2026 Billing and Coding Update

Presenter: Kim Cavitt, AuD

At this time, it's my pleasure to welcome back to AudiologyOnline Dr. Kim Cavitt. Dr. Cavitt was a clinical audiologist and preceptor at the Ohio State University and Northwestern University and has served as an adjunct lecturer at Northwestern and Western Michigan universities since 2001. She has operated her own audiology consulting firm, Audiology Resources Incorporated. Through Audiology Resources, she provides comprehensive operational compliance and revenue cycle consulting service to hearing healthcare providers. She's the past president of the Academy of Doctors of audiology.

And Dr. Cavitt, always great having you here. I'll turn the microphone over to you. Thank you, Dr. Smaka, and thank you, Kimberly, and thank you, AudiologyOnline, for having me today. In the first few slides are the disclosures, the limitations and risks and learning outcomes. And they're in your handouts, also in the slides, and I recommend you review them at your own leisure.

So we're just going to go ahead and get started. Claims denials are on the rise and they're being driven by AI decisioning. What that means is that a health plan is putting in their medical policies or reimbursement policies codes in the background. And then when your claim comes through their process, if it doesn't meet the criteria of coverage, it, it's immediately getting kicked out and denied prior to it actually really being even processed. So that is being driven by backend AI decisioning.

Claims denials can be reduced by you in your office, every one of your providers having a working knowledge of applicable medical coverage and reimbursement policies for each individual payer and applying that knowledge to your clinical processes. It's also vital. It's always been vital, but it's becoming more and more vital that for every clinical visit you have clear, comprehensive and timely documentation of medical necessity and visit outcomes. Why did you do what you did? Why are you recommending what you're recommending?

What did you find in that visit? What is the care plan? You, you need that all to be in the medical record. If you cannot legitimately document why you did what you did, the medical necessity, I would

reconsider performance of that procedure. And it's also important that you correctly use and document ICD10 diagnosis codes, CPT procedure codes and HCPCs codes and their applicable modifiers when the modifier is required.

So it's really, really important that especially that you know if you're going to be in network, what the rules of engagement for that health plan are. You document your visits and that you code them appropriately.

We're going to talk about patient Notifications. The first one is informed consent. Audiologists are required in many instances and in many states to obtain informed consent prior to the provision of care. It is you as the provider's responsibility to make sure that if informed consent is required that you are obtaining informed consent. A patient must be informed in writing and acknowledge in writing the potential benefits, risk and alternatives involved in any medical procedure or course of treatment.

This is very common in many, many states. You must get that written consent prior to the provision of any care, including telehealth. So I'm going to give you some examples of informed consent. You may need informed consent for treatment. You may need separate informed consent for telehealth.

If you provide telehealth services, you may need separate informed consent for use of electronic communications that you are using that you are texting them because they may have text messaging rates may apply. You need to make sure that patients understand that they may have text messaging rates by receiving texts from you. So you have to get their authority in order to do that. And you may need them to all be separate. In the slides and in the handouts.

You're going to see hyperlinks to give you more information that might be useful for for your particular situation. And it can be more intensive and more expansive state by state.

As I said a moment ago, state laws will vary on telehealth access. Some allowances and coverage were just tied to Covid. What I have found in my research is that most states allow for telehealth explicitly except for the state of Hawaii. But what is common when they allow for telehealth is you have to have specific informed consent for telehealth. If you are unsure how to create these forms, what these forms need to say what the laws are.

This is where legal counsel can be helpful in interpretation, interpreting the laws and how they apply to your clinical situation and creating compliant consent forms for your state and for that situation.

We talked about this several years ago, but I want to talk about it again. About patient notifications which are no surprises act and good faith estimates. All uninsured patients that lack health care coverage. And what's important in audiology is anyone who is self paying. That means they are paying in full for the item or service and it's not being billed to their health plan.

They're 100% self pay. When someone is self pay for a medical device for a medical service which hearing aid services are because those are medical devices, you must they must receive a good faith estimate if their visit is being scheduled more than 72 hours in advance. If you are unsure how the how the no Surprises act applies to you, this is again where legal counsel can be very valuable to give you a definitive answer for your clinical situation and the responsibilities within it. But a general rule of thumb is if the patient has no insurance, that means you can't bill a health plan or they have insurance and you're not billing a health plan, then they need to receive a good faith estimate. Good faith estimates are you don't have to have them if if you are billing a health plan.

So if the pa if the health plan is being billed, you don't have to have a good faith estimate. I've got links again to the no Surprises Act. This is a federal act because this is all about transparency in this map it when you link on it. This is from the Commonwealth Fund. So the no Surprises act went into effect in 2023.

Prior to that, states had their own 23 states had their own balance billing and no surprises laws on the books. Those books did not necessarily go away when the federal law came into play. So this is why an attorney may be useful because you may have state requirements that are greater than the federal requirement. So this is why it's important to know does your state what does your state stand on on patient notification of financial responsibilities versus the federal government?

We also have advanced beneficiary notices or ABNs. ABNs are only applicable to traditional original red, white and blue card Medicare. They have no applicability to Medicare Advantage. They are not legally binding to Medicare Advantage. The ABN form just recently changed, so the old form was dated January 26th.

January of 26. You have until May 12th of this year to change to the new form. And the new form is dated March 31st of 2029. So the 1-31-2026 form is valid until March 12th of 2026. After that date, you must be using the March 31st of 2029 form.

If the patient asks you to review the form with them, you must review the form with them. This form has required and volunteering uses Required means that you can't bill the patient if you don't have it in place. Voluntary means that the item or service is statutorily excluded or does not meet the definition of a Medicare benefit and thus you can bill the patient even if you don't have an advanced beneficiary notice in place. You're just using it to inform a Medicare beneficiary their financial responsibilities. The ABN must be completed prior to the rendering of care and we as audiologists are mandatory claim submitters.

So if a patient selects option one, we must submit a claim on their behalf. So anytime a Medicare beneficiary requests that we submit a claim on their behalf, audiologists must submit claims on their behalf and even for statutorily excluded items or services. In that case, you're going to add the

appropriate GY modifier to let the payer know that the item or service is statutorily excluded. So if they select option 1, we must select we must submit the claim the Required Uses of an ABN Anytime you're using an unlisted code like 92700, L7510 or L9900, these are unlisted COD for services that a health plan covers. So 92700 unlisted owner rhinological item or service that means a procedure without a code.

