent, also not uncommon. This is going to be very unique to your state and you have to obtain that before the provision of care.

So right now I'm bringing this up because if you are not using informed consent for treatment, for telehealth, or for electronic communications, you need to investigate whether or not that's required for your state. What types of informed consent are required and is there a specific language that needs to be used? And there are some links here that can give you some more information. I want to jump now into modifiers. There are some changes around modifiers and I want to bring it up.

And it's really around the use of the distinct procedural service or the 59 modifier that now has been kind of broken up into pieces. And I'm going to show you some different pieces where you would use an x modifier rather than a 59. So a 59 is for distinct procedural service. It's used still in situations where you are unbundling parts of a

bundled code. So let's say, for example, you do air and you do an SRT into scrim, but you're not doing no, you do, but you're not doing bone.

So here you would add nine, two, 5525-925-5659 that you are. These are distinct procedures and you're breaking them up into their pieces. Now there's also an Xe modifier that's a separate encounter, a service that is distinct because it occurred during this separate encounter. So you saw a patient a second time for testing on the same date of service. Now you might have an xs modifier, separate structure, a service that's distinct because it's performed on a separate structure or organ.

This is one of the options that you could possibly use in billing for bilateral cochlear implants. I'm going to show you a few different options on another slide, but I wanted to bring this modifier up first that you're working on a different structure. Xu means an unusual non overlapping service. So this is when you're performing one of the cochlear implant programming codes, 92601 through 60, four and 92626 and 27, the evaluation of auditory processing status 92584 electrocochleography or for telemetry, or 9568, that is, acoustic reflex testing, which you can use for ESRT. So if you are performing these procedures on the same patient, same data service, you would want to add those Xu modifiers in this situation to let them know that these are non overlapping unique services.

Let's talk about some of the options for billing bilateral implant services. There is no one size fits all magic option. You might try one, it might get denied. You might have to send a corrected claim and try another. And you might find a situation where they don't ever, no matter how you bill it, reimburse you for the second implant.

But here are some options that do work. One option is billing is two units. So 92602, subsequent reprogramming of someone birth to seven years of age. You could bill that code with two units. You've done it twice.

You could add a 50 modifier. 50 modifier means bilateral or binaural, so 9260 250. You could have two separate line items, 92602 rtxs, 92602 ltxs, or the most successful option. But the most inconvenient is that you would see a patient on the separate data service for the second year. That is the only way to guarantee that payment is the separate data service on the second year.

Otherwise, you might have to try different things with different payers to see if you can increase your reimbursement. So I'm going to give you the AMA disclaimer. The AMA owns the CPT code set, and this is just a disclaimer that they own it. So let's talk about cochlear implant neural telemetry for a minute. Per the AMA, which owns the code set, 92584 is the code for intraoperative monitoring and for post operative neural telemetry.

So if you were doing intraoperative telemetry, you would use 92584. If you're doing postoperative telemetry use 92584. Now, there is an NCCI that is national correct coding initiative. They can create coding edits that if two things are performed on the same patient, on the same data service, they don't pay both of them. That's what a coding edit is.

So there is a coding edit that exists for Medicare and Medicaid that 926-049-2601 through 604 and 92584, if they're billed on the same patient on the same date of service, they're not both reimbursed. There's no way to override that. You can't charge the patient privately. They're going to say a coding edit applies here. Some private insurances apply the coding edit, some private insurances do not.

I also want to bring up the 92584 has a TCPC split and can be performed by a technician under the general supervision, I mean the direct supervision of a physician, not an audiologist. I want to also show you why you don't use the ABR code for 92651. So an ABR code is not appropriate for neurotelemetry. And this piece of

documentation outlines the why neural telemetry is only represented by 92584. It is not to be represented by any of the ABR code family.

9259-2650 through 926-5565 not represented by any of those codes, only to be represented by 92584. And again, this is going to document this for you. On January 1, 2024, new codes went into effect specific to auditory osseointegrated device. An auditory ossu integrated device is a baha, an adhere, a Ponto, anything that is a bone conduction device, whether it is osteointegrated or non osseointegrated. If it is in this family of an osseointegrated prosthetic device represented by an l code.

This 92622 is the diagnostic analysis that's programming initial activation and verification. So anything post verification of an auditory osteointegrated sound processor, any type 1st 60 minutes. The use of 92622 does not require implantation. You must spend at least 31 minutes or you have to add the 52 modifier for reduced service. And you need to document the start and end time of this procedure in your medical record.

926323 is each additional 15 minutes of diagnostic, analysis, programming, or verification of an auditory osteointegrated sound processor. For six three, you have to spend at least eight minutes and document start and end time in the medical record. These are not for cochlear implant services. These two codes have nothing to do with a cochlear implant. They are for auditory osteointegraded devices.

