eAudiology: Case-Based Options for Coding Audiology Services

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Well, thank you, Sarah, and good evening, everyone, and thank you for joining us this evening. I know that at the end of a long day, at least if you're on the east coast, this is the end of your clinic day. So we appreciate you joining us. And if you're not joining us live, thank you for choosing to watch this particular presentation. So I am going to turn off my video now as I present the slides, because I don't want to be looking at myself as I'm talking.

All right, so before we get started, I do want to at least provide our disclosures. We have no financial disclosures, but Dr. Burton is the Director of Audiology at the Easterseals center for Better hearing in Connecticut. Dr. Gilla is an assistant professor at Lamar University in Texas.

And I'm employed as a professor at the University of Akron in Ohio. So we do receive salaries, obviously from our employers. And we are all volunteers for the American Academy of Audiology. Anna Gilla serves as the chair of the Coding and Reimbursement Committee. Annette and I both serve on the Practice Policy Advisory Committee.

And Anna also is a ex officio member of that committee. And those two committees are obviously the two that focus most on coding and reimbursement issues. We're also involved in some other professional organizations, but none of those should have any, should not have any concerns relative to those participations. So our hope at the end of this presentation, at least, our overarching goal, is to really present just some ideas for all of you to consider that would allow you to increase revenue for services that you're already providing. But perhaps there aren't a CPT code that actually represents that particular service.

And if you think about it, in audiology, we really have a relatively small CPT code set, and certainly some of what is included in our scope of practice is actually not represented in the current code set. I would also offer that much of what we do beyond our diagnostic and then some of our hearing aid services is not well captured. So, you know, we hope at least at the end of this, you'll be able to

describe some alternatives for coding audiology services that actually fall outside the CPT code set, that you'll be able to do those in an ethical and legal manner that you feel very comfortable with and that you could support as you talk to your facility administrators, whether that be, you know, in a large hospital setting or in smaller practices, and that you'll be able to summarize how coding for these non covered audiology services actually can elevate the value of the services that we provide to consumers. As an individual working in a university speech and hearing center, I'm constantly trying to help our students recognize the value of the services we provide. It's always a difficult challenge for them because talking about money is always a challenge for young professionals because they're not recognizing yet the value.

And so I want them to understand it and be able to articulate that really well to our patients.

So if we think about the current payment policy relative to Medicare or other payers, you know, Medicare really only reimburses audiologists for certain diagnostic tests and then commercial payers, it's very contract specific. So we know that treatment services through at least traditional Medicare are statutorily excluded. And then with our commercial payers, some may not cover even all of the diagnostic tests that Medicare cover, some may cover some treatment services that Medicare doesn't cover. But all of those are really contract specific. And while this presentation is really not about payer contracts, any contract you enter into, it's always in your best interest to really know what is described as covered services within that contract and knowing what the limitations or the exclusions might be.

So our first audience question again, if you feel so inclined, please feel free to type this in the chat. If you're not, that's perfectly fine as well. But I want you to consider, when you're performing at least our basic diagnostic testing, CPT code 92557, which includes Pure Tone, Airbone, SRT and word recognition, what other services do you actually provide either prior to completing those diagnostic tests or after completion of those diagnostic tests? I'll give you a minute and if no one responds, that's okay,

we'll just move on.

All right, well, I'm not seeing anybody respond, so let's just, let's just move on. So I think it would be helpful if we really just dissect this diagnostic code. So reimbursement for any of our diagnostic procedures are based on the value of that code. And while, you know, I don't want to describe the whole process of the valuation of codes, what you do need to understand is when a new code for a procedure or a new procedure or a revised procedure is created, it goes through a process, an application process, it gets approved, the CPT code itself gets approved. And then if it is a service that Medicare covers, it typically goes through a committee of the American Medical association that actually values that code.

And there's a couple organizations, the American Academy of Audiology and the American Speech, Language and Hearing association, actually serve as the representatives that help that panel or that committee understand our code set. And usually what we need to identify when the code is created is the specific, specific activities or the tasks that are part of that code. So specifically describing what we're doing as we're encountering that patient and we're providing service to them. So if we were to dissect that particular diagnostic code, 92557, the activities or the tasks that are included during that encounter are Pre time of three minutes, an intra time of 20 minutes, and that actually that intra time is you performing those tests, performing pure tone, airbone, SRT and describm masking as needed, etc. And then there's a post time.

So the pre time, if you think about that three minutes, it's a very brief amount of time, but it really just allows you to look at the referral that you've received and get ready and set up for the test. Then we actually complete the test and then following the test, that five minutes, really just briefly, is a brief review of the results. We have to complete a medical report and then send information to the referring physician. And that whole encounter is 28 minutes. But my guess is you're spending either more time

than that in some practices.

