Simplifying Upgrades: Streamlining the Process

Presenters: Emily Livingston, AuD, CCC-A, Rhetzie Felton, Nicole Marinovich

Welcome everyone and thank you for joining us. My name is Allie Young. I'm a marketing manager here at Advanced Bionics and before moving into marketing I worked as a cochlear implant audiologist for years. So I know firsthand that processor upgrades are so rewarding and beneficial to your patients, but sometimes can feel like the most time consuming, non billable task on your list. So today we're going to talk about that process, how to simplify answer some of your questions.

We want this to be just a conversation, but before we dive in, I'm going to introduce our expert panelists who you'll be hearing from throughout today's session. First up we have Dr. Emily Livingston who is a cochlear implant audiologist at New York Eye and Ear Infirmary. Dr. Livingston is dedicated to improving patient outcomes through evidence based patient centered care and will be sharing insights both as an expert today and the voice of many of you joining. Next up we have Retsi Felton. She is the manager of reimbursement services at ab.

She's our go to resource for all things insurance, prior authorization and payer. And Nicole Marinovich is our upgrade specialist. She'll be bringing the upgrade workflow to life as our resident specialist here. We're very lucky to have all three of them with us today and we thank you for joining. I also want to acknowledge that Lori Hambrick is a member of our education and training team at ab.

She'll be managing the chat for us and also leading the Q and A session towards the end. So as questions come up, please type them into the chat and we'll make sure we address them. So let's begin with the why. What do upgrades change for your patients? So Dr. Livingston, if you can start us off, maybe share a story from your clinical experience about how a processor upgrade impacted a patient's day to day life.

Yeah, of course. So I have a patient who's been a long term AB user who upgraded from the Q90 platform to the M90 platform. She was absolutely thrilled with Bluetooth connectivity. She was really excited to FaceTime her family and friends and be able to hear them more clearly. She was also really

excited about remote programming.

She lives pretty far away from our clinic, so being able to make those adjustments was really exciting for her. So she was smiling our whole upgrade appointment, which is really rewarding. Yeah. And those smiles and that confidence piece can change a lot for your patients, but it also can be hard to measure in the booth. So sometimes just remembering those stories and how it's impacted can Be really helpful.

Now we know why it's important. Can you share a little bit about what you find challenging about the upgrade process as a clinician? Yeah. I think some of the hardest parts is patients are really eager to upgrade to new technology. So sometimes they come in really ready to get the new thing, but it's hard to know what's been going on since I've seen them last.

So being able to know what kind of progress they've been making, know any issues with the device, and then, of course, the big one, knowing their insurance restrictions in terms of upgrading. So that's kind of the harder parts of that situation for me. Absolutely. Thank you for sharing that. Is there anything that you think other clinicians might want to know about the upgrade process?

I think, like I said, you know, the hardest part is navigating those insurance plans and knowing what to do. So I was wondering if you guys had any advice on that.

Absolutely. You know, insurance differences can definitely make the process challenging. Each plan has its own criteria for coverage. Their internal timelines can vary quite a bit. For example, some plans require prior authorization before the treatment can even begin.

For some insurers, that review process can take a couple days, while others can take several weeks, sometimes up to 30 days. Because of those differences, it's important to start the process early and help avoid any coverage lapses or potential issues with the health plan. I want to point out that

insurance may also cover process replacements for a variety of reasons, including device condition, performance concerns, lifestyle changes that have a significant impact to their daily activities.

Yeah. Nicole, do you have any guidance on the right time to start that upgrade process? Yeah, definitely. As soon as there's any question or concern, it's best to start those conversations. The earlier those conversations start to happen, the more likely the process is able to be smooth and timely.

Okay, so earlier is better. But who should they contact first when one of their patients is ready for an upgrade? When ready for an upgrade, please contact the upgrades team. Patients and clinicians can definitely contact the upgrades team directly. We'll have that contact information for you added both in the chat and as part of the resources for the session later.

We basically help initiate the process and make sure that everything's aligned. I had a quick question on that. I can be a little controlling as an audiologist and want to know what's going on with my patients. Could you tell me what. What happens when I send a patient to the upgrades team so that I can tell my patient what they should expect?

