Decoding the New Hearing Device Services: Real-World Applications, in partnership with the American Academy of Audiology

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At this time, it's my pleasure to introduce our webinar and kick it off today. The title is Decoding the New Hearing Device Services, Real World Applications. Today's course is in partnership with the American Academy of Audiology. We do one to two courses a month with the Academy. They really bring in our top tier experts in audiology and we are so pleased to have Dr. Burton and Dr. Miller with us today.

Dr. Burton is the Director of Easterseal center for better hearing, CT. Dr. Miller is a professor of instruction and the Audiology Graduate Coordinator at the University of Akron. She also serves on the Clinical Education Coordinator for the Northeast Ohio AUD Consortium. And as I mentioned earlier, please read more about our presenters in your handout today. At this time, I'll turn the floor over to Dr. Miller. Thank you for the introduction, Carolyn.

So before we begin, I have a few words from Tish Gaffney, the past president of the American Academy of Audiology. Welcome. I'm Tish Gaffney, the president of the American Academy of Audiology and I'm here to share important information about the organization. The Academy is dedicated to achieving recognition of audiologists as the experts in hearing and balance care and the field of audiology as an independent clinical specialty that is integral to the healthcare team. Through our partnership with Audiology Online, we're excited to offer courses like this one to help you broaden your knowledge and skills.

We also offer the latest resources in practice management and evidence based clinical practice so you can grow professionally and improve patient care. We advocate for our members in Washington and across the country to ensure that the voices of audiologists are heard and we help connect audiologists to one another through our valuable networking opportunities like our annual convention. To learn more about the Academy, make sure to visit audiology.org thank you.

Here are our disclosures and some additional course information. And then finally, here are the learning outcomes for our course. Today I'm going to get us started. My name is Erin Miller and I'm going to set

the stage for our presentation today. We wanted to at least talk a bit about the rationale for the development of this new code set, to talk a little bit about what the problems were relative to the legacy codes.

Again, remembering that this code set became available on January 1st of this year and then to talk about the development process and then we will get into the actual codes themselves and of course we'll develop and discuss some of the clinical scenarios that we are hopeful will help you understand how to use the code set. So jumping into that, I think the primary Issue that we had with the legacy hearing aid codes was that there was no vignette or description of service. Now to help you understand the vignette that really just describes the typical patient that would receive the services, whether in this case that be the hearing aid services that we provide. The description of service, however, is quite important because it describes, describes the work that you as the audiologist would be performing with that particular patient. And that lays the groundwork for an understanding of what we do from both payers as well as other professionals.

So without having that description of service with the legacy codes, it really resulted in us having some fairly significant problems trying to advocate for reimbursement of those services and also for us to help those other professionals appreciate the work that's involved when we are actually fitting determining the need for amplification or for any of the follow up services. If we consider those legacy codes. And there were six codes, but I would actually put these into three buckets. There was a hearing aid examination and selection code. One was for monaural and one was for binaural.

And then we had hearing aid check codes, one for monaural and one for binaural. And then we had electroacoustic analysis for hearing aid, monaural and binaural. So really three sets of codes. When we talked to colleagues as we were considering the development of new hearing aid services device codes, we had a lot of different facility experiences regarding how they would define a hearing aid

examination and selection in their particular facility, as well as how some individuals were using the hearing aid check code. Most of us would define the electroacoustic analysis similarly.

You know, there is a process if you're going to complete ANSI testing or if you're going to evaluate perhaps one of the features, but the other codes, there was a lot of differences and how we would define that, and that's problematic when you're trying to work with payers to help them understand what it is that we're doing rather than just passing a hearing aid to a patient. So, you know, when we talked to colleagues, members in our organization, but across, you know, different memberships, we learned that there was some concern certainly relative to the increase in the number of Medicare Part C plans that were offering supplemental hearing aid coverage. So that was creating some issues with recognition of the services. There were also some pretty significant and growing concerns across the audiology community itself regarding the recognition of the hearing aid services separate from the devices when dealing with third party administrators who were managing coverage for both device and services. And then I think probably what tipped us over the line to say we really needed to, to take a hard look and consider a change in the hearing aid codes that were available was the build back better legislation that came out in late 2021.

Now I've been practicing for a number of years and almost every legislative session there is legislation that is introduced that has language for the coverage of hearing aids from Medicare beneficiaries. But this build back better legislation got us to a different point than we had ever been in the past. It did pass through the House of Representatives, so through one of the chambers of Congress, and it included federal funding in the neighborhood of $35 billion. It's the first time federal funding had been aligned with the legislation. So that got us thinking maybe we really needed to take a look at this.

When we looked at that legislation, it really did not do the service that we provide for our patients justice in that legislation. So we really needed to take a hard look at these codes. So the process of developing

the codes really came from a number of different entities. We have consultants who are coding experts. You know, we bring to the table our knowledge about what it is that we do as professionals.

But we do need people who understand this process through both CPT and then in some cases with co development through evaluation process. We certainly looked for input from audiology societies that represented different segments of the profession. So we wanted to ensure that we had individuals really across the lifespan as well as from different facilities, because we know the codes may be used different, differently in different facilities. So we wanted to have that clinical expertise and we're able to have those professionals interact during this process of development. We then need to look at our practice standards and guidelines because that helped us create the structure for the code set.

And I think as you see that structure, you'll appreciate that much of that came from our current practice standards and guideline documents. And then we needed to look at practice analyses. And the practice analyses really helped us establish where you as professionals see the current practice. And we had a couple of different practice analyses, both through the American Academy of Audiology and the American Speech Language Hearing association to depend on, because those had been done recently. So that really sets the stage.

I think then where we need to have a little bit more of an in depth conversation today is really the difference between our diagnostic code set and the evaluative and therapeutic services, which is where this new code set for the hearing device services exists. So I know that we're all very familiar with the diagnostic CPT codes. They reside in the audiologic function Test subtests of the CPT manual. And with the diagnostic test, they're very precise in what needs to be included when you're performing those services. Unlike this new hearing aid services codes that reside in the evaluative and therapeutic services subsection, which absolutely give the clinician much greater flexibility based on the individual needs of the patient that you are seeing.

And so I know there has been questions and we've addressed some of these and we'll talk about resources later in the presentation, but we've addressed some of those questions relative to must you perform everything that exists in the current code descriptor and in this particular set of codes? That's not necessary. And I'm going to provide an example here next that I hope will illustrate that a little bit further. So if we look at one of our core codes for audiologic evaluation, 92557, there is time for us to review medical information that might have come from either a referral or an order or the patient's chart. And we set up for the testing.

And then integral to this particular diagnostic code is that we must complete pure tone, airbone, SRT and word rec. And we have a certain period of time that typically occurred when this code was surveyed years ago. Then there's a post service time where we briefly review those results with the patient, we complete whatever medical report is necessary and then send that off if there was a referring physician. So this is very precise. We must complete all of these components of this code to actually report the code.

Should we not perform some of those services, we would need to choose a different code. And there are other codes that represent parts of 92557. When we're looking at, for example, the candidacy code or 92628, there is time, of course, for us to look at the test results, because in this case those diagnostic tests would already have been performed. And then we have an opportunity to complete a number of different tests, whatever would be relevant to that patient. Now, in the long descriptor of the code, it does mention different tests as examples, but they do not exclude other tests that may be performed.

In the descriptor, it says you could perform LDLs. Maybe that's not appropriate for your pediatric patient, so you're not going to perform that particular test, but another patient that may be very appropriate for them, or speech and noise testing. Maybe you're going to perform that on some patients

and not others if they have very poor word recognition ability and quiet. So you are choosing as the clinician making a clinical decision on what is necessary to help you then determine whether or not the patient is a candidate for amplification, in this case with the candidacy code. And then certainly at the end you have time to prepare a report of the outcomes and document that encounter in the patient's record.