Neither code 622 or 623 can be billed with 92626 or 92627 because these codes 622 and 623 include verification so you can't use 626 and 627. These are also post fitting activation codes only. They are not for evaluation. They are post fitting activation codes and they can be billed with an AB modifier. And the AB modifier is when you have the one visit in twelve months without an order.

For traditional Medicare I always like to bring up 927-009-2700 is the unlisted code, unlisted owner, rhinological item or service that is used when a procedure does not have a CPT code. It could be replaced with an evaluation of management code. If in your state you as an audiologist are allowed to evaluate and manage and it needs to be clearly defined in your state, licensure in your scope, which is a requirement of the code set 92700 must be submitted to a health plan. For claims processing. A physician order is required.

For traditional Medicare you can't use an AB modifier here coverage is limited. They're individually reviewed. You would need an advanced beneficiary notice. For traditional Medicare the patient can with an ABN pay you your usual and customary rate on the date of service. But again, it's always going to require that physician order.

If you are in network with other health plans, you'll need a notice of non coverage and in that case your patient again can pay your usual and customary rate. And the reason for non coverage is that there is not a code to represent a more specific code to represent this procedure. It initially can be submitted electronically. If attachments are not are not you're not able to submit attachments in your initial billing you can submit electronically and then most payers are going to request supplemental documentation. So in your supplemental documentation you're going to need a copy of the patient's report for that data service and that's documenting the medical necessity of what you're performing.

I also recommend one page info sheets. You can make these once your billers can have access to them as a PDF, as a hard copy if they're faxing, and in that one page info sheet on that procedure that you're billing for 9700, you would have a description of the procedure, the clinical utility of the procedure, any procedure that it's similar to and it's code, the time required to perform the procedure in isolation, the skills of the tester the equipment used, any peer reviewed research links showing the evidence of

that procedure, and your usual and customary fee, but your report needs to show why it's medically necessary for that patient. Here are some examples of procedures that you might bill using the 92700. I am going to highlight a few of them. The communication and functional needs assessment if a communication functional needs assessment is done in accordance with evidence, it is a diagnostic procedure because the outcome may or may not be a hearing aid.

As such, a communication function needs assessment could be billed using 92700 or billed using an evaluation management code. Again, as allowed by your scope of practice, you might use 92700 for high frequency behavioral observation eustachian two function use of goggles saccade testing sensory organization tests speech and noise and isolation removal of incidental strumen independent of audiometric testing fistula testing the white because white does not have a code and you are not to use rotation testing for that. A vestibular auto rotation test Fukada acceptable noise level testing or an important one auditory prosthetic device evaluation and selection because there is no code specific to auditory prosthetic device evaluation, I'm not talking about the pushing of the buttons. I'm talking about the rest of the evaluation. Reviewing medical records select determining what device is the most appropriate taught creating a care plan that is not included in the put and bush and pushing of 926, two, six, and 27.

This could be a separate procedure that you could charge for separately and oftentimes would be the patient responsibility.

I also want to talk about how you bill hearing protection and hearing and hearing enhancement or hearing aid. When the individual has normal hearing and an electronic hearing protection device is appropriate, you would use 92574, an ALD type code. It would be billed as units or separate line items with the right left modifier. If you're doing two when the individual has an aidable hearing loss and you're selecting this hearing

aid as medically necessary to treat the hearing loss, you should bill v. 5298, billed as units again or separate line items with a right left modifier.

You should not be using digital hearing aid codes for these products. You should not. It's just not appropriate because of the different distinction. You want to make sure that you're saying this is a device that isn't otherwise classified and you're doing that by using v 5298. I want to talk a little bit about evaluation and management.

Coding and audiology. E M codes or evaluation management codes are the codes that physicians and non physician practitioners such as nurse practitioners and physicians assistants use to bill for their office visits, they must be billed consistently. So if you are going to utilize E M codes, you don't just bill the health plans to pay you, you have to utilize them consistently for that same type of patient in that same type of situation. These codes are for evaluations only. They're not for hearing aid follow up, and they're not actually appropriate in my opinion, for hearing aid visits.

They are for diagnostic evaluative purposes. The code selection is based upon new or established patient. A patient is established if they've seen you or anyone else in your practice in the last three years. It's also based on time and on complexity of the patient because of complexities and risk, the morbidity and mortality. Even if an audiologist can use an E m code, they should really avoid any codes above a three.

