Empowered Patients, Efficient Practices: Cracking Coding and Reimbursement in the United States

Presenters: Andrea Overton, AuD, Lindsey Van Looy, AuD, CCC-A, Lori Hambrick, AuD

Hey everyone, thanks again for attending today's session. My name is Lori Hambrick. I am the principal education and training specialist on the global education and training team at Advanced Bionics. Thank you so much for attending today's webinar part five and the final portion of the empowered patient efficient Practices series. During this webinar series, we have addressed ways to improve clinical efficiency.

We've discussed ways to get the right patients into your clinic. We've also talked about candidacy surgery activation and follow up protocols. We have identified a b tools and resources that support both you and your patients throughout their CI journey. If you missed the previous sessions, you can access all of the webinars in this series with the registration link that is going to be shared in the chat.

Today's guests will be discussing coding and reimbursement in the US.

Let's start with the goals and objectives for today's session. After this course, you will be able to identify one important consideration when billing for services for CI recipients. Explain one consideration when billing for services for bimodal recipients, and identify one consideration when billing for telehealth services for CI recipients.

I'd like to ask today's guests to introduce themselves. Doctor Van Lloyd, would you like to go first?

Hi everyone. My name is Lindsey van Loy. I'm an audiologist in the adult clinic at UNC. And I see a mixture of cochlears implant patients, hearsing aid patients, diagnostics, and tinnitus patients. Doctor overlapping?

Hi, my name is Andrea overlapping and I'm an audiologist at the University of North Carolina. And I oversee our adult cochlears implant program. I'd like to thank audiology online and advanced bionics for the invitation for us to join you today. And I'd also like to preface this with neither of neither of us.

Lindsey or I are experts in coding and reimbursement, but we are clinical audiologists and we have tried our very best to seek out information and learsn more about the system and hope to relay that information to you so that you can make informed decisions about how you want your own program to move forward.

Thank you both for being here today. So let's get into this topic of coding and reimbursement.

So I'm going to start by putting some words up on the screen.

How do these words make you feel? Do these words make you feel very pleased with yourself because you know all there is to know about billing and coding, and you feel like an expert, or are you experiencing other feelings? Doctor Van Loy and Doctor overlapping how did these words make you feel before you took time to increase your understanding about billing and reimbursement?

For me, these words would have filled me with anxiety or making me feel overwhelmed. What about you, Doctor Everton? I think overwhelmed. Daunting. Confused?

Honestly, a little bit like my head is spinning just trying to figure out what it all means. And how do I make that work for our practice? I would imagine. Well, first, thank you for sharing your feelings. And I would imagine a lot of attendees on today's call have similar feelings, but that's okay.

I'm sorry to start the webinar by giving you a little bit of anxiety, but that's why we're here today, and why we're going to have Doctor Van Loy and Doctor overlapping share all that they have learsned with you to help you feel more confident in the area of billing and coding for CI recipients.

Not only will Doctor Van Loy and Doctor overlapping provide you with valuable information, I want to make sure to point out that AB is also here to support you. For example, we have a CI coding quick

reference guide that you can use clinically and that is available in the resources section for this webinar. And I was just told this morning that today we have a new resource that will go live. The AB website is going to have a new webpage dedicated to providing support with billing for CI care, whether that care is in person or remote. And I'd like to start today's session with a question for Doctor van Loy.

Doctor van loy, what trends are currently occurring in billing and coding related to cochlears implants? I think that's a great first question to start with. And there was actually a great article in ears and hearsing by Melissa hall et al that was published a couple of yearss back in 2022 that has given us some good insight on trends in cochlears implant billing and coding across the US. We're going to share the pubmed link for the article in the chat so you guys can read it at your leisure. In their study, what they did was they electronically distributed a survey to audiologists across the country who see and bill for cochlears implant services.

Billing questions were presented and answered, and then they were coded as correct or incorrect based on the National Corrective Coding Initiative, or NCCI coding edits. The majority of the respondents, which was over 80%, reported that they agreed or strongly agreed with the statement that they understand billing and coding practices for cochlears implants. However, the researschers actually ended up seeing significant variability in billing practices in the areas of unilateral programming, speech testing, bilateral programming, ECAP testing, and ESRT. To pull a couple highlights from this article, the authors found that slightly less than half of respondents were submitting codes that followed the NCCI edits when completing booth testing and reprogramming on the same day and at UNC, this would be one of our most common appointment types. Another surprising takeaway from the article was that nearsly half of the respondents reported that they bill for CI programming for only one years when they've actually completed bilateral reprogramming.

That means that they're forfeiting a chance to be reprogramming for what is essentially double the work with this context, in the ever growing number of patients who are evaluated and implanted each years across the country, it's clears that there are confusions that need to be addressed if our clinics are going to be reprogramming appropriately and remain profitable, all while balancing clinical efficiency. Guidance can sometimes be contradictory, which also makes this very confusing, and it's constantly changing years to years and across the different payer types.

Doctor van Loy, you mentioned that slightly less than half of the respondents are submitting codes that follow the recommended NCCI edits. Will you explain what the NCCI edits are and where others can learsn more about them? Yeah, of course. The NCCI coding edits provide guidance in situations when you're billing for multiple different CPT codes on the same day. For some background, CPT stands for current procedural terminology, and each code is made up of five different digits.

Each unique code is intended to represent the services and procedures that physicians, allied health professionals, non physician practitioners, hospitals, outpatient facilities and laboratories may use. The American Medical association owns the CPT code set and their descriptors, and they dictate how they're allowed to be used when CPT changes come out. They are found published in the CPT assistant the CPT coding system is the preferred system that's utilized for coding and describing healthcare services for both CMS as well as a lot of other private payers. The NCCI edits were developed by CMS, but some private insurance also apply these coding edits, too. On this slide you're going to see the NCCI edits arranged as a table, and this table is put together by ASHA.

