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2025 Coding and Reimbursement Update

Kim Cavitt, AuD

Audiology Resources, Inc.

Disclosures

- **Presenter Disclosure:** Financial: Kim Cavitt is the owner of Audiology Resources, Inc. She is a consultant for the Academy of Doctors of Audiology, the Illinois Academy of Audiology, and an advisor for Tuned. She is also an advisory member for P-CHAT. She received an honorarium for this course. Non-financial: Kim Cavitt is a task force chair for the Illinois Academy of Audiology and a committee member of the Academy of Doctors of Audiology.
- **Content Disclosure**: This learning event does not focus exclusively on any specific product or service.
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Limitations/Risks

Please review these bullets and make any revisions/additions as applicable for your course.

- The applicability and accuracy of the course content may vary by the clinical, geographical, and cultural context; you should evaluate the course accordingly.
- As healthcare is rapidly evolving, new findings may change the validity of the information presented in this course. Providers should always consult the latest research and guidelines from professional associations.
- The interventions discussed in this course may be limited in generalizability, requiring practitioners to consider specific individual and population factors.
- The course may not cover all possible risk factors, diagnostic methods, or treatment options, and complex cases may require additional considerations.
- Healthcare providers should apply cultural competence and sensitivity to ensure effective and respectful care based on their patients' diverse needs.
- Providers should always evaluate the limitations of diagnostic and screening tools, considering their potential for false results as well as any ethical implications.
- It is the responsibility of course participants to critically evaluate the evidence from multiple sources to guide professional practice.

Learner Outcomes

- After this course, participants will be able to explain how to locate their state informed consent and credit card surcharge laws.
- After this course, participants will be able to explain how to locate the list the telehealth place of service and modifier codes allowed for Medicare and insurance coverage.
- After this course, participants will be able to list the technician supervision requirements.
- After this course, participants will be able to distinguish between different types of Medicare plans.
- After this course, participants will be able to discuss how to apply applicable health plan medical policies to

Changes for 2025

- No audiology specific CPT, HCPCS, or ICD 10 coding updates/additions for January 1, 2025.
  - US may switch to ICD 11 sometime over the next three years.
- Will see further Medicare allowable rate reductions of 2-3% (may still see an end of year legislative package to ward off decrease).
- Applications for ASLP compact privileges may be open in late 2025.

HIPAA UPDATES

- https://www.hhs.gov/hipaa/newsroom/index.html
  - Patients allowed inspect their health records in person and take notes and photographs of their health records, free of charge.
  - The establishment of a new fee structure related to copes of medical records: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html#:~:text=Flat%20fee%20for%20electronic%20copies,supplies%2C%20and%20any%20applicable%20postage.
    - Covered entities are required to post on their websites their estimated fee schedules for providing individuals access to their PHI and medical records.
    - The time frame for providing copies of requested health records reduced from 30 days to 15 days, including shorting the maximum permitted extension to 15 days.
  - Allows an exception to the Minimum Necessary Standard for disclosures of PHI for individual-level care coordination and case management.
    - Broadened the definition of healthcare operations to cover care coordination and case management.
  - Heightened security policies to protect against cyberattacks.
    - https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

Informed Consent

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

Informed Consent

- Treatment, Telehealth, Email and/or Text
  - May need separate consent for each.
  - State laws will vary on telehealth access and need for separate, informed consent.
  - Seek the advice of legal counsel for interpretation and to create a compliant informed consent form(s) for your state and situation.
    - Resources:
    - https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/obtaining-informed-consent/
    - https://www.asha.org/siteassets/uploadedFiles/State-Telepractice-Policy-COVID-Tracking.pdf
    - https://www.cchpca.org/topic/consent-requirements-medicaid-medicare

Credit Card Surcharge

- There are state laws dictating what you can charge and/or how it is represented to the purchaser.
  - There are pros and cons, for the patient, for a credit card purchase as some offer buyer protections and warranty extensions and well as point accruals.
- Options:
  - Raise prices by 3-5% for everyone.
  - Cash discount
    - Need to confirm that it does not conflict with any language in managed care agreement.
      - Can avoid this by only applying cash discount to patient responsibility.
  - Surcharge
    - Regulated by state.
- https://merchantcostconsulting.com/lower-credit-card-processing-fees/credit-card-surcharge-laws-by-state/

