2025 Billing & Coding Update

Presenter: Kim Cavitt, AuD

At this time, it's my pleasure to welcome back to Audiology Online Dr. Kim Cavitt. She was a clinical audiologist and preceptor at the Ohio State University and Northwestern University as well as an adjunct lecturer at Northwestern and Western Michigan since 2001. She has owned and operated her audiology consulting firm Audiology Resources. They provide comprehensive operational compliance and revenue cycle consulting services to hearing health care provider as well as her online boot camp which is a great resource for audiologists.

She is a past president of the Academy of Doctors of Audiology and has a long history of service to this profession. We love her courses. We're so grateful for all the contributions she's done for Audiology Online over the years. And at this time, Dr. Cavitt, I'll turn it over to you.

Thank you Dr. Smocka, and thank you for Audiology Online for inviting me back for I think this might be my 10th or 11th coding reimbursement update. You're going to see my disclosures here on my disclosure slide and all of the limitations and risks. You'll also see the learner outcomes which will be highlighted throughout the presentation. These are also materials that are available in your handouts.

So let's get started. There are no specific CPT, HCPC or ICD10 coding updates or additions that went into effect on January 1st of 2025. The US may switch to ICD11. Possibly everything around healthcare is kind of up in the air right now, but we may switch to ICD11 in the next three years we were scheduled to switch. Whether that happens or not remains to be seen.

We will also potentially see further reductions. You may see at the end of the year a legislative package that might ward off some of these increases, but you may continue to see further Medicare allowable rate reductions and applications for the privileges of practice around those of you in the compact states could open as late as 2025. So let's talk a little bit about HIPAA. HIPAA had some changes that did go into effect in the last year, and you're going to see hyperlinks throughout the materials. They all functioned when I submitted the slides about a month ago, so they should all be functional.

But to give you a little bit more information, patients are allowed to inspect their health records in person and take notes or photographs of their health records at no charge. Also, they have now established a new fee structure related to the copying of medical records, and this fee structure could differ from that at your state. And so ultimately it is which is the least expensive if your state is Least expensive. That's what's going to come in. If HIPAA's least if the HIPAA federal regulations are least expensive, that's what will kick in.

Covered entities are required to post on their website their estimated fee schedules for providing individuals or your patients access to their protected health information and medical records. And you have 15 days now from the request to give them access to their records. Also allows for exception of what's minimally necessary standards for disclosures of phi. It's broad in that description and you need to have heightened security. So in the fall there was a proposed rule about hipaa.

Whether it gets the final rule remains to be seen, but the main part of that proposed HIPAA rule was that like decades update and it was going to be a lot around the security of your electronic systems. So I would really recommend everyone out there start to hone up how secure your systems are.

Informed consent Informed consent is actually something very commonly required at the state level and you have to get this informed consent prior to providing care. The patient must be informed and acknowledge in writing all the potential risks, benefits, alternatives involved in any medical or surgical treatment or course of treatment. And you must obtain again prior to providing care. This is going to greatly vary, as I said in the beginning, state by state. You also may need very specific informed consent to email or text someone, especially because of FCC regulations around telecommunications and for telehealth.

So those are things you need to look at in your state laws where your informed consent responsibilities lie.

You may need separate consent for treatment, email, text, telehealth. Again, state laws are going to kick into play. If you're unsure, consult your legal counsel. People ask me all the time about credit card surcharges. So as credit card processing rates have increased, people want to know can they pass that on to their patient?

So there are state laws that can dictate what you can charge and how it's presented to the purchaser. There's pros and cons for the patient for the credit card purchase, as well as some offer or buyer protections or warranty protections. So sometimes it is actually in the patient's best interest to use a credit card. Your options are to raise your prices by your average or maximum credit card processing fee for everyone. You can go that option.

You can go a cash discount option. Now one thing about a cash discount option, you need to confirm that that doesn't conflict with any language in any managed care agreements you've assigned. You could avoid this by by applying your cash discount to all patient responsibility or that surcharge which can be regulated by the state where you're charging people and an extra fee if they use a credit card that could be state, state regulated. Telehealth is a means of delivery and not a service itself. Coverage is dictated by a health plan and every health plan may not cover telehealth.

Every state. I just did a project where I researched this has now telehealth allowances. Except for the state of Hawaii. There is no language that I would I've been able to locate or that you know Asha and their state by state guide. I always use that as my double check mechanism that they've been able to locate.

For the state of Hawaii. You have to utilize systems that are HIPAA secure. So you. If you're using Zoom, it has to be Zoom for healthcare. If you're using Skype, it needs to be Skype for healthcare.