But AAA also has created a version of this, and you can find both of those tables listed in the link below the table. Column one lists the programming code, and then column two would list another audiology code, and then in columns three and four, you can see if they may or may not be billed on the same day by the same provider for either office or outpatient hospital facility settings. This would be indicated

as a y for yes or an n for no. The CCI edits are for provider based services provided in clinics, private practices, and physician offices, while OCE stands for outpatient code editor and these are for outpatient hospitals and other facility based services. The table also specifies if you need a modifier when billing these codes together, so in this case, it's specifying the use of the 59 modifier if you aren't familiar with it yet.

The 59 modifier stands for distinct procedural service. However, this is also a good time to note that other payers besides CMS could require a more specific modifier instead of 59, such as the Xe separate encounter modifier, Xe for separate organ or structure, or they may utilize Xu, which will be an unusual non overlapping procedure. We'll talk more about these optionss in just a little bit. A common question that comes up when talking about what can and cannot be billed on the same day ends up being about an advanced beneficiary notice or an ABN. In these cases, the patient would typically sign a document stating that they understand that the second code that's in column two is not covered and that they would have to pay out of pocket that day, whatever the customary amount might be.

Unfortunately, if your payer follows these edits and the table says you can't bill both on the same day, you cannot charge privately with an abnor. Thank you for covering some of those details about the NCCI coding edits another frequent topic of discussion related to billing is something I commonly hears, which is do I use 92626 or 92627? Doctor van Louis, will you explain use of those codes? Yes. So 92626 is a code that's used to describe time spent for evaluation of the auditory function for cochlears implant candidate, or monitoring a post operative status or progress with a cochlears implant.

92626 encompasses the first hour spent with the patient and you have to complete and document at least 31 minutes in order to bill this code. By document, I specifically mean that your documentation must list a start and end time that is 31 minutes or greater if you aren't consistently being reprogramming for this code. This is a common reason why 92627 would be added as an additional

code on top of 92626 to reflect an additional 15 minutes of evaluation after the first hour, similar to 92626. In order to bill you would need to have completed at least an additional eight minutes after the first hour in order to build this code. So what things can you actually include in this code?

I've included some helpful links at the bottom, but to summarize, 92626 can include face to face case history that focuses on hearsing loss and amplification history. It can include discussing results of questionnaires such as the ciqlite, tHi, or SSQ, and along with the implications for candidacy, their expected progress with the cochlears implant as well. If you program a hearsing aid for testing on that same day, the time spent programming or reprogramming that hearsing aid can be included. Monoral and binaural testing in quiet and in noise, as well as sound field thresholds can be used. So CNC testing, AZ biotesting, and 92626 can also include perceptual tasks that may be more common with pediatrics, such as the earsly speech reception test, open set and closed set tests.

And one more thing I want to mention here is that you can bill for these codes even if the patient ultimately is not a candidate or if they end up not pursuing implantation. So it's still important to be to be billing for these codes even if they're not moving forward with a cochlears implant.

Sorry, Lori. One thing I would just add about that is that when we say adding in the start and end time, we literally just have our speech perception table and then have right on underneath it start time. And then you enter the time and then end time and enter that. So it's all calculated right there. It doesn't take a whole lot of effort, but that way it's directly under and always documented.

Thank you. Before we get into the deeper discussion of billing for cochlears implant recipients, let's talk a little bit more about cochlears implant candidacy and evaluation. Doctor Van Loy, what do you do at UNC to make the candidacy and evaluation process more efficient? When thinking about clinical efficiency, a major goal for a successful program should be prioritizing services that can be billed while trying to reduce non billable time. So there are a lot of things that we do during a cochlears implant

evaluation appointment that is not covered by 92626 or 92627.

I think of things like reviewing medical records, developing care plans, choosing a company and external equipment, counseling on how a CI works, expectations with a CI, and then answering patient questions, as well as completing order forms. This would all be considered non billable activities on average, I would say for an evaluation appointment. I typically spend 30 to 45 minutes of non billable time on tasks such as these per patient. A new trend in larger centers is hiring on a specific cochlears implant coordinator or even an audiology technician to help with some of these non billable tasks. However, plenty of centers do not have these dedicated positions.

For these centers, I would recommend not only advocating for these positions, but also would recommend a strong communication with your AB cochlears implant consumer specialist who is a tremendous resources for our recipient counseling device and kit selections, and they even will assist with order forms for new recipients that have already selected all itemss of their kit at the evaluation appointment. We can send a brief email with this information to our consumer specialist, and they'll assist with filling out the applicable parts of the form, and then they'll send it back to us for final review. This saves us about ten minutes per patient. If the patient is still deciding on accessories, the consumer specialist will meet with the patient to answer questions, and then they'll send us the drafted order form for our review. In these cases, it can save us 40 to 70 minutes of administrative time.

There's also the AV success team, which will also help AB recipients to learsn about their accessories, provide upgrade consultations, assist with setting up telehealth remote sessions. So if you're not already relying on these services regularly, this would be one of my strongest places to start when recommending ways to improve clinical efficiency. Doctor overlapping, will you share how you work with AB staff to reduce the amount of time you spend on non billable activities during your candidacy and evaluation process to improve clinical efficiency? Absolutely. I agree with Lindsey.

I think this is an invaluable resource, and I think sometimes, at least for me, it can be hard to remember what exactly is included with all of these different resources. I like to think of it as two different services, and it's really just dependent on where the patient is in their cochlears implant journey, candidacy or if they're already implanted. So first are the AB cochlears implant consumer specialists, and that's who Lindsey's referencing with, assisting patients on completing applicable parts of the order form and accessories. But we utilize their support in a lot of different ways. These are folks that are knowledgeable hearsing care professionals, and they provide support to our cochlears implant candidates who want to learsn more about the cochlears implant process surgery activation.