So you only would want to look at 99202 or 20 three depending on the complexity or 992-112-1212 or two one three per the American Medical association. And this is why it needs to be in your scope of practice. Who can access evaluation management codes is an individual who is qualified by education, by training, by licensure and regulation that's important and facility privileging who performs with a professional service within his or her scope of practice. And your scope of practice is defined by your state and is independently reporting the so you can't bill ever incident two and

use e m. So you all have to determine can an audiologist in your state evaluate and manage.

You want this determination in writing from your state licensure board or from a healthcare attorney who's making an advice of counsel for you, why you need it in writing first and why it needs to be in your licensure. The code set requires it. The AMA controls the code set they own and their guidance requires that to build that code set, you must have these qualifications. Your malpractice coverage is null and void if you're found to be practicing outside your scope and practice and something bad happens. And most practical and most important, if a patient denies an EM code and transfers the payment to provider responsibility, the only way you can override that coverage decision and push that responsibility to the patient regardless of what the patient signed in your office.

If you're in network, you're bound to the terms of that remittance. So you're going to need to be able to appeal that decision by showing them, hey, that's okay if you're not gonna pay for it, but it needs to be assigned to patient responsibility because it's in my scope of practice, and I've seen a lot of success being able to override remittances by showing it clearly that it's in an audiologist scope of practice. In 2024, there were some changes in the minimum total time of the evaluation and management service. I also want to stress this. You're paid separately for the time of the audio.

You're paid separately for the time of the tympanometry. This is the time of the evaluation and management service. That's the time you're being reimbursed for. So now they put minimum times. So 99202 minimum of 15 minutes.

203 minimum of 30 minutes. And 202 and 203 are for new patients. 9921, 210 minutes. 9921, 320 minutes. And you need to again, to document that start and end time.

And I will say this is an update. That's why I hope you don't feel like I'm jumping around. I'm trying to update you on changes that have occurred over the past year. That's what today is about. It's not foundational.

It's about updating you on changes in coding reimbursement.

If you are given an item at no charge, you should not charge a health plan or a patient, really, for an item or service that you received at no charge. But specifically, you should never charge a health plan for an item or service you received at no charge. Those should be then if you got it for no charge, should be given to the end user and no charge. The audiology compact here is the link to the compact. It is still not operational and functional.

So I don't want people to think that if you're in a compact state and your patients in another compact state, that you can right now see that patient without a license where your patient is. That's not the case yet because the compact is not operational and functional. You need to be licensed still right now in which the state in which the patient is currently housed or living, to provide them with remote care, unless that end state where the patient is, allows for some limited allowances. Five visits a year is one state. So you want to know what are the requirements to see a patient in another state right now?

And the general rule right now is that you need to be licensed in the state in which the patient is seated, because that's the rules that they are governed under in that moment of time. I do want to go through OTC again because we've seen some ripple effects of OTC. Here are the links. If you've never read the OTC legislation. I strongly recommend that you read it.

The FDA requirements for a prescription hearing aid are that they receive a user brochure. It can be a QR code, it can be a printer brochure, but your patients need access to the user brochure. If the patient is birth to 17 years of age, they need a medical clearance for every fitting, and it needs to be in the FDA language. Now, some of your states may still require it. Some states, if you did not change your dispensing law in your state since October of 2022, if you did not change it when the OTC regs came out, you still may have a medical clearance or a medical waiver required or red flags in your state, and you're still obligated to the dispensing law in your state.

In the previous slide, I'm talking about the FDA. Your state actually can make rules that exceed the FDA, except where the FDA, like you, can't make rules around the dispensing of OTC. But if you still have dispensing laws on the books that still require clearance for adults or still require a medical waiver or still require red flags, you still need to follow those rules until they are changed or they've made guidance that, that says you can ignore those rules. I want to talk about a little bit of the difference between the OTC and the prescription class. The OTC class cannot be restricted by law unless dispensed by licensed provider.

And then the state could impose restrictions on the licensed provider, not on the class. There's no requirements for a licensed provider. There's no requirements for evaluation. It is self fitting and it must be able to be adjusted by the user. There's manufacturing and label requirements.

And I do want to stress here right now, OTC class is FDA approved. Prescription class is FDA registered. So there is other steps that OTC has to go through. Right now. Returns and receipts are determined by the seller and what products make up this class.

I can't give you every product that makes up this class because it's constantly evolving. I can't give you a definitive list. So right now, I would say, ergo is OTC. Lexi is OTC. Newhera is OTC.

Go is OTC. Audience is OTC. There's classifications of MD hearing that are OTC. There's lots of different products that are OTC versus the prescription class. The prescription class, they took all the other old classes, air conduction, bone conduction, wireless, and legacy.