You can't use FaceTime, you can't use Twitch, you can't, you can't use Google Meets like you have to be able to use a system that is secure. You still can't cross right now state lines for telehealth just because you're in a state that's in the compact and another entities in the state that's in the compact. The compact is not yet functional. On April 9th of 2025 it is not yet functional. So if you want to see a patient in another state, you have to meet the provisions of that state.

Some states do allow allowances for a certain number of days, but that is very, very state dependent. But some states like my state of Illinois, to see someone in the state of Illinois, you have to be licensed in the state of Illinois. And that's not going to change even when the compact functions because we're not a compact state. So it's really, really important when you're seeing people out of state that you are following the rules of the state and where the patient is doesn't matter what they're a citizen of. They're governed when they're there of the laws of that state.

I also want people to Always consider the Q3014 when you're providing telehealth. That is a bit of a means of delivery code. It is a site facility fee. That's to try to encapture the charges of providing telehealth that is not recognized by every health plan. Health plans may even assign it to provider responsibility and not allow you to charge the patient.

So before you start providing telehealth, it's important to know how your health plan A do the health plans cover it? B if they don't cover it, do they allow you to bill the patient? And C do they recognize a code such as Q3014?

Here are the codes that are allowed to be provided for Medicare for telehealth. This has been extended. This telehealth we are not audiology is not a permanent telehealth provider. We are at the

behest of Congress and getting extensions in telehealth coverage. We got an extension to from March 31st.

Now they've taken it to September 30th. So between now and September 30th these are the procedures that you could provide via telehealth and have medic traditional red, white and blue Medicare coverage. That does not mean you would have coverage from a Medicare Advantage plan or a Medicare dual plan. This is traditional Medicare covers these codes guaranteed until September 30th.

So there are some codes around remote monitoring of treatment. 98975 is remote therapeutic monitoring, therapy, adherence therapy, response, initial setup and patient education on the use of equipment and then 98980 remote therapeutic monitoring, treatment management services physician or other qualified healthcare professional time in a calendar month requiring you need at least one interactive communication with that patient within the calendar month to be able to use any of these codes. And the 98980 is the first 20 minutes or actually the first 11 to 20 minutes and then 98981 is each additional 11 to 20 minutes and it's listed separately. So you would never be able to use 98981 without 98980 first. This is for the use of computer software, remote programming software like with a cochlear implant, remote mobile application or manufacturer specific portal that you might want to use to adjust a hearing aid or an implantable device.

It's not covered by Medicare and it may not. It may be covered by a commercial health plan. That's going to very much depend on the health plan. But I wanted you to know these codes were available. It's also important around telehealth that you have place of service codes so that you're not you always have to change from the typical place of service 11 which is office to either O2 which is telehealth provided in other than a patient's home.

Let me give an example of that. The pete you have a remote location with a technician staffing it. They're in another remote clinic setting. That would be 02. Even though that might be an office.

That might be your office. If you are providing the care via telehealth. That's a remote location. O2 if you're providing care when the patient's in their home, that's 10 telehealth provided in the patient's home. You have to change the place of service codes now.

And I apologize in an update. We're kind of jumping around a bit. I want to get some clarity around the use of technicians in an audiology practice. Technicians can be an audiology assistant. They can be in some ways a dispenser if they're practicing things that aren't directly related to a hearing aid.

Medicare is very clear that technicians and audiology assistants can only provide technical services. That's the touching of the buttons that they are performing the procedure but not interpreting it when the procedure has a technical and professional component split. Let's give some examples of codes that have that otoacoustic emissions and the vestibular family of codes. With the exception of VEMPs, those are the only codes that have a TCPC split. That means they're the only codes that could be provided by a technician under the supervision of a physician, which you're going to get to in number three.

Technicians and audiology assistants must be trained and that training needs to be documented. They can only provide covered services under the direct supervision of a physician, not an audiologist. A physician. This is clearly documented in the Medicare Policy manual. It has to be a physician and an ENT in medical setting.

The technical component must be performed again by the technician, but it must be interpreted and reported by the physician, not an audiologist. So it can only be procedures, otoacoustic emissions, vestibular family of codes. With the exception of VEMPs. They have to be formally trained. They have to be supervised, directly supervised.

That means they are in the office suite and readily available for care by a physician. And the physician needs to interpret and report the test results, not an audiologist. An audiologist really isn't involved in this in any way, shape or form. 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 service. Every state does not have a provision for an audiology assistant or a technician.

The lack of mention in licensure does not mean it's allowed. Instead, you could be supporting the unlicensed practice of audiology or medicine, especially if something went wrong. It's important to get clarification from your state or from a healthcare attorney about your ability to utilize audiology assistance and technicians when it's not specifically mentioned in your state licensure. It's also important to know that when you bill services of an audiology assistant to an insurer under the MPI of an audiologist and it's not explicitly allowed, you will be following filing a false claim. You could be supporting the unlawful practice of audiology and hearing aid dispensing without a license and that could be problematic again in audit.