Maybe they want to meet other people who have cochlears implants, and in general, they just help answer questions about AV patients. Typically meet with them before a cochlears implant evaluation or after, and then it can be viewed as kind of a continuation of the conversation that you may have had with, with that patient. Second would be the AB success team, and that consists of caring care professionals as well. But they're this time supporting recipients. And the A B success team will help recipients learsn about their equipment before their initial activation or after as well.

And essentially, they're helping patients download apps, connect to Bluetooth, Roger devices, prepare for any remote programming appointments. We've been using them to help assist with pursuing upgrades. That's been extremely helpful, and a lot of our patients have attended these free sessions. I do think it's important to always remind patients that they're free. It's not something they have to pay for, but it's really allowed them to become more knowledgeable about their kits and accessories, learsn about warranty coverage, care maintenance, and how to really request additional equipment.

So I guess this is really kind of like, you know, in yearss past, and we thought of like, having your go to person for your specific clinic, but now there's just a team of individuals, which means that somebody is always accessible and patients just have more availability for one on one appointment. And I think it's

fair to say when we first started trying to utilize this, I'll be honest, our initial approach was not terribly successful. At the time. We were just printing out information, handing out flyers, briefly mentioning it with patients at the end of their appointment. And unsurprisingly, we didn't have great utilization.

So we really had to revamp our process. And our new approach really tries to kind of streamline things and, and create multiple touch points for patients. So one thing we did, we created a save the link smartphrase. So we send that to patients through our electronic medical record system. It's quick, it's easy, it's already templated, and it gives the patients all the information at their fingertips.

I think the added bonus is that each message then comes with a notification prompt. So it's like an additional built in reminder for the patient. And then our cochlears implant coordinator now sends templated information through an email to our patients. And that's happening after their cochlears implant evaluations and then after their initial activations as well. So just one other form of touch point.

Thank you. It's great to hears the different ways that you all are improving your clinical efficiency and also hearsing ways that AB provides support to both you, your CI candidates, and your AB recipients. I want to be sure to mention that AB has many resources to support you and your patients throughout their CI journey. No matter where you are in the world, AB is here to support you and your patients. Now, the name of specific resources and specific teams at AB may differ depending on where you are located, but one thing that doesn't change is our commitment to supporting you and your AB recipients.

Doctor overlapping, do you have any other tips on how your program has set yourself up to be successful in utilizing a b support for these non billable activities? Yeah, so we, of course, want to stay compliant with patient information, especially considering that some of this information is shared prior to a patient undergoing surgery. So we were instructed by our hospital compliance to have a release of medical record form completed for every patient. And I'll be honest, that seemed really daunting at first. So in order to make this as easy as possible, we decided to create a pre filled out form.

It's provided to the patient at their cochlears implant evaluation appointment. And all they have to do is read it, sign it, and date it, and then we just easily scan it into their medical record. We currently have it in both Spanish and in English, and we're typically providing it to the patient during the downtime between completing any boost testing and counseling. So it was already sort of a, essentially a dead time within that appointment. And as you can see here, the release includes all three cochlears implant manufacturers.

And I think I can even advance that to zoom in on it. I think the part that's really unique here is that it has all three manufacturers. So no matter what device the patient decides on, we can share their information and pass off these non billable tasks right from the very start. And I think another added bonus is that once, because this is signed, we're able to directly send a list of upcoming surgeries with patient contact info to the manufacturer. And then the manufacturer goes ahead and makes the connection to the patient and sends us completed order forms to submit.

So it really takes a lot of the ownership off of the audiologist and we're already having to complete this release anyway. As doctor van Loy mentioned earslier, this saves an incredible amount of time and a lot of back and forth phone calls and messages of the patient that I know we, we all deal with regularly. And I do think that there's been a distinct shift in patient willingness to reach out to manufacturers after surgery for their equipment questions and their needs. So I think it really provides a great avenue for patients to begin their self advocacy from a very earsly stage before we get into a deeper discussion about hospital based care versus provider based care. I'd like to share a polling question about what you're doing during billing, so it should pop up on your screen when billing for services.

How do you bill hospital based, provider based, both or you don't know, which is one of the reasons why you're here. So I'll give you some time to answer that. And the answers are still coming in.

Okay, it looks like things have slowed down. So let's see our results. The highest percentage is provider based. Then second, I don't know. So we have a lot of people here to learsn from you, doctor Van Loy and doctor overlapping, and then hospital based, and then a few who are billing for both.

We'll go ahead and move that slide. And I'd like to ask you a question, doctor overlapping. Will you explain the difference between hospital based versus provider based care? Sure. This is typically related to the billing process for services provided in the outpatient setting, and it's related to the Medicare billing status and process for hospitals and clinics.

So depending on which you fall under, there can be more or less out of pocket costs for the patient, and they tend to differ based on the patient's hospital benefits, hospital deductible coinsurance payment. And on the screen here, you'll see there's a map of North Carolina. And the stars that are in light blue represent our hospital based clinic locations, and then dark blue represent our provider based locations. Hospital based essentially means that the charges for the clinic and the physician may be separate. So the patient may receive two separate bills.

So a facility charge and a provider charge. And you can think of this as an extension of the hospital where the entity is billing under just one NPI versus provider based or professional billing. And that means that you may be part of a hospital, possibly even located miles away from the main hospital campus. But the main thing is that it's typically used for services provided by individuals, healthcare providers. So you're billing under each individual provider's NPI versus hospital based, which is just billing under that one NPI.

I think this type of terminology was new to me prior to opening up any of our new satellite clinics, and I felt like, honestly, it was pretty perplexing. It typically isn't anything that we have any control over. We can't easily change it. So for me, I think it's helpful to bring it back to what this means for us as audiology audiologists. And essentially, it means that you can have different billing.