Telehealth

- Telehealth is a means of delivery, not a service itself.
- Coverage is dictated by the health plan; every health plan may not cover telehealth services.
- Must utilize system that meet HIPAA security requirements.
- State law dictates your ability to provide telehealth services.
  - Still cannot across state lines to provide telehealth (without licensure in the state in which the patient is currently residing).
  - ASHA State by State Guide
  - Audiology Compact
    - Not yet functional.
  - Q3014: Telehealth site originating fee
    - Allowed by some health plans, including Medicaid.

Medicare Covered Telehealth Codes – Synchronous and Audio/visual – Valid Through September 30, 2025 (unless re-extended)

- 92550
- 92552
- 92553
- 92555
- 92556
- 92557
- 92563
- 92565
- 92567
- 92568
- 92570
- 92587
- 92588
- 92601

Remote Monitoring of Treatment Program

- 98975: Remote therapeutic monitoring (e.g., therapy adherence, therapy response); initial set-up and patient education on use of equipment
- 98980: Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes
- 98981: Each additional 20 minutes (listed separately in addition to code for primary procedure)
  - Use of computer software (such as LACE), remote programming software, a mobile application, and/or a manufacturer specific portal to remotely monitor/track patient utilization or adjust/change a hearing aid or implantable device.
  - This is not covered by Medicare and many commercial health plans.

Place of Service Codes for Telehealth

- 02: Telehealth provided other than in patient's home
- 10: Telehealth provided in patient's home

Use of Technicians in an Audiology Practice

- Medicare is very clear that:
  - 1) technicians/audiology assistants can only provide technical services (performing the procedure but not interpreting and reporting the procedure) when the procedure has a TC/PC split,
  - 2) technicians/audiology assistants must be trained, and, most importantly,
  - 3) can only provide covered services under the direct supervision of a physician (not an audiologist). This is clearly documented in chapter 15, section 80.3 (D) and 80.3.1 of the Medicare Benefit Policy Manual. Many state Medicaid programs and commercial insurers follow these same requirements.
  - In ENT and medical settings, the technical component of 92540-92546, 92548-92549, and 92587-92588 can be provided by a trained technician under the direct supervision of a **physician (who interprets and reports the procedures).**

Use of Technicians in an Audiology Practice

- It is important that providers confirm the scope of practice requirements of audiology assistants and technicians in their state and the supervision and billing limitations of each payer before utilizing technicians and audiology assistants in their practice for managed care covered services.
- Lack of mention in licensure does not mean it is allowed; instead you could be supporting unlicensed practice of audiology or medicine.
- It is important to get clarification from your state or a healthcare attorney on the ability to utilize audiology assistants and technicians when not specifically addressed in licensure.

Use of Technicians in an Audiology Practice

- It is also important to know that, when you bill the services of an audiology assistant or technician to an insurer or third-party under the NPI of an audiologist and it is not explicitly allowed, you could be supporting the unlawful practice of audiology or hearing aid dispensing without a license and/or filing a false claim.
- Please consult all payers before allowing audiology assistants or technicians to provide covered services to their beneficiaries and determine, with each payer, how these services are to be billed.

Binocular Microscopy

- Binocular Microscopy (CPT Code 92504), requires use of a binocular microscope to visualize the ear canal and tympanic membrane. You can see an example of a binocular microscope here.
- Binocular microscopy may be medically reasonable and necessary when
  - 1) you have a binocular microscope (an otoscope or video otoscope is insufficient to meet the code description),
  - 2) you were unable to visualize clinically significant portions of the ear canal or tympanic membrane with an otoscope and
  - 3) your documentation supports the medical necessity of the procedure for the specific patient.
- Use of this code implies binaural. As a result, a 50 (bilateral procedure) modifier would be inappropriate. If only one ear is viewed, the 52 (reduced services) modifier must be added.
- In the October 2011; Volume 21: Issue 10 of *CPT Assistant,* which documents appropriate code use across all health plans, the following was provided:
  - **"Question:** :Please provide an example of when it is appropriate to report code 92504.
  - **Answer** : An example for reporting code 92504, *Binocular microscopy (separate diagnostic procedure)*, is when a patient presents with ear fullness and decreased hearing. Routine otoscopy suggests an abnormality of the tympanic membrane. To further evaluate this finding, binocular microscopy is performed".