L7520 that's a service around a prosthetic. L9900 is an item or service around a prosthetic. So whenever you're using those codes, you would need an ABN in place prior to the provision of care. It's important to note that the ABN does allow you to collect your usual and customary payment in full at the time of service. Now you also want to collect an ABN if you're not sure if right in the moment that you're seeing the patient they are covered under a home health hospice or skilled nursing stay.

They that means that they're in a part A stay and most audiologists are not part A providers. They're part B providers only, so they cannot bill for part A services. So in those cases you would need an ABN in place so that the patient understands that they're going to be financially responsible if the health plan or if Medicare does not cover the claim. And three the patients may have had audiometric testing without an order in the past 12 months and you're not sure if the ABA AB modifier was used. So you're seeing a patient, you don't have an order, you want to use the AB modifier.

That means that one visit in 12 months that for a non acute, non vestibular related, non hearing aid related service that you don't have an order, you have that one visit every every 12 months. But if you're not sure if the patient's had a visit within the last 12 months and you don't have an order and you're going to be using the AB modifier, you may want to have in place a required ABN and finally that you have a local coverage determination in effect in your locality. Local coverage determinations is where the Medicare administrative contractor or the Mac has made rules that are more are more specific than Medicare has indicated. Those are very common with first coast or with Palmetto or with

Novitas, especially with Novitas where you may need that ABN in place prior to the provision of care because you don't know if you're going to meet the coverage requirements of the of the local coverage determination until after you've seen the patient.

ABNs also have voluntary uses that means the item or service is excluded from coverage or does not meet the definition of a Medicare benefit. This is serving as a Medicare notice of non coverage when an item or service is never covered when provided by an audiologist or sometimes never covered ever. In the case of a hearing aid, this is when you're using that GY modifier item or service statutorily excluded or does not meet the definition of a Medicare benefit and the gx which means you have that voluntary waiver on file that you have had them sign a voluntary abn. Here are some situations where you would use a voluntary ABN Routine or annual testing where no medical necessity was met. Medicare only covers hearing tests that are medically reasonable and necessary in accordance with the Chapter 15 of the Medicare Benefit Policy Manual Section 80.3, which is going to outline when Medicare covers services.

If you don't meet those requirements, then the patient is responsible for the cost of the test. You can't give it away for free because you can't charge Medicare for something you you're giving to other people for free. And if you're going to be charging the beneficiary, you might want to have a voluntary ABN in place for hearing aids or testing for the sole purpose of obtaining a hearing aid for treatment services that might be covered by another provider such as cerumen removal, cancer repositioning tinnitus management or auditory rehabilitation Tinnitus maskers or devices Evaluation management codes as allowed by the scope of practice in your state. Audiologic vestibular testing where a vestibular order was not obtained and it was required. Evaluations the result of solicitation.

You cannot remind somebody of a task you are due for or you can have. Once you do that, if medical necessity has not been met then you that test is not going to be covered. Audiologic testing that was

completed by a student in the absence of 100% personal supervision. Audiologic testing that requires the skills of an audiologist or physician that was completed by a technician and any screenings. This is where voluntary ABNs can come into utility.

Also, you're going to have when you participate in commercial insurance in your contract you're going to have requirements for notification of non coverage. This again is typically required by commercial health plans and third party networks. And this type of form has has utility with Medicare Advantage plans. It needs to explain why you've determined that the item or service is not uncovered, that it's excluded in their benefit that it is. They don't have a benefit.

It's not mentioned any number of your specialty, it's not covered by your specialty. This means that your practice needs to have the patient acknowledge in writing their understanding and acceptance of the costs associated with the items or services not covered by their health plan. This needs to be in place before the service is rendered and the item or the item is assessed dispensed. When you're using notices of non coverage, you typically are collecting your usual and customary rate. There are some exceptions to that.

When we're talking about Medicare Advantage With Medicare Advantage for diagnostic services that are medically necessary, if you're out of network with that plan, you can only collect the Medicare limiting charge. You cannot collect your usual and customary rate for a medically necessary Medicare covered diagnostic service. You can only collect the limiting charge. So typically you're going to collect your usual and customary except in those Medicare Advantage cases for diagnostic services. This can be invaluable in out of network situations where you might have state balance billing requirements that the good faith estimate won't satisfy or you have state surprise billing laws where where or Medicare involvement or Advantage where the payer requirements are saying you need to notify the patient specifically as to what's not covered, why it's not covered and what your usual and customary cost is.

This is one of the most misused forms I am finding in an audiology practice. That's the upgrade or top up waiver first I should say and I should have put in a bullet. Not every health plan that you are in network for allows for upgrades or top ups. It's very benefit driven. But not every health plan does allow you or allow the patient to upgrade.

It doesn't. I used to tell my patients your health plan doesn't allow me to let you pay the difference.

It is allowed by most Blue Cross Blue Shield association plans and United Healthcare commercial plans. And when I say Blue Cross Blue Shield Association I mean their commercial plans. Blue Cross Blue Shield plans that may not allow for the upgrade are those where coverage is based upon billed charges or those that it's an invoice plus arrangement. Because in those cases, what are you upgrading from? In this situation you need to offer, and this needs to be indicated in writing, a basic or standard that is minimally medically necessary hearing aid at no charge, no charge except for unmet and applicable deductibles, co payments and coinsurance and the charges of prior notified non covered service.

In this case, the patient is acknowledging in the form that they could have gotten the device within their benefits minimally medically necessary. That is what insurance companies are responsible to cover what is minimally medically necessary, but that the patient has decided to upgrade and pay the difference between the allowable rate and the usual and customary rate. And your form needs to reflect that they could have gotten something within their benefit and they're choosing to upgrade. I want to stress one more time that the only plans that allow for upgrades UnitedHealthcare allows for it by medical policy. Blue Cross Blue Shield association plans, except for when you have a contract based upon percentage of bill charges or invoice plus allows for upgrades.

But you have to make sure that you've acknowledged that they could have gotten something within the benefit. Aetna Cigna but CIGNA goes through a hearing hearing benefit plan manager. Some of but

Aetna does not allow generally for upgrades unless you have negotiated that within your contract. Most other health plans, local health plans you may have in your community do not allow for upgrades unless you specifically allow that within your contract.

You also have the option of what's called an insurance waiver. In an insurance waiver, the patient is waiving their health plan benefits, including with hearing benefit plan. So the third party that the patient is saying I understand that I have benefits, but I am waiving those benefits. I'm waiving those, including hearing benefit plans. This is allowed by HIPAA Omnibus.