This seems pretty maybe consistent with what you might do in a stat audio in an ENT practice where you're not really spending a great deal of time prior to or after the actual diagnostic test. But I would venture to say that in many practices we're spending considerably more time before performing the service and after performing the service. And much of those activities would really be considered what's called evaluation and management services. And currently the evaluation and management services are not covered by Medicare. There's no coverage for that for audiologists.

And then if it's a contract or a commercial payer, that would be contract specific. And to be frank, you know, there aren't that many that I'm aware of. At least none of the payers that we contract with will cover the evaluation and management services that we're providing our patients. So when you're thinking about evaluation and management, these really include things like the clinical decisions that you're making, some of the counseling that you're providing to patients, whether that be, you know, at the end of the appointment, you can think that many of us are going to have to perform at least some type of a focused history with the patient prior to seeing them. Because while we might get some limited information from the physician, we need to know more specifics about their hearing issue or balance issue and then it also includes coordination of care.

Those are all of the elements of an evaluation and management code. And all of those things are certainly within the scope of practice of an audiologist. So we're not really being paid for those services at this point in time.

If we look at some payer specific policy, and this is just one example, if you participate or under contract with other payers, I would really highly encourage you to get into their portals or on their website and take a look at the specific policies relative to the payment of these types of services. So this is just one example and this is from United Healthcare. And if you look at their reimbursement policy relative to EM

services, it indicates that they will not reimburse these services when they're reported by a non physician. And then they include the specific non physician healthcare professionals that are not, would not be paid for these services. And as you can see here, audiology is included as one of those non physician healthcare professionals.

And so I've had some colleagues who will report to me, well, I get paid by UnitedHealthcare and I always say look at your contract, this is one of the payment policies. But even if you are being paid, just be mindful that that doesn't mean you should have been paid. And they could always come back later and want you to pay back those fees that they reimbursed you for this service. So it really is very important that you understand your contract.

So for any non covered services, it really is the patient's responsibility to pay for the service you're providing. It certainly our responsible responsibility as the provider is to make sure we are meeting the obligations of the codes that we're billing to the payer. But if there are services that are outside of that contract, then we as the professional need to determine what is the value of that service and what are we going to charge for that service. So usually in a practice they're going to look at both the amount of time it takes to provide the service as well as some of the other resources that are needed to provide the service. So in our practice we decided that we needed to start billing our patients for some of these services that were outside of the covered services for just this diagnostic evaluation.

So we decided we were going to create a fee for new patients and then a fee for established patients.

And we went through a process and this really all started during COVID and we were seeing some of our costs certainly associated with both disinfecting materials or disinfection materials and ppe. Those costs were going up and we weren't charging any differently. We were also able to see less patients at that time because we were spending more time providing some services just to ensure that we had a safe environment for patients to enter. So what we decided to do in our center is just advise our

patients that, you know, the payers don't actually cover some of the services like counseling that we're providing and helping them sort of walk through what their treatment options would be and that when they were coming in for these services that there would be an additional office visit charge to cover those services. We advised the patients when they called into schedule that there would be a charge.

We also provided notification on our website. We send out a newsletter twice a year. We put it in our newsletter to inform them of this change in our fee policy. And then we decided that we wouldn't charge them on their first visit back to the center after we implemented the fee, but rather we would talk with them at that visit and let them know that the next time they came in there would be this additional fee at that visit. We also provided them with a written letter that included our entire fee schedule.

So they had that available.

So we were concerned about this for a number of reasons. Certainly, you know, we have patients that come into our practice and we do very little marketing. So we, they come in by word of mouth. And we didn't want to upset our patients, so we wanted to get a reaction. And we do an annual satisfaction survey.

And we added some questions relative to this change in our fee structure. And so we got some of the information from our annual satisfaction survey that I'm providing to you, as well as just the initial reaction that we had from the patient. So some of this is an approximation from those two different ways we sort of receive feedback from patients. I would say 85% really understood the necessity for the charge. They were always sort of surprised by how reasonable our services were and they had no concern whatsoever.

We had about 10% of patients who were somewhat upset. We could see it visibly when we were talking to them about it. But ultimately they decided to continue to reschedule their appointments. We typically

see our existing patients who are being treated with amplification back every six months, and they continued to schedule those visits. And then we had about 5% of the patients who said, look, you know, this is getting too expensive.

We're not going to reschedule the return visit. But many of them have returned since that time, but they're just not coming on the every six month schedule. Some of them have decided to come back just annually for a visit, and some have decided they would come back just as needed. And this is pretty similar what we found to an article that Ian Windmill had published in seminars in hearing back in 2016. And he proposed a similar scenario where, you know, most of our patients would recognize that there's value to these services that aren't currently covered by payers.

So what we saw was an immediate increase in revenue for our services. And obviously there were no additional expenses. Expenses. Now, again, we were already covering those additional expenses relative to Covid, but, you know, we didn't have any. Besides that, we didn't have any additional expenses.

We thought it was really important. We spent a lot of time talking about can we see more patients? And that would allow us to increase revenue. But in a clinic where we have new, very young audiologists or audiology students, we knew that we wouldn't be able to reduce the appointment time and still maintain the quality of service we were providing, ultimately leading to good outcomes. So we didn't really want to go that route.