So when we look at all of these new CPT codes, you know, the CPT codes themselves really are the codes that report any kind of a medical or surgical or diagnostic procedure or service. And they are understood by payers and others who utilize the code set. This code set is owned and developed by the American Medical association. And there's a process we go through with a committee to present potentially new codes or we may be asked to revise current codes. There is another set of codes that we're very familiar with in audiology or the hiccups picks level 2 codes, the V codes.

And these are the codes that identify products or supplies and other services that aren't included in CPT. HCPCs codes are owned in the public domain. They are created by the Centers for Medicare and Medicaid Services. And I know there's been some question why did we not develop more or additional V codes rather than the CPT codes? But we have been instructed and we did consult and have been told that all future service codes, professional service codes must be developed through the CPT editorial process.

There are, we recognize, a few V codes that have some hearing aid related services that currently exist. There is no intention to change any of those codes. Current V codes. We'll talk about this again because I think this is really an important point to take home that none of those V codes have changed and there likely will be payers that will continue to use the V codes and will not be using the new CPT codes. So, you know, that's important, an important key takeaway that we'll talk about later as well as far as code valuation, the legacy codes that existed, the six code codes we I described earlier, were not

valued through the AMA RUC process.

And that's the process where codes are actually valued. These new codes were also not valued. We requested carrier pricing on it and the RUC committee accepted that codes that are not covered by CMS are not required to go through the process. If they were required covered by cms, then you do need to go through the RUC process. But these are statutorily excluded by Medicare hearing aid services.

And that's why we did not pursue RUC evaluation. So we as professionals will need to continue to advocate with payers regarding pricing for these services. But now we have descriptions of the services that we are providing which will make that process easier.

Then finally, I think as we wrap up this foundational piece of the presentation, payer adoption is going to take time. When we look at previous codes that were created, it took sometimes months and sometimes years for those codes to be accepted by payers. And it did take some advocacy on the part of individual providers, and sometimes our organizations as well, for them to adopt those new CPT codes. Just because they become available on January 1st does not necessarily mean that all payers are ready for those new codes. There may be some payers who just choose not to utilize the CPT codes.

We did talk with some third party administrators and tried to get a sense of, you know, where they stand with this. I'm not saying they will change or not change at this point, but you know, we certainly knew that in January they had no intention of moving forward with using the CPT codes. So we'll talk a little bit more about payer advocacy later in the presentation.

So to lay the groundwork for what Dr. Burton is going to talk about, you know, I think we need to at least begin with how do we come up with the different buckets of codes that currently exist. So we reflected

on what happens as a patient seeks our care for any kind of treatment for their hearing loss. So we really looked at the patient journey for relative to air conduction hearing aids and that resulted in us developing these phases of care. So we wanted to determine is the patient actually a candidate for amplification? Now certainly the audiometric information we have informs some of that decision, but we also have information from our patient that may inform that as well.

So we have a candidacy grouping and then we have selection because some people might meet the needs to go further and to evaluate them further with additional tests to determine candidacy. They may choose not to move forward with amplification. So we wanted to ensure that your time during that evaluation for candidacy could be recognized as far as, you know, separate from a selection for an actual product that might be chosen. Then we have another bucket of the fitting, which I think is maybe a little bit more self explanatory for all of us. And then follow up, which really has not been discussed much previously.

We had that hearing aid check, but a check again meant a lot of different things to many different facilities and providers. And I think this follow up encompasses more of what type of services we would be providing during that period after the initial fitting of the product. And so I'm going to turn this over to Annette Burton. Who's going to take the next phase and really look at an in depth review review of the hearing aid services codes. Annette.

Thank you, Erin. So we're going to take a look at each of the new codes. Since many of these codes are timed encounters, I'll then move into how to calculate time and provide documentation and recommendations, tips and examples. So let's see here. So the first two codes for candidacy reflect the work that goes beyond the diagnosis of hearing loss.

And so this encounter would capture the professional work of reviewing the findings of the diagnostic hearing testing with the patient so that they do understand their hearing loss, and also choosing and

performing additional tests that would better identify the patient's specific areas of difficulty and need. Some of these tests include speech and noise, LDLs, ANLs, needs questionnaires, et cetera. A lot of us were doing all of this along with 92557 and this isn't really part of 92557. And so now we have the ability to account for that work. Also in this, which is not in the diagnostic codes, is the ability to capture and report the time that you're also spending with the patient, formulating a treatment plan and making diagnosis or making a recommendation.

At the end of this encounter, the patient may or may not want to proceed with your recommendations or they might be unable to move into selection at this visit for various reasons. This is the point where this particular encounter would end.

The next two slides here are for selection.

This reflects the work that would need to be done when the patient has decided to move ahead with the devices. And now you need to determine what type of hearing aid would be best for the patient. In this encounter, you're making very specific recommendations. But when you're selecting the devices, and this is work that we're already doing, we're just now have codes to better describe it. We provide both formal and informal assessments of the patient's hearing aid goals, their ability to manipulate devices.

All of this information is incorporated with the diagnostic testing that was also done. You're able to complete a full recommendation. So currently the candidacy and selection codes cannot be reported on the same date of service. And the selection counter does allow for time if you needed to complete some tests that maybe weren't done previously by another provider or you know, in the candidacy process to help you decide what is best for the patient. So you know, in the selection process if the speech and noise testing wasn't done prior and you don't have those records, but you really do need that information to help select the hearing Aids for the patient that is allowed to be done as well.

So sort of think about it as candidacy would be if you're not going to be moving forward with selecting hearing aids and selection is that you are moving forward with hearing aids.

So as Erin said, you know, the hearing aid fitting codes are pretty self explanatory when you are the work that you're doing here is that you're determining once the patient is receiving the hearing aid, is it a proper fit, does it fit in the ear? You might have to do some feedback testing or do you have to choose the right size domes? If you're using domes and not a custom product, the hearing aid settings are optimized for the patient's hearing loss and you're doing that in the software and you're also providing instruction to the patient, family and caregivers on the expectations that you're going to have with having hearing aids device operation and care. And you also may be connecting the hearing aids to other devices such as their phone, remote mics, other assistive technology. And so those are the things that go into the fitting code.

So the hearing aid post fitting follow up code is something that is sort of a newer concept because we did have the hearing aid check as Erin said. But hearing aid check really didn't always encompass everything that might happen in a follow up visit. This is a hearing aid established patient office visit code in the post fitting follow up. It accounts for time spent with the patient after they've received the hearing aids. When you're going to be reporting this code really depends on a lot of factors that are not really within the control of the code set, but in control of contractual obligations that you might have for the purchase of hearing aids.

Many states have purchase agreements that need to be given to the patient prior to, you know, them receiving the product. And it may in some states I outline how much that product is going to cost and it may include a 30 day trial period, 60 day trial period. Some payers have agreements that like with the third parties, for example, you might have say a 60 day trial period and it also allows for three additional visits after those 60 days and then you can start, you know, billing for services after that. So it really

depends on when you're going to use these codes or if you're going to be using them in two different ways. One would be for something that was sort of in the global period time where you can't bill extra and sometimes would be for your normal office visits outside of that.

And so some of the things that you would be doing is anytime the patient comes in and it's a patient facing encounter and they have maybe some troubleshoot, some concerns about maybe not hearing as well anymore, or you just want to see them for follow up, to monitor their progress, make adjustments to their settings. Many people see people maybe every few months for cleaning checks, that kind of thing, or to review device operation and care. Or maybe they need their phone connected or their phone reconnected or now they want to learn more about the features of the app. So the time used for hearing aid post fitting follow up really does fit for all of these scenarios. And also it would fit for a scenario if a patient who has existing hearing aids that's not your patient, but maybe they're coming to you for a second opinion, maybe they're on vacation and something happened to their hearing aid and they end up in your office.

Or if somebody is wanting to establish care with you as a provider, and this post fitting follow up could be used for that as well.