So HIPAA Omnibus allows for people to not submit things to their health insurance if they so choose. You need an appropriately worded waiver that says that you understand that the patient may have had coverage and benefits through their health plan or through their hearing benefit plan manager or their third party, but that patient is waiving those benefits and that you are not going to submit anything to the health plan as the provider and the patient is agreeing that they're not submitting anything to the health plan as the patient and you a payer, especially a third party or hearing benefit plan manager may have their own language. They may have their own language and their own waiver form to use and you need to consult your contracts for that. But if they don't, you need to have a waiver in place that acknowledges they could have had coverage or benefits or discounts. They had those available to them, they've chosen to waive them and go directly through you.

So Medicare has had a few updates in 2026. This is Medicare Part B deductible is $283. Medicare telehealth coverage has been extended now to December 31st of 2027 for the codes that are in the Medicare telehealth codeless. I've given also a link here to the Medicare fee schedule lookup where you can look up your allowable rate and you can look up the Medicare limiting charge. And I've added a link to the Medicare Advantage plan documents that you can find by zip code.

Because Medicare Advantage, those plan documents as to what they cover and what they don't or what benefit or discount exists, those are available to the public. You can see that at this link. You can search by the zip code and then you can search by payer. You can search if it's Medicare, if it's Medicare dual. And you're going to see the hearing aid benefits listed under extra benefits.

Now I'm going to start. The rest of this update is going to be around the 12 new hearing aid service codes. So effective January 1st of 2026, these six codes which were never covered by traditional Medicare, but these six codes were deleted. So, 925-909-2591, hearing aid exam and selection. 92592 and 92593, hearing aid check and 925-949-2595, electro acoustic evaluation.

Those codes were deleted effective January 1st. So, no health plan and is going to recognize these codes. It is going to trigger a denial 100% of the time. It has been replaced by 12 new codes. Now when a code is created there will be some information typically in the Medicare proposed and final rule.

There'll be information in the CPT manual that's created by the American Medical association who owns the CPT code set. And they're going to create a manual called CPT Changes which I've linked to you. I think you can buy one now for about $50. That's going to describe the codes in greater detail. My presentation is going to be to adhere to the guidance that is presented in CPT changes because the AMA owns the code set and they own the manual and the language in that manual.

I am going to defer to the most conservative interpretation of the codes because it's something that in appeal you can use as leverage that you met the requirements of the code in accordance with the ama. So my presentation is completely based upon what is in CPT changes.

Some providers are more affected by these code changes than others. The providers that this is going to impact the lease. So the provider whether offering a bundled, unbundled or itemized hearing aid delivery who's out of network for every health plan payer insurer except for traditional Medicare, this will

have little to no impact on you. You don't have to have it have any impact on you because your patients are all paying your usual and customary rates in full for the cost of the items or services. It's not going to affect you as much if you're an in and out of network provider who never utilized the codes that were deleted 92590 or 92595 and never provided services that were represented by 92700.

You were providers who were generally billing the hearing aid and the ear molds or you were using maybe hickpick codes of a V5010 assessment for hearing aid, V5011 fitting orientation checking or V5020 conformity to represent your services and not using 92590 through 92595. And if you're uncertain how the changes are impacting you, please review your professional fees and billing policies and allowances from the health plans that you are contracted with. But in general, if you don't participate in insurance or you don't itemize your claim, you've never itemized your claim. These codes don't have to have really any impact on you.

Now this is who it's going to and has impacted the most the provider the in network provider who offers and bills an unbundle or itemized hearing aid delivery in network providers of health plans, payers and insurers who recognize the six codes were deleted and who recognized hearing aid Services billed by 92700 or V5299 as non covered and you were allowed to bill these codes. These payers could include commercial health plans and insurers, specifically Blue Cross, Blue Shield association and Aetna health plans who often already paid in an itemized manner. State Medicaid programs these are have been greatly affected early periodic screening, diagnosis and treatment programs, EI type programs, state vocational rehab programs, state and federal workers compensation programs and VA Community care which has though already updated their fee schedule to recognize the new code set. Some of the important features of the new codes Scope of practice matters. So you're going to see things in the code that you may need to make sure are in your scope of practice in your specific state in order for you to bill them.

And that's going to be important again in appeal processes that you can defend. Why you should be allowed to be paid for an item or service documentation. If it isn't documented, it didn't happen. So documentation has always been important. As I said in the very first slide, it's becoming more and more vital that you're documenting items or services.

Why did you do. Why is that hearing aid medically necessary? Why are those features medically necessary? Why did you perform this procedure? What was the outcome of this procedure?

What is the care plan and why that is going to need to be in your documentation. Unilateral or bilateral. You may need to indicate, and I should have added the word may here, that you may need to indicate a 50 because the codes say unilateral or bilateral. If you get denied that it's inconsistent that you have an inconsistent code, that may mean that they want to see the modifier of a 50 or LT or RT. Some payers don't want to see it, some payers don't care, some payers may want to see it.

That's going to be very payer dependent, inclusive bundled nature of these code. You need to perform all aspects of the procedure in order to bill it. And that's going to. I'll show you that when we get to each individual code. You need to be very cognizant of the applicability to children and certain individuals who may be developmentally or cognitively challenged or non native English speaker to know.

Can you make these codes and their requirements apply? And you cannot append these codes because they're timed with a 52 modifier. So 52 reduced service, you can't add that ever to a timed code. You have to just meet the minimum requirements of the time you have a required report. And that means an audiological evaluation or management report.

You have that for the candidacy codes, for the selection codes and for the fitting codes. And you can add the 52 modifier for the codes for verification of behavioral or probe mic. If you only not be not not not pro mic, not behavioral, sorry. You can add the 52 modifier for probe MIC or electroacoustic

analysis verification. If you only assessed one ear.

Now you have time requirements. These are time codes. And this is important when you're doing multiple time codes on the same patient on the same date of Service, you need to time in and time out of each individual timed procedure. Let's use an example of a hearing aid evaluation. Hae that's a very typical, that's going to have typically an audiogram in that.

And now you may have candidacy and selection. So the audiogram can't be included in the total time because it's paid for separately. Candidacy and selection are two separate codes with two separate timestamps. So you're going to have to have the time in and timeout of candidacy, the time in and time out of selection. So it has to document the in and out time of each specific time procedure.