Easy to get caught because the patient would all the patient has to say is somebody's on their claim and they never saw that person. So it's really important that you know what the rules are of using these support staff which are incredibly valuable to our practice. You just have to do it legally. And please consult all payers again before utilizing an audiology assistant for services that you're billing to a health plan. There's been a lot of question last year about binocular microscopy.

Binocular microscopy is code 92504 and it requires a binocular microscope binocular both eyes to visualize the ear canal and tympanic membrane. You can see I've given a link of a binocular microscope in the photo binocular microscopy. If we're following the guidance of the American Medical association who owns the code set and Medicare binocular microscopy may be medically necessary.

When you have a binocular microscope, not an otoscope or a video otoscope, it has to be binocular. That's in the description of the code.

You are unable to visualize significant portions of the ear canal or tympanic membrane with a traditional otoscope and your documentation supports medical necessity of the procedure for this specific patient. Use of this code implies binaural. As a result, the 50 modifier would be inappropriate. You don't need 50 modifier bilateral procedure. You don't need to add a 50 modifier because it implies binaural and if only one ear is viewed, you're going to add your 52 reduced services modifier.

52 modifiers always use when you're billing a procedure 92557 audiogram for example. But you're only testing one ear. So anytime you're only testing one ear in the audiologic procedure, with the exception of cerumen removal or the cochlear implant codes, you're going to need a 52 modifier. Here is from CPT Assistant. So the American Medical association owns the code set.

They get to determine from CPT Assistant and another publication when new codes come out called CPT changes how codes are used. And this is a monthly publication and this is from 2011. Please give an example of when it's appropriate to provide binocular microscopy, and it would be when the patient presents with ill fullness and decreased hearing. Routine otoscopy suggests an abnormality of the tic membrane. To further evaluate this finding, you needed binocular microscopy.

You needed, again, better magnification. But I want to stress you have to have a binocular microscope to use this code.

There's a lot of confusion about removal billing of removal of impacted cerumen. So impacted is the operative word here. Impacted means that you cannot see clinically significant portions of the ear canal. It's not the little ball that you can see around it is impacted. And it requires some semblance of instrumentation to remove.

Now, always around removal of impacted cerumen, your scope of practice matters. Every audiologist in every state does not have it in their scope of practice to remove cerumen. This is from a coding standpoint, a surgical procedure. It's invasive. So again, please make sure that removal of impacted cerumen is in your scope of practice before performing the procedure.

Now, Medicare made and Medicaid made what is called a coding edit. A coding edit is when they believe one procedure is inclusive to the other procedure and that they are, that one overlaps. And that means you can't bill for both and you can't get money for the patient from both because they believe one includes the other. So Medicare and Medicaid have a coding edit that says removal of impacted cerumen is inclusive to audiometric testing. 92552 through 92557 there are coding edits for Medicare and Medicaid.

So if you remove impacted cerumen on the same date of service as an audiogram, the patient cannot pay privately for the removal of the impacted cerumen. It's inclusive. If you were to bill it, which you are a mandatory biller for Medicare then, and they're going to have a coding edit that says you can't bill the patient. There's no waiver that will override this. There is no modifier that will override this.

You cannot bill and receive payment for removal of impacted cerumen whether the patient pays you privately or not. For a Medicare or Medicaid patient on the same date as audiometric testing, the only way that you could do get this payment is that it's removed on a different date of service. You just can't get reimbursed for both and the patient cannot be financially responsible privately for Medicare and Medicaid. Medicare never covers room and removal. There I Some of these things that I talk about I pick up from social media.

I'm Medicare is paying me for serum removal. They don't cover serum removal provided by an audiologist. If you are getting paid, you are getting paid in error and you should be returning that

money. Medicare never covers cerumen removal provided by an audiologist. Commercial insurers may cover cerumen removal provided by an audiologist, but Medicare does not.

I also want to clarify the billing of electronic hearing protection or hearing aid. In general, health plans don't cover services or items for recreational, occupational or educational reasons. They don't cover an FM health insurance that someone may need in school or at work and they don't cover hearing protection for recreational purposes. They cover items and services that are medically reasonable and necessary to manage or treat an illness, disorder or condition. These considerations are super important when we're talking about electronic hearing protection.

They in general, health plans do not cover hearing aids in the absence of documented peripheral hearing loss. So you have to have a hearing loss to use a hearing aid benefit. Health plans generally do not cover hearing aids for hearing protection or the treatment of tinnitus, balance, or auditory processing in the absence of at least a documented mild hearing loss. I want to add this is oftentimes outlined in their medical policies which are readily available on their websites if they exist. If they have a medical policy on this, it will be on their website.