So, for example, if a patient is seen in a hospital based location, their bill may go toward their deductible, versus if you're seen in a provider based location, it may be seen as a copay. And there are advantages and disadvantages to both. You can potentially have a little bit different reimbursement depending on the entity and the payer contracts. And then personally, as a clinician, I think it may be easier or more difficult to view reimbursement with one versus the other. So, for instance, in our case, it's definitely easier to see reimbursement for provider based versus hospital based clinics.

And I believe we're including a hospital based versus provider based billing information. There's a medical biller encoder website that I think is coming through the chat now and then, just in relation to hospital based and provider based clinics. I wanted to share something with you all that's been really helpful for our practice, and I thought it might be helpful for others as well. And full disclosure, while I'd love to take credit for this idea, this is definitely 100% an english king original idea. English is the manager of our audiology department and she's been in the cochlears implant field for many yearss.

As our program's clinical needs continued to grow with increasing staff, clinic locations, and frankly, the complexity of patient appointments, coupled with all of the billing confusion, we ended up creating billing templates to help streamline what to bill, how to bill, and now we update them every fiscal years to ensure that they're up to date. We have one that's for our hospital based practices and one that's for provider based, and a sample should be accessible to you through this module, and if you find it useful, great. Feel free to edit it with your clinic specific billing guidelines. I feel like in general, in a world where we all want to minimize the amount of non billable time we spend each day, there's no need to recreate the wheel. And just another comment on top of that would be that when I first came to UNC, I came from another clinic and I found these PDF sheets to be very helpful in ensuring the way that I was billing was in line with the way everyone else was also billing.

Doctor Everton, will you walk me through what the billing looks like for your. Sorry, let me start over. Will you walk me through what the billing for CI evaluation looks like for your program and how you make sure that you are being fully reprogramming for what you're doing during that candidacy evaluation?

Certainly a typical evaluation slot for our adult clinic is two and a half hours, which I do recognize as a luxury. The majority of our cochlears implant evaluation are referrals from our community, and the patient hasn't yet been seen by UNC prior to the appointment. So I'd estimate we spend roughly 45 minutes on face to face case history, the unaided audiogram, and then we probably spend another 45 to 60 minutes on aided speech perception testing, administering questionnaires, a cognitive screener, and for the unaided audiogram, we're billing 92557 for comprehensive audio evaluation. Or in certain cases, if the patient has been seen in the last six months and we just need to confirm stability of thresholds, we might just bill 92552 for air conduction instead. We would also complete and bill for temps or temps and reflexes with 92567 or 92550.

And then if we complete oaes, if it's warranted, we would bill 92587. As Lindsey mentioned earslier, 92626 is a code used to describe time for the evaluation of the auditory function for cochlears implant candidacy. And it is a time based code that's accounting for the first hour spent with the patient. You do have to have a minimum of that 31 minutes to bill. 92627 could be an added additional code to reflect an additional 15 minutes of an evaluation.

And that's something that you might utilize if you have one of those evaluations that just seems to go over a little bit longer. But that is how we would capture 9266 or 9267. It would be how we capture our face to face case history, discussion of questionnaires, aided testing, and at UNC, our hearsing aids are typically programmed and verified days prior based off of the referring audiogram. But naturally, if the patient comes in and their audiogram has shifted, then we would use 92626 to reflect the time spent

verifying a hearsing aid if it was done on the same day as the evaluation. And like we mentioned before, you do need to provide a start and end time in your documentation for these two codes.

That roughly leaves us with about 30 to 45 minutes of time that's non billable in the sense that we don't have a CPT code that reflects our services for this. So, thinking like further counseling, generating a treatment plan, reviewing any expectations for the cochlears implant, talking about risks, surgery follow up, and just general counseling on device optionss. So Kim Kavett, who is my personal billing and coding North Star, talked about non billable time related to CIS in the 2024 coding and reimbursement update here on audiology online and she talks about the use of the unlisted Oto rhino service code 92700, which can be used when a procedure like CI counseling or device selection doesn't have a CPT code. So she talks about this as an options for both Medicare and non Medicare beneficiaries. But if you have Medicare, you have to make sure that you have a few things.

So a physician order, the patient has to fill out an ABN and on that date of service they will pay a customary rate versus for non Medicare the process is similar, but a physician order would not be required and you can submit to your health plan for claims processing and I believe we're sharing the link to the audiology online webinar in the chat. There's both a 2023 and a 2024 that are available and I I personally am anxiously awaiting a 2025 update. And another thing I would mention about the Kim Cavett the 2024 update. One of the people in the chat were asking about the use of evaluation in management codes. It's not something that we're currently utilizing at UNC.

The majority of our patients are actually Medicaid and Medicare, so it wouldn't be appropriate. However, if you want to learsn more about evaluation and management codes, I would highly recommend I listening to the Kim Cavett 2024 talk because she does specifically mention it. Thank you for that. You all have mentioned modifiers a little bit already and there are some included on this slide. Doctor overlapping, will you share more about using modifiers?

Definitely. So there should be a list of modifiers now on the screen, and some of them may seem really familiar and others may be new to you. So hopefully having the most commonly used modifiers in one place will be helpful. This is in no way an exhaustive list, but it may help you determine how you'd like to use them within your own practice. And just as a general reminder, we use these modifiers to bypass the edits and we use them sparingly and only when clinically justified.

So these are separated in both in black and blue and the black font are perhaps the most familiar modifiers for everyone. RT and LT are right and left, so probably the most obvious. It's designating laterality and then 59 the use of that communicates to the payer that the procedure is separate and distinct from other services provided that day, like a comprehensive audio or a CI programming code. Next would be modifier 50 and the use of that indicates a bilateral procedure, and then following that is modifier 22, which indicates an increased procedural services over what the code is initially intended. Next would be modifier 76, and that indicates a repeat procedure or service on the same day.