So for 30 for 60 minute required time you need to spend at least 31 minutes. For 30 minute code time code you need to have spent at least 16 minutes. For a 15 minute time code you need to have spent at least 8 minutes. You can include time for report writing documented if that report is done on the same date of service. You can include report writing time if you haven't written the report yet.

So you have to get that report or documentation done within the same date of service to be able to include that time in the time of that specific code. We also have some add on codes here. These are add on codes or codes. They cannot be billed in isolation. That means they can't be built by themselves.

They can only be billed in conjunction with the code that they're added onto. So verification, behavioral and probe mic are add on codes that can be added on to the fitting or the follow up service visits to indicate the type of verification. Their time that you're spending for an add on code must be extracted because they're paid for separately. So you can't include the time of the real ear in the total time of the fitting. You have to pull out the time of the real ear out.

Because that code is paid separately.

And this is important, it requires performance by a qualified healthcare professional. Now the American Medical association has a definition of what is considered a qualified healthcare professional. A qualified healthcare professional is a physician or other qualified individual who's qualified by education, training, licensure, regulation when applicable and facility privileging when applicable, performing a professional service within his or her scope of practice. And that is independently, this is key. They are not billing incident two, they are independently reporting that service.

That means they're independently documenting it and independently bill it. Payment payers can determine if these services can be provided by hearing aid dispensers and legally established audiology assistants or technicians. Incident to an audiologist or dispenser that's going to be payer. Payer determined. You need to have this role established and licensure to meet the requirements at a minimum to be a qualified healthcare professional.

And audiology assistants are not all mentioned in licensure. Now we're going to start going through the individual codes. So the first code is 92628 evaluation for hearing aid candidacy. Unilateral or bilateral that's one or two years including review and integration of audiologic function tests. Assessment and interpretation of hearing needs for example Speech and noise, super threshold hearing measures.

Discussion of candidacy results. Counseling on treatment options with report and comma when performed. Which is important because it says and comma when performed. That means everything after that is optional. Assessment of cognitive and communication status, it's optional.

Everything before that is required part of the code. This is going to be your first. 92628 is the first 16 to 37 minutes of candidacy evaluation. It cannot be billed with osseointegrated device diet programming

or verification or cochlear implant verification on the same year, on the same date of service. So this is where you're going to have to use those RTLT modifiers.

This is where they are going to come into play. That if you are have an implant on one side, whether it's an osseointegrated implant or a cochlear implant on one ear and you're doing hearing a candidacy work on the other the implant work ear needs to have the RT or LT modifier for that ear on it. And then on the other ear for your candidacy it's going to need to have the opposite ear. That's where those modifiers are going to come into play. You also cannot report candidacy on the same day the service as you are doing a hearing aid follow up service or on the same day that you are fitting an accessory.

Now 92629 is each additional 8 to 58 2. We got to add 8 on 8 to 20.

I gotta add the time on you've got it to get to the next 15. So eight to 23 minutes each. Additional eight to 23 minutes and you're limited to two units max. And that has now been added to the code that you are limited to 2 units max of 92629. Now if you want some links to screenings and assessments that may help you meet the requirements of this code I have provided some links here.

What is super threshold testing and your cognitive and screenings. These are all hyperlinks to help you get more information. The ability to perform assessment of cognitive and communication status can be dependent on state scope of practice and that's just important to know. Not all of you in your state scope of practice are allowed to perform cognitive and communications, even screenings, let alone assessment. If you want information on inventories and questionnaires, I have provided links to those here as well.

Now documentation of 92628 and 2.9 it's less prescriptive per CPT changes of the new codes. It's one of the least prescriptive. It has a lot of if you did it if you did it if provided where some of the other codes do not have NCB changes. Don't say if provided here they do. So this code you need to document

otoscopy that is actually in the code description and CPT changes.

You need to document the results of review of the medical record including diagnostic test results. You need a focused medical history. You need the results of provided inventories if they're provided, the results of speech noise if provided, the results of MCL UCL if provided. You also need to document your candidacy recommendation, treatment plan and counseling outcomes. If you don't meet the requirements all the requirements on the previous slide of 9262A, you can utilize V5010 assessment for hearing aid with an RT LT or 50 modifier or as allowed by state scope of practice, an evaluation and management code of 992-020-31213.

If you are meeting the requirements of evaluation management that are part of that code. Audiologists in only nine states are explicitly allowed to evaluate and manage.

The next code is hearing aid selection 92631 and 3.2. So that's hearing aid selection services unilateral or bilateral including review of audiologic function tests and hearing aid candidacy evaluation assessment of visual and dexterity limitations and psychosocial factors establishment of device type output requirements, signal processing strategies and additional features Discussion of device recommendations with report first 30 minutes so first 3016 to 37 minutes. It again cannot be billed for the same year as an osseointegrated device or cochlear implant verification and it cannot be billed in conjunction with a hearing aid follow up service or a fitting of a hearing aid accessory. And this is your additional 2 units max again of the additional 15 minutes to the additional 8 to 23 minutes. If you need this first link here is from the Shirley Ryan Ability Lab formerly known as the Rehab Institute of Chicago.

The Shirley Ryan Ability Lab has a link that has all sorts of screening measures that you can access if there's a charge, they'll link you to the vendor, but they have a lot of great tools. So if you need information on screening for or assessing communication status, speech, language screening, a vision screening, dexterity or psychosocial factors, here are some links to some screening tools to meet the

requirements of the code. The ability to perform assessment of visual and dexterity limitations can again be dependent on state scope of practice. Here I got a link. I believe it's from the American Psychological association as to what constitutes psychosocial factors.

That's the combination of psychological, mental and social influences that affect an individual's thoughts, emotions, behaviors and overall health. And so it's really that full patient interview to determine how how the hearing loss is affecting their life and their communication. This code is very prescriptive and it needs to be documented in the required report. You need to again document otoscopy. This is a separate procedure from candidacy.

So in your report it can be a combined report, but you need to make sure that otoscopy is again documented. The results of the review of the medical record, the results of the assessment for the hearing aid or hearing aid candidacy or evaluation management. The focus medical history the results of assessment of visual and dexterity limitations it does not say if provided. The results of assessment of visual and dexterity limitations, psychosocial factors and the discussion of device recommendations including device type output requirements, signal processing strategies and additional features. You need to document why you are selecting what you are selecting the why behind it.