Some health plans, including United Healthcare, Tricare, Aetna, and many Blue Cross Blue Shield association plans, have medical policies that dictate what is the minimum hearing loss, medical necessity, recommendations and clearance, and importantly, documentation that's required to access a hearing aid benefit. I also want to add here you don't use hearing aid codes for bone anchor devices or auditory osseointegrated devices, whether they're implanted or not implanted. They're not hearing aids, they're prosthetic devices. You don't use a hearing aid benefit or hearing aid codes for that either. You need to review the medical policies.

So billing the device. The hearing aid must if they are hard of hearing, they have to meet the requirements of what constitutes a covered hearing loss. I recommend the use of v.529A as two

separate line items. These are hearing aids not otherwise classified or and I'm sorry, this is this or V5130, which is binaural in the ear. That's hearing aids without technology.

Some of these devices do not meet the threshold of being a digital hearing aid. So you wouldn't use V5257 or V5160. You're going to need to use either the unlisted V5298 two separate line items with a right left modifier or V5130 which is binaural in the earth without technology. If they are normal hearing or the hearing loss does not meet the tech the medical policy requirements. You really need to consider this.

A PSAP or V5274 assistive listening device is not otherwise classified. This is a really important slide. You have to meet the requirements of the code health plans. This is one of the reasons why health plans are instituting prior authorization requirements so that they can see that the patient actually has a hearing loss for a hearing aid benefit.

Now I want to talk about specific considerations around specific insurance cards. Let's start here with traditional Medicare. This is a traditional Medicare card. If someone gives you a card that has their social on it, that card's not valid. You may see cards that just say part A that will typically tell you that person is still working.

So their actual part B or medical daily medical coverage is still through another insurer really kind of avoid the coverage starts. That doesn't mean that that card is typically is currently valid. That number that date really means very very little. You just want to make sure the name is correct, that their social isn't on it and do they have part A and part B. So we as audiologists cannot opt out of traditional Medicare.

We can't enter into private contracts with Medicare beneficiaries. We do not have an opt out provision. We also are a mandatory claim submitter. This is all outlined in chapter 15. Section 8 really starts in

section 40.

But sections 40 through like 80.6 of the Medicare Benefit Policy Manual. Do not assume that an item or service is non covered. Just because the treatment plan includes a hearing aid. If the patient meets that the hearing test is medically necessary, that they've noticed a change in history or condition, they've had medications, they have a comorbidity. Just because that outcome is a hearing aid doesn't mean that hearing test is not covered.

That means that are you meeting the criteria that you can use the ab modifier that one non acute visit non vestibular related in 12 months or you might need a physician order. But you can't charge a Medicare beneficiary for a service, whether it's Medicare or Medicare Advantage, for a service that Medicare would have covered privately. Now, with Advantage, if you're not in network with, if you're non participating with Medicare, you can charge the limiting charge. If you're not participating with the Advantage plan, you can charge the limiting charge, but you can't charge people your usual and customary rate for a service that Medicare would have covered. Traditional Medicare has a deductible.

It's $257. So Medicare is not going to pay anything until that patient has met their $257 deductible. And most patients are responsible for that deductible. There's, there's a Plan F supplement that people would be in their 90s to have. If they have Plan F, that Plan F supplement will pay their deductible, but no other.

I think we're now to Plan K. None of the supplements now cover the deductible. It's a responsibility of the member.

Now, traditional Medicare, some things to consider. If they only give you that card, that's the only card they give you. You want to know do they have a Medicare supplement or a Medigap plan? Do they also have commercial insurance, especially if it only says A on the card or do they have Medicaid? Because

if it only says A on the card, you want to know do you have commercial insurance or Medicaid?

And if the patient also gives you the Medicare Advantage card. In their defense, they were they can flip in and out of those two programs every year and they were told to keep their old Medicare card. Even if they go to Advantage, they're told to keep their own Medicare card because they might go back to it. So if they give you both cards, check the eligibility of the Advantage plan via the payer portal. Audiology services for Medicare are completely outlined here at this link and then give you hyperlinks to even more information.

So if you have traditional Medicare, you're going to oftentimes have a Medicare supplement. These are the most common Medicare supplements. The one on the left, the ARP is the most common supplement in the United States. It will say Plan F. That's the.

If it says Plan F, that's the one where they pay for deductible. The the whole role of these plans is to cover the Medicare coinsurance. Traditional Medicare covers 80% of the allowable rate. The Medicare supplement covers the 20% coinsurance. Now if they have associated hearing aid benefits, they are typically unfunded discount benefits through a hearing benefit or third party network.