And again, we had some genuine concern because we really are dependent on our patients to market services for us, and we want them to feel very positively about our center, not just about how well they're doing with amplification. And we thought this could negatively impact that, but it really didn't. So I think our fears were unfounded. Again, yes. Were there a small percentage of people who might not have been overly excited about this change?

Yes, that's true, but I would say the bulk of patients were understanding. And certainly we've had no questions from our new patients when they're told there's this additional office visit. I think it's an expectation because they do see these kinds of charges in other practices. And, you know, I always think about going to see my optometrist, and there's always an additional diagnostic test that he wants to do to look at my optic nerve. And he tells me right away it's not covered.

You know, I can opt in or I can opt out, but he feels it's warranted and provides additional detail to monitor my eye health. And so I. I pay that. And so I think patients are used to some of this happening now. So the next case that I want to talk about is auditory processing evaluations.

If you're currently providing them, great. If you're not, would you provide them if you could be fairly reimbursed? We have an auditory processing clinic that is one day a week in our practice. And frankly, a lot of our students would like to be performing these evaluations when they leave the university setting. But they talk to their preceptors in community settings and they'll tell them, hey, look, we cannot provide this service because we just cannot be reimbursed appropriately for it.

And so we've come up with some ways, and I did this when I was in private practice many years ago so that I could continue to provide the service and yet be reimbursed fairly for the amount of time it does take both to complete the evaluation, but also the necessary follow up that occurs.

So if we really look at this particular code and dissect it, this is code 92620, which is the evaluation of central auditory function with report. And that's the initial 60 minutes. And then there is an add on code for additional time spent performing the diagnostic evaluation and that's nine to six to one. And when we look at this code broken up, the pre time is considered seven minutes. And in a timed code, the intra time is the amount of time that's indicated in the code.

So the intra time where we're actually completing the tests needed, that's 60 minutes. And then a post time of 10 minutes. And so that would give you a total time of 77 minutes. And then again, if you spend additional time on diagnostic tests, you could add on that CPT 92621 code for those additional 15 minutes. But I would say, you know, this is a very limited amount of time often to complete this testing.

And I certainly spend considerably more time in my follow up with the patient following the testing and trying to help them understand the results of the evaluation and then what our next step would be when we consider coverage for these services, it is a covered benefit for Medicare. And again, like other services that we've already talked about, like evaluation and management relative to auditory processing, it could be contract specific. So some commercial payers will cover the cost of the evaluation and other payers do not. So I'm going to provide you with an example of a policy that does not cover auditory processing. And this is the Aetna policy.

And they specifically say that they consider diagnostic tests or any treatment for the management of auditory processing disorders as experimental or investigational. And so we tell our patients we'll always check for them. We have no problem reaching out to their payer to ensure that we know which codes we're going to be billing and determine whether or not there is coverage. But oftentimes, even when there is coverage, it's not going to cover the time you're spending on the report and the additional follow up that's necessary. So we decided that in order to be able to manage that appropriately with our school age children, we have decided to have a charge for an educational report.

So as I indicated in that code there is a report required. But that report in the amount of time is basically saying here's what is going on, but not the detail that we put in the educational report, which ends up usually being a five page report. And so with the complexity of those reports and the amount of time it takes, we felt it was necessary to charge for that particular report. We give patients an option. We tell parents, you know, if you want this educational report because it is so detailed and it takes a lot of our

time, it will be more expensive.

We'll provide a basic summary of the test results that's included in the diagnostic charge. Most of I can't remember in the past at least decade, any parent who did not want the educational report, you have to consider that we're also going to need to reach out to other individuals, individuals in the educational setting, whether that be the speech language pathologist or other staff, the special education director, etc. So there are going to be additional time spent performing those activities as well that are not included in the diagnostic tests. And I will say I spend a lot more time counseling both the child and the parent and talking about the treatment options and what we can do to, you know, further facilitate their child being successful in, in the academic environment with our adult patients and, and probably in the past five years, our adult patients coming in for auditory processing evaluation testing exceeds by at least half the children that we see. So we're seeing many more adults now than I did certainly a decade ago.

So providing an educational report would not be really relevant to this population. So instead we've created a consultation for APD treatment charge for these patients. Again, their reports are also more complex and take a lot more time. And I do spend more time on phone calls. Many of the patients that we see coming into our clinic are coming from maybe three or four hours away because there aren't many practitioners providing this service.

And I would really like to encourage more people to do that so patients don't have to travel so far. But because of that we end up spending more time also in trying to relay those results to other individuals like their treating physician, maybe other professionals they're working with. And it does take a lot more time in counseling with this population. Additionally, we found that many times we are treating these individuals with other options. So we're fitting many of these patients with traditional prescription fit hearing aids.