And in some cases that can be used for bilateral testing, which we'll talk a little bit more in greater detail. And then there's the use of 52, which is indicating a reduced or eliminated service. So for instance, if you have a code that's bilateral, but you were only able to complete something on one years, for whatever reason, you would use 52 for that reduction. And then now we'll kind of switch gearss to those blue codes and you'll notice that these are X codes, which for me were a little bit less familiar. But we started to utilize these more around the time that we started our provider based clinics.

And that was based on our coding and reimbursement team's recommendation. So our CMS recipients charges kept getting coding back to us. And so we were being asked to add these additional modifiers like XE, XP, Xe. And then they were asked, we were also asked to add an additional comment, so we began using that. And essentially these X codes are just providing greater reporting specificity and they again have to be backed by appropriate documentation.

So Xe, I would say, is probably one of our more commonly used X modifiers. It's indicating a separate organ or structure, and it can be used to indicate that a procedure or service was distinct or independent from non evaluation management services performed on the same day. So basically this is telling the payer that the procedure is distinct because it was performed on a separate organ or structure than the intended bundled procedure. So an example of this would be maybe completing ESRT reprogramming and 9626 on the same day. Within our provider based entities, Xe is used to indicate that the service or procedure is distinct and separate from other services on the same day.

So you can think of this as the same service but a separate encounter. So an example would be if you were testing a patient for the second time on the same day, maybe you tested them, programmed them, and then tested them again, but it's all on the same date of service. And then the Xu modifier indicates an unusual non overlapping service that's distinct because it doesn't overlap usual components of the main service. So an example of this, actually from Kim Kabat's update, recommended to use that when billing 92601 through 92604 and the reflex code of 92568. And then XP is the use of a separate practitioner.

So this service would be distinct because it's completed by a completely different practitioner. So if you were to maybe split an appointment across two providers. You might want to use XP.

Thank you for this information. The modifiers can get quite confusing, and for additional information on modifiers from the Medicare Learsning Network, you can review the resource that is available for you titled proper use of modifier 59 ex XP, Xe and Xu Doctor overlapping, will you share your recommendations on how to bill for unilateral CI recipients? Absolutely. I do want to strongly emphasize that our programs billing has been with significant guidance from both our compliance and our coding departments, and it may look different than others. So our hospital system may function differently than another hospital system versus a private practice versus a completely different payer population.

And so my hope with these guides is to provide guidance just on the optionss that are available so that you can choose accordingly. So of course these are just going to be a list of commonly used codes for unilateral CI services and they may differ depending on your patient specific appointment. So use this suggestion and all of the feature with care. But you'll notice here that we have the billing and coding separated out by hospital based in black and then the provider based billing guidelines. So anything additional would be bolded in blue so you can sort of visually differentiate.

You'll see this pattern continue through all of our billing guides that are shared. And again, keep in mind these separated worked well for us, but you may require a meeting with whoever is helping you with your billing and coding to make sure that these modifiers are successful for you. I would say that the three primary codes for unilateral patient are 92626. So the evaluation of auditory rehab status 92550 if ESRT are being completed, and 92604 for reprogramming 92627 so that extra 15 minutes code is honestly rarely needed for unilateral patient. But if if it is something that you need, it is an options.

I think we've talked a lot about 92626, so I won't belabor that. But I would like to switch gearss a little bit and talk about optimizing reimbursement for ESRT. And we do that by using 92550. So that tip and reflex measure. It does require the use of a 59 modifier, but it is acceptable by the NCCI and we often need this modifier in order to receive payment for both 92550 and 92604.

But they absolutely can be built on the same day. And you'll notice on this screen I have the 59 and the 52 modifier denoted. That's because 92550 is considered a bilateral code. And for a unilateral patient, you would presumably only complete a Tympan ESRT measurements in one ears, so that 52 modifier would represent that reduction.

You'll also notice that the excess modifier listed as the primary modifier for provider based billing in blue is there to indicate a separate organ or structure. But just know that throughout all of these billing guides that you can interchange that with whatever X code is most pertinent for your specific need or

payer. I just didn't want to add all of the X modifiers and kind of muddy up the screen. But one thing that I do think is important of this is we were instructed to add a brief comment in our billing and charge sheet. So anytime we use an x modifier, we have to include something, and it can be simple.

Something that says like this is related to the evaluation of the device or ESRT or one ears or whatever it may be. But I do think that that's something that's been useful and important for our practice. And then in terms of programming, I think as probably we all know that 92601 to 92604, our programming or our reprogramming codes, 92601 is the diagnostic analysis of a cochlears implant. To think like an initial activation for someone younger than seven yearss old, 92602 is the subsequent reprogramming. Also for under seven yearss, 92603 is that diagnostic analysis of the cochlears implant seven yearss or older.

So again, initial activation and then 92604 would be the subsequent reprogramming. So anybody seven yearss and older, you'll notice on all of the remaining slides I have it listed as 92604. But again, these are also interchangeable. And I think in general for unilateral programming we do have a few optionss. AAA guidelines indicate that these codes build in isolation, reflects unilateral CI programming.

So with that in mind, we can enter 92604 with one unit, no modifiers, or we can enter 92604 with either a right or a left modifier. That is the recommended method by both Asha and AAA. So that's the avenue I would lean towards. And I believe there should be a link getting pushed through as well so that you can take home some of those resources too.

Thank you for sharing those details about billing for unilateral CI recipients. What about bilateral CI recipients?

So the same primary codes apply for bilateral versus unilateral, but it's really in the way in which you use them where things differ. So 9266 would of course remain the same, but with a bilateral patient,

you potentially have a greater likelihood of needing to use 92627 for the evaluation if it exceeds 1 hour. And then as a reminder, 92601 through nine two 6604 are codes that when billed in isolation, reflect unilateral CI programming and not the programming of two earss. And as you probably recall from Lindsey's earslier slides when we talked about trends in the US for billing bilateral services, nearsly half of CI providers are only billing for one years and they're not attempting to be reprogramming for the work of programming the other ears, which is obviously a clears problem. So we do have lots of different optionss for bilateral billing and each pair can require their own specific set of modifiers, which we've listed several of them on the screen.