Billing Removal of Impacted Cerumen

- Scope of practice matters.
- As a result of the **Medicare/Medicaid** coding edits, clearinghouses and payers reject the use of 69209 or 69210 for the removal of impacted cerumen on the same date of service as any audiometric testing (92552-92557).
  - Audiology mandatory claims submitter to Medicare (https://www.cms.gov/medicare/prevention/prevntiongeninfo/downloads/bp102c15.pdf; section 80.3 (H)).
  - CMS deems ALL cerumen removal inclusive to the audiometric testing (92552-92557) if removed by an audiologist.
  - May NEVER apply to commercial insurers so bill normally to all payers.
- The edit cannot be overridden by a 59 or XU modifier.
- **You cannot bill the patient privately for the cerumen removal when a coding edit exists.**
- **ONLY OPTION TO AVOID THIS:** Perform audiometric testing on separate date of service from cerumen removal.

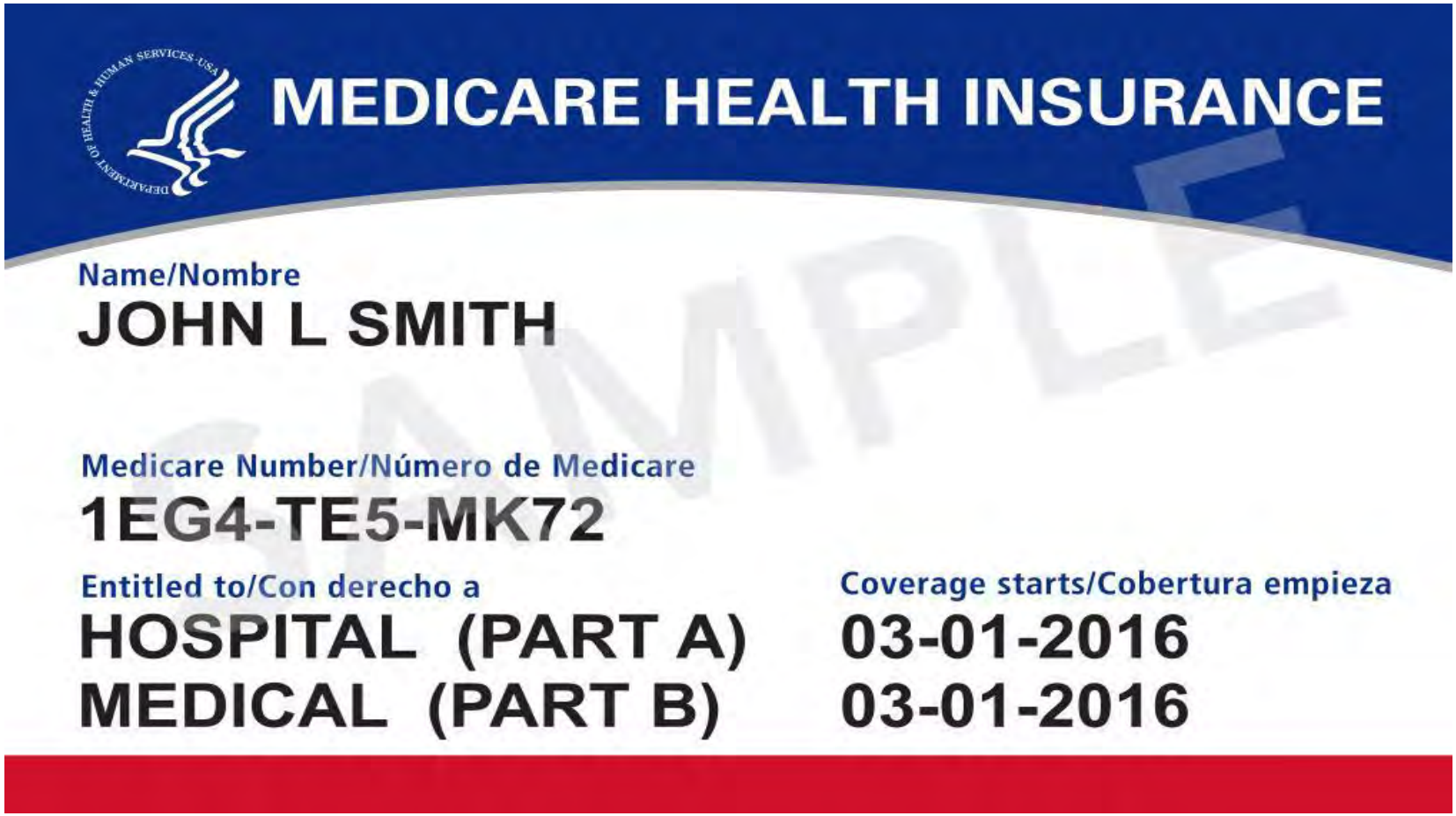
Coverage of Cerumen Removal

- Medicare
  - Medicare does not cover cerumen removal provided by an audiologist.
    i. https://www.ssa.gov/OP_Home/ssact/title18/1861.htm, section (s) and (ll)
    ii. https://www.cms.gov/medicare/payment/fee-schedules/physician/audiology-services
    iii. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.PDF, sections 80.3 and 80.6
    iv. https://www.entnet.org/resource/cpt-for-ent-cerumen-removal-2/
    v. https://www.asha.org/practice/reimbursement/medicare/aud_coding_rules/?srsltid=AfmBOoq0j0ukF2hgjMyHx8Yp8Z33WdvIRTyWsULWNLIwxFzQpEesp-YC
    vi. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33945&ver=18&=
    vii. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56454&ver=10&=
    viii. https://www.asha.org/practice/reimbursement/medicare/cerumen/?srsltid=AfmBOoptROwEYvGyNYBE242O12FZqNSpwzE77PRseBdW2d3k_B0ROtw4
- Commercial insurance
  - Coverage is dependent on scope of practice AND payer contract.

Billing Electronic Hearing Protection/Hearing Aid

- In general, health plans do not cover items or services for recreational, occupational, or educational uses. They cover items and services that are medically reasonable and necessary to manage or treat an illness, disorder, or condition.
- These considerations are important when considering the billing of electronic hearing protection to a health plan:
  - Health care plans, as a general rule of thumb, do not cover hearing aids in the absence of a documented peripheral hearing loss.
  - Health plans generally do not cover hearing aids for ear protection or for the treatment of tinnitus, balance, or auditory processing in the absence of at least a documented mild hearing loss (26dB).