Why is this what the aid that you are prescribing for this patient? Because remember prescription hearing aids require a prescription. That's an FDA requirement. So you need to make sure you have a prescription that is including device type output requirement, signal processing strategies and additional features. If you don't meet the requirements of 92631 you can utilize V5010 assessment for hearing aid with an RT or LT modifier.

Now I'm going to go to 92634 Hearing Aid Fitting Services, unilateral bilateral including device analysis, programming, verification, counseling, orientation and training. And when performed again that's maybe hearing assistive device supplemental technology fitting for 60 minutes. So first 31 to 67

minutes and you cannot perform a fitting on the same day as a follow up service or the fitting. The code for the fitting of the hearing assisted listening device. And Then this is 92635.

This is each additional 15 minutes of a hearing aid fitting. So this is another code that is descriptive per CPD changes and this needs to be documented in the medical record, otoscopy, physical fit programming verification. That means that you've done probe, mic or behavioral orientation including cleaning, maintenance, battery replacement or charging, insertion removal and the use of aids, the hearing aid connection to other devices, counseling and follow up services. So this is in the descriptor for a hearing aid fitting 926-349-2635 code. If you don't meet the requirements of 92634 you can use V5011 with an RTLT or 50 modifiers and and the dispensing fee code.

The appropriate dispensing fee code which you can still use. Even if you did meet the requirements, you could still use a dispensing fee code if it's recognized and when performed V5020 for conformity or auditory rehabilitation 926-309-263-92641 Hearing aid verification electroacoustic analysis because it's not an add on code and the hearing aid assistive listening device. If you are fitting an assistive listening device on that same data service you can't bill 92642 on the same date of service if you're billing the 926-3435 codes. But if you're using V5011 you can bill 92642.

Now we're to hearing aid post fitting follow up services unilateral or bilateral including confirmation of physical fit, validation of patient benefit and performance, sound quality of device adjustments e.g. verification programming adjustments, device connections and training as indicated and when performed hearing assistive device supplemental technology fitting services first 30 minutes. So we're going to the first 16 to 37 minutes. This is a good time to tell you on the candidacy and selection codes. Excuse me for a second.

The codes themselves say that they are limited to two units. That is not when you get to fitting or follow up, but a payer, any payer, if you are a network can restrict the number of units they cover of the

additional 15 minutes they can reduce or restrict those requirements. So you want to make sure that you are documenting starts and end time. You cannot report a hearing aid service. This is important for those of you who are who fit, who evaluate and fit on the same day.

That is something that you can't do. You can't do a candidacy and selection and fit on the same day and use candidacy and selection codes as you fit. So 926-282-93132 hearing aid follow up services or fitting of the assistive device. Those cannot be performed on the same day the service as a hearing aid fitting.

Very important to denote. Now this is a little bit less prescriptive, but it's important that you, that you document this. Oh, what did I. I'm in follow up. Oh my gosh. Excuse me for a second.

We're in follow up services. We're not in fitting. So you can't bill for follow up services. Excuse me, I lost track of the codes. You can't bill for follow up services on the same day as candidacy, selection or fitting.

But you can bill. Let's go back because I want to make sure that I'm clarifying this. You can bill for candidacy and selection and fit on the same day. My apologies, I got lost in the codes for a bit. So my complete, utter apologies.

So let's. I'm going to go back again to fitting because I want to make sure everyone understands. So you can do candidacy and selection and fit the patient on the same day to service, but make sure that you have segmented the individual times of each thing. This was candidacy start and end and report time. This is selection, start and end and report time.

This is fitting start and end and documentation.

So these are your requirements for fitting. Otoscopy, physical fit programming, verification that you did pro mic or behavior on the date of fitting. That in CPT changes does not at all say if provided. It is in the descriptor that verification, behavioral or pro mic was performed. That you have met all of these orientation requirements, that you've converted, documented any connection to other devices such as a phone, counseling and follow up services.

So let me start over again now we're to follow up. My apologies. These codes are starting to blend in my head sometimes. This is for hearing aid postfitting follow up services. So it's confirmation of physical fit, validation of patient benefit and performance, sound quality of device, your adjustments, any adjustments that you may have made including verification, programming adjustments, device connections and device training as indicated and when performed, hearing assistive device, supplemental technology fitting services, first 30 minutes.

So it's going to be that first 16 to 37 minutes. You can't report follow up where I made my error. My apologies. You cannot report follow up on the same day you're doing a candidacy determination, a hearing device selection, a hearing aid fitting or you're fitting a supplemental assistive listening device. Those cannot be done on the same date of service.

Now at your follow up visit you need to document otoscopy again, you need to document that you performed a listening check. You need to document the physical fit, condition of aids and overall comfort. Now on physical fit, you may decide as a practice with their appropriate with the appropriate informed consent from the patient that you're taking a photo. I know practices that that's how they're meeting the physical fit requirement. They're taking a photo of the physical fit.

It's really up to you. But you may need specific informed consent in order to be able to take a photo and be able to store that photo securely. The condition of the hearing aids and the overall comfort. You need to document data log. So what is the data log information you need to document?

Programming adjustment as needed. So if you made a programming adjustment that needs to be documented. Informal verification of sound quality. So that's informal. That's the only verification you saw back in fitting I literally highlighted from CPT changes all the things that were in the code descriptor.

Informal was not in fitting. Informal is here at that follow up verification. Behavioral appropriate mic. But that's as needed. Routine review of routine care and maintenance results of baseline communication inventories.

You're going to see that that doesn't say as needed discussion of other assistive listing devices and follow up services.

So that's important that this is documented. I want to go backwards for a moment on purpose this you have to get to 16 minutes.

Now you can get to 16 minutes if you're doing all these things. But if you are doing that the patient is just coming in and you're changing a wax guard, you're not going to get to all of these requirements and you might not get to 16 minutes. So to use this code for follow up, you have to meet all of these requirements the same. I'm going backwards again for all of these codes for fitting. You need to meet all of these requirements as are outlined and those need to be documented the same when you get to follow up.

So follow up is one where you may not meet the requirements of the code. Especially when you're doing that routine clean and check. You're not going to have done everything and you may not meet time. That's where you can lean into V5011 that with an RTL Tier 50 modifier or V5299 a comprehensive time visit. You're just not meeting these all of these requirements.

And when performed you can add on conformity evaluation RTLT with a 50 or with a 50 modifier. RT right ear LT left ear 50 means binaural or bilateral 92630 or 3.3 a very underused code for audiologists. This is a good Time for me to tell people that we code to represent the services we provide. It's not just always about coverage. Even though coverage for auditory rehabilitation is very common with Medicaid beneficiaries.