One of the optionss is that you could use a 22 modifier, so that modifier that stands for increased procedural services. You could also enter two units of 92604, so one with a right and then one with a left modifier, and an additional 76 modifier which indicates a repeated procedure. We personally have had the most success at UNC using a single unit of 92604 with a 50 modifier. So signifying that bilateral procedure and ultimately our compliance and coding team instructed us that this has optimized our reimbursement across payers and it minimizes the numbers, the number of our coding backed claims. And I think one important thing to consider here is that the payers, so maybe Unitedhealthcare, Blue Cross Blue Shield, Aetna, they can deny the claim, and then the only other options is that you would need to submit a correct claim.

And the only real way to avoid this entirely is testing and programming each ears on a separate day, which some centers do choose to do. This is definitely the best options to guarantee payment for both earss, but it obviously has some significant implications and can be incredibly burdensome for both clinics. So thinking about space personnel, our schedule availability, but I think even more importantly, patients thinking about their travel time to clinic, maybe they have to stay in a hotel overlapping, taking time off of work, et cetera. So in a world where we're trying to improve access, this is clearsly the least efficient options. So for our practice, we've chosen to take a route where we might not recuperate as

much per line items, but overall found a balance that takes into account our clinic schedules.

One thing I would just like to add in is that for ESRT, if we did a TIF in ESRT in both probe codes for right and left, we'd bill 92550 just with a 59 modifier. But Kim coding had also suggested at one point that you can use the Xu modifier for this as well.

And I just want to mention that you can learsn more about using codes during device programming on the ASHA website, and that link will be in the chat as well. And doctor overlapping, thank you for helping everyone gain an increased understanding on billing for unilateral and bilateral recipients. Doctor van Loy, will you share tips for billing recipients who are bimodal? Yeah, absolutely. So as we start to think about billing for bimodal services, we need to think back to those NCCI edits again.

There are certain restrictions in what you can bill on the same day that's going to affect our bimodal patients. Specifically, you cannot bill for unaided contralateral diagnostic testing such as 92552. So air conduction or 92557, comprehensive audio on the same day that you complete cochlears implant programming or reprogram. You also cannot bill for a number of hearsing aid related CPT codes on the same day as 92626 or 92627. So these would include 92590 through 92595, which are hearsing aid evaluation, fitting, follow up, and selection codes.

However, what you can bill on the same day as 92626 and 92627 are V codes. The V codes we commonly use here at UNC are listed here, which would reflect billing for the cost of the hearsing aid fitting service charge and then the cost of the ears modifiers. Our office is a bundled clinic for hearsing aid services, so V 5011 reflects our fitting fee and our bundled professional services for three yearss. If the patient is cell phone, they would pay for the hearsing aids before they leave the clinic, and then if they have an insurance benefit, we would submit for reimbursement. Thank you for sharing that information about billing for bimodal recipients.

What about when you're working with a CI recipient who also has acoustic ears hook? Are there special considerations for those recipients? Yeah, absolutely. We're seeing more and more patients with residual hearsing, and so we have to have a protocol for fitting the acoustic ears hook, which we would charge patients for as a separate organization code. V code that we use is v 50 20, the conformity code.

This captures our services for verifying the low frequency gain via real ears measures. Most patients, again, would pay for this out of pocket, but some insurance would cover it.

Great. Thank you. I appreciate the additional information about billing and coding for recipients who also have acoustic ears hook. So let's see if there are any questions to answer here. I'm looking at the time.

We have a lot of questions and as we mentioned before, audiology online will follow up with us and make sure that we get all the questions in case we don't get to some today. So to make sure that we are able to address the additional information that you two have prepared, let's continue and thank you both for reviewing information on billing for the many different types of CI recipients. Another hot topic in audiology right now is telehealth, and many audiologists are interested, but unsure how to start the process of incorporating it into their clinical practice. Doctor overlapping, what steps did you take to implement telehealth at UNC? I think the first step that we took was to lay a foundation earsly so that we could ensure we'd be successful.

So we tried it with non billable services. So things like pre CI counseling, troubleshooting appointments, documenting issues with equipment for things like upgrades, letters of medical necessity. The main advantage of this is that patients, providers and administrative support then became comfortable with this appointment type. So knowing how to schedule and complete utilizing interpreter services, etcetera. And then we kind of laid out a number of PowerPoint slides, smart phrases, made sure

equipment was all functioning beforehand, and then the next step was, and probably the most cumbersome, was obtaining hospital approval, compliance approval.

We worked a lot with our ab counterparts and ultimately we're able to use this by using individual logins and passwords for NOAA. And then last is just becoming familiar with remote support app and target CI. So we just make sure that the firmware is updated to patient sound processors and then practice in clinic. So sometimes I just have a patient come in, we download the app. It takes under two minutes to download pears and get connected.

And I think it's just a nice way, it's low pressure, it's a nice way to feel confident and reassured moving forward.

Thank you. It's really helpful to have an understanding of how you got started utilizing telehealth, and other professionals can use this as a template or at least some ideas on how to proceed with incorporating it into their clinical practice. So a big question related to telehealth is, is it covered by insurance? So in regard to Medicare and Medicaid, the CMS Consolidated Appropriations act has extended telehealth coverage for audiology until the end of this years, and legislation is working to get this extended further. And it's ongoing.

I think it's clears that in general, there's a trend in healthcare towards remote services. So as it currently stands, when performing remote programming through the support app. You would still bill your reprogramming code as long as you meet CMS requirements, and you'll be reprogramming the appropriate telehealth amount, which we'll touch on in just a moment. But specifically, CMS does require that the service is synchronous. So two way interactive technology that allows for communication between the practitioner and patient, and for commercial insurance plans.