So now we have some verification codes. And what these codes are are codes for verification that is done using measurable techniques which involve equipment beyond our normal equipment with just the hearing aid fitting. Because everyone's not going to use these codes all the time. The first two codes, as you can see, have a little plus in front of them and that means that they're an add on code. And so an add on code does need to be paired with another procedure.

So post behavioral verification and hearing aid probe mic measures can be reported when you are doing a fitting visit or a post fitting follow up. So you can use those codes in there to report those activities during that time. The last code is a code that is kind of standalone. So in some cases it's not

patient facing time. When you are reporting separate codes that have their own CPT numbers, then you cannot include that in the time for the fitting.

That has to be sort of take it out or subtract it out. So the behavioral verification code is essentially anytime that you're taking the patient out of the office and putting them back into the booth and doing some sort of measures of the performance of the hearing aid for the patient's hearing loss with amplification, that could be aided speech and noise, it could be a comparison of unaided versus aided speech and noise threshold information, functional gain, anything that involves you having the patient in the booth and you are measuring the performance of the hearing aids as a result of the patient's hearing loss. So for probe mic measures, you are using separate equipment as well. And so if you are taking probe mic measures to determine, you know, the hearing aids effect on the hearing loss, that would be when you could report this 92639. Now, sometimes there are situations where, for example, in pediatrics we might not be able to do probe bike measures as we would on an adult.

And most of the equipment does have the ability to make simulated measures based on some of the data that you've already entered into the system and recds, et cetera. And so it is still appropriate to report this 3.9 code as a probe mic measure if you're doing it in simulation on that same date of service. In terms of the electroacoustic analysis code, that is pretty much, I would think, a direct crosswalk to the previous code of 925-9 4 and 5. The only difference is now you don't have monral and binaural, unlike the timed codes which are for either monral or or binaural activities, because the time is judging how long you're spending. These verification codes are considered to be binaural codes or two devices done, except for in behavioral verification.

But like for, I'm sorry, for probe mic and electroacoustic analysis, if you were only performing it on one ear, you would need to use the 52 modifier.

And then the last code for hearing assistive device supplemental fittings. And so this code is probably not going to be used as much as we would think. But it was specifically created by, for situations when a hearing assistive device fitting was being performed. A lot of us probably used to bundle that into the price of the device. But now we do have the ability to account for the professional work and not just we're handing somebody something.

And so if you are providing assistive device supplemental items during the hearing aid fitting or during the post fitting follow up, you would not be reporting this 92642. But what you would be doing is including that in the time of the hearing aid fitting or the post fitting follow up. But if you're doing it separately, you could report this code and here's two examples. So if you had a candidacy evaluation and after going over, you know, the results with the patient and making your recommendations, your recommendations might be that, you know, if the major thing that was happening with them was the television, and that's really all they were interested in and they wanted television amplifier. If you carry those and you were providing that to the patient, you could report 92642 when you're providing that along with the candidacy eval, but you still wouldn't report that time that you spent showing them how to use it and showing them how to connect it to the television and such in the candidacy eval portion of the time.

So the other example might be if maybe you had mentioned a television connector that connects directly to the hearing aids and thought that that would be something that the patient really would benefit for. And they came with another family member like their daughter, and the patient said, no, you know, I really don't want that. And then everybody goes home and then the family decides, yes, mom, you know, we really do want you to have that. We're going to buy it for you. And they're coming in specifically just for, for that.

So it's not necessarily we're talking about the hearing aids again or connecting them back into noaa, that kind of thing. But what would happen is that that visit would be if you were setting up that television device, pairing it to the hearing aids and showing them how to use it, that kind of thing. So this code is going to be a lot more not commonly used, but it's also there also for FM setups for educational audiology when we're having to maybe verify what's going on with that, that's what that code is for.

I'm going to spend some time now talking about audiology, the use of time codes, because in audiology do have very few timed codes. And unless you're performing APD or cochlear implant candidacy evals or the osseointegrated device evals, you really may not be very familiar with how time codes work.

This table here, you can find a version of this table in the CPT manual and you can find versions of this table that you could print out and keep, you know, on your desk in the AAA and ASHA resource websites. And it really shows you how the time codes work. So in cpt there's a number of ways to count for time, but unless it's otherwise specified, it typically works this way. But they put the table right into the code set. So there's no question of how we're reporting time here.

So when we see the third column over where it says time in code, that's in the descriptor that says it's 30 minutes. But there is a range of time that you can spend to be able to bill for that 30 minute code. And so the range as you see is 16 to 37 minutes. And so for each code it sort of tells you what you need to do.

And so, you know, some of us learn a little differently than others and I will admit that I was quite confused with how that table worked. So I thought of some other ways to present to sort of explain it, just in case you were like me and just were a little bit confused. So how minimum time is calculated in this way is it's mostly 50% of the total time of the code and an extra minute. So if it were a 60 minute code like hearing aid fitting, you would have to perform all of the activities that are related to that hearing fitting code in 31 minutes. That's the minimum amount of time that you can spend to be able to

report that code.

If there's a 30 minute code, it is 16 minutes. So half of the code time, total time plus one minute. So 16 minutes is the minimum amount of time that you need to be able to report that code. Now, the 15 minute isn't an extra minute, but it is still half of the code. Seven and a half minutes plus another half minute gives you the eight minutes.

What happens is when we're counting time, we have to look at the activities that were performed on the date of the encounter. As Erin said before, you're reviewing the medical record and then you're performing the eligible activities in the encounter that are listed in the code descriptor as they are needed for the patient. So you don't have to do every single thing in the descriptor. You can also count the time for documenting the encounter into the medical record. And so, for example, with the hearing aid fitting code or the selection code, you wouldn't be necessarily counting time for when you're ordering the hearing aid or you're in the portal looking for prior authorization numbers from a payer.

But it is really the documentation of the time that you spent with the patient describing what was done.

So I've prepared multiple examples here of using multiple codes on the same date of service, you know, for your reference in the handouts. So the first example is a hearing aid selection code and hearing aid fitting code. And if you wanted to report both of those base codes on the date of service, the activities are unique to each service need to be accounted for independently. So if you were going to report both of these codes, the minimum time for each code must be reached in order to report both codes. And your documentation needs to kind of align with that.

So 47 minutes would be the minimum amount of time that you would be able to spend with the patient to report. 92631 and 9263431 is a 30 minute code. So 16 minutes is the minimum and 34 is the base code. And so that's a 60 minute code. So that's 31, that's how we got to that 47 minutes.

So the next example is hearing aid candidacy and one unit of the 15 minute add on. So the minimum time to report both 92628 and 92629 would be 38 minutes. So you have your full base code. So you can't do the minimum because now you're adding that extra 15 minutes. So it has to be the full 30 minutes plus the minimum of 8 minutes for the add on.

And so the last example I have here is an example of two units added on to 92628. And so the minimum amount of time here would be 53 minutes. So you have the full 30 minutes of the base code plus the full 15 minutes of the first add on unit and 8 minutes of the second, which is the minimum.

When we're documenting for timed codes only the activities that cannot be identified with another CPT code should be reported. So for example, if you're doing those verification codes that have their own cpt, remember, you cannot include that time in the other part of the encounter. Your medical record should provide a clear picture of the entire encounter. That's not new. We've always said that no matter what it is that you're doing, you really have to let people know what it is you did and why.

Right. And so if you're using, thinking about using vague references like start and stop time, I would recommend to avoid that because you really do need to quantify in your notes what it is that you did during that time. So over the years a lot of other societies have a lot more time codes than audiology. And so we really looked at to what was going on with physician reporting, with E M and so for example, and also physical therapy, you know, how do they report their time codes? And we also checked with a number of compliance professionals in terms of from an auditor's standpoint, what are they looking for?