We did in our clinic have a pilot study where we were fitting some, not OTC at the time, but PSAPs for this population. We didn't find them to be as successful patients, returned them, and ended up with prescription fit hearing aids. And there are some other treatment options if you want to provide other kind of auditory training. We don't have the capacity right now to do that, but there are other ways to increase revenues relative to this service. So, you know, these are just a couple considerations, and I am going to pass it over to Anna.

So, Anna, you can take it away. Thank you, Erin. I appreciate it. And I want to echo what you've said about clinics offering auditory Processing disorder testing. I feel like there are many practices out there that would really love to offer those services, but perhaps do not opt to do so because of the revenue issue.

And in case three here, I think that this is going to be a very similar situation where many practitioners that I've talked to do you offer auditory rehabilitation services? And we can ask our audience here if we would like, on whether you guys have provided auditory rehabilitative services in your practice. And if you're not providing those services, how many of you would like to add that service? And Erin, it kind of goes back to what you had said earlier about auditory processing, that many people would like to have those services in their offices, but sometimes due to issues related to revenue, the option is to not. And so it's my hope with this next case that we'll be able to make a decent argument on how you might be able to pull these services into the menu that you're offering your patients.

So back to our coverage schematic here. When we're thinking about auditory rehabilitative services, we'll talk first a little bit about the Medicare payer and then some commercial payers after that. Under Medicare, technically, auditory rehabilitation services are a covered benefit. And we're going to dig into those technicalities here in just a moment. And to Erin's point from earlier, each one of these commercial payers is going to be contract specific.

So you'll have to look at the coverage policies for each payer to determine whether auditory rehabilitation services would be covered or covered when provided by a specific practitioner.

So to that end, we'll go ahead and start with the traditional Medicare coverage policies and reminder, this is the traditional Medicare Part A and Part B. What we're going to talk about in this section does not necessarily apply to all Medicare Advantage plans. So we're going to keep it in that realm of traditional Medicare. And unfortunately for audiologists, traditional Medicare doesn't have a provision in there to reimburse audiologists for any therapeutic services. And those therapeutic services would include things like auditory rehabilitation.

Conversely, if you are a practicing speech language pathologist, the treatment such as auditory rehabilitation may be covered when performed by those specific practitioners. So what does this mean for us as audiologists? Well, if we are not a speech language pathologist, a licensed speech language pathologist, there's no provision to reimburse us for this auditory rehabilitation service. So then that means that for us as audiologists, this would become a non covered service. And any services that are non covered, much like Erin had mentioned earlier about evaluation and management services not being covered, these become then the responsibility, the financial responsibility of the patient.

So of course, do your due diligence and be nice to your patients and make sure that you inform them of those charges and why they may not be covered under this certain circumstance so that they can have an idea and not get any surprises in their bill.

So we'll go ahead and look at an example of a private payer policy for auditory rehabilitation programs or here, oral rehabilitation. So in these, in these policies, these coverage policies, you'll typically see a section related to medical necessity. And this is what you'll have to substantiate in your documentation to show that the procedures that you're doing are actually necessary, medically necessary for this patient. And under the specific policy from Aetna, they are considering our rehabilitation to be medically

necessary in a couple of circumstances. Those circumstances would be for speech therapy for individuals with hearing loss and after placement or implantation of a cochlear implant.

Aetna also considers our rehabilitation in a different light for cochlear implant users who have reached a plateau in performance. And this second provision here, where it's saying that the AR would not be medically necessary for plateaued CI users, is pretty consistent with just therapeutic services. In general. We don't continue to provide rehabilitative services when someone is plateaued or reach their goals. At that point, we would make sure that we discharged them from therapy and then they would come back to see us if new issues arise.

So the second provision here is not all too surprising to me. Digging in a little bit deeper, there's another section here on experimental and investigational aspects of the specific intervention, oral rehabilitation. And this payer is considering AR as experimental and investigational for individuals with hearing loss who don't have a cochlear implant or for the treatment of tinnitus. And they cite this non coverage determination because of an insufficient body of evidence to support the efficacy of oral rehabilitation for individuals with hearing loss who aren't using a cochlear implant, maybe individuals who are using a hearing aid, or maybe individuals who have hearing loss that aren't using any technology at all. And they're also stating here that there's insufficient evidence to show that oral rehabilitation treatment for the purpose of alleviating tinnitus symptoms doesn't have enough evidence to support that as an efficacious intervention.

So any researchers out there who are studying AR programs, this would be a great place to start in your next study.

So when we think about options for coverage and increasing revenue to our clinics, beyond the actual auditory rehabilitation itself, there are other activities that we may be doing for which there is no reportable code or things that we are not asking or billing patients for. These may include things like the

rehabilitation, the evaluation for the rehabilitation program. So you may do some additional goals or needs assessments with the patients. That could be manual dexterity assessments. It could be inventories related to technology readiness or technology availability to determine whether someone would be a better candidate for an in person AR program versus more of a computer based program.