Most insurance cover at least some form of telehealth care, but you could, if you have a billing department or yourself, you could contact the insurance provider to see if they do.

And I think this is important. I included this slide simply to say that this is something that is impacting a lot of areas across the country, and I would venture against the world. So this is in 2022. Doctor Aisling series looked at the catchment areas of large CI programs in the United States, and you can see here North Carolina is depicted in green, but you can see in general that the idea that patients are having to travel long distances to access CI care isn't unique. It's happening all over.

It's an ongoing issue that effects many, and remote programming can be a great resource for all of us. Absolutely. And I want to mention that we have the PubMed link to the Nasseri article. We'll have that placed in the chat as well. And based on that information in the article and what you just covered, we see how spread out CI centers are and how many centers need to provide services to patients who are a great distance away.

Doctor van Loy, what needs to be considered when providing services to patients who are far away from your clinic? When providing services to patients who are far away from the clinic as it currently stands, you can only provide remote care if you are licensed in the state that the patient is physically located in, unless the state the patient is physically located in has some kind of limited allowance. Additionally, telehealth also has to be specifically listed within the scope of practice in the bylaws of the state that your license is in. If you're unsure about this, I would recommend checking out the ASHA state by state telepractice requirements, and that link will be put into the chat. One exciting legislation in the works is the audiology interstate compact called the ASLPIC.

Audiologists who are licensed and in good standing in a compact member state will be eligible to practice in other compact member states via a compact privilege, which is equivalent to a license, and this is set to become available to apply to in 2025. But at the moment it's not yet operational at this time,

33 states have enacted ASL PIC legislation to be a part of the compact, and personally I see this being very helpful when providing telehealth services while I'm in North Carolina, and then if I have an out of state patient who's in their home in Tennessee or South Carolina or Virginia, so say them again that lengthy trip to come see me for kind of a number of appointments that may be appropriate to utilize as a telehealth appointment. Thank you for sharing that. I know that ASLP IC has come up a number of times in the other webinars in the series, so again, the information is in the chat if you want to learsn more about it. Now, a question that comes up in just about every discussion I have about telehealth is how do I bill for it?

So will you share how you're billing for telehealth at UNc?

Absolutely. So to preface it is going to be up to your individual payer to determine if they're going to cover telehealth and how they would like it to be noted on the claim. So in general, you will want to use the CPT code that you normally would utilize for that service provided, but you would add one of the telehealth modifiers and or telehealth place of service site. So some common modifiers you may see are 95 or GT. 95 means the service was provided synchronously in real time over a HIPAA compliant communication technology, and a GT modifier is essentially the same thing, but some payers prefer that modifier 295.

CMS has temporarily expanded the umbrella of telehealth practitioners to include audiologists until December 31 of this years and 92601 through 92604 continuous CPT codes that have provisional coverage. As it stands in the first link on this page, CMS states that they recommend to bill covered telehealth services to your Medicare administrative contractor, your Mac, and then they would pay you the appropriate telehealth amount under the physician fee schedule. Again, CMS does list that 92601 through 92604 require a visual component along with the audio component in order to meet their requirements, although this may be different depending on the payer. Both ASHA and the professional

billing section of the CMS PDF link that's on this slide indicate that audiologists should specify the place of service when billing for telehealth, so they recommend PoS ten should be used when providing telehealth services in the patient's home and POS zero two when the patient is in a location other than their home, such as a satellite office. Telehealth services billed with PoS zero two will be paid at the facility rate and those billed at Pos ten will be paid at at the non facility rate as it relates to the physician fee schedule.

In a practical sense, when figuring out how telehealth will work in your clinic, some clinics will have a billing specialist or a practice manager who is tracking your codes and reimbursements. At UNC on our hospital side, we have found this is very difficult to get specifics from our billing department. However, with our provider based clinics, we're able to get much more specifics on our reimbursement rates and we can do this within our electronic medical record system effort. I also within epic, you're able to create shared patient lists, and this is has been something we've utilized to track our remote programming patients and then to check later to see if we were reprogramming appropriately. Thank you for sharing this information about billing and coding for telehealth.

Yeah. And so at this point, let's assume we all understand how to bill based on the information that you've provided. Are you actually getting paid for telehealth services? Yeah. So we were able to find out if we were getting paid for telehealth by looking within epic for our provider based clinics.

And to do this, you would first open the epic taskbar, and then you would click the guarantee your account. A window would pop up where you would put in the MRN, and then you would click accept there we go. And then you would be seeing this page and then you would click proof of treatment inquiry, and then you would locate the date of service of interest. And then that will show you your CPT codes that you billed on that date. If you had any modifiers, any insurance payments, as well as any contractual, contractual write offs.

If you want more specifics on the reimbursement, you would click on that code for details. Just the next slide. Yep. And there it would tell you what was reprogramming. So for this example, Medicare reprogramming for $81.28.

And it specifies that this was the minimum of fee schedule for Medicare when looking at in person visits versus remote programming visits with our AB patients. So far we've been able to be reprogramming at the same rate for in person that we did for the virtual session, which is really awesome. We thought it pertinent to include two different examples with different codes and payers. In our example, Cigna was reprogramming at its contractual agreement minimum and the same with Medicare. While we are listing only Cigna and Medicare here, the contractual allowable amounts depend on the individual contract for each carrier and the hospital and clinic.

And this may differ place to place. In general, we average 60% of charge amounts for contracts with our private carriers like Blue Cross, Blue Shield, Aetna and Cigna. The take home here being that as long as the payer allows for telehealth and they allow it to be completed in a synchronous fashion, and telehealth practice is part of your state licenses, scope of practice, and the patient was physically in the state that your license is held in, it would stand to reason that we could expect reimbursement. Thank you for sharing those examples. It's great to hears that you're getting reprogramming for remote programming with your aB recipient and at the same rate as in person programming sessions.