Sure. When speaking with patients, the upgrades team will basically walk them through an intake process, so we'll ensure that their contact information is correct or updated if needed. We'll discuss current equipment concerns, we'll check warranty information, obtain or re verify their insurance information. And based on the insurance details provided, we'll outline what their plans requirements are for pursuing an upgrade, as well as guide them through any potential steps they might need to take in order to pursue that upgrade. If in that moment, based on all the information that we gather, that patient is eligible for an upgrade, we'll then move forward with the order form, provide an estimate for processing time, and walk them through when they'll be contacted next.

If in that moment they're not eligible for an upgrade, we'll connect them with the AB Success team or with the customer service team to be able to fully address whatever need it is that they have right in that moment.

I bet that intake process adds a lot of clarity that hopefully will lower callbacks both to customer service providers to save them some time. It sounds like certainly a process. Can you review those steps, Nicole, to kind of peel back the curtain a little bit? Yeah, definitely. We'll have a quick outline for you in the chat as well.

But once intake is initiated and it is determined that the patient is eligible and able to move forward, order forms then become that next piece in the puzzle. So the upgrades team can help facilitate that order form directly with the patient, or clinicians can also complete that order form either through the editable PDF or fully online through the AB portal. An order is started from that point based on the order form selections. The reimbursement services team within AB will then partner with the presiding professional to gather any and all documentation that's required by that patient, specifically health plan. Once all the documents are in order, an authorization request is submitted to the health plan.

After the health plan processes and provides an approval, the upgrade team will then connect back with the patient directly to help finalize and ship their order. And then lastly, patients can then schedule their programming appointment with their new equipment.

Thank you for that. There are a lot of steps there and if we can take a minute to maybe focus in on the paperwork or really documentation to help make that less of a hurdle. I wonder if that would assist because there's so many steps in there that's good to know about, but let's focus in on the documentation portion a little bit. Yeah, as an audiologist, I want to know what are some key points in the documentation that I should make sure I have completed. So that way it's a Smooth process for the insurance approval?

Yes. The key is ensuring there's complete documentation that clearly supports the health plan's medical necessity criteria. That typically starts with thorough chart notes that explain why the replacement is needed. From a clinical standpoint, it's important to document any issues the patient is experiencing with their current processor, along with audiological support to show how those issues are impacting their performance. The notes should include any troubleshooting attempts that outline steps taken to try to resolve the issues.

The documentation should focus on demonstrating that the sound processor itself is malfunctioning or no longer meeting the patient's needs, and that a replacement is medically necessary, rather than simply an upgrade preference. Okay. And are there any other pitfalls or something that I should know about when dealing with the insurance so that way we can make it again a smoother process? Yes, great question. One common pitfall is the use of the term upgrade.

From an insurance perspective, it's better to use the formal language tied to the billing code, such as sound processor replacement, because that aligns with the health plan's evaluation and how they determine benefit coverage. Another issue is incomplete or vague documentation. For example, the chart notes may not clearly describe the device's issues, or the rationale for replacement may be too general, mentioning the age of the equipment only. Also, sometimes there's inconsistencies with the chart notes not matching what's stated in the letter of medical necessity. So to help avoid these challenges, it's important to ensure that the documentation is clear, specific, and consistent across all records with detailed notes that support the clinical need for the sound processor to be replaced itself.

Okay. And so we've been talking lots about documentation, which is obviously challenging along with navigating the insurance. Do you have any other tips in making sure that's smoother? Absolutely. Documentation can definitely be challenging, but a few steps can help make the process a little smoother.

First, start early. That gives the clinic time to gather everything needed before the coverage timeline becomes an issue. It's also to help schedule an office visit if the recipient hasn't been seen recently, so that the issues they are experiencing with their current device can be clearly documented and it's part of their formal medical records, as this will be a requirement for the health plan. Another tip could be to designate a point person at the clinic that will coordinate with the insurance representative here at ab. And finally, maximizing the use of the AB Pro portal as much as possible.