And so just starting a stopwatch and saying, okay, we're starting this here and I'm done at, you know, started at 11, done at 11:45. Well, what happens if you forgot to turn off the stopwatch or you forgot to put the stopwatch on, it's really not a good reflection. But you do have to keep an eye on how much time you spent. But you don't necessarily have to report the exact time in terms of 11 o' clock to 11:45.

But your organization may have rules that you need to do that or you have to use it in your emr or there may be payers.

We did check. There's really not too many payers and CPT does not have any guidelines as to how to document time. So it really is more about the patient encounter.

When we're documenting various elements, the activities performed in the encounter would be your narrative and your findings. What was done, what was the outcome, what were your recommendations? Objective measures like the probe mic measures. You're going to have your graphs, you're going to have the test scores of some of these assessment tools that you've used. You're going to also have interpretation of what those results mean.

Informal assessments. When we're asking people about comfort level and how does their voice sound and those kinds of informal verifications, that's part of the narrative of your finding.

Your treatment and recommendation and plans are in there as well. This really isn't anything new, but it's just to remind her of why it's important to say what you did. So we spent some time looking at how other professions were sort of reporting this and you might see some of this when you're getting referrals maybe from physician office. They may have a time statement at the end of their documentation. So here's an example.

Total time spent for Mr. Smith's evaluation for hearing aid candidacy today was 20 minutes. This includes time spent before the visit, reviewing the chart, time spent during the visit and time spent after the visit on documentation.

And if you had to also exclude some time from that encounter, you could also consider putting another sentence in at the bottom. In this case we had this hearing aid fitting encounter, but there was also

probe mic. And so at the bottom we have total time excludes the time spent for performing probe mic verification.

So we're going to do something that I think that you all would like in terms of taking some examples from some more real life situations. And I'm going to turn the floor over to Dr. Miller at this point.

Thanks, Annette. I'm going to just throw a little wrench in before we get to the clinical scenarios because there's been and we are seeing some questions come in and there's a couple that I think might be relevant if we answer right now. We do have time at the end of the session where we're going to answer questions, but there are a couple that are explicitly relevant to what you just talked about. And so I thought maybe we could address that because a couple came in relative to using the code 92642, which is the hearing Assistive device code in combination with the fitting and then somebody also asked with follow up. So can you just address that again that the time for those services is included in the other base code?

Because I think that might help a few of the listeners today. Yeah, so the hearing assistive device code is not reported when you are using the hearing aid fitting code or the post fitting follow up code because those activities of say for example, connecting a remote microphone or connecting a phone or connecting a television device is reported within the work of that encounter. And that's right in actually in the instructions in the language, the instructional language in cpt. Like if you were to actually look in the book, there is a paragraph or a few paragraphs that sort of give some other guidance about this. And it is specifically intended because that is the type of work that we are doing in the encounter anyways.

So that code was really just designed for situations where we weren't doing a fitting or we weren't doing a post fitting follow up so that audiologists could still report their professional time for those encounters. Yeah, hopefully that addresses the question because I do think it's important your time is valuable to

actually provide those services. But it's accounted for in the other code, the fitting or the follow up code. So you don't need to add that code. And as Annette said, that code probably will be used less often.

But we did believe there were some situations where you might just be performing that fitting of the device at a time that was not within a fitting or a follow up. And I think probably the example with the candidacy and then the patient doesn't move forward with amplification, traditional amplification, a selection, yet you're deciding to fit some kind of an assistive listening device would work. I think that's a great example. The other question that came in, and again there's several, but I think that's relevant to this section, if we can answer it is can you not use probe mic when you're fitting a new ear mold? So you know, and I can take this, if I were fitting a new ear mold, I would be utilizing the follow up code.

So any of those add on probe mic or behavioral verification codes can be added to the fitting and follow up. It's just the time spent performing that needs to be extracted from the time of that base code for the fitting or follow up. Hopefully that answers. I think those were probably the most relevant to your section. And I'll leave some of the other questions for us to answer at the end, if that's okay.

With you, Dr. Burton. All right, so we're going to move forward into talking about some, maybe some typical or simple scenarios when we might be utilizing the codes and then also maybe some more complex ones. And we wanted to include both the use of these codes in the adult population as well as in the pediatric population because we do know there are some differences. So the first code, we're starting from the beginning of our journey for our patient through this process of obtaining amplification. So this would be for evaluation for hearing aid candidacy.

And so I'll describe our patient. This is a 68 year old male who was initially seen for an audiologic evaluation. The patient had reported during that visit that, you know, they're not hearing as well. And then the patient also said, says that they're experiencing some intermittent ear popping or crackling. Your results were negative for middle ear involvement because you performed tympanometry and the

results indicated that you had a moderate sensorineural hearing loss and you were considering this individual for amplification.

So your initial evaluation on that date would be certainly include the audiologic function test, you know, the Comprehensive Audiometry, 92557. And then of course, in this case, because there was medical necessity to complete some additional admittance testing, you performed 92567 or tympanometry.

So following that review of their diagnostic results, the patient decides at that visit they want to explore treatment options. And so you're going to move forward. And that's where I would begin my hearing aid candidacy evaluation. Right. That's when 92628 begins.

So I would at least start, you know, if I had spent a half an hour with the patient prior for the evaluation, that time's not included. But as I begin talking about what are some of the treatment options or are there additional questions, tests that I need to perform in order to determine candidacy. That's when I would start. And I'm going to put in air quotes my timer. Again, I don't know that the timer is the most important part of these time codes, but at least recognizing this is when that part of the evaluation is beginning.

So I might have the patient in this case complete the hhia. I decide I need to perform perform LDL testing and I perform it at three different frequencies in each ear. And then I also decide it's important, based on conversations with the patient, that I perform speech and noise testing. I choose the quicksand as my test and I'm evaluating each ear separately. And perhaps I complete the testing binaurally as well.

So then Part of our time is, you know, the cognition of us putting all of this information together. Right. So we have to think through. Now we have our audiologic test which indicated, you know, the patient is a candidate for amplification. Now I have some additional candidacy tests.

Maybe I have some information from the questionnaire that I need to review with the patient and talk through these other tests. So this code includes us counseling the patient on the impact of their hearing loss on, you know, their day to day communicative function with other individuals. We also would want to talk about some of the other psychosocial implications of them not choosing treatment at this point in time and review how this might impact their overall health. All of that is included in the time of this code. So talking through that.

And then we're going to need to review what our recommendations are for this patient. So, you know, are we recommending binaural amplification in this case? Likely. So because they have binaural hearing loss, you know, we would want to, you know, talk about, you know, or answer any questions, additional questions that either they, the patient themselves have or typically there's family members who are coming in with patients that might have additional questions. Sometimes they want to dive a little bit deeper into some of the implications of not treating the hearing loss at this stage time, all of our time for those services are included in this candidacy.

But then the patient says at the end, look, you know, I'm not ready to do anything about this today, but you know, maybe they'll consider amplification in the future. And so as I would report this, then, you know, I need to finalize that appointment with the patient. I need to include any of the test data that was completed if I did, you know, LDLs or speech and noise. However, we're going to report that in our medical records and document that maybe I'm giving some additional information to the patient relative to a return visit for a selection or maybe information on different models of amplification, you know, whatever additional materials I need to provide and then documenting that. So in this particular encounter I spent 40 minutes and that was completing the additional testing that I performed, counseling the patient relative to the implications of their hearing loss, answering their questions or their family's questions.

So in this case I would report 92628, which is the evaluation for hearing aid candidacy. That's the 30 minute code. And because I spent 40 minutes, I would choose one additional 92629. So the add on code. I've met the minimum standard.

So I met the minimum of the 38 minutes to report both the base code and the add on code for this particular encounter. So in my documentation, and again, this is one example of the documentation, we're not saying your documentation has to look exactly as we've written it in this presentation. So I want, I want to be clear about that. But this is one way to make sure we've included all of the segments that are necessary in the documentation. So I might say total time spent caring for the patient was 40 minutes.