And they combine them under prescription. There are manufacturing and labor requirements. Again, it also requires a prescription. So when people are getting aggravated at payers that are saying we require a prescription, they're requiring a prescription because the FDA requires a prescription to dispense that device. So they are only to be sold to, on the prescription or order of a practitioner license by law to use or order prescribe the devices.

This is what the rule is. It requires a medical clearance for children and can be regulated by the state for sale and distribution. So your state needs to give you the ability to prescribe hearing aids. Here is the language from the OTC rule, what prescription hearing aids are and that they are to be sold on the prescription of a provider. Your state can define what your prescription looks like, who can prescribe, and what's required on the prescription.

National associations cannot come in and fix your state prescription. That's going to be something that the audiologist in your state and the dispensers in your state need to work together to create. Can you prescribe and what does that prescription look like? Your state determines whether or not you have the legal authority to prescribe a hearing aid and what's required. And then the health plan determines if they require a prescription and they need to do that because the FDA does.

Health plans may stop covering hearing aids, and I'm going to defend them here. Because the FDA requires a prescription, they may not legally be able to cover something if it's not prescribed. So it's going to be commonplace that you have to produce a prescription and your state will define what that prescription looks like. You need to be a member of your state association and donate time and treasure to create this prescriptive language to combat scope creep and to expand or enhance your scope of practice. Like if you want to be able to evaluate and manage, that's how you do that is to be part of your state association and introduce legislation to make those changes to your licensure.

Now we're going to jump into third party coverage. So coverage is dependent on medical necessity. No medical necessity, no coverage. You need to document, document and document again. You need to be able to outline why you did what you did.

That's medical necessity. And why do you need the make, model and style of hearing aids and associated features to fit this patient? What is the why? You need to be able to communicate the why.

I'm doing things a little bit differently now, and I'm going to talk about, I'm going to show you different insurance cards, and then I'm going to show you what you need to know. About that insurance. So here is a traditional red, white and blue Medicare card. So when you see that card, if you need an ABN, ABns apply here. And if you see that card, you also want to see a Medicare supplement card or a Medigap card.

Traditional Medicare covers 80% either a Medicare supplement or the patient covers the 20. So you want to know when you see a red wine blue Medicare card, do they

have a supplement? Here is a link to the Medicare fee schedule if you'd like to see the Medicare fees for 2024. Medicare has a deductible. It's dollar 240.

Who's responsible for the deductible? Varies patient to patient. Most supplements do not cover the deductible with the exception of a plan f supplement. Some Medicare part C plans have deductibles, some don't. You can go online or call to check the eligibility benefits.

About Medicare Part C here is the list of audiologic procedures that can be provided for non acute physician non acute conditions without a physician order. Once every twelve months. These are the codes. You can use an Ab modifier on one visit per twelve months. That physician order change went into effect January 1 of 2023.

Technically, audiologists can provide non acute hearing assessment unrelated to vestibular or hearing aids and once every twelve months without an order. It applies to traditional Medicare. Medicare Advantage plans generally do not require an order unless it's specifying your agreement. HMO's are usually the exception. Vestibular services and nine to 700 will always require an order.

For traditional Medicare, it is recommended that practices either utilize an advanced beneficiary notice prior to assessment or secure physician referral if their practice has no use, no record of use of the AB by their practice or another practice in the last twelve months doesn't have a physician order or, and are planning, as a result of the lacto physician order to use an Ab modifier. If you, if you're not sure if the patients use the AB in the last twelve months, have them sign an abnormal triage can be very, very helpful here. This is why. When was the last time at scheduling? When was the last time you had your hearing tested?

Yes, I appreciate that some patients are not good historians, but some patients are, and that can give you the instances. Oh, I've never had my hearing tested. Great. Then you don't need to worry about the ABN in that situation. You can use the AB modifier, not get an order for that situation if they've never had their hearing tested.

If you don't have an order, leave the qualifier name and referring provider blank on the claim form. Add the AB modifier to every Medicare covered service item on the claim. Vestibular services 92700 and services associated with acute diagnoses always require an order and do not put some ordered services on the claim and some not ordered services on the claim. Either everything is ordered or everything is not ordered. Don't have an AB on some things and not an AB on others.

Here are some examples of supplements. You will see supplement on the card or both of these examples have a supplement. This is the COVID the coinsurance. Most do not cover the deductible except for a plan. F it's associated if there are hearing aid benefits with a supplement, 99% of the time they're discount unfunded benefits through a hearing benefit plan or third party network.

You don't need to call these are typically going to be through a third party network. So if you don't participate with a third party network, you don't have to worry about this. If you do participate with third party network and this patient was not referred to, you get to determine am I going to put this person through the third party network or am I going to do it directly the practice and you have to weigh the ethics and pros and cons of that. Here are some examples of Medicare Advantage cards. You'll see advantage.