But when you are rehabilitating someone beyond counseling, I want to go, I am going backwards a lot and I apologize. But this is important. Counseling is included in the fitting when you get to follow up. Counseling is not included. That would be that you are billing auditory rehabilitation.

92630 prelingual hearing loss. 92633 postlingual hearing loss if you build it. I see this a lot of time. I'm only on LinkedIn now in social media. But I have a lot of convers with people that they wish that they had been provided with rehabilitation or at least that be an option.

Rehabilitation can be an option for people who may want to pay for it health plans. Some pay for it, some don't. When they don't pay for it, it's the patient signs a notice of non coverage and the patient's financial responsible at your usual and customary rates. But if a speech pathologist were doing this, they'd be charging for it. If we are doing it, we need to be charging for it as well.

And then you will have 92641 hearing aid verification. You could have electroacoustic analysis. You do a 52 modifier if you only ran it in one ear and then 92642 that hearing assistive device, supplemental technology fitting services. For example, you're fitting an FM or DM system, a remote microphone, an alerting device, a streamer, anything of that nature.

Okay, now these two codes are a little more complicated. So now we are to behavioral verification of the amplification including aided thresholds, functional gain, speech and noise when performed. 92638

and 92639 are add on codes. That means they cannot be billed in isolation. They can only be billed when they are billed on the same date of service for the same patient with a hearing aid fitting or hearing aid follow up.

If you were to bill 92638 without a fitting or a follow up code, it's going to immediately be denied. They only can they're added on to another code. So 92638 is behavioral. You'll notice that it you can't 52 modifier because you can't only test one ear in the sound field. Well, you can't, not when you're talking about amplification.

You can, but you're essentially always assessing Both ears practically 92639 is Pro Mic measurement. That is the verification with probe mic. That's also an add on code. You can add the 52 modifier here. If you only assess one ear now there's no guarantees that the payer will cover both add on codes if you did both on the same patient on the same date of service.

But let's walk through how this works from a documentation standpoint. They have to be separately documented because they are separate codes. What I mean by separately documented, it can all be in one large report but it should be separately headed with its with the start and end time. These are not timed but because you're subtracting the time of their provision from the hearing aid fitting or the hearing aid follow up codes, you're going to need this start and end time too because you're going to need behavioral verification. Assessment began at blah blah blah blah blah blah and ended at blah blah blah blah blah blah blah.

And make sure that is subtracted from that total time. Otherwise you're double billing. So documentation here is going to be key that you have pulled that out. If this were me. I'm just saying if this were me.

The easiest way to operationalize this is on a hearing aid fitting or follow up visit. Let's talk about fitting first. On a hearing aid fitting date you do the pro mic verification first. That's what you do first. So then you can start with that.

Okay, you haven't started your timer yet on your fitting and then you start the timer on the fitting once that is completed. When we're talking about pro mic on a follow up visit you could do it last so that you can have that be what you end with. You've ended your follow up visit. The pro mic is coming after. Now you may have some situations which I totally recognize that you have to go back to the follow up visit based upon the outcomes of the real ear.

I understand that but that can just. But the norm will be that after you've done your follow up work, if you need to do really or you do that last. Now let's talk about behavioral. You may always just do that last because that is whether it's the fitting, whether it is the follow up. Yes, you may have situations where you have to go back to the fitting or follow up timing to.

To do more things. Yes, but you may more commonly not. And you can do those maybe at the end. Now let's talk about the documentation requirements of these codes.

92638 that is the sound field, behavioral assessment, maybe speech and noise maybe functional gain. You need to document otoscopy again. So you're going to need to document that you performed otoscopy and the results of the behavioral verification. 92639 you're going to document the medical record otoscopy again and the results of the pro mic verification. And you need to make sure this is what's going to be harder for people that the data from the real ear is in the medical record.

This is where you may need integration from your test suite or test box, your noaa, whatever, whatever is storing your real ear. Or you may need to print and scan depending on what your situation is. So you may need integration so that the this test data is in the medical record or. Or you're going to need to

print and scan.

Now if you don't meet the requirements of 9263A or 92639 and when, I mean you don't meet the requirements that's generally meaning that you're doing them in isolation. So if you were ever just doing real ear in isolation or let's we're going backwards again. You're not meeting all of these requirements of the follow up. You're not meeting all these requirements but you're doing real ear. Let's go to this slide.

This is where you can do your hearing aid fitting, checking orientation or checking V5011 plus then add the conformity of V5020. And I appreciate that this is complicated. That's why I'm trying. You're going to see me over the next few minutes go backwards and we're going to kind of walk through a patient now. Now we're on to EAA or electroacoustic analysis.

So we're going to go Forward backwards again. 92638 is verification of the sound field.

92639 is individual ear real ear pro mic measures. 92641 is a running an aid in a hitbox. That's electroacoustic analysis. You have to have a hitbox to be able or hearing aid test box to be able to run electroacoustic analysis. This is a very important procedure to run on all new and repaired hearing aids to the defense of the manufacturers.

They leave the manufacturer, they pass quality control. But these devices have been on a journey. They have been on a journey, sometimes a many month journey to get to your office. And that last phase of that journey is with the ups of the FedEx guy in a crazy throwing endeavor. Yes, they are secured in boxes but things can happen from heat, from damage or something getting crushed from moisture getting in because of heat.

Because of the conditions. You should run all new and repaired hearing aids through a hitbox and bill for it before you put them on a patient. Depending what I have seen data, depending on clinics. These are in clinics who run everything and who always have somewhere between 10 and 20% of new and repaired hearing aids will not meet spec. A very common issue is is microphone issues that they're flipped or that they're off a twinge and they're non functional.

So you always also want to run a directional mic test. But EAA is a very valuable thing in an audiology or hearing aid dispensing practice. So this is running a hearing aid test box and making sure it's meeting specifications or determining on how it's actually running. Invaluable if you're assessing a OTC type device. If you only assess one hearing aid, you're going to add that 52 modifier.

You're not going to include the time of this procedure in the total time of your fitting or in your evaluation. But it is not an add on code. So it can be billed in isolation. So this code can be built in isolation and it has. There is no other code that really well represents this code.

That code was deleted. You could. The closest code you could use to represent it would be V5020. If not if. If the 92642 is not recognized but V5020 is, you need that procedure.