  - Some health plans, including UHC, Tricare, Aetna, and many BCBS Association plans, have medical policies that indicate requirements for minimum hearing loss, medical necessity, recommendations/clearance, and, importantly, documentation. We encourage you to locate and review these policies yourselves if you participate with or bill health plans for hearing aids.
- Billing the device based upon indication:
  - Hard of hearing
    - Must meet the requirements of coverage of the health plan.
    - V5298 as two line items with RT and LT modifier (Hearing aid not otherwise classified; as pre-programmed) or V5130 (binaural, in the ear)
  - Normal hearing or hearing loss that does not meet the medical policy requirements of coverage
    - V5274 (assistive listening device that is not otherwise classified)

Insurance Card Examples – Traditional Medicare



Opt Out of Medicare

- Audiologists still cannot opt out of Medicare and enter into private contracts with Medicare beneficiaries for the provision of covered services.
- Do not assume an item or service is non-covered just because the treatment plan includes hearing aids and, as a result, charge the beneficiary privately for the service.
  - While Medicare does not cover "examination for the purpose of prescribing, fitting, or changing hearing aids" or "routine" services (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf), coverage of audiometric testing is not automatically precluded JUST because the patient is a hearing aid user or because the treatment plan includes hearing aids. The Update to Audiology Policy (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r84BP.pdf) indicated: "It is appropriate to pay for audiological services for patients who have sensorineural hearing loss and who wear hearing aids if the reason for the test is anything other than evaluation of the hearing aid. For example, there may be a perceived change in hearing or tinnitus that makes testing appropriate and covered. Such testing might rule out other reasons for the symptoms (auditory nerve lesions, middle ear infections) and result in subsequent evaluation of the hearing aid (not covered) or aural rehabilitation by a speech-language pathologist (covered)". So, in other words, if the testing is physician ordered and medical necessity has been documented, Medicare will cover the testing. The patient should not be held financially responsible.
    - Or an AB modifier is appropriately used.
  - *The solution: Allow the patient to access their health plan benefits by reviewing the patient's case history, documenting medical necessity for the services provided, and billing the health plan for medical necessary services.*