This included the time spent before the visit reviewing their medical chart, including prior diagnostic testing, time spent during the visit completing and reviewing the patient questionnaire, speech and noise testing and LDL testing, a review of the results with the patient, and counseling regarding treatment authorization options, and time spent after the visit completing documentation in the medical record.

All right, so Dr. Burton, I think I'm going to send this next one over to you. Okay, thank you, Erin. So this is another candidacy evaluation scenario. And so we have a nine year old male who has recently acquired unilateral sensorineural hearing loss in the right ear and was referred for a candidacy evaluation to a different provider.

So the provider would review the referral information that came in, which would be the notes from the ENT office that referred them. They would also look at all of the audiologic testing that was performed and also the imaging report. And so when we greet the family and take a focused medical history on what happened and when was the onset of the hearing loss and discussion of any perceived hearing difficulties, otoscopy was then performed and unaided speech testing was completed, speech and

noise. And so then after that point, then we'd stop and sort of have a chat with the family about the initial findings, including the test results and discussing the impact of single sided deafness. So to sort of demonstrate what some of those problems are and also to confirm with the child and the family what types of problems they're noticing as well.

And so then we would talk maybe about a cross system and maybe demonstrate it, put it on the patient, do some aided speech and noise testing, and discuss some of the results and options for treatment. And so this encounter took a long time because the family had lots of questions that relate to the device. What other options are there besides trying, you know, a contralateral routing system? Why is this happening? You know, so a lot of counseling going on that is sometimes even beyond just talking about what is wrong with the hearing.

Right. And so after all of that, the family has decided that they would like to preside, proceed with a trial of that and the appointment was made for selection.

So in this encounter the total time was 53 minutes. And you know, you're reporting the base code and two units of the add on code. And so that's an example, another example of candidacy when a patient is wanting to move ahead.

So the documentation of the encounter would be the narrative of, you know, how the encounter went. You know, the child presented with this hearing loss and the following tests were done and the family was counseled on the different options for amplification versus, you know, explaining maybe an AOD implant versus that versus cochlear implant. You know, you're giving all the different options for that or you know, devices in school and you made recommendations, you have all your test scores in there. And then, you know, maybe you have just this little paragraph here that talks about all of the rest. And the hearing aid selection, I didn't mean to go there, was not done at this time because we needed to then get prior authorization from insurance.

And so they were going to have to come back anyways. And so that's why, you know, that would be rescheduled.

And then the selection of bowel would be done. So here's an example of a hearing aid selection. So we have an 80 year old male with a bilateral sensorineural hearing loss seen for hearing aid selection visit following a candidacy evaluation from a different provider. And I don't feel that this is unique to our facility, but especially with the third party networks, there's lots of people that maybe start with one provider and end up having to go to another provider because that provider is not participating with those plans. Or maybe the patient has insurance that that provider does not take.

And so we're seeing more and more people kind of coming in with some of this candidacy evaluation done. But in order to get the hearing aid they have to go see someone else.

So once again we would review the medical records and view everything that was done by the previous provider. And for example, if some of those things weren't done in terms of LDL speech and noise, anything else that you feel that wasn't done that you need testing to do to help you with that selection, you can do those things in the candidacy, I mean in the selection eval as opposed to just solely exclusively for candidacy. So obviously we want to look in their ears to make sure everything is where it's supposed to be and nothing's not, that's not supposed to be in their ears. And then taking a focused medical history in this case would be important because you know, this patient ended up having diabetes and had some neuropathy in their hands and also had a rotator cuff injury that really wasn't going to be repaired surgically. So they had limited mobility in their shoulders and the ability to raise their hands above their head.

So once the hearing needs were assessments and goals were completed, we realized that the patient was having difficulty on their cell phone.

Concerns were that, you know, the television's too loud, unable to hear the wife, but they really didn't go out a lot and weren't, you know, in many outside situations. So we would review the test results with the patient and discuss the extent of the hand and shoulder issues because that might be a factor in what mod, what type of hearing aid that you would be ordering in terms of form factor. And since the phone was very important to them, you know, there are some manufacturers over others that maybe work better with, you know, the Android platform versus the iPhone platform. So that also kind of goes into some of that decision making process that we're all doing when we're discussing our recommendations and looking at. And so I know that in the past we've heard questions about, well, how do we do a dexterity evaluation or why, how do we do visual?

You know, all of those things factor into our decisions. So if somebody is visually impaired, colorblind, maybe, maybe they need shells, you know, that are white one side and black the other side because they can't see red and blue, you know, so it's not necessarily that you have to make a formal eval evaluation of vision or a formal evaluation of dexterity, but talking to the patient to find out what those limitations are is going to help you formulate your opinions of what types of recommendations you would make following making the recommendations of the level of technology and the type of technology. In this case, we decided on a rechargeable half shell because it might be a little bit easier than, you know, a ric. And impressions were taken in both ears. So total time for this encounter was 65 minutes.

The hearing aid selection is for 55 minutes and the ear impressions were 10. So in this case, we're reporting the ear impression units for one for each year. And so we have to exclude that out of the total time for the hearing aid selection. And so there's one unit of the 30 minute code and two units of the base code.

Okay.

And so once again, your documentation, in my opinion, similar to what you would normally do, clear picture of what happened at that encounter. And then at the bottom, and this is, we're not telling you how to do this we're just giving you examples of what you can do. And everybody makes their documentation differently. Right. And so this is just an example of, you know, how I would do it.

It doesn't mean it's right or wrong, but this is an example. Okay. So I'm going to turn this back over to Dr. Miller. Okay. And there were a couple questions that came in relevant to a couple of these scenarios that we can try to answer.

Now, again, don't be upset if I'm not pulling a question you've asked. We'll try to get to the these questions at the end as well. But somebody asked in the first example for candidacy, would you need to specifically state that you are excluding the time spent on the other two CPT codes, which were 92557 and 92567? I likely would in my documentation say that had been completed and then the hearing aid evaluation began and included those activities and took that amount of time. I don't know that I would put an exclusionary statement in my documentation.

But again, I think it would depend on how you're completing your documentation. Yes, you can't include that time certainly in candidacy when you've performed the audiologic function test. But I think really the specifics of it, you know, I wouldn't put an exclusionary statement. I would have just said, you know, the hearing aid evaluate or the hearing aid candidacy began and you know, these were the additional tests performed, etc. As I did on the documentation slide.

And again, as Annette stated, these are examples. This is not black and white. It doesn't have to be done this way. It's just giving you an idea of what other professionals who use time codes much more often than we have in Audiology have found helps meet the necessity for if there's an audit for compliance and it includes all of the services that were provided. But it doesn't have to be specifically

as we stated it.

So I think that was the most relevant one. And we'll get to some of the others later. So I'll move on to hearing aid fitting. And this is, I would say, a pretty traditional hearing aid fit fitting. I find of all of the codes, maybe this is the least variable as far as services being provided.

There are things we have to do in a hearing aid fitting. But I will mention some of the verification and what was meant in some of the long descriptor versus adding verification in a more formal way, because that is a question that came up and hopefully I'll answer that question as I go through this particular clinical scenario. So again, the case detail for this patient, it's a 74 year old male who's returning to your office for the fitting of a monaural right hearing aid. They have a moderate sloping to a moderately severe sensorineural hearing loss in the right ear with good word recognition ability and a severe to profound sensorineural hearing loss in the left ear with poor word recognition ability. And they are considering CI for that left ear.

So we are doing a monaural fitting of the right. So I, you know, really my time begins as I sit down with this patient and begin the fitting process. So, you know, I'm going to look into their ear, I'm going to ensure that the hearing instruments are what I had ordered. I'm going to ensure the physical fit. In this case, you know, if it was an ear mold I was fitting, it could be a dome if it were another case.