Doctor overlapping, what are some benefits that you and your patients have experienced since implementing telehealth?

I think it helps to have just a little bit of background on our area, and I'll try to be brief because I know we're close on time, but in 2024, Doctor Evan Nix and colleagues looked at the distribution of where our patients were coming from across the state, which you can see depicted here. And in general, it takes patients on average an hour and a half to get to our clinic, and that's just one way. So obviously that

introduces a lot of financial burden to patients. So whether it's gas money, time off of work, the perceived burden of asking a family or friend to take them to the appointment, and that's not even taking into account the patients who live in an assisted living facility or who are unable to travel. So that obviously is problematic.

Keeping that in mind and thinking about the substantial growth within our particular practice and the number of patients we see, we knew we had to do something in order to maintain a large caseload of active patients and continue to grow our program. So about two yearss ago, we made an update to our adult clinical protocol, and now we see all newly implanted patients four times. So initial activation one month, three months, and at one years, and then we are currently seeing all established patients one time per years.

So we clearsly don't have the space to see all of our patients on an annual basis. That is definitely a problem. We want to be data driven and how we develop our protocols, but we need to re examine how we structure annual follow ups and how to utilize remote care to leverage that so, on this graph, what you can see is that we have 1754 adult patients that have been implanted since 2005. They all need annual appointments. We have roughly 230 new adult surgeries per years.

So multiply that times four. We have a minimum of 920 appointments that are needed. But then that comes out to about 2600 appointments that we need per years. But our actual availability is only 2080 cochlears implant slots per years. So that's obviously problematic.

So we essentially simply just don't have the space and the time just to see these patients. So what we ultimately ended up, or what we're thinking about doing now that we've been working with remote care and we've been able to see that we can get reprogramming for it, is that if we were to take our annual follow up patients and half of them were to come in in person, so, alternating every other years, and the other half were to be remote for a 30 minutes check in, so our normal follow up appointment would be 2

hours, and we could cut it down to 30 minutes, that we would all of a sudden be able to limit that discrepancy. So we would still have the 920 appointments for our newly implanted recipients, but we would have half of the in person follow ups at 877. And then those remote sessions would then come out to roughly 219 per years. So that comes out to 2016 appointments needed, which is much more in line with what our availability is.

So it's just one example of how we're thinking about utilizing remote care to improve our bandwidth.

But I think overall, we've really had a great experience with remote programming. It's improved access to care for those that live far away or can't travel to our clinic. It's reduced travel time for folks that no longer have to necessarily take off of work or school, pay for childcare, gas, hotel. I think it's also really allowed us to easily include family members and support, which is such an important aspect of patient care. And I think we haven't seen the full impact of what that brings to the table by having this remote connection.

And then again, it's convenient for both patients and families. So who knows? Maybe there's even the possibility of working from home. Some. Whoever thought that was possible is an audiologist.

But I think overall, it's an important opportunity to manage a large, growing patient population a little bit more efficiently. And it allows us to meet patient needs in a new environment, meaningful way. Thank you. And thank you so much for sharing the benefits of incorporating telehealth into your clinical practice at UNC and some of the ideas that you haven't implemented yet but are considering those are really great and beneficial for everyone on the webinar to hears. I'd like to wrap up my questions for you, Doctor Van Loy and Doctor overlapping, with one final question, which is, will each of you share one action that you would recommend other clinicians take to improve clinical efficiency?

Doctor Benloy, would you like to start? Yeah. So something to leave with would be that we don't always have control of what code and modifier combination your payer is going to accept, or even necessarily have control of what we're going to be reprogramming for. But we do have control over is the extent of managing our time spent on non billable activities. So if you are to be practicing at the top of your license, which is what we all aspire to do, we need to find ways to offload non billable tasks.

It can certainly be hard to justify a non revenue generating position such as a cochlears implant coordinator, but if you can get the position approved even at part time, it will certainly free up hours of your time to spend seeing other patients. Additionally, I cannot stress enough how important it is to get your patients in contact with their I consumer specialist and a BEe support team who can provide essential support that if completed by the audiologist, would be considered non billable. Thank you, doctor van Loy. What about you, doctor overlapping? I'd say set yourself up for success and create tools that can be adapted as things change.

Cochlears implants, and specifically the reimbursement of cochlears implants, is an ever evolving field and it can feel really overwhelming to keep up with in the midst of a busy clinic. So I think I by giving yourself access to tools like prepared documentation, billing guides, etcetera, you're putting yourself in a more advantageous position to approach these changes quickly and efficiently. Thank you. In the interest of time, since we are five minutes over, I'm not going to take any other questions live. I want to thank Katie Vaden, who's on the call, Andrea, Doctor overlapping and Doctor van Loy for answering questions as they came in.

And also let all you who are on the call today know that audiology online will provide us with all of the questions. So for any outstanding questions, we can work with today's presenters to find the answers to the questions and then follow up with you via email. For those of you who are attending this session, again, we really want your feedback it's super valuable to us. We like to provide these different

learsning opportunities and want your feedback about how beneficial you think they are. So please use the QR code or the link that is in the chat or that will be placed in the chat so that you can access the survey.

It's just two questions. It will take under 1 minute of your time and we would love to have your feedback. And then finally, I do want to mention that we have another webinar coming up in November. The next webinar that's going to be hosted by AB is an hour long webinar with Doctor Renee Gifford, and she's going to expand on the topic of clinical efficiency that she was speaking on way back on September 5. In this initial session of this webinar series, if you're interested in attending that webinar, you can access it via a link that will be placed in the chat.

There's also a flyer about the session in the resources that are provided for this session. So thank you again, Doctor overlapping. Thank you again, Doctor Van Loy. Thank you to all of you who are on the call today, your interest, your questions, your engagement, we really appreciate it. And everybody, have a great rest of your day.

Thanks so much.