Medicare has a Deductible

- Traditional Medicare deductible for 2025 is $257.
  - The beneficiary is typically responsible for the deductible.

Considerations with Traditional Medicare

- If ONLY present this card:
  - Ask if they have a Medicare supplement (Medi-Gap) plan, commercial insurance coverage, or Medicaid.
- If this card only indicates Part A coverage:
  - Ask if they also have commercial insurance or Medicaid coverage.
- If the patient also gives you a Medicare Advantage card:
  - Cannot have valid traditional Medicare and Medicare Advantage at the same time.
  - Verify the eligibility of the Medicare Advantage card through payer portal.

Audiology Services

https://www.cms.gov/medicare/payment/fee-schedules/physician/audiology-services

Insurance Card Examples – Medicare Supplement (Medi-Gap)

Medicare Supplement

- Its primary role is to cover the Medicare 20% co-insurance.
  - Most do not cover the deductible (except Plan F).
- Its associated hearing aid “benefits” are typically unfunded, discount benefits through hearing benefit plan/third-party networks.
  - https://www.uhc.com/medicare/health-plans/medsupp-details.html/34787/G01/2024
  - Calling to verify benefits may trigger the plan contacting the member.
    - Portal review (UHC) typically does not trigger a contact to the member.

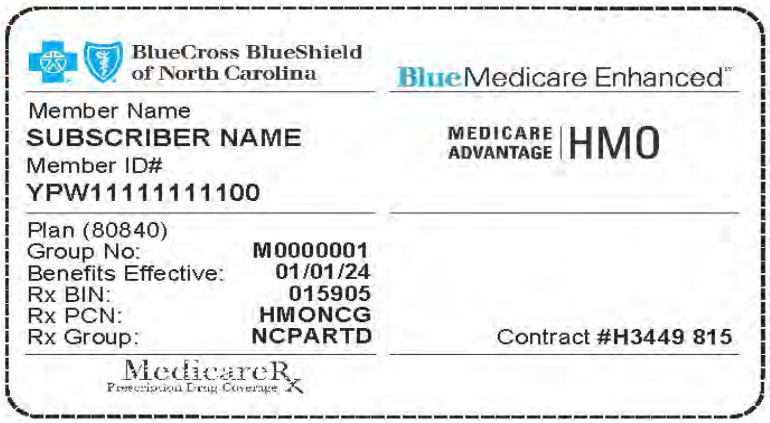
Insurance Card Examples – Medicare Part C (Advantage)

UHC

BCBS

Insurance Card Examples – Medicare Part C (Advantage) – Card Doesn't Say "Advantage"

Insurance Card Examples – Medicare Part C (Advantage) – Card Doesn't Say "Advantage"



Verification of Eligibility for Medicare Advantage

- At the outset of the plan year (typically able to find this information after November 1 for the following year) or during the plan year, Google the typical, specific Medicare Advantage plans available in your rea and review the plan documents for hearing, hearing aid and auditory prosthetic device coverage and “benefits” AND third-party involvement.
- https://www.medicare.gov/plan-compare/#/?year=2025&lang=en