Of course, the conduct of the program when performed by audiologists may not be covered by insurance. So that would be another option to move that to patient financial responsibility. And for anyone who's conducted an AR program, we know that there is a significant amount of effort placed in monitoring of these patients, kind of retesting, making sure that they're making progress, developing those reports for that monitoring, and also interpreting any of those assessments that we use. It could be questionnaire inventories or it could be more diagnostic focused upon completion of the program. Once people are released, we do of course need to create a discharge note indicating why they are being discharged from therapy.

That could be due to a plateau in performance. It could be due to all of the communication goals now have been met. And going back to Erin's previous slides on auditory processing, the amount of work that's involved in either educational or vocational reports can be quite cumbersome. And those are not activities that are typically accounted for in the CPT codes. So for vocational, you may need to sit down and write reports on whether patients have auditory fitness for duty or whether they're okay to return to work.

For those other educational reports, you may be report writing for IEPs or providing other supporting documentation for classroom accommodations for children with hearing loss. Now, before I Leave this slide. I did want to turn your attention to these two CPT codes at the right hand side of the slide. These are the two codes that can be reported for activities related to auditory rehabilitation. But thinking back to that coverage slide, we know that through traditional Medicare Part A and Part B, these would not be

covered when performed by an audiologist.

And you would need to look at each contract for each commercial payer to see if these would be covered when performed by an audiologist.

So switching gears a little bit, I feel like we've touched on every single part of the scope of audiologists so far. And we'll hop in next on Vendor Vestibular. So a quick, quick question to the audience that you can be thinking about is what of the vestibular assessments that we do or have access to in clinic? Which ones of those do not have a CPT code available to report?

As you think about that might provide an example. So video. Yes. Oh, thank you, Taylor. Absolutely.

So Video Head Impulse Test would be a great example of a vestibular assessment that's being fairly regular, performed across clinics and does not have a CPT code to report for those services. So let's dig in a little bit on how we might attack that in clinic.

So for any CPT or any activity that you have that does not have a CPT code, you may report your activities using 92700. And 92700 is defined as an other otorhinolaryngological service or procedure. So these to be services or procedures that are not captured by any other CPT code on the list. Of course, if you're doing some vestibular testing that does have an existing code, you would report that CPT code. This is only going to apply for those procedures or services that do not have a dedicated code.

For 92700, the fee is going to be set by your office. So that'll be your usual and customary fee for that specific procedure. But the payment is going to be set by your contract with insurance. So you may want to dig in on your contracts and fee schedule with commercial payers or others to see if 92700 is carved out in your contract and what the fees would be set at for your reimbursement.

Duly noted that 92700 should not be billed using multiple units on the same date of service. That is not customary to use the this code that way. So if you are utilizing 92700, try to assure that you're only billing one unit of that service per Day and documentation requirements for 92700 may vary by payer. And the documentation requirements for the use of 92700 are going to be a little bit more detailed because this is kind of a catch all code. And so in your documentation you're going to need to talk about what procedures you performed, why you did them, why it as a professional to do those.

So let's dig in a little bit deeper on what some of those documentation requirements may look like.

So first you want to make sure that you have a copy of the patient report and results. Because this doesn't have a dedicated CPT code, the person looking at your claim may not have any clue about what you have done. So making sure that you do have that patient report and the results available is, is crucial. Then we're going to get into the true documentation piece here on what you did and the description of the procedures. So for example, you may want to include the nature of the procedure.

So this could be simply that you performed a video head impulse test. You're then going to want to describe the extent of the procedure, what was your required effort in that general test, setup up, maybe calibration of equipment, because this may be patient specific and each piece of equipment needs to be recalibrated per patient the audiologist and say exactly what the audiologist is doing, that you're directing abrupt head movements and specific planar orientations based on the necessary test conditions. After that you'll need to describe why this procedure was medically necessary. So why is this medically necessary? Well, we know in the example of VHIT that this is going to be useful in detecting specific issues related to the vestibulo ocular reflex.

We could differentiate VHIT from other existing procedures such as rotary chair calorics by saying that these faster head movements simulate real life head movements a little bit better and they are distinct

and different from the lower frequencies that are assessed through other procedures such as rotary chair sinusoidal harmonic acceleration or calorics, for example. You may also want to say that the VHIT helps you get some ear specific or canal specific information and that's an additional utility of that test and why that specific test was needed. You'll want to also document the amount of time required for the procedure. You'll try to make sure that you document either start and stop time or a total time utilized to perform that procedure. You'll also want to document the professional skill required.

And you see this commonly in insurance coverage policies. And the idea and the spirit of this is why Is it that an audiologist needs to do this? Why is it that someone who's trained and credentialed needs to be able to do this? And for us as audiologists, we know that we're uniquely trained to conduct and interpret vestibular tests. We as audiologists are also uniquely trained to identify any potential contraindications to these tests.