But we have to ensure physical fit as our first step in any fitting. And in this case, the patient reports to us, the the ear mold is tight, uncomfortable in the ear. And so then I know I have to do modification of that ear mold and that's included in the time I have to go, I leave that room, I might have to go to my repair lab. I'm going to do some modification of that ear mold to ensure that we have a comfortable fit for that patient so we can proceed with the rest of the fitting. So after that modification, I, you know, check the fit of the ear mode again and you know, they felt it was comfortable and so we move forward.

We have the device now connected. I probably had it connected and it disconnected when I went to my other room. So I'm reconnecting the hearing instrument to my NOAA software and then need to, you know, move forward with the fitting. So, you know, this might include the need to run a feedback manager that's certainly manufacturer specific. Some manufacturers recommend that with every fitting, others recommend only to perform that when needed.

I might be choosing or maybe selecting a different prescriptive formula than the default based on the needs of my patient. And then I do a simple verification of sound quality or a simple verification of loudness judgment for speech. You know, when we looked at verification and we still have to go on what typically occurs in appointments, and when we looked at the evidence of how many audiologists were performing probe mic measures, we didn't reach the threshold of what is considered typical, which would be 51% of all audiologists would be performing that. And so there was quite some discussion as we were developing this code that we didn't want to include verification in a formal way in the fitting code, but that there would be additional codes for those individuals, providers who are performing probe mic measures or behavioral measures or other kinds of more formal verification. So while it does state that we're talking about what typically happens when we initially fit the hearing instrument, we're saying to the patient, you know, how does my voice sound to you?

And I know these are not formal verifications. We all appreciate that and understand that. But there are still unfortunately too many individuals who are fitting amplification that that is all they are performing. And so in this case we would have performed that simple verification. But then we want to complete a more formal verification for the patient.

So we are completing probe mic measures. Again, this is a right ear only fitting. So we're going to report that particular measurement separately and I'll show you that here in a moment. And then we might be making additional programming adjustments based on the verification that we just completed.

Perhaps we need to increase gain or reduce outputs, whatever the case may be, as we perform that and what our goals are for this particular patient, we're likely going to then need to review how the features are currently set, make adjustments to them, review that with the patient.

You know, sometimes considerations are made for new patients where we don't add a lot of user enabled features. And that would be a discussion with the patient. We might determine whether or not they have a need for additional program memories. Again, that could be manufacturer specific. It could be a patient who enjoys music and we might need to add a music program or something like that.

Then we finalize the settings in the hearing instrument itself. Then there's still quite a bit of work that happens after that point where we have to orient the patient and do some training relative to the use of the hearing instruments. And that could include everything from, you know, daily cleaning and maintenance that they need to perform in order to, to have, you know, products that are going to work long term. Certainly we're going to have to either review charging the instruments and or replacing the batteries. So that can take some time.

You know, my preference is always to watch the patient perform all of these tasks while they are with you. So at least there's some visual memory of them performing them when they are able to. And so our encounter would continue on as well because it's highly likely that many of our patients are going to want to have their devices connected to their mobile phones and then we need to orient them on the use. You know, I, I like to leave the room, call them, make sure they can hear how, you know, understand how to increase the volume. You know, all the things that we're doing.

You know, there's a lot of details to this. It becomes routine, perhaps to us, but for our patient, these are necessary parts of this fitting process. Then we're going to counsel the patient relative to effective communication strategies. I mean, in this case, and this is, I believe, the beauty of having these codes that are either unilateral or bilateral fittings. You know, I would argue the point that in a unilateral fitting

like this one, our counseling and talking about techniques on how they're going to maximize the effectiveness of the hearing instrument, as well as some of the realistic expectations will take longer in this fitting than it will in a, in a bilateral fitting of hearing instruments.

And, you know, and I think that's, that was something we discussed at length. And I was happy that the codes are inclusive of whether you fit one or two hearing instruments. Then of course we're going to answer any additional questions that the patient or their family might have about the devices. We need to document the outcomes of that fitting encounter in the patient record, which is necessary. And then, you know, when are, when is the patient coming back?

Is there additional information that we need to provide relative to when we want to see them the next time?

So in this case, I spent 62 minutes and I would record the hearing aid fitting services code, which is a 60 minute code. I spent 54 minutes for the hearing aid fitting. 8 minutes of my time during that encounter was spent completing verification with probe microphones on that right ear only. As Dr. Burton had said earlier on, you know, when we are performing those verification on one ear, you do need to use the 52 modifier in this case because we were only performing probe mic measures on that right ear.

So again, our documentation really states who we're seeing and all of those necessary pieces. Again, this might be inclusive of every single thing. Yours might not look exactly like this. I know I always like to include what the otoscopy was on that date. So I have that documented in the patient chart.

And so, you know, maybe you don't provide as much detail as I might have in this particular documentation of the encounter. I usually also in this case, we had some modifications that were necessary for this particular fitting. And so I like to say in my chart note, just for my own record as well,

what did I do when I modified that so that if the patient comes back at the post fitting follow up and they're still having difficulty either with insertion because it's tight or some other issue is going on that I've already documented exactly what I did at that initial visit. So again, maybe more detail here. I think the most pertinent part of this documentation of the encounter is that I have at the end that my total time excluded the time for completing the probe mic measure.

So as I said, my appointment time was 62 minutes, but eight minutes of that was for the probe mic measures. So I'm reporting that my total time spent for that hearing aid fitting was 54 minutes. And then I'm going to send this back to Annette. Okay, thank you, Erin. So this is an example of a hearing aid post fitting follow up service.

So we have a 55 year old female who received hearing aids several years ago. They feel that they're not hearing as well as when she first received them. She's also having difficulty with her phone as it no longer seems to connect with to the app.

So what I did here is when you're having to make a decision when someone's coming in and they're basically saying that they're not hearing as well, but they're also having problems with the hearing aid. So we all would have to tease out, of course, is it the hearing or is it the hearing aid? Right. So in this case we would make a decision to look in their ears and make sure, you know, they don't have a wax impaction but also perform a hearing test. And so in this particular case, and we might say, well, you know, we really need to do a hearing test, would that be okay with you?

You know, going to be an additional charge. Maybe the person has traditional Medicare and we would let them know that that wouldn't be a covered service and that it would be self pay and make sure they're okay with that. So remember, if it is a statutorily excluded service, so a hearing test for the sole purpose of modifying the hearing aids, you could do it that way or going to throw a little wrench in here when we're looking at someone, it's why the person came in. So if they're thinking that it's the problem

with their hearing aid and it is related to the hearing aid and they need their phone done and all of these other things. This one's kind of a gray area and I did it on purpose because with that AV modifier, if somebody's reporting new signs and symptoms with decreased hearing, potentially that could be something that's covered.

So that's really going to be your judgment Call. And I know that this probably makes some of our heads explode because audiologists like black and white and gray is really not why we got into audiology. In this particular case, we decided to say that this was a non covered service because we were trying to figure out if something was wrong with the hearing aid versus not.

Everything that is highlighted is what I was then going to count. And this is not a scenario that actually happened, but something that could definitely happen.

How I would do it is I would count the audiogram and reviewing the previous medical record and looking in their ears as part of the time for the audiogram. It's just, just easier, right, to do it that way. And then everything else that's highlighted here is more related to the hearing aid post fitting encounter. Because when they came in their first complaint was, is that they don't think these hearing aids are working. They weren't hearing as well as they had been in the past.

So, you know, that was their chief complaint. And then after we did the hearing test and decided that maybe there was a slight decrease in one ear, we would discuss the test results of that hearing test. So we would present the audiogram, let them know there is a slight decrease. Talk about the action plan of, you know, changing the settings. But before that we have to make sure that the hearing aid itself isn't working, that there's not some physical things going on.

So we would obviously examine the hearing aid, check the wax filters, change the domes, do a listening check, then you're connecting it to the manufacturer's model and you need a firmware update.