They are not directly through that health plan or through United Healthcare. So if they have the ARP supplement that would their hearing benefit would be a discount plan through UnitedHealthcare Hearing. If you call to verify benefits, you might trigger the plan contacting the member. You can typically see what they have available through a payer portal or through some Google research of that insurance or supplemental plan. So a good thing to tell you here, Medicare supplements, Medicare Advantage plans, all the information has to be publicly available so you don't have to call.

You should be able to google some of that information. Now we've got to Medicare Advantage. Medicare Advantage replaces traditional Medicare. You can't have both at the same time. You either

have traditional Medicare or you have Advantage.

Some of the cards will say Advantage on them. Some cards don't say Advantage, but you'll see the Medicare Rx on the card or it might say the word Medicare on them. Other cards may again not say Advantage. You'll see Medicare here or the Medicare Rx. The Medicare Rx should always kind of tell you that that's an Advantage plan.

Now at the outset of every year it's all of their Medicare enrollment changes on January 1st, but during that from like November 1st to December 1st or mid December. You are able to find the information by following this link and putting in the zip codes near you of the Advantage plans in your area. And you can literally pull up what the hearing benefit is if you learned nothing useful today. This is life changing for people. So Advantage plans are typically tied to county in your state.

So some smaller states you may only have like six or seven options. Some states like Florida, you may have 300 options in a county. But you can look up all the options that are available at your zip code at this link here. It's available right now. You would never have to call an Advantage plan again ever to find out about a hearing aid benefit.

They're all at this link again tied to your state and your county. So if you have someone come from out of state with something, you're going to need to look up the county they came from, where did they live or where do they live that it's tied to. So you're in Florida, that patient has one from Illinois. You'll look up their Illinois county zip code to find their hearing aid benefit. You can typically start this Google process in November.

They'll be available then for 2026. But you don't have to call to check these benefits. Here's an example of what you might see populate this is a United Healthcare example, you're going to see the hearing aids. This is literally a screenshot. The exam to diagnose and treat hearing or balance issues.

If they're in network, they don't pay any copays or if they're seeing somebody in their advantage network, no copay. If it's out of network, they're going to pay $65 copay on the data service routine. This asterisk here on routine means that that routine hearing exam is only going to be available through a UnitedHealthcare hearing provider. So if you're not in UnitedHealthcare hearing in this example and a member comes to you and says I get a routine hearing test, the free one is only available through United Healthcare Hearing. If they wanted to get it from you, who doesn't participate in that plan, it's going to be $65.

Again it's going to show you here the co pays are going to range from and that's going to show and that asterisk again is going to defer you back to United Health Care hearing.

So most advantage plans have hearing aid discount plans through a hearing benefit plan or third party. Some exceptions to that might be if it's a unionized or employer based advantage plan, then that might be of more of a funded benefit. If out of network you can only collect either that coinsurance or so it said for the hearing test, for example, you're out of network, you collect $65. Make sure your hearing test is more than that or you can only collect what you bill or and you could collect the Medicare limiting charge for any other procedures you provided. If you provided timinometry or acoustic conditions or whatever, you could collect your Medicare limiting charge for those procedures.

If you're out of network. Some part C plans have deductibles and co pays and some don't. As we saw in that example, a $65 copay may exist exists for out of networks for a hearing test. This is all available in this portal because advantage information has to be readily available to consumers. Most HMOs if they have an HMO plan, don't have any out of network benefits.

Some HMOs may require prior authorization from the primary care and that will be indicated when you look at that plan document. When you're looking, you're looking for a plan document or a summary of

benefits. Some may have specialist CO payments, especially in the HMO space, but they don't require a physician order. Except some HMOs that require that referral.

If you're in network with an advantage plan. Don't collect anything on the data service except for unmet deductibles, applicable coinsurance, copayments and the usual and customary cost of prior notified non covered services. You're going to complete an organizational predetermination or a notice of non coverage for any service that is unlisted that you're using a 92700 or a V5299 or an L9900 codon and then you'll submit the claim. If you're out of network you'll have them complete a notice of non coverage prior to the provision of care. You're going to collect your unmet deductibles, applicable coinsurance, applicable co payments and the Medicare limiting charge for any Medicare covered service and then the usual customary cost again of any prior notified non covered services.

You're going to submit the claim. You're not going to accept assignment on the claim because you're out of network and you reimburse the patient in accordance with remittance. When you are out of network do not accept assignment on the claim unless you want to collect the allowable rate which you might not know as payment in full.

Many part C plans cover routine. It's not typically for individuals with documented hearing loss otologic condition. There's no code specific to routine testing. It may only be available through that third party network participating provider and it might mean a screening a 92551 or V5008 it might mean pure tone air only because it's routine it's not diagnostic or it could mean that audiometry for the hearing evalu hearing aid evaluation. So 6 9A it doesn't include that routine hearing as benefit does not include any other procedure but audiometrics.