You need to document the procedure, what you did and you need to be able to store that test data again in the medical record.

The final code is the hearing aid assistive device supplemental technology fitting services. For example fitting a frequency modulated FMDM system remote microphone alerting devices. The this code is built into other things so it can't be billed in conjunction with a candidacy, a fitting, a follow up or with in isolation which 926-0639 which are only billed with those other codes anyway. You can build multiple units if you fill multiple accessories on the same data service. You need to document the medical record then formal verification of sound quality.

And you need to document that you demonstrate instructed on function maintenance and troubleshooting. Now this code. A general rule of thumb is if the health plan doesn't pay for the assistive technology, they won't pay for the fitting of the assisted technology. This is generally going to be a private pay code. So is the assistive device or technology.

Very rarely are those covered by health plans. Health plans cover what is minimally medically necessary. You can see sometimes some Medicaid programs might cover this. But if a service is for educational, recreational or occupational reasons, they are not covered by health insurance. Those are things that are private pay or paid for by the employer or paid for by the school system.

This is not always something that a health plan, a health insurance is going to cover. You may see vocational rehab actually cover these. In some cases there's a reason for the code, but it's not always to build a health insurer.

Now we're going, we're not going to go to questions yet because we are purposefully going all the way back to the beginning of this code set. Now, what is commonly going to happen, the first thing you need to do before you utilize any of these codes. First thing, if you are in network with a health plan, how do, how does that specific health plan recognize and allow both the 12 new Hearing Aid Service codes and the HCPCS V codes around hearing aids? Step one. So before you utilize the 12 new codes, you need to know what are the allowable rates for these 12 new codes plus the HCPCs V codes V5008 through V5299?

What are the what codes are recognized by each specific payer and what codes, what is their allowable rate? Step 1 Step 2 what is your delivery? Can you meet, can your staff, can your providers for the situation, what is your care standards of your practice? Are you going to meet the requirements of these codes? Are you going to meet them?

So you need to know can you meet the requirements of the codes? Can you meet the requirements of the codes? From state scope of practice standpoint, can you meet the requirements of the codes? So let's for the sake of argument, you're meeting all the requirements of the 12 new hearing aid service codes, the CPT codes and you're meeting which are less no requirements, hardly. You're meeting the V HCPCS codes.

Great. Now let's take a service like candidacy which is going to be the same as assessment for hearing aid. V5010. That's represents the same service. So candidacy and selection are representing the Same service as V5010.

Great. Which code? If they're both allowed which codes, either combination of candidacy and selection or B5010 has higher allowable rates.

That's how you're going to help to try to make the decision of what codes to use. You're, you're going to meet the requirements of the V code because there are no requirements really for the most part. But are you meeting the requirements of these 12 hearing aid services codes, if you're meeting both requirements, all the requirements, which ones have the higher allowable rate. Now it's a moot point if you're not meeting requirements of the hearing aid service code of the new 12 new hearing aid service codes. If you cannot meet all the requirements of the code and document that, then you're going to be forced into the V code.

Or depending on the benefit type, you can still maybe bill bundle. Because some benefit types, if it's a fixed dollar amount benefit, some of those, like a United Health Care benefit, doesn't matter if it's billed, itemized or bundled, they're only going to pay X an up to benefit or a benefit based upon allowable rates or a max benefit or an invoice plus benefit, you're going to need to itemize or you're leaving money on the table. So in those types of situations you need to determine what codes does the health

plan allow and recognize what codes do they allow and recognize which codes have what, which codes did I meet the requirements of and which codes have the highest allowable rates. So that's all going to come into equations and that's can vary plan by plan, benefit by benefit even. What matters in the situation is that for every time you fit hearing aid A with this, the hearing aid A with all the same features, the same style, the same level and length of follow up care, that that price that you bill, that private pay patient for hearing aid A, your total that you're billing to insurance adds up to that.

That your totals are always the same. That's what matters. They can be built differently because different health plans recognize different codes. It's that your total, the same make, model and style of hearing aid with the same type and level of follow up care, that that price is the same for a private pay patient and an insurance patient. That's what matters.

How you blow it up into its pieces is going to go back to what codes do they recognize? Did you meet the requirements of the code, including scope of practice requirements, did you and who provided the care requirements? Because I will tell you, in my humble opinion, it's harder for an audiology assistant to meet some of these requirements of the codes because do they meet the definition of a qualified health care professional in the eyes of a payer? I'm not making that determination. That's a payer determination to get to make.

And you may need to pose these questions either with or without the help of an attorney to the health plan. So what's the benefit type from that you get from verification? Who's a payer, what's the benefit type? What's the allowable rates? What codes do they allow and recognize?

Did you meet the requirements of the code and what has the highest allowable rate. That's all going to come into this equation.

You can have situations where you're billing, candidacy and selection using a CPT code and where you might be doing a fitting using a V code because the V code had a higher allowable rate.

That's why you're going to really need to do a lot of reconnaissance on the contracts that you participate with and to go back to the beginning of these codes. When we started here, what we started at was that these codes are going to apply to more, to more clinic situations than other people. So if you're out of network, you can just always bill the CPT codes. Now because you're out of network, it doesn't matter what's recognized or not recognized, you're out of network. You don't know what that is.

It's when you're in network that you have to do some research on the payers that you're contracted with and how, what, what their medical policies and coverage policies are, what codes they allow and recognize what rates are attached to those. And then in the verification process what's that specific benefit?

So we've got. I want to go through these again because this is a massive change. 92628 and 29 is candidacy. Are they a candidacy for hearing aids? Are they, are what, what are they a candidate for?

What do they need? 926 and you have to meet the requirements of that. The these are the requirements of that code. If you don't meet the requirements you can lean in for candidacy to the hear assessment for hearing aid or E M for candidacy. E M only as allowed by your state scope of practice.

Now selection is picking prescribing the hearing aid. The FDA requires a prescription to fit prescription hearing aids. Do you have the ability in state licensure to prescribe? You need to get that in place as well. So this is selecting the appropriate hearing aid and assistive technologies.

And why are you selecting it? That needs to be documented here. If you don't again meet these requirements you would lean into V5010 for assessment for hearing aid. You have an exit ramp

everywhere.

Now you fitting the hearing aid. 926-349-2635 this is your fitting.

Does the health plan recognize these codes and if not do they recognize either either or, either and V5011 fitting, orientation, checking and or a dispensing fee code. V5160 that's an example. But you have to meet the requirements of the fitting and document it in the record. You don't now you're leaning into itemizing but you can itemize across the both the CPT and the HCPC code set depending on what you actually did. But it's important to always know.