It includes the LMN template if needed, and allows clinics to upload chart notes directly onto the portal so that AB receives the documentation immediately and can help move the process forward with the health plan more efficiently.

That per Portal does. Some have some really good tools on it in addition to what we've talked about already. Nicole, how does AB support this process? Yeah, AB also supports with new device orientation. So when an upgrade ships, patients are then introduced to our AB Success team.

AB Success Team is available through phone, email, web chat and appointments can also be pre scheduled. Completing a new device orientation with ABST helps patients arrive at their programming appointment already familiar with their new equipment. This hopefully cuts down on questions asked during and after those programming appointments. So it allows in clinic interactions to be a little bit more singularly focused. Patients can also stay connected with ABST for ongoing support and resources for sustained success with their equipment going forward.

Dr. Livingston, from your clinical experience, how have you noticed or appreciated this type of support? Yeah, I've used AB Success Team a lot with my patients. Sometimes they end up going before the appointment, which is the most helpful and sometimes they'll go after. I find that it's alleviated a lot of stress for the patients because they don't have to worry so much about all of those extra things during

the appointment. We can just focus on how it sounds and feeling more confident.

So I find that it makes the appointment run a lot smoother and patients seem calmer. That's wonderful. I think that is another one of those things that is not something you measure in the sound booth but really makes patients lives better and yours as well hopefully.

Thank you all, all of our experts for this discussion. We do want to give a lot of time towards hearing from the audience and answering some questions. So we are going to go through that. But just as our key takeaways, it sounds like starting early, standardizing documentation and leveraging maybe the Pro portal and the ELMS for that with order forms using AB support teams can reduce those non billable times and also helping patients know and setting expectations on what to expect when they transition or when they're starting to talk to a manufacturer. Hopefully they've done that before, but potentially if this is a new space for them.

So I'm going to let Lori take over and ask some of the questions.

Thank you Allie. We've had some really good questions come in. Let's see. I'd like to start with this one. I think this question is going to be for you Redc.

Is there a way for providers and patients to check the status of an upgrade request without calling the support line? Yes, there's a couple ways to check the status without calling the support line. Providers can use the AB Pro portal that offers real time status updates on insurance requests. It allows the clinics to see where things are in the process. Additionally, you can also email AB's insurance team for updates if needed, which can be a little bit more convenient than calling at times.

Great, thank you. That's really helpful. There's a number of ways to get that information. I know personally I don't like to talk on the phone very much, so I appreciate all the other ways in which

information can be gathered. All right, let's see.

Actually, we have another one that I think is for you, Retsi. So what if there's a situation where the recipient's processor is not broken, but they would benefit from technology with features that they don't currently have access to? Great question. In those situations, it's helpful to ask some probing questions to the recipient to understand how the current processor may be limiting them in their everyday life. Some health plans may consider replacement of working equipment if there is a significant impact to their daily activities.

For example, if someone works as a firefighter, they may need a processor that can optimize their hearing in high noise and emergency environments where it's more difficult to hear clearly. So documenting these type of real life challenges can really help support the rationale for replacement. Great, thank you. That information is very helpful.

So, let's see. I know that during this discussion you all went through the steps that are part of the process. I think this is Nicole. But if it's actually toward Retsi, feel free to take over Retsi. But a question that came in is, does AB prefer for the patient to start the process or the clinician?

I think I can take that one. I. It would actually be okay in either scenario, whether it is the clinician or the patient. Of course, the conversation will be tailored slightly differently, but we have support in place for both scenarios. I think if it's the clinic that is starting the process, then it allows just for some direct information gathering and for touching on those elements and anything else that might need to be involved in that particular startup process.

If the patient does it, we'll definitely still go ahead and walk them through anything that's needed and provide as much support as is necessary based on what their initial situation is. You know, everybody's always in a different spot. Sometimes they've been seen, you know, just that week, or maybe they just

finished an appointment and they're calling in and they're really excited about the opportunity. It could have been a couple months prior though. So depending on what that scenario is, we'll basically walk them through whatever's needed.