Here's where there clearly says advantage on the card. Also known Medicare Part c encompasses Medicare Part a inpatient part b outpatient part d drugs typically in Medigap. That means they don't have another card. Not all Medicare advantage plans

are created equal. Some, if you pay more, can mimic commercial insurance and be better than Medicare, cover way more things than Medicare.

Some lower costs are more challenging, have more stop gaps, have more controls, have more physician referral requirements. They're not all created equal. A general rule of thumb if you see a Medicare Advantage card if in network with the advantage plan, do not collect anything on the data service but applicable unmet deductibles, coinsurance and co payments, and the usual and customary costs of prior notified non covered services. If you need an organization predetermination, they need to sign for the non covered services. A notice of non coverage if you're out of network with the advantage plan, I would have the patient complete a notice of non coverage prior to the provision of care.

You can collect unmet deductibles, applicable coinsurance, and applicable copayments up through the Medicare limiting charge. You can charge your usual and customary to an advantage patient for a Medicare covered service. You can charge the Medicare limiting charge on the date of service for covered service, anything medically necessary and meeting coverage requirements, and you can charge your usual and customary costs for any non covered service. And you're going to reimburse the patient in accordance with the remittance because you do need to submit a claim on their behalf for advantage hearing aid benefit tips these are typically not always typically discount programs. Unless a union employee, retiree advantage plan, or a state coverage mandate exists, there are oftentimes discount programs.

Hearing aid benefits with advantage are typically only available through the hearing benefit plan or third party network. Most will not have access to out of network benefits. This is very plan by plan. Calling to verify benefits may trigger the plan contacting the member and sending them to someone in the plan. So if someone has

advantage, a good assumption is that unless it's a union or will have the union name, or an employer will have their employer name on the card.

If it is just a straight advantage with no employer or union on the card, it is typically a discount benefit through a third party network. If it has an employer or a union, they might be able to go, it might have funding, and they might occasionally be able to go to the network. But not commonly. Medicare Advantage plans may cover routine testing. There is no code specific to a routine test.

Routine in healthcare typically refers to screenings. So, for example, when they're talking about they cover routine testing. They might cover hearing screening, they might cover puritone air, or they might cover audiometry for hearing aid evaluation to determine level or degree of hearing loss. They might not cover 92557. Medicaid is going to vary.

Here's some examples of some Medicaid cards. The rules and fee schedules are published and vary greatly state by state. 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 don't cover routine testing.

Prior authorization is common and cannot be retroactively obtained. They don't. Itemization is typical. They often cover many items and services that are medically necessary and performed, and they often cover things like auditory rehab, electroacoustic analysis, or real ear measurement. If you're out of network, they're typically not out of network benefits.

They need to see an in network provider to access their benefits. You can typically see a Medicaid patient state dependent, again as a cash pay patient once they receive a good faith estimate and a notice of non coverage that they understand that they're

paying out of pocket and that you are not billing Medicaid because you are out of network. Here are some examples of dual eligible that means they have Medicare and Medicaid. Even if you are non par Medicare or out of network, you must accept assignment on these claims. You cannot collect Medicare payment upfront when an ABN is utilized.

Many programs do not allow providers to collect unmet deductibles or coinsurance. Out of network coverage is extremely variable. It's complicated. There's a lot of rules around out of network and many services require prior auth. I strongly recommend if you're seeing someone with a dual card that you refer those individuals to in network participating providers.

It's very complicated to provide because of the allowances that Medicare beneficiaries are given around being able to access their benefits. It becomes complicated to see them when you're out of network. Here are some commercial insurance card examples. The one on the left is an FEP card and you'll see in the, in the map of the US it says standard. There, there's an option called basic.

They differ. So standard versus basic, that will be on the card. And here's a commercial United healthcare the choice plus which is their most common commercial network? Commercial insurance is employer or private coverage for those under 65 or retiree benefits for those over 65. It may cover routine testing.

Hearing aid coverage is typically directly through the health plan. Now that is evolving, but right now it's still typically through the health plan itself. Some exceptions Cigna uses amplifone for their hearing aid benefits. UHC uses uh hearing for some of their benefits. And that's going to keep slowly transitioning over time that more and more commercial benefits are going to be available through UHC.

Hearing health plans create medical policies and the medical policy is there are rules for coverage. Many third party payers don't cover amplification for the treatment of tinnitus or auditory processing in the absence of hearing loss. I'm going to throw that out there now. And some of the medical policies links I've put for you here. For the blues, I would type in Blue Cross Blue Shield medical policy, your state name and you should be able to find the link fairly straightforwardly.