Does the health plan recognize a dispensing fee code? UnitedHealthcare doesn't. That's in their policy. They don't cover dispensing fee. They don't recognize them.

A good thing? Not a good thing, but something to tell you about UnitedHealthcare. When these new codes came into effect, they removed all hearing aid service codes from their allowable rate from their policy. They're all gone. So what I would tell you about UnitedHealthcare is I would be billing a UnitedHealthcare commercial plan bundled even if I was an unbundled, I would bundle everything back under the hearing aid and the patients pay the difference between the allowable $2,500 a year and anything they're upgrading above that if they are upgrading and have an upgrade waiver in place.

But I wouldn't itemized to UHC commercial because they don't cover dispensing fees and they don't recognize any of the hearing aid service codes. And in United I would never bill them for service. They only cover evaluation and fitting. That's very clear in their medical policy. Now you're getting to post fitting follow up services.

Post fitting follow up. Are you spending enough time are you spending enough time on that postfitting follow up and are you meeting all these requirements of the code? If not, you're leaning into again

probably itemizing things based on the services you you actually performed using a V and or CBT code set.

If you do verification, it should be done at fitting to meet the requirements of the fitting code. If and if done a follow up that time needs to be pulled out time needs to be pulled out of that fitting or follow up code because you can't double dip on the time.

You got to make sure you're storing the tracings of both Real Ear and of eaa. How are you going to store them? That's the requirements of the code. If you can't do that, you're going to have to lean into that V5020 because that doesn't have a requirement to store the tracings. But you need to know what code does the health plan recognize and at what dollars?

Because I have seen allowable rate schedules now where the V code pays way more than the new hearing aid service code. So you want to do the math.

Now you've got eaa, you're running something in the test box. This can be billed in isolation. This can be 52 modified if you only. But you have to be able to store the tracing again and you can't include this time in the time of a fitting or follow up. It needs to be pulled out separate procedure, separately covered and the fitting of the assistive technology.

So I wanted to kind of go, go through it once and go back through it. I apologize for my flub around fitting and follow up. I think I've corrected it. But if anyone. We're going to move on to questions here because I think we're right in the sweet spot of timing.

I am going to go to the questions that are in the queue. So if anybody has any questions.

Is an ABN required for patients who don't have Medicare, for example, billing a 92700 for someone who has United Insurance? Okay, I'm going to back up an advanced beneficiary notice. That exact form and that exact word that is only applicable to original traditional red wine, blue Medicare, that form has no validity. And outside of traditional Medicare. But United Health Care, Medicare Advantage, United Health Care commercial, if you are in network is going to have in their contract and I'm going to say they're going to have it because UnitedHealth Care has a standard national contract, which I've read a thousand times and it has a requirement in it for notices of non coverage.

So in this situation with 92700, you would have a patient sign a notice of non coverage. And that patient can your notes of non coverage be worded that the patient is going to pay your usual and customary rate at the time of visit. You're going to say that your reason for non coverage is this is an unlisted procedure. Unlisted procedure. There's no specific code to represent it.

That's why it's non, potentially non covered. And that the patient pays you their usual and customary cost of the day of service. So for United Healthcare, if you were in Network or even if you're out of network with Advantage, you're going to need a notice of non coverage. For that 92700 situation. You cannot use an ABN form.

Can 92636 be billed for hearing aid drop off? Okay. Did you meet the requirements of the code. That's the most important thing. You're going to have a problem, in my humble opinion, meeting the requirements of the code and a drop off.

Because the requirements of the code are talking about physical fit and sound quality. Like you're not going to have all that information in a drop off situation. So in my opinion, you're generally not going to meet the requirements of 92636 in a drop off situation. So you're going to need to lean into in that situation either a V5011, a V5299 or if you actually did a repair, a V5014. Could you please explain the difference between 5011 and 5020?

V5011's descriptor is fitting orientation checking of hearing aid. That means you are fitting and orientating a hearing aid or you are doing a hearing aid check. In its loosest term, V5020 is a conformity evaluation that is a form of verification either behavioral probe, mic or electroacoustic analysis. It is that you are determining that the hearing aid is conforming to the hearing loss or to specifications. Do insurance plans with third party hearing aid programs such as UHCU offer, uh.

Do they ever pay any of these services, these new codes or the old? I cannot give you a singular answer to that question. And why? I can't give you a singular answer because some states have different coverages or different rules. Like in my state of Illinois we have a coverage for repairs.

So UHC hearing or ear professionals network may they have a process for how they cover repairs if people want to use their benefit for that instead. So I can't give you a singular answer to that. But in general, everything around the evaluation, fitting and follow up for one year is included in your professional fee and they will not pay any of these extra codes separately. Now there are some situations where if your standard of care is that you're doing communication and functional needs assessments on all of your patients and it's all private pay and your doing that with a UHC hearing patient that you can charge them privately for that and you can bill these codes to the patient after their one year of covered service. But in that professional fee is everything around evaluation, fitting and follow up.

Communication needs assessments are different in that because the outcome may not be a hearing aid. It's not about a hearing aid, it's about creating a communication strategy. And for some people that outcome is a cochlear implant. For some people that outcome is just an assistive technology. It's not specifically about a hearing aid.

If the insurance will pay both the V codes and the new 12 codes, can we bill both on different dates? No, no, not if. Not for different dates of service. For different dates of service, yes. So if you're in some situations meeting the requirements of the code, and in other situations you're not meeting requirements of the code, yes, you can.

You cannot build both codes on the same patient on the same date of service.

Well, I think that I have been through all of the questions. We nailed the timing here. I want to thank AudiologyOnline and thank everyone I'm going to add one more time, Please ignore slide 39, because that slide in between me submitting the slides and I forgot to remove that slide this morning, so I apologize. So that slide needs to be removed. But otherwise, thank you so much.

If you have any further questions, I really am going to direct you to your the state and national associations of which you are a member, and they can guide you further with any questions, guidance, and support. Thank you. Thank you, Dr. Cavitt. You always get so much information into this time. It's kind of like speed dating.

Not that I've ever done it, but it's like coding and billing. Speed dating with Dr. Cavitt. But thank you so much. Thanks, everybody, for your questions. Thank you.

And we hope to see you all in another webinar soon. Appreciate you, Dr. Cavitt. Thank you. Thank you.