So no to manometry, no signations, nothing else. It only that routine benefit only includes audiometrics.

Now we're going to talk about commercial insurance. I you're going to notice that I skipped over Medicaid. Medicaid is very very state specific. In some states we have a lot of Californians very county specific. If we're talking about California we could have a four hour course in medi cal.

I always strongly encourage people when it comes to Medicaid consult your state guidance. That is where you're going to get the most information because even the Medicare Medicaid managed care organizations or MCOs they ultimately have to at a minimum provide and follow the state rules. So be very clear on what those state rules are. Now we're going to talk about commercial insurance. These are examples of commercial insurance cards.

You notice you don't see Medicare anywhere on them or a Medicare rx. They're typically going to oftentimes have your employer on them. Let's talk first about Anthem. Anthem is really no more. Anthem is transitioning.

They're in their transition period to something called Elevance Health. And it is in these states listed above that they are in that transition period. Facility. If you are an audiology provider in any of these states listed above, you are probably out of network for hearing AIDS. For codes V5008 through V5299, you are probably an out of network provider.

There can be some exceptions in facilities, healthcare facilities or ENT because they've negotiated that back in. If you are in private practice, you are most likely out of network for V5008 through V5299. What I want to stress about this, you are still in network for the 92 codes, including 92590 through 92595. You are just out of network for V5008 through V5299. So your patients need to understand that you may show up on a network list under audiology, but if they look under hearing aid, that network list will be blank because the only network providers are true is through TRU Hearing.

So you are still in network for everything but V5008 through V5299. The beauty of this in some ways are you they essentially carved out hearing aids for you and some of these patients will have out of network benefits. So it's really, really going to be important that you verify the benefits and determine what their out of network benefits are. I've given you a lot of information for you to consider here, but the important things to know are look yourself up. Are you in network for audiology and are you in network for hearing aids in the provider directory just to prove to yourself?

2. When you're verifying benefits, you need to now verify out of network hearing aid benefits. And for some it's exactly the same. Exactly the same benefit. They should pay you in full on the data service.

You're out of network now, so people should pay you in full on the date of service. You submit the claim the patient get. You don't accept assignment and the patient gets reimbursed. If you start accepting assignment, you are not going to get your usual and customary rate. Do not accept assignment.

On these claims, you don't accept assignment. And then typically in that case the patient will get reimbursed or out of network benefit.

Since we last met, FEP has finalized their hearing aid policy. FEP is the federal employee plan. At this link that I'm showing you here, this is the Office of Personnel Management. If you click on here you're going to see a map of the United States and you're going to see all the states listed. If you click on your state you will see all of the coverage policies for your state.

For federal employees, you don't have to call about these. All these policies are readily available at this link. Hearing aid benefits are not one size fits all. It really depends on the federal health plan they have. And allowable rates are very health plan dependent.

Here are the links to the FEP policies around hearing aids. They changed on April 1st of 2024 and they are quarterly evaluated although they have not made any changes since this April date. So for FEP you must have Blue Cross Blue Shield fep. I should clarify, you must have a hearing loss of greater than 26 decibels or appeal the coverage limitation. This is where more information like inventories and speech noise and unaided relayer can be invaluable.

It requires a prescription. This is a good time to tell you that many of you have yet to add prescriptive rights to your audiology or state hearing aid dispensing laws. Right now people are letting that slide. But when a health plan gets an opportunity to not cover something because you cannot legally prescribe, they may take that opportunity because the FDA says that you have to be able to prescribe. And so to the defense of the health plan, they need it by prescription because that's what the FDA requires.

And all of you need to join your state association so that you can work towards making these change. FEP is an allowance benefit. It's dollars towards it's not intended to cover everything anymore. It's dollars towards it is 2500 per calendar year for people birth to age 22, 22 and older. So it's really birth to age 21 because 22 and older is 2500 every five calendar years.

And that $2500 allowance includes dispensing fees, fittings, batteries and repair. It doesn't say service repair services included in the benefit limits described above and the patients responsible for everything in excess of the 2,500 you must be medically necessary. It must be an approved hearing aid that's registered with the fda. It must be dispensed by prescription or signed written order from a licensed healthcare Provider who's practicing within the scope of their license and the hearing aid must be purchased within six months of the date of the prescription. You must have audiometric testing and a minimum of air, bone, SRT and speech recognition.

The degree of hearing loss is confirmed by audiometry or other age appropriate testing to be greater than 26dB for conductive hearing losses, responsive, unresponsive to medical or surgical interventions,

sensorineural hearing loss or mixed hearing losses. This is what FEP does not cover and this is in quotes because this is directly from their policy. They don't cover accessories which are for convenience and not medically necessary. They don't cover streamers or remote TV adapters, they don't cover phone clips, they don't cover remote controls, they don't cover remote microphones and they don't cover apps. They do not cover apps hearing aids that have been returned for refund during the trial or adjustment period.