I've got the link to community care down here as well. These are the coverage policies. You have to meet their coverage policies for them to cover a hearing aid or tinnitus or oaes or AVR or VSIB. There are rules around lots of different procedures, and it's not unique to audiology. You have to follow the coverage rules.

The United Healthcare commercial medical policy did change. It changed on February 1, 2024, and they removed the requirement for the written recommendation from a physician. They removed that requirement. I have this in quotes so that you can see what the benefit is. Standard plans include coverage for a hearing aid that's purchased through an audiologist, dispenser, otolaryngologist, or authorized provider.

Benefits for the it's the benefits for the hearing aid and fitting and testing. They do not cover long term care, they do not cover follow up, they don't cover batteries, they don't cover accessories, and they don't cover dispensing fees for certain plans. Benefits are also provided for over the counter hearing aids. So UnitedHealthcare does have coverage for over the counter hearing aids. UnitedHealthcare allows for the upgrade because UnitedHealthcare covers what is minimum minimally medically necessary to meet the patient's needs.

So if more than one type of hearing aid can meet the member's functional needs, so you need to document this in the medical record. Benefits are available only for the hearing aid that meets the minimum specifications of the member's needs. If the

member purchases a hearing aid that exceeds 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 other difference in costs. I would recommend use of a waiver form that clearly reflects this, that UnitedHealthcare pays for what's minimally medically necessary, which is clearly been documented in the research. They do not care if it's connected.

They do not care if it's rechargeable. They care for what's minimally medically necessary. So if you need connectivity, if you need advanced features, if you need rechargeability, your medical record needs to document why that's medically necessary for your patient.

Aetna has medical policies with minimum requirements of hearing loss. Air conduction hearing aids are considered medically necessary when the following criteria are met hearing thresholds of 40 dbhl or greater at 5123 or four or hearing thresholds 26 decibels hl or greater at three of these frequencies or speech recognition less than 94% Aetna considers the following experimental hearing aids for the improvement of balance hearing aids for indications hearing aids and semi implantable hearing aids for all other indication, including improvement for depression and cognitive decline in the elderly could include for tinnitus, for auditory processing for all other indications other than the hearing loss dictated above and anything that is a free floating piezoelectric microphone in an implantable hearing aid. Those are Aetna's policies. Aetna does cover over the counter. If it has been FDA cleared, they will cover an over the counter anthem policies.

If you are an anthem Blue Cross Blue shield provider are really important to read because they also have policies around the coverage of degree of hearing loss and hearing loss is due to one of the following etiologies sensorineural mix can conductive and you need a document in the medical record if it's conducted conductive, why it's

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not being medically or surgically treated and you have to have a degree of hearing loss of 26 decibels or poor. So I would tell you to lean into a three or four frequency average and be documenting that again in the medical record.

Binaural hearing aids you need to have in your records with anthem post fit that binaural testing improves speech recognition versus a binaural hearing aids improve speech recognition versus a monorail hearing aid that needs to be in your documentation and testing you provide and perform. Air conduction hearing aids with advanced features are considered medically necessary when the technology enhancement is needed to improve the hearing quality for the wearer. So you need to document that replacement. Super important because health plans are over, that you're the minute that someone's renewed that you're replacing. So you need to document your why replacement of narrow conduction hearing aid that's 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 to sufficiently resume its original functionality.

So you really need to show that it can be repaired or it's audiologically inappropriate and that needs to be documented again in the medical record. They're not medically necessary when provided solely for the convenience of the wearer or to improve cosmetic appearance. So you're going to need, if you are doing in the ear in the canal, things that are smaller, whatever your lyric, if you're doing this, you need to document your why? Why do they need these advanced features? Why is that medically necessary for this patient?

Because you have to understand the research does not support. No study has ever been done that supports that people have superior outcome, satisfaction or performance, that every person has that with premium technology, you have to document the why for the patient in front of you. Also with anthem, replacement of a

currently functional air conduction hearing device that's under warranty for the sole purpose of obtaining device with updated technology is not considered medically necessary unless the new updated device can provide a significant functional advantage over the device that was originally issued. You're going to need to show evidence. What is the evidence that this device is is going to yield better performance and outcomes than the one they already have?

And I would be using an upgrade waiver and I've given a link here to some anthem upgrade waiver guidance from Anthem of Maine Tricare Tricare only covers hearing aids and hearing services if you have the hearing loss that meets its criteria, which are exactly the same as Aetna's. And Tricare is for active duty military and their family.

FEP or the federal employee plan or federal employee health plan. Here is a link to a map. So if you click on this link, you're going to see a map. You can go to your state and you can see the plan documents of every federal health plan that's available. It's not one size fits all.