Might explain why the phone's not working anymore. And so you might make some minor changes based on the reprogramming, based on the decrease in hearing.

And we want to re verify those new settings using probe mic measures. I wanted to do that hypothetically. And so I would also perform the probe mic measures. Verification, simple verification of sound quality, comfort and loudness, review, cleaning the domes and replacement of filters. Because one of the reasons why one hearing aid wasn't working at all was the filter was clogged.

And so we reviewed that with the patient and had them perform that as well. Reconnect to the app, review additional features on the app and answer any questions.

So total time for the visit, 62 minutes. And that's the total time that I was with the patient, not the total time for the hearing aid post fitting follow up services. So you are reporting 92557. And so that time has to be excluded from the hearing aid post fitting follow up time and you are also excluding the pro mic measures. And so that leaves you with 23 minutes for the hearing aid post fitting follow up service.

And remember, even though we have these times here for 92557 and 93693, those are time excluded, but you know, they are not timed codes.

So once again, in terms of the documentation would be similar to how I normally write documentation. I didn't actually write exactly what I was going to say because it's just concepts for you. So the reason for the visit, the chief complaint, what happened during the visit, all the things that we did, we did an audiogram, we had those results. We talk about, you know, very slight decrease in one ear activities involved involving the hearing aid, the clean and check review of data logging to see if the patient's even using the hearing aids, how long they're using the hearing aids, what the hearing aids are doing. You're doing some changes to the programming you've performed probe mic, you know, which shows that you know you're getting the desired benefit and reconnection of the phone app, counseling and

education.

So that's not what would actually say in the report. It's all of the elements that I would be discussing in my narrative. And so your medical record needs to support all the activities. So you are writing a report, you're putting that in the medical record for the audiogram. So you have your graphs, you have, you know, those interpretation, you have the printouts of your probe mic.

You've already discussed in your narrative what that meant. And so that would be it.

So once again, this is, you know, how I personally am going to do it. Just because it just seems like it's. Now I'm just adding the two paragraphs, right? And I'm normally just doing my normal documentation. So total time for the hearing aid post fitting follow up encounter today was 30 minutes.

This includes time spent during the visit. Notice I didn't put time reviewing the record because I reviewed the record and I'm sort of considering that as part of the audiogram and time spent after the visit on documentation related to post fitting follow up. So it's not documentation for doing the audiogram. Okay. And then I would put total time excludes the time spent related to performing audiogram and probe mic verification.

So our last one is going to be Dr. Miller. All right, so this is a pretty straightforward, I think hearing aid post fitting follow up service and one that I see quite often certainly in our practice. This is an 82 year old female who's returning, you know, 13 months after her post fitting. You know, again, every practice will have their own policies relative to what their period of time is before they would be choosing a post fitting follow up. In our case, in our practice we have a year of service.

We sort of do an unbundled bundled kind of method, but within our dispensing fee that's unbundled from the device, we include a year of services. So this would be post that period of time reports the aids

aren't functioning well. So something has happened. And she has an inability to maintain consistent Bluetooth connection. So not unlike many of what you are hearing in your practices today, I'm sure.

So again, my monitoring of the time really begins at the start of the encounter. So, you know, I talk with the patient and determine what's going on and then we move forward and complete otoscopy, determining if we need to do any kind of cerument management at that particular appointment and then do a routine listening check which revealed, at least based on a comparison of the listening check to their audiogram, the aids seem weak to us upon the listening check. Certainly we're not providing sufficient gain for that particular patient's hearing loss.

And so thankfully this is a pretty simple issue that again we see pretty often. So we check the aids and we note that the wax guards are at least partially blocked and that was what was causing the aid to seem weak. So we replace the wax guards and do a clean and check on that on that day. We listen to the hearing instruments post completing that and they reveal good function. They certainly seem to have the appropriate gain for the patient's hearing loss.

And we refit them to the patient and they say, oh yeah, great, this is, this is like it was sounding before. I can hear again and everybody's happy. But we also had the patient report some of the difficulty with connectivity, losing connectivity. And so we want to check the hearing instruments to ensure that they have the latest firmware updates because that can cause some of those issues with connectivity. And so we connect the hearing instruments to the software, they needed a firmware update, we manage that firmware update and maybe I take a look at the data logging as well to ensure there might not be anything else.

Since we haven't seen this patient back for a little bit, maybe there are some additional changes that might be beneficial to the patient based on their typical listening environment. So we may take a look at data logging at that point in time as well. Then we're going to review the findings. And in this case this

might be a situation where you know, this is the first time that this has happened with the wax guards. Maybe they don't have a lot of wax in their ear typically, but just enough got in to block them off.

So we might want to spend a little bit of time also reinstructing them on how to replace the wax guards, what they should be doing to monitor the hearing instruments, you know, when they start to hear, you know, not here as well, or they seem a little weak, you know, the, the first thing they want to do is take a look at these wax guards. So at least reviewing some of those basic, you know, day to day maintenance kinds of needs for the patient. So in this case, I spent 23 minutes with the patient and I would then just report one of the basic code 92636 for the hearing aid close fitting follow up services. Again, I met that minimum threshold of 16 minutes. This was a question that has come up a little bit in some of the questions that have been presented, like what do you do if you don't meet the minimum threshold?

Well, it's not this code you report because there are, for these CPT codes, there are minimum thresholds you must meet. And so you wouldn't report this code. There may be, you know, somebody had suggested some other V codes and there may be some other V codes that you could report if those are reportable in your practice as well. But again, these are time codes. So you need to meet that minimum threshold of 16 minutes.

And again, that includes your, your time reviewing the chart. Just keep this in mind. It's not, it's not just, you know, that I cleaned the hearing instruments and did the firmware update, but then I had to document what I did. So it's the total time, not just the time on the actual service to resolve this patient's problem. So again, in the documentation you're going to see, I pretty consistently stayed with how, you know, the plan that I have for documenting this that we're including all of the things that we've done.

We usually put in our chart notes that we listen to it prior to the cleaning and listen to it after, particularly when there's a reported problem so that we can document if the patient comes in reporting,

everything's great, no problems. I might combine those to say pre and post listening checks. We're good. But in this case, because there was a problem, I likely am going to report that separately that the aids were weak on the listening, initial listening check, and then what they sounded like post clinic cleaning.

All right, so we have a few key takeaways that we would like to at least address and some summary of what we hope you take away from this. And then we will get to the questions. And I've tried to combine a few of them so that we can answer several of your questions at one time and I'll present those to Dr. Burton as well and we can go back and forth or she can answer the questions. So our summary and key takeaways. I really want you to leave this knowing that there has been absolutely no Change to the HCPCs Level 2V codes.

They remain as they are. There's no intention of making changes to that code set. There will be payers that will continue to use that code set. At least now, you know, that may take some advocacy on our part to some of those payers to help them appreciate what the current CPT codes now offer by way of both what typically is done the typical patient that we're looking at, but more importantly those description of services. So, you know, when we were going through these scenarios, we really were laying out how we had to write the description of service as we were applying for the CPT codes.

That panel needs to appreciate and understand what is being done at each point in that encounter with the patient. And you will note that in even the long descriptors of these codes it might say may be included or eg, those are examples of things. But again, not all of those elements might need to be included. Included every single time. So keep that in mind.

Certainly I would say payers rarely have all of the CPT codes updates fully integrated. On January 1st. I know there was a bit of angst for this change. They certainly we know that payers don't have those codes in place. I look back to when there was a fairly large change in some of our electrophysiology

codes.

ABR codes, when they were expanded to be more descriptive of the services being provided from everything from a neurodiagnostic evaluation to a threshold search, and there were more codes created. It took some time and some advocacy, both by provider and organizations to help payers appreciate those new codes. Probably most recently, if we think about that AB modifier for Medicare. And this was a Medicare driven in their federal regulations. So this was all they knew it was happening.