Great, thank you. I appreciate that. Nicole. I think this next one is actually going to be for Red Sea. But again, if I pick the wrong person on this call to answer, feel free to have the appropriate person chime in.

But the question is, would a phone note suffice as a visit note? That's a really great question, especially now in the time of virtual appointments and virtual everything since COVID So yes, phone notes are acceptable. However, they should be clearly documented in the patient's file at the clinical office. So as long as it's part of their formal medical record, that's acceptable by the health plans. Great, thank you.

Let's see, we've got a lot of questions coming in now. Let's go with this one. I think this is for Nicole, but can the upgrade team help with Medicaid patients, both pediatrics and adults? Absolutely. There are multiple plans.

Whether it's Medicaid, Medicare, private coverage, we can help with basically any plan. There are some exceptions and that would be something. And Red Sea, please chime in if so. But both the upgrades team and the reimbursement services team can help outline whether or not there is a particular exclusion depending on what their coverage is and whether there's contracts or not. But we should be able to help with Medicaid patients?

Yes. Great, thank you. That again, so helpful. I appreciate it. Let's see, scrolling through the question, I have a question here for Dr. Livingston.

How do you handle long term recipients who haven't been seen in years but request an upgrade? So for patients we haven't seen in a while, we have them come in for a reevaluation visit just to see where they're at again so that we can talk about the new features, how that aligns with their life and having them have, you know, realistic expectations of what the new technology can or cannot do for them. And then of course, as we've been kind of talking about, loop in AB for eligibility and confirm that we can move forward. Great, thank you. All right, sorting through a number of questions.

Thanks for all the great questions. Let's see, looks like this one's probably for Retsi. How can clinics educate patients about their insurance coverage and potential out of pocket costs for upgrades? Yeah, well, first and foremost it's important not to assume that the insurance company will cover everything 100% or to even estimate the out of pocket amounts when confirming the patient's benefits. The best approach is to Review the processor benefit.

That's with the directly with the patient's health plan. Our AB insurance team does this. We verify benefits, clarify the potential CO pays, we look at the HCPCS code for the equipment and we check that against the patient's health plan and their specific group policy to provide a clear understanding of what their individual costs may be.

Thank you, Retsi. See, I think one of the questions that was asked about the phone notes versus the in person visit or does a phone note work? The initial question was a long duration of time and there's a few questions that were asked about what if it's just been six months and that is a clinical decision if you decide to bring them back in or if a phone note would suffice. But it is probably very dependent on how long is that time, who is the patient, all those types of things. So there were a couple questions that were asked about what if it's six months?

That is a long time. But it's not a, it's not two years, it's, you know, so there is some difference in clinical judgment. You can deciding what is best for your clinic and what is your clinic policy on whether to bring

them in for an evaluation or do a phone note. Thank you, Allie. I appreciate that additional information.

So the next question is for Nicole. What should patients do if they're denied for an upgrade? So if a patient's denied for an upgrade, they should definitely contact the reimbursement services department. Retsi and her team is definitely the go to resource for that scenario. In most cases there is a possibility for appeal and AB will help support and facilitate that.

The appeal process might involve an added partnership both with the patient and with the clinic to help probably update documentation, specificity or help gather additional forms that are going to be requested through that appeal process.

Thank you, Nicole. Related to all of these different processes, this is all very, very helpful. This question is actually related to payment. Does AB offer any type of payment plan available for recipients? We do offer payment plans.

Currently we have a firm as our major partner for payment plans. We have connection with CareCredit as well for certain scenarios. So we definitely have some options available and we can handle all of that with the recipient directly. They can pay over the phone. We also have an online payment system now which has been super successful.

It's been very helpful for a lot of patients who prefer not to provide their credit card number over the phone. So there's plenty of options for finalizing their order and having it shipped to them. Great. Thank you, we have a question. Oh, it just moved because another one came in.

Let me get it back to where I can see it. Okay, here we go. I've heard from other companies that LMNs are no longer needed. Is that true? Yes, that's true.

I'm sorry. Yes, that could be true. In most cases, many health plans no longer require formal letter of medical necessity. However, supporting clinical documentation to substantiate the need for the process of replacement is still essential. Those details can be outlined in the patient's chart note or their history and physical records.