And we know that, particularly in the case of vhit, that we have to be able to direct the patient's head with a specific speed. And so that may require a level of expertise well beyond other lower level providers. And lastly, you'll describe any of the equipment and supplies used as part of your assessment. And then in your documentation be sure to also include how those activities in that procedure are distinct from any existing CPT code. We had talked about this previously where VHIT is very different from things like rotary chair or calorics.

And so you could also include that statement as part of your documentation when you're using 92700 to report for services that don't have a CPT code. If you want to learn more on this topic, there's a really great Audiology Today article written by Brandy Stevens on demystifying CBT code 92700. So I would encourage you to take a deep dive into 92700 prior to using it. And many of these items here and more are outlined in that article. I will go ahead and pass it over next to Annette who is going to talk to us a little bit about hearing aids and third party payers.

Thank you Anna. So I have the homestretch baton here. So for this part of our talk we're going to really try to discuss hearing aids. But before I wanted to get into that, here's a question for you to ponder and if you'd like to answer it or there's actually it's a two part question. So after a defined period do you charge for follow up visits for your self pay hearing aid patients?

And the second question is do you what about for patients who have coverage through a third party payer contract? So do you basically charge for follow up visits for either population and do you do it differently for one versus the other?

So in the past non covered services for hearing aids really wasn't as much of an issue because there weren't many insurances that were covering hearing aids and we also now have many more insurances that cover some part of hearing aids. And so we have the state mandated coverages for children and sometimes children and adults, various combinations of those things. So a lot more employer sponsored plans are now, you know, putting a hearing aid benefit in their employees coverage package. But the major change is that the Medicare Advantage programs, you know, have these supplemental benefits that a lot of times do include things like hearing aids and vision and dental. And as you know, traditional Medicare doesn't cover hearing aids.

But one of the reasons why I'm going to spend some time talking about, you know, this whole Medicare Advantage phenomenon is because Medicare in and of itself is the largest hearing insurance company in the country. There are 65 million people that are enrolled in Medicare. And it used to be that traditional Medicare was the plan of choice. That's Medicare Part A and Part B. And we know under there the hearing aids are never covered and a lot of the services that, you know, Anna and Erin were talking about are never covered either.

But Medicare Advantage is a different animal because they do have these optional or supplemental benefits. And hearing aids are very, very popular as a supplemental benefit. And as we've seen over

the past five years, more and more of these Medicare Advantage plans started including some sort of hearing aid coverage in the supplemental benefits. In fact for 2023, it's over 92% of the Medicare Advantage plan choices that a beneficiary has now have a supplemental hearing benefit. And it used to be a lot lower than that.

And what's also interesting is that the number of people that are enrolling in a Medicare Advantage plan instead of traditional Medicare has grown in 2022 was about 40%. And now as of 2023 there are more people enrolled in a Medicare Advantage plan as opposed to traditional Medicare. And we just assume that that trajectory is going to keep growing. And so that really does then make it a little bit more involved because now insurance is more involved, whereas it really wasn't in the past. And so when insurance is involved, a lot of the services that maybe you would have sort of included for a patient that self pay in your overall, you know, device and fitting packages are not necessarily accounted for when a third party payer is covering the hearing aids.

So we're going to go over some of that in here, but I'm going to sort of talk a little bit about the third party payers usually is what we would call a, a third party administrator because commercial insurance, many, many commercial insurance plans at this point carve out certain services because it's very, very expensive for them to have to process claims for very small percentage of care. So you think about the E M codes or X rays and those kinds of things that's something that, you know, a million claims a day get done. But the hearing aids, it's probably much smaller and vision and rehab and diabetes management. So a lot of the commercial insurances like Aetna and Cigna, Anthem, UnitedHealthcare, they work with what we call third party administrators to be able to provide those benefits. And so they contract with another company to provide those benefits as a part of the third party's overall benefit package for the beneficiary.

And so what happens is that the third party administrators, like for example, in the hearing aid world, there's United Healthcare Hearing Truhearing, Hear USA Nation's Hearing Amplifon, and I might be forgetting some of them, Hear usa those are all third party administrators. And so what they do is they partner with the commercial insurances to be able to provide these benefits. And so the third party administrators, you know, that I just named really have to have a very robust hearing provider network so that they can manage all the beneficiaries that are in an Aetna plan or a, a, you know, United Health Care plan. And so it's really something, especially when they're building those networks, they're going to maybe even reach out to you as a provider to sign up. And so that's really the time when you have the ability to negotiate before signing on for the contract.

So you really need to read the contracts very carefully. And what we've learned through having dealt with insurance for a very long time is that you can negotiate some of these things and it's, you know, not always just what it is that they present to you. So I'll give you a few examples. So carve outs mean that you can kind of negotiate which services you're going to provide and which services you're not going to provide. So for example, in the commercial insurance world, sometimes people are only credentialed and enrolled for providing diagnostic procedures and they're not enrolled in the hearing aid piece.