They created the AB modifier and yet it took them, you know, in some cases, depending on the Mac, up to nine months until they were really recognizing that and they had a plan of how to move forward. So, you know, I just think we need to, you know, be reasonable. We recognize that payers aren't going to have these codes fully integrated into their systems at this point in time. And it may take in some cases a couple years. I look at things like our Medicaid here in the state where I reside, sometimes it takes them longer to for uptake of any kinds of new codes.

And that takes some effort from our state organization as well. You know, what is not a covered service should be self pay. You know, these are services that are necessary for patients to have the best outcomes with their treatment. And therefore, you know, we need to be comfortable with patients paying for services that aren't otherwise covered. And my guess would be that many of the legacy codes were not covered codes, but it was hard to even try to get them covered.

And I'm not saying there aren't payers out there that did cover them. We are aware that there are, but universally they were not well covered. But it was hard to even promote or advocacy for coverage of those codes when there really was no description of service. So what I might advocate for, if I was calling a payer and what the next audiologist in my state might advocate for, we might be saying different things were being performed. And so I think that's very helpful for us to have it well defined on, you know, what services would be included.

And so I think, you know, we need to utilize the resources that we're helping create our organizations that can assist with payer advocacy. And there are quite a few resources available now that we'll share here in a moment.

And then as far as documenting the time, I hope we've pointed out a couple times that this is just how we see it working in our practices. You know, I can tell you as somebody who has performed a timed evaluation for a number of years for apd, I was pretty consistent documenting when I started and when I ended that evaluation, and I was assuming that was adequate. And after reviewing what many other providers are doing for their documentation of time codes, I felt I was inadequate in how I was documenting those services by simply just putting that time. Now, I'm not saying that that might not be acceptable in the future. I can tell you there are some groups, particularly for physician EM codes, that are looking at EMR as a way of documentation for the time, but they also have complexity in their EM as well that needs to be documented.

So we're just trying to provide an example, one way to do it. I think you have to do what you feel you're comfortable with as well. And if you want to reach out to payers that do cover this service to ensure that you're meeting any of their needs. I think that would be appropriate. Again, these codes are designed to provide clinical flexibility.

And so they're different from our diagnostic codes that are. These must be performed to meet the minimal testing required to actually record that code for the encounter with the patient. And so I think we need to think about these very differently. I look at them as assessment and management. This is part of that management.

That's why they're in that evaluative and therapeutic section or subsection of the CPT manual. So everything in the descriptor does not need to be performed. It really is what is appropriate for that

particular patient. And it is going to vary from adult to pediatric patient. There were one question that came in about minimally, what do we need to perform in the hearing aid selection?

Well, again, I can say you minimally must meet the 16 minute threshold, and you need to determine what are the additional tests or questionnaires that are going to help you when you're making a selection with your patient. I feel pretty confident I will always meet the 16 minute threshold. Those discussions, particularly for new patients, go on for quite a while because they have a lot of questions about, you know, different styles or different levels of technology that you're discussing with them. I do recognize for returning patients, those visits might be a little bit more in line with what they've done previously. And so there's maybe not quite as much discussion, but still a lot of changes in technology from, you know, the time they were fit previously that usually need to be discussed.

And so, you know, our role, as always, is to perform what is necessary and appropriate for the individual patient that we're seeing. And so, Annette, I'll send it back to you.

So this logo here was created as the joint collaborative effort between the American Academy of Audiology and asha. And so when you see this logo, these are most likely guidance that has, you know, that's here that has been jointly agreed upon in terms of what's there. So if you have any questions that are, you know, specific to coding and if you would, you can reach either organization by the reimbursementaudiology.org for AAA and reimbursementasha.org for ASHA.

But take some time to visit, you know, each of the sites because they're not static documents. You know, the FAQs get updated as we're all seeing more questions and, you know, helping people understand things. And sometimes there's things that, you know, we hadn't really thought about. And we will address that too. And so there's lots of resources and there will be continuing resources.

And so there's videos, there's different types of documents, articles. You know, this is an ongoing thing. So that's pretty much all that we have for today. We thank you so much. And we're going to take some time to field some more questions.

Okay, so Annette, what I've tried to do is combine some questions that I think will address maybe several people's questions in one. So let me read this and I'll let you answer as I keep trying to go back and forth through the questions that were presented. So this is one relative to timed code. So when you are documenting time, does the time spent for ordering the hearing aid or ordering the ear molds or any of those activities. Activities, you know, perhaps even going into a portal and requesting prior authorization through a portal, do we document that as part of the time associated with that in this case would be selection code.

Yeah. So the CPT codes are really designed for patient facing activities that are discussed described in the descriptor. And so those activities that were just mentioned, probably the time and the overhead for that really should be incorporated in the markup for the devices because that is not part of the selection, that is part of the pure procurement of getting the hearing aid needs.

Okay, so this is one that came up from a few individuals. So what happens if a patient drops off, for example repair or maybe something is happening to their hearing instrument and they're not sure exactly what's going on. Can you use that post fitting follow up code to report the activities that you're going to be performing for that drop off device?

So once again, these CPT codes are for patient facing activities. So if somebody's dropping off the hearing aid and that happens very frequently, what we're currently doing, a lot of people is, is they're using the V5014 repair code, you know, the miscellaneous repair code for that, because you're really not necessarily meeting the standards of the post fitting follow up because you're not necessarily, you're just working on the device and you're not seeing the patient. So I would look at that as more of a

straight repair. But what I will say is that if you did perform electroacoustic analysis, you could use that code because that doesn't have. That is a verification of the device itself.

But when you are presenting the bill, you might wonder what people are doing now is probably similar to what you should still do because the post fitting follow up is really a patient facing thing. So if you were using a repair code for that drop off, then I would continue to do that.

Okay, so this is another question that came up a few times in the Q and A. Do we need to perform all of the components listed in the description in order to build a code? So for example, in behavioral model verification it says, you know, aided speech in noise testing or functional gain, etc. In those long descriptors. So can you address that?

So these codes were designed to provide clinical flexibility. And so unlike the diagnostic codes where you are evaluating a certain, certain thing, this gives you more clinical flexibility. And if you read the descriptors, there's lots of different terms in there. There's if performed, when performed, including those mean that those are examples because we really can't create codes that would cover every scenario in which tests. And a good example would be if you were doing cochlear implant candidacy code which also lives in that same family.

The descriptors are getting longer for CPT across the board and they're just providing more detail for providers and for insurance and for billers. And so if you think about that 926-262 7 people are choosing the different tests that they want. It's not prescriptive that you must do this and you must do that. Same with the cochlear implant candidacy codes, the AOD codes, the APD codes, you can choose the test that you need. The APD just has a restriction that you must at least do three tests to be able to report that timed code.

But they're not telling you which tests. And so think of it more of that way as opposed of to 92557 which says that you have to do air, bone, speech and word recognition. Right. So if you miss one of those, you have to either use another code or if you're not doing the two ears, you have to use the 52 modifier.

And that might be all we have time for today. But any questions that were submitted, we've asked that audiology online send those to us. So perhaps we can create some additional FAQs that will be then uploaded to the sites, the resource site. So I'm going to move to our next slide because I believe Carolyn needs to come back on and finalize a few things with attendees. Yes, thank you both so much.

This was so well organized, well paced and those scenarios were fantastic. And thank you to our members. All the questions that you send into these webinars help us all dig a little deeper and clarify things. So great all around. Really appreciate Dr. Burton and Dr. Miller, your expertise.

And just to remind everyone to please complete the exam that will be in your account on Audiology online. If you are earning CEUs, it will be available in about 10 to 15 minutes. And for those of us in the live webinar today, that expires within seven days. So thank you again. Thanks to the Academy for bringing this much needed topic to the profession.

And we wish everybody a great rest of your day. Okay, thank you. Thank you.