Example

Medical benefits			
		In-network	**Out-of-network**
Hearing services	Exam to diagnose and treat hearing and balance issues[2]	$0 copay	$65 copay
	Routine hearing exam	$0 copay, 1 per year*	$65 copay, 1 per year*
	Hearing aids[2]	Copays from $99 to $1,249 for a broad selection of OTC and brand-name hearing aids* • Access to one of the largest national networks of hearing professionals with more than 7,000 locations • Broad range of popular hearing aids including Beltone™, Oticon, Phonak, ReSound, Signia, Starkey®, Unitron™ and Widex® • 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period	
Routine dental benefits	Optional Dental Rider	Additional dental benefits available with a separate premium. Please see optional benefits section below for details.	
	Preventive	$0 copay for preventive dental including oral exams, X-rays, routine cleanings and fluoride* • No annual deductible • Medicare Advantage's largest national dental network • Freedom to see any dentist • If you choose to see an out-of-network dentist you might be billed more, even for services listed as $0 copay	

Medicare Advantage (Part C)

- Most have unfunded hearing aid discount plans through hearing benefit plans.
- If out of network, can only collect the Medicare Limiting Charge for Medicare covered items and services.
- Some Medicare Part C plans have deductibles and co-pays and some do not.
  - Can find out if go online or call to check eligibility and benefits.
- Most HMOs do not offer out of network benefits.
- Some HMOs may require prior authorization from the PCP.
- Some HMOs may have specialist co-payments.
- Medicare Advantage (except HMOs) do not require a physician order..
  - Need to consult each plan to determine requirements and plan documents are readily available online.

Medicare Advantage (Part C)

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

Routine Hearing Tests

- Many Part C plans cover routine testing.
  - Not typically for individuals with documented hearing loss or otologic condition.
  - There is no code specific to routine testing.
  - Might only be available through third-party network participating provider.
  - ”Routine” in healthcare typically refers to screenings or basic testing.
    - Hearing Screening (92551 or V5008)
    - Pure-tone, air (92552)
    - Audiometry for hearing aid evaluation to determine the level and degree of hearing loss (S0618)
      - Does NOT include any other procedures.

Insurance Card Examples – Commercial Insurance

BSBS

UHC

Anthem in CT, OH, IN, NH, GA, NV, CO, MO, and WI

- Facility and ENT providers should consult their administration to insure benefit not negotiated.
- Per a letter sent to in-network Anthem providers in these states listed above that, effective July 22, 2024, all Anthem Blue Cross Blue Shield Provider Agreements in these states will be amended to remove codes V5008-V5299 from their existing provider agreements. **This action makes these providers in these states out of network for hearing aids through Anthem.** If Anthem providers want to remain in-network for hearing aid devices and services provided to Anthem members, they will need to contract directly through TruHearing to provide these services in-network, if they are not already a TruHearing provider.
- Customer service providers at Anthem do not have access to your provider agreement and cannot provide guidance on your network status; they can ONLY provide you with information on the coverage and benefits of audiology, hearing aid and auditory prosthetic device items and services for this specific member.
- **Anthem providers, in these states listed above, are still considered in-network for diagnostic and evaluation and management services (as allowed by licensure), some hearing aid codes (S0618 and 92590-92595), auditory prosthetic devices (when covered benefits) unless the audiology provider terminates their Anthem provider agreement.**

Anthem in CT, OH, IN, NH, GA, NV, CO, MO, and WI

- If a provider chooses not to contract with TruHearing by July 22,2024, the provider will be deemed out of network for Anthem members for hearing aid devices and services. TruHearing is the in-network hearing aid service provider.

- **Hearing aid coverage and benefits will vary GREATLY state by state and plan by plan. As a result, many Anthem members will be able to access their benefits through out of network providers who do not participate with Tru-Hearing or who did not have this member referred to their office by TruHearing.**

- When an Anthem member with commercial hearing aid benefits wants to access these benefits through an out of network provider, the **CT, OH, IN, NH, GA, NV, CO, MO, and WI** out of network hearing aid provider, needs to consider the following:
- You will need to be able to communicate these differences to the Anthem member as some out of network benefits have markedly greater out of pocket costs.
- If the Anthem member does not have out of network benefits, is the plan:
    - A discount only plan?
        - If so, you may be able to match the available "benefit option".
    - If a funded, in-network hearing aid benefit, does the plan allow for prior authorized, out of network care on a case-by-case basis?
        - This would require you follow a prior authorization process similar to FEP and outline the medical necessity of the type, style, and features of prescribed hearing aid and the rationale (distance, provider type, etc.) for out of network care allowances.
- How does your current Anthem contract address codes S0618 and 92590-92595, which were not removed from existing contracts?
    - These codes may still be allowable and billable through Anthem.
- In verification of coverage and benefits, does the Anthem member have out of network hearing aid benefits?
    - If yes, how are they different from in-network benefits?