So that was something very common years ago when people would contract with say Aetna or Anthem, you know, maybe they would just contract for diagnostics and they weren't required to provide hearing aid benefits. So what you can do sometimes with these third party administrators is maybe carve out the patients that you will see. And a good example is something that happened in our state where a very large union that provided retirement benefits for their beneficiaries decided to work with a third party administrator. And so that third party administrator had to then build a network within our state to be able, able to kind of take all of those patients. And so when you're dealing with Medicare Advantage plans there are basically two types.

There's the, the Medicare Advantage plans that beneficiaries can purchase through the Medicare marketplace. And then there are also retirees or union plans that are self funded as a part of their overall retirement package. And those are not the ones that CMS kind of is more in charge of. They're self insured. And so sometimes you might have, you know, that's a very lucrative market for those commercial insurances to have Medicare Advantage plans that are not just marketplace but are self insured.

So what happened is that this third party, well, the insurance company basically got the contract to provide the retirement benefits for a very large union in our state. So they have about 50,000 members. And our patient, many of our patients, patients belong to that retiree union. And so we really didn't want to not be able to participate with this third party hearing network because we didn't want to abandon our patients. But we knew that we really couldn't absorb all of the rest of the people that are in that commercial marketplace Medicare Advantage plan.

And the reason is, is because, you know, you don't get paid as much with these Medicare Advantage plan supplements. And there's a lot more paperwork, there's portals, there's just a lot more administrative time and it really just makes it hard for you to even have patient availability for your existing patient that may not be part of a Medicare Advantage plan. And so we negotiated to just sign on for that one contract only, but were carved out and are not required to participate for any of the regular marketplace plans. And so that's something to consider that you can sometimes restrict, predict, you know, which contracts you're going to deal with. A lot of the third party hearing aid plans in their coverage policies they will say that they will pay for basically the hearing aid and during their trial period and maybe a few follow up visits after that.

And a lot of these plans kind of indicate how much you can charge the patient for follow up care after, after you know, their benefit is over. And so you can sometimes negotiate those charges that you know,

those follow up care charges in the future. And the other thing that you can negotiate is the ability to bill insurance for medically necessary diagnostic testing. This isn't as much of a problem as it was a few years ago because the companies are getting better at separating things that would be covered under the part B benefit that the Medicare Advantage plan has to cover versus the non covered service of, you know, doing testing for a hearing aid. But, you know, we kind of tried to clean up that language in, you know, those contracts that we have to basically make it clear that if a patient is coming in and it is a medically covered diagnostic procedure under the Medicare Benefit, that we're, and if we're, you know, already contracted for diagnostic services with that insurance company, that we would be billing the insurance company for those things and not rolling it into the hearing test that is usually related to the hearing aid.

And it's really, really important to don't sign on to every single contract just because you're afraid that you're going to lose patience. Because sometimes these contracts really allow you to receive funding that's going to cover your costs of, you know, your operational costs. So I've seen things where if the patient comes in for a hearing test and has the fitting and gets the hearing aid and then decides that they don't want it, that you're not reimbursed at all for anything because you're only reimbursed first for if the patient keeps the hearing aid. So that's really, you know, a plan that you probably wouldn't want to sign on with because you're looking at probably about three hours at least worth of your time, your office time for that whole process and then you don't get anything. I've seen other plans where the aftercare is expected to be part of, of the initial fitting fee.

And so it's, you know, several hundred dollars for your fitting fee, but it's also supposed to cover every follow up visit good for the life of the hearing aid. And that's really not a reasonable expectation. And so it's okay to say no because if you do sign on to plans that you know are not sustainable financially, it's going to be very hard for you to keep your doors open.

So when we're talking about hearing aid coverage through insurance, it's not typically everything is expected to be covered. So what usually is covered when an insurance company or an insurance plan is paying for a hearing aid for their beneficiary? It's usually the hearing aid and fitting and follow up fees for a designated time period. It's usually maybe the state mandated trial period or maybe longer, 45 days, 60 days, new ear molds that kind of came with the hearing aids and maybe some repairs and follow up visits for a certain time period after the trial visit. It's not really intended for covering every single transaction that happens with that patient following receiving the hearing aid.

So things that you may not see covered are visits for the life of the working life of the hearing aid, replace the ear mold, routine accessories, batteries. It really just depends on the payer. But most insurance plans don't intend that the price that they're paying you is for those things. And so that you really need to sort of restructure how you're doing your billing so that they better understand what is happening.

Second. Okay, so the reason that we asked that question originally is that that at least in our clinic we're starting to sort of reconsider, you know, what that half, what that fitting charges, what that fitting fee includes. And so initially our fitting fee included follow up visits and any care for, you know, a year. And then after that patients would have to pay for the visits that they came in for. And we also did that with our Medicaid because that was required as a part of what Medicaid pays for is the fitting and the follow up for a year.