Not every federal health plan covers hearing aids. Not every federal health plan has $2,500 every five year benefit. It really is dependent on the FEP plan that they selected. But you can see the plan links to the plan documents whether hearing aids are covered or not from this link. Now other than the Blue Cross Blue Shield association plans, it will not show you the allowable rate.

The Blue cross Blue Shield plan document will. The others will not generally show you the allowable rate. Allowable rates are payer dependent. Here is a link to the medical policies of today. So every Blue cross Blue Shield federal employee plan, no matter what you're told on the phone, requires prior authorization.

You must have prior authorization and it cannot be obtained retroactively. It has to be before the procedure is provided. The second link is to their coverage policies. You should be for associations that you are a member of your state and national associations that you're a member of. There should probably be a coverage update on April 1, 2024 to FEP.

I am not at liberty to share what that update is going to say, but you need to make sure that you know that this is what it is right now, today on May 28, but on April 1, the coverage policy will change. Now, I also have to stress that federal FEP gives the 33 Blue cross Blue Shield association plans guidance. How they administer the benefit is up to each of the 33 Blue cross blue shield plans. So federal FEP cannot dictate a prior authorization form, cannot dictate a prior authorization number, cannot make them have facts, cannot make them go through a validity. Every one of the 33 plans gets to administer this separately.

They also get to interpret the guidance themselves.

So I would strongly stress that if you get denied and prior off and you're denied based upon the policy, you appeal with the policy and ask for specialty review. That means you'll be reviewed by an audiologist or probably an otolaryngologist or somebody from our discipline, closer to our discipline. If you get denied in peer to peer, you then want to go where the patient, you give the patient all the information that you submitted and have the patient file an appeal because your appeals are exhausted after peer to peer. But the patient can appeal. But I would not be appealing things that are not allowed by the policy.

And I'm, I'm just telling you it's that they have normal hearing. I don't know that that's worth appeal. You're going to need to really document the medical necessity for that patient FEP plan standard beneficiaries receive covered service at out of network

providers. This is actually something that has actually changed. So I'm going to this is a typo that I should have fixed.

FEP. All FEP, FEP standard and FEP basic can, can see out of network providers. Blue focus is a discount program. There's not coverage and they can't see really out of network providers because they can't get access to the discount benefit unless they go through one of the discount plans. So I apologize for my typo here.

Standard and basic do allow for out of network blue focus is is a discount plan. Prior authorization is required. Documentation of medical necessity has always been required. This is not new. Every contract you all have ever signed, every single one has a requirement of medical necessity.

So you should be documenting medical necessity for every health plan. All state FEP plans have a different process. There are typically prior authorization approval options available through the local Blue Cross blue shield provider, FEP blue, or the availability portal. And there is a phone option and that number differs by state. Here's your minimum test battery in the medical policy as it was effective on January 1.

Here is what I recommend people start to include in their requests the test results required by the state. Three or four frequency average documentation medical necessity results of a standardized inventory speech and noise unaided real ear to illustrate that the aided ear cannot meet the unaided ear cannot meet nal two targets it should be unaided ear. The results of any screenings cognitive APD dexterity, mobile proficiency, speech language findings from the patient interview regarding audiologic and communication needs copies of any medical referrals, orders, findings or evaluations. Medical clearance or waiver is still required by the state the prescription of the make, model and style of hearing aid being prescribed and documentation of

medical necessity for type, cell and features of hearing aid being prescribed, including any peer reviewed research supporting evidence.

The FEP plan is a $2,500 allowance is dollars towards hearing aids for children up to age 22. So birth to 21 is 2500 per calendar year and this is a great rationale for an unbundled delivery because they don't need to pay for long term care. Because FEP does cover repair services. Hearing aids 22 and older is 2500 every five calendar years. There is an appeal process for years three to five if someone has a significant change in hearing and need the benefits for hearing aid, dispensing fees, fittings, batteries, repair servicers are included in that $2,500 benefit limit and the patient is responsible for anything above 2500.

Medical necessity. This is their documentation of medical necessity. It shall mean the healthcare services that you provide in accordance with accepted standards of care that's clinically appropriate, not primarily for the convenience of the patient, not part of an associated scholastic education or vocational training. They don't pay for anything educational or vocational and in the case of inpatient able to be provided safely in an inpatient setting. The FEP aid must be FDA approved, must be dispensed by prescription so they only cover prescription hearing aids determined and documented by audiometric testing which I told you the minimums before and completed in the six months prior to the hearing aid purchase.

So whatever your state requires, they require an audio within the last six months, moderate hearing loss of 40 decibels or greater and that is a pure based on a pure tone average and they're using a three frequency average, you need conductive, unresponsive and that needs to be documented, sensory, neural or mixed.