And the documentation should clearly support that the medical necessity is needed and the vice related concerns. And a separate element may not be required at all. Well, that makes it easier. Let's see. Another one just came in and I know it's for you, Retsi.

So while the camera's focused on you, is AB in network with most major insurance plans? AB is in network with most major insurance plans. We also have an initiative to become contracted providers with quite a number of health plans. We're focusing on that as a primary focus. However, if we are not contracted, that doesn't negate the patient's opportunity to allow AB to work with their health plan.

We do individual requests. We ask for in network benefit exceptions. There's a lot of ways that we allow the patient to take advantage of the higher in network benefit level even though we're out of network with their specific plan. Oh, wow. I wish everybody did that.

I think about managing my own healthcare and how helpful that would be. That's great to know. Thank you, Retsi. Let's see, we have time for a couple more questions. So, Nicole, how do you recommend setting expectations for turnaround time for from the beginning of the process with the documentation submission to the approval process?

I would recommend just being open about the fact that processing time does differ for each health plan. So AB will typically provide an estimated range but still highlight the fact that results could be earlier or later than that general timeframe. So it's just more about providing that open, more fluid answer because we're kind of at the mercy of how the health plan is processing at that time. So I wouldn't want

to over promise something to somebody, but definitely provide a realistic time frame or expectation. Okay, thank you.

So there's a lot of information that, I mean, maybe not a lot, but based on the guidance you've given, the clinician needs to or the. We need information about what's going on with the patient and there's a documentation process. Does AB review The paperwork before submission to renew. Good grief. I can't talk.

Let me say that again. If a clinic is struggling with documentation accuracy or happens to make some kind of error, does AB review the paperwork before submitting to the insurance to reduce the amount of denials?

We actually do review all clinical documentation. Upon our receipt, we compare it against the patient's individual health plan specific guidelines for processor replacement to help ensure that the medical criteria that they're seeking is a part of the clinical notes that we receive from the clinic. We do this to help ensure that it's aligned with the payer's requirements and to help minimize denials at the onset.

That's great. I know insurances can be very particular, so having more than one set of eyes on the documentation is probably very helpful. All right, there's so many questions. Just wanted to say before we get to the end, we're not there quite yet, but any questions we don't get to in this live session will be documented and we'll be sure to follow up with you. So I'm going through all these great questions that have come through and.

And we will follow up with you with any outstanding questions so that we make sure your questions are answered. All right, let's see. We've only got two minutes left, so let's move on to this question. We had a question before for Nicole about what expectations to provide to patients related to the turnaround time. And then this question is related to that.

What is the average turnaround time from documentation submission to approval, and what are the different things that can impact that? Sure. The average turnaround time from the time the documentation is submitted to the health plan can vary. It typically takes from a few days up to approximately three weeks. And, you know, the factors that influence this timeline include whether prior authorization is required, the completeness and the accuracy of the submitted documentation, and the health plan's internal review process, if you will.

Some health plans can process a straightforward request within two to three days, while others may take two to four weeks. And that's if some additional clarifications are needed, et cetera. So again, starting the process early and ensuring the documentation is thorough helps minimize these delays. One important factor to keep in mind is that the insurance company's review process does not begin until they receive the necessary medical records. Very good point.

All right, thank you for that additional information. And it looks like we are at the end of today's session. I want to wrap up by saying thank you to all of you who joined us today, all of you who took time out of your busy clinic or school day, or whatever kind of environment you're in when you're working with cochlear implant recipients. We appreciate that you joined us here. I want to also thank the other AB staff that are here, and especially our guest, Dr. Emily Livingston, who is supporting patients day to day, just like many of you are.

As a reminder, please make sure you visit the AB Pro portal to see those new features that we talked about. Some of those include the features like completing the ELMS and then filling out online order forms, which will make things more smooth and simple for you during your busy clinic days. So I will actually quickly put the link in the chat to the AB Pro portal so you have that there and then just say a final thank you so much. We again appreciate your time and have a great rest of your day.