But not every third party contract says that. And so you really have to look at each individual one because they are paying you maybe a lower than expected rate, but they're also not expecting you to provide all of that service that you may have done with someone that's paying on their own because maybe you're bundling some of those services in there. And so when you're now starting to have to charge patients at different time periods when they're coming back for follow up care or charge for

supplies or that kind of thing, you might want to consider maybe with the self pay patients that are not working through insurance is to come up with some sort of packages for that includes, you know, professional bundled services and items for a certain time period. But really it just doesn't make sense even with self pay that you would just, you know, charge one price and any single time they come in for, you know, the next three to five years that everything's included. It's not really a sustainable model.

But also this gives you ways to kind of offer your self pay patients something different than what maybe the third party was intending to pay for. So if you want to wanted to include batteries for the life of the hearing aid, or if you wanted to include accessories like domes, you know, for the life of the hearing aid, wax filters, etc. But you know, if it's all spelled out in the package, then it sort of makes sense. And so then you're able to, you know, charge for those things. And you know, sometimes patients really do like to have the, the security that they know that, you know, they're paying for this and that they can come see you and not have to worry about paying each time.

The other thing that you should also consider is that sometimes someone may get a hearing aid through one of the third party network programs and maybe their year's not over, but they've decided they want to try someone else in the network. Or maybe that network went out of, I mean, that provider went out of business. That actually happened to us. We got someone that basically got a hearing aid and three months later their practice closed. And then the person had to find someone else.

And so they called the third party administrator and they just gave them names of other people that were in the network. And so when this patient came in, they were under the impression that they would have, you know, continue to have free care, you know, because the year wasn't over or whatever the contract for the insurance was. And so we, you know, had to help them understand that that, you know, payment was to that other provider and that, you know, there would be office charges for this patient that were not covered under, you know, the payment that was made for the hearing aid. And, you know,

that person was kind of upset. But you know, the third party plan did back us up on that because, you know, that fitting fee was paid to another, another provider.

And so if there isn't a provision for that for the patient to go to someone else and the third party is going to then pay you, then you would be able to provide that service for a fee.

So when we're talking about this notice of non coverage, this is not necessarily just for the hearing aids that I'm talking about, but really in relationship to all the topics that were presented today, especially the diagnostic services. It is very transparent, as both Erin and Anna said. I mean, very important to be transparent about the non covered services. And a good practice is to provide some notifications of what is covered and what's not covered in advance. And each payer that you are maybe a participating provider with has different rules about notices of non coverage and what it is that you should or should not do.

I wanted to just kind of share that. Just like when we use the words Xerox for copies and Google Googling something as an Internet search, these terms have become kind of generic and used synonymously and they're not really necessarily the same thing. And so when we talk about an avn, a lot of times people sort of use that term synonymously with a notice of non coverage coverage. So I just wanted to make clear that the ABN is only for original traditional Medicare and it is not to be used for Medicare Advantage plans or any commercial insurances. Each of those different insurance programs have their own rules about notice of non coverage.

And so if you are dealing with things, you know, if you're an in network provider, you definitely need to make sure that you kind of consult those so that you can, you know, give the correct forms or maybe you have to create your own. So when a service is provided that is a never covered service under traditional Medicare, an ABN is not required, but it is optional to just notify the beneficiary that it's not covered or that it's never covered. And all of the things that were presented today are things that are

never covered under traditional Medicare. But like I said, you need to check the payer policies for the rest of the.

So in closing, whether you're a veterinarian, a hairstylist, accountant, mechanic, the services that you provide are very important and have value. Let's all think about the last time we brought our beloved pet to the vet for free. When has that ever happened? Right. It doesn't.

And no one really expects that. So don't give your professional services away for free either. And please try to think of ways, you know, to ethically charge for the services and your time. So we're going to open this up now for questions and thank you very, very much for hanging in there with us on this topic today.

While you're thinking of your questions for our presenters, I just wanted to go over again about how to get your CEU certificates. So all you need to do is go back to the registration page on Eaudiology. You need to complete an assessment and an evaluation and you can then go on to get your CEU certificate.

We're hoping for at least one question. Yeah, we'll stick around here. We'll look at the chat here to see if we have any questions.

And if someone is either watching the recording or they're too shy right now to post a question. Is there a way to contact you if they have something specific they'd like to ask you? Absolutely. Yeah. I'll put.

Will this go up to everyone? Let me see. I'm gonna put the video. Not for the video though. Okay.

If you want to update your slides and put contact information at the end of it, I can post that on the website. Yep, we can do that. Okay, perfect. One great way to submit your questions is to the inbox for the coding and reimbursement committee for the American Academy of Audiology. And the way to

contact us is reimbursementaudiology.org so that's reimbursementaudiology.org we are there to help you with any questions, and any specific information that you can provide to help us answer those questions is greatly appreciated.

Great. That's perfect. I encourage anyone with questions to contact the committee. Sounds great. Well, thanks everyone.

Yep. We're going to go ahead and wrap up today. Check Eaudiology for more upcoming webinars. And thank you for attending today.