If in years three to five you need to again request a prior authorization for early replacement, you need this types of documentation or even after year five members

past history of hearing aid use, pertinent medical history and description of functional status relevant to treatment. Why is this medically necessary? Your comprehensive test results, date, type of testing results and the need for the replacement hearing aid that the currently used device is no longer functionally adequately so the aid has to be deemed unrepairable or inappropriate and they're not going to replace anything under warranty if it's still appropriate. They need a significant change in hearing a 15 decibels change at least one frequency between five and four, the recommendation of the type of replacement device and the follow up plan for assessing effectiveness outcome for use of the replacement device what's the trial period and the warranty information that needs to be included in the prior authorization request for replacements.

They don't cover, really accessories. This is their non covered list. They don't cover accessories for convenience or, and are not medically necessary. They don't cover hearing aids, but in return for refund within the trial or adjustment period, they don't cover repairs for hearing aids for hearing aid performed under warranty. They don't cover repair replacement for hearing aids due to loss, misuse or abuse, and they don't cover over the counter hearing aids.

But again, these policies should be changing on April 1 of 2024, and you'll get additional guidance from the national and state associations you're a member of. Health plans may ask you for prescription, prior authorization or prior authorization number, medical clearance, possibly even from an ENT, because even though your state might not require medical clearance, a health plan can require medical clearance, a documentation of medical necessity, and they may ask you for an invoice. They have the contractual right to ask you for an invoice that's in really any contract I read. These requests will be outlined in the denial remittance.

If you do not complete all components of 92557, is it best to bill separately or with the 52 modifier? For example, if you complete AR, SRT, and word rec, is it best to bill

92552 and 92556 instead of 925-5752 yes, it's actually best to bill nine, two, 5525-925-5659 why can't bill patient privately for 92584 billed on the same day of 92601? If an ABN is signed, say Medicare won't pay it, because when there is a coding edit, the guidelines of being a Medicare or Medicaid provider are that you follow the coding edits, and coding edits do not allow you, when they're applied. They do not allow you to bill a patient for the non covered service that is part of being a provider. Oh, getting things for free and not charging.

Oh, yeah, it applies to everyone. That's why actually, the precedent in healthcare is physicians who get drug samples can't charge you for the drug samples. I mean, that's where the precedent really comes from, is that if they got it for free, they can't charge you for it. What is an example of a no charge item? Are you saying that if a hearing aid company provides hearing aids as a discount, you buy again one free?

That is, be free to the patient? Yes. There are precedents that you cannot charge for the item. There are lots of precedents. I would encourage people.

I'm not, I don't want to name company names here, but there was a recent case from the office of the Inspector General around an implant manufacturer giving away hearing aids as part of an implant purchase. And that has been stopped because it was deemed a kickback, so. Or suggestive of a kickback. So, yes, you shouldn't be. There's lots of precedents, lots of precedents in healthcare, even in our industry around implants of the billing for things you receive for free can follow up telehealth services.

We provide another state that you are not licensed in and a bundled service that was initially performed within your state. No, because if that patient saw a provider in that state, they'd be governed by the laws and rules of that state. So any service you're providing when someone is out of state would be something that you would need to be licensed in the state in which the patient is. It is our clinic understanding that you don't

need an AVN for services that are statutely excluded from Medicare coverage. Is that correct?

That is correct. That would be unless you want to use an ABN as a voluntary notification. If an item or service is statutorily excluded for Medicare coverage, an ABN would be voluntary. And I think I can take one more question. What is the best way to build cans repositioning as audiologists, considering that's not a covered code to bill it privately to the patient, can it be billed incident two, since it isn't covered?

Or is it best to have an AVN filled out and bill the patient? Well, you can only bill incident two if you work somewhere with physicians. And yes, it can be billed incident two can with repositioning 95992 can be billed incident two. Incident two, the patient's attending physician. So it needs to be someone that they have seen.

So it can be bills with incident too. Most clinics bill it actually privately. They have the patient sign an ABN and they have them pay for it. They have it paid for it privately.

I am going to end the questions here.

Thank you so much for everyone who has been in attendance. We really, really appreciate you coming for your annual updates. Those of you who are members of state or national associations, you may be able to get additional guidance or answers to your questions from those associations. You also, those of you who have audiology, online CEU memberships, you can also watch other webinars for myself or any of my colleagues in this space actually gain some additional information as well. I want to thank my partners at audiology online for another great annual update.

And we really appreciate you attending. And I'm going to kick this over to Doctor Hund. Thank you so much, Doctor Cavitt. We'll go ahead and close the classroom. Thanks, everyone.

Have a great day.

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