Third-party Medical Policies 2025 – FEP

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

Third-Party Medical Policies 2025 – BCBS FEP

- https://www.fepblue.org/our-plans/medicare/compare-plans#:~:text=Hearing%20Aids&text=Prior%20approval%20will%20be%20required,aids%20and%20hearing%20aid%20supplies.
- https://www.fepblue.org/-/media/PDFs/Medical-Policies/2024/March/Mar-2024-Medical-Policies/Remove---Replace/FEP-UM-Guideline-005-Hearing-Aids-2024-benefit.pdf

Third-Party Medical Policies 2025 – BCBS FEP

- BCBS FEP plan:
  - Must have a hearing loss of greater than 26dBHL OR appeal the coverage limitation.
    - This is where more information (inventories, speech in noise, unaided real ear) could be invaluable.
  - Requires a prescription.
  - This is an allowance benefit.
    - “Hearing aids for children up to age 22, limited to $2,500 per calendar year.
      - Here is a rationale for an unbundled delivery.
    - Hearing aids for adults age 22 and over, limited to $2,500 every 5 calendar years. Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.”
    - The patient is responsible for all costs which exceed $2500.

Third-Party Medical Policies 2025 – BCBS FEP

- "Medical Necessity* requirements for hearing aids:
  - 1. Must be approved, listed, and/or registered with the FDA as a prescription device
  - 2. Dispensed by prescription or signed written order from a licensed healthcare provider who is practicing within the scope of their license. Hearing aid purchase within 6 months of the date of prescription
  - 3. Hearing loss determined and documented by audiometric testing (hearing test) completed in the 6 months prior to hearing aid purchase.
    - Test must include: Air, bone, SRT and speech recognition testing.
  - 4. The degree of hearing loss is confirmed by audiometry or other age-appropriate testing to be greater than 26 dB hearing loss (HL) for:
    - a. conductive hearing loss unresponsive to medical or surgical interventions
    - b. sensorineural hearing loss
    - c. mixed hearing loss (combination of conduction hearing loss and sensorineural hearing loss)

Third-Party Medical Policies 2025 – BCBS FEP

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

Non-Participation/Out of Network

There are pros and cons to network participation.

Non-participation is the ONLY way to retain private pay, usual and customary rates BUT it comes with caveats.

The Decision to Participate or to Not Participate

- Cost of acquisition of a new patient.
- Afford to provide standard of care, at the agreed upon rates, required by the plan.
- Available out of network benefits.
- Potential lost revenues if do not participate.
- Creation of a competitive offering.
  - If you are unbundled and the benefit is unfunded.

In Versus Out of Network Provider Status

In-Network

- Lower cost of patient acquisition.
- Will get referrals from other in-network providers.
- Will be listed in provider directory for health plan.
- Must submit claims to health plan for covered services.
- Will reduce billed charges to allowable rate if non-covered.
- Must accept the allowable rate as payment in full.
- Must have a patient sign a notice of non-coverage prior to the provision of non-covered services.
    - Can collect usual and customary rate for prior notified non-covered services on the date of service.

Out of Network

- May not get physician referrals from in-network provider.
- Lose a competitive advantage versus big box, DTC and OTC retailers.
- Patient may have no benefits (HMO) or reduced benefits.
- May not be able to have payer portal access.
- May not be able to get back in-network if terminate.
- May be required, by state law, to submit claims.
    - Will need to set up payer ID with clearinghouse.
- If not submitting claims, to health plan, often still subject to good faith estimate and, possibly, a notice of non-coverage.
- Can collect usual and customary rate for services on the date of service.