They don't cover repair of a hearing aid. We're talking about repairs under under warranty, repair or replacement of hearing aids due to loss, misuse or abuse. I want to stress that one they don't cover replacement hearing aids due to loss, misuse or bruise and they do not cover over the counter devices or PSAPs.

There are pros and cons being in network, I see them more and more every day. Health plans are on your end, making it more and more difficult to navigate their systems. I totally get that. And participation. Non participation is the only way to retain private pay, usual and customary rates.

But non participation does come with a little bit of caveats. And I want to talk about the differences between in and out of network. When you're thinking about not participating, you need to think about your when you're looking at the monetary differences, you also need to include the cost of acquisition of a new patient because that is what a health plan does give you. They give you new patients with no marketing dollars on your end. So what is that cost of acquisition for you?

Are you able to provide your standard of care at the agreed upon rates required by the plan? What is the availability of out of network benefits for this plan? What are your potential loss revenues if you don't participate? So when I work with clients, I have them run. If we can run a year, that's great.

You want to terminate X insurance? Let's run X insurance. How many patients came to you with X insurance? How many patients did that represent? How many referral sources did that represent?

How many dollars did that represent? Because that's your worst case scenario, that is if you went out of network. This is the worst dollars because some people will stay with you, but what if they old and that is your worst case scenario and you need to know can your practice survive losing that as your worst case scenario? And are you in an itemized or unbundled space that you could create a competitive offering? Especially when we're talking about third party networks.

Some differences between in and out of network in network is a lower cost of patient acquisition. You'll get referrals from other in network providers. You'll get listed in the provider directory. You have to submit claims. They will reduce oftentimes bill charges to allowable rates.

If you bill things and they're still not covered, you must accept the allowable rate as payment in full and you have to have the patient sign notice of non coverage prior to provision of care of non covered services. Now if you're out of network, you may not get physician referrals from in network providers. You may lose a competitive advantage to big box OTC and DTC who would all. Maybe Costco doesn't want to be in network, but a lot of these other entities would love to be in network. This is a competitive advantage you have over them.

They may have no benefits or reduced benefits. They may not be able you won't get payer portal access. You might not be able to get back in network if you terminate. Especially in states like Florida and Arizona, you may be required by state law to still submit claims. If not submitting claims, you're still subject to the good faith estimate and possibly a notice of non coverage.

But you do get to collect your usual and customary rates.

Please analyze your situation before you terminate. What are the socioeconomics? What does this represent to your practice? Just analyze your situation completely. You should always when you're out of network, except for Medicare, dual collect your payment in full on on the date of service.

Remember, dual eligible you can't collect anything from a patient if someone has Medicare and Medicaid. You just have to submit and collect payment as payment in full. If your Medicare if you're out of network to Medicare Advantage, you can only collect the Medicare limiting charge for Medicare covered services. You don't accept the assignment on the claim and you decide Medicare and Medicaid. You have to submit if you're out of network for their MCO plans.

But if it is commercial insurance, it's up to you whether you submit a claim on the patient's behalf or not. If you opt to participate, you have to have a strong working knowledge of the payer guidance and medical policies and allowable rate schedules. You have to learn what you signed up for. You have to maximize capacities of your internal office management systems and payer portals. You have to have strong documentation of medical necessity and has to be done in a timely manner.

You have to have no exceptions. Establish revenue cycle processes. You must effectively verify benefits for items and services over a specific cost threshold. You must appeal with documentation when appropriately denied. Sometimes you need to utilize legal counsel and your staff all needs to be trained.

Everybody from your providers to owners to managers, all your staff People need to be trained on their role in the process. I also want to close out with just some information on the different types of hearing aid benefits. Unfunded benefits are where the health plan negotiated discounts on hearing aid and related items and services. The patient's really paying in full for the cost of the items or services at this discounted or copay rate and it's administered through a hearing benefit plan or third party network. Funded is when the health plan is paying in whole or in part towards the cost of the items or services.

It can be administered directly by the health plan or a hearing benefit plan or third party network. Inclusive benefit. What items and services are included in the third party benefit? It's also deemed often defined by medical policy or the allowable rate schedule. An allowance benefit is dollars towards.

It's not intended to cover the entire cost of the hearing aids and related services. They can pay the difference in an allowance benefit between the allowance and the usual and customary rate, but the allowance is in the benefit when it's verified. Some examples are the Federal Employee Health Plan Through Blue Cross Blue Shield you can have a fixed negotiated rate based upon your practices allowable rate schedule 100% allowable for itemization of your hearing aid claims or all your claims is vital here and this is common with some Blue Cross Blue Shield association commercial plans. A fixed dollar amount. The benefit is a fixed number and not based upon your allowable rate schedule.

