



AUDIOLOGYRESOURCESINC

ESSENTIAL TOPICS IN CODING AND REIMBURSEMENT 2018

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DISCLOSURES

Financial

- Audiology Resources, Inc. (ownership)
- Northwestern University (adjunct faculty)
- Academy of Doctors of Audiology (consulting)
- Michigan Audiology Coalition (consulting)
- AudiologyOnline (consulting)

Non-Financial

- Illinois Academy of Audiology (board member)
- Illinois Board of Speech Pathology and Audiology (vice-chair)
- Audiology Quality Consortium (interim chair)
- American Speech Language Hearing Association Audiology Group (member)
- Academy of Doctors of Audiology (committee member)

LEARNING OUTCOMES

- Participants will be able to:
 - Define MIPs and its role in audiology.
 - List the ICD I0, CPT and HCPCS coding changes for 2018.
 - Describe the key questions to determine when analyzing third-party payer agreements.

2018 CODING CHANGES

- CPT (Current Procedural Terminology)
 - Classifies procedures.
 - HCPCS (Healthcare Common Procedure Coding System)