Out of Network as an Option

- Analyze your situation before joining or terminating.
  - How many NEW patients are referred to your practice by this insurer (lower cost of acquisition)?
  - How many patients are represented by this payer?
  - How many dollars are represented by this payer?
  - How many referral sources are represented by these patients who are represented by this payer?
    - Some referring providers cannot refer to out of network providers.
  - Does this payer contractually allow for hearing aid upgrades?
  - Does the payer offer lucrative, audiology direct, hearing aid coverage and benefits?
  - Does the payer utilize a provider network for their hearing aid coverage and benefits?
  - What are the socioeconomics of the area?

Non-Participation/Out of Network as an Option

- **You should ALWAYS (except Medicare Dual Eligible) collect payment in full, of your usual and customary rate on the date of service.**
- **DO NOT ACCEPT ASSIGNMENT ON THE CLAIM.**
- Your office can submit claims to the payer as a courtesy to the patient.
  - The patient is reimbursed, from the payer, their out of network benefits.

If You Opt to Participate…

(or possibly even if you don't)

How to most successfully navigate managed care:

1. Have a strong working knowledge of the payer guidelines, medical policies, and allowable rate schedules of the payers your practice is contracted with.
2. Maximize capacities of internal office management systems and payer portals.
3. Have strong documentation supporting medical necessity for the specific patient.
4. Have a no exceptions, established revenue cycle processes.
5. Effectively verify benefits for items and services over a specific threshold.
6. Appeal, with documentation, when inappropriately denied.
7. Utilize legal counsel.
8. Train all of your staff.

Hearing Aid Benefit Types

- Unfunded
  - A “benefit” where the health plan negotiated ”discounts” on hearing aids and related items and services.
  - The patient pays in full for the costs of the items and services.
  - Administered through a hearing benefit plan/third-party network.
- Funded
  - The health plan is paying in whole or in part for the cost of the item of service.
  - Can be administered directly by the health plan or a hearing benefit plan/third-party network.
- Inclusive
  - What items and services are included in the hearing aid benefit.
  - Often defined by medical policy or allowable rate schedule.

Hearing aid Benefit Options

- Allowance
  - Dollars towards.
  - Patient can pay the difference between the allowance and the usual and customary rate of the hearing aids and related services.
  - Examples: BCBS FEHP
- Fixed, negotiated allowable rate.
  - Based upon your practice's allowable rate schedule.
  - 100% of allowable for…
  - Itemization is vital here.
  - Examples: Some BCBS association commercial plans.
- Fixed dollar amount.
  - The benefit is a fixed number and not based upon your allowable rate schedule.
  - Itemization may push things to patient responsibility.
  - Example: UHC commercial and its $2500 per ear benefit.

Hearing aid Benefit Options

- Invoice plus
  - This is where you must submit an invoice for coverage.
  - The health plan pays the hearing aid invoice plus a percentage.
  - Upgrades not possible.
  - Itemization is vital here.
  - Example: BCBS of Georgia
- Max benefit
  - The health plan covers a “max” fixed dollar amount for the hearing aid and related items and services.
  - hey do not cover $X for the hearing aid; they cover a maximum of $x dollars for the hearing aid and related services.
    - Hearing aid and related services paid at allowable rate.
  - Itemization is vital here.
    - It’s the only way to truly maximize the benefit.
- Percentage of allowable rate
  - The health plan covers a percentage of the allowable rate for hearing aids and related services.
  - The remaining percentage is co-insurance and should be paid at the time of visit.
  - Itemization is vital here.
  - Example: Some BCBS Association plans

Hearing aid Benefit Options

- Percentage of dollars billed
  - The health plan covers a percentage of the dollars billed for hearing aids and related items and services.
    - Often 50-70%
  - Upgrades not possible,
  - VERY hard to operationalize and meet the contract requirements of standard pricing.
    - May need documentation from health plan, in writing, allowing for cash pay discounting.
  - Unbundled delivery is difficult with this type of benefit.
  - Rarer benefit type.
- “Up to”
  - The health plan covers “up to” a fixed dollar amount for the hearing aid and related items and services.
  - They do not cover $X for the hearing aid; they cover a maximum of $x dollars for the hearing aid and related services.
    - Hearing aid and related services paid at allowable rate.
  - Itemization is vital here.
    - It’s the only way to truly maximize the benefit.

Thank you for attending!

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