Itemization may push things to patron responsibility. This is a common UnitedHealthcare commercial and is $2,500 per year benefit. You can have an invoice plus this is where you must submit an invoice for coverage. The health plan pays the hearing aid invoice plus a percentage. Upgrades here are not possible for hearing aids.

Itemization is vital here and that can be Blue Cross Blue Shield of Georgia is an example of that. A max benefit is the same as kind of an up to benefit that to cover a max or ceiling of a fixed dollar amount for the hearing aid and related items and services. They do not cover the X for the hearing aid. They cover a maximum of X for the hearing aid and all related services. And everything is paid an allowable rate up to this ceiling.

Itemization is vital here. If not, you're leaving money on the table because itemization is the only way to truly maximize the benefit. You also have the percentage of the allowable rate they pay a percentage of the of. Of what? Like 80% with a 20% coinsurance.

So the remaining is going to be paid by the patient and should be paid at the time of visit. Again, itemization is important here. And that's some Blue Cross Blue Shield association plans. Percentage of dollars billed is whatever you bill. They're going to pay you a percentage of that.

Often as low as 50 to 70%. Upgrades again are not possible here because they're just paying a percentage of whatever you bill. It's very hard to operationalize and meet contractual requirements of standard pricing. You may need documentation writing from the health plan to be able to give a cash discount to everyone else. Unbundled delivery is really difficult in this type of benefit.

Luckily it's a very rare benefit type but it's one I would always recommend people renegotiate and then your up to benefit. The health plan covers up to same as that max of that ceiling. So it's. It's exactly the same as a max benefit would be.

Thank you all for attending again. Don't forget to complete your exam. I'm going to get into the questions. I nailed it at time. Let me find Q.

Gotta find the questions here. There we I see them. Okay. Any advice for on billing for care coordination for a nurse navigator. This would help triage and coordinate follow up of newborn hearing screenings, diagnostic tests in a high volume audio audiology clinic.

No, I actually I would need to know more about the services that this person is rendering to know are they rendering services that have a code. So no. And I will tell you that in my old life when we did things like this this was not done by a nurse. What CPT code can an non audiologist drop for an aabr? ABR codes do not have a TCPC split to them so I can offer you no advice.

Now I have to throw out a little bit of a caveat. If you're in California I would have you to look at your CCS or your medi cal because they may have created a code for that purpose. Can you expand on using technicians for codes that are not billed to insurance. What I would say there is, then you're going to lean into Is a technician allowed in your state and what is the scope of practice of that technician in that state? Is there one?

If there isn't one, they can do whatever you allow them to do under your comfortably allow them to do under your supervision if it's allowed. But there are a structure. Then you can only do what is allowed in their scope of practice. If it's not allowed, I would suggest that you consult legal counsel as to what a technician can do in your office. When routine does not include a procedure a provider deems medically necessary, how would we bill?

Well, it depends on who you're billing because if it's not medically necessary and you are billing Medicare, you would bill with a GY modifier item or service not medically necessary. It does not meet the definition of a Medicare benefit. In other situations it's going to be very situational. It's hard for me to answer without more information.

Can I look at question five on the exam? I'm so sorry, I can't look at 5 on the exam right now because I can't see it. Can I explain how to decline assignment? It's on it. It's a box that you check on a claim.

So there is literally a box on a claim that says are you accepting assignment or not? And I forget the number on. I think it might be box 27 on a CMS 1500 form. I might be guessing. I think I might be 27.

But you want to. That's where you're not accepting assignment. It's literally a box on a claim. So it is true that you never charge a patient a Medicare out of pocket for removal if they're not having hearing tests that day? Yes.

No. You can. You can charge a patient privately for cerume removal if they're not having a hearing test that day. As long as you are allowed by state licensure to remove cerumen. And it would be true whether you're in or out of network.

You can charge a Medicare beneficiary as long as they're not having a hearing test that day privately for serum removal, as long at your usual and customary rate as long as it is allowed within your state scope of practice. Is a $2,500 benefit per calendar year for patients birth of 22 available from Blue Cross Blue Shield for Feb. Yes. Yes, that is correct. I want to thank everyone for coming and for all of your questions.

I'm going to end on if you have additional questions, I recommend that you reach out to the state or national association that you are a member of. This should be a member benefit of those associations. So please don't hesitate if you are a member of a state or national association. Reach out to those associations. If you need further guidance or clarification.

I want to thank Audiology Online again for having me, and I hope you all have a wonderful day. Thank you so much, Dr. Cavitt. And that wraps today's webinar. Great to see everybody.

Hope to see an upcoming course. Have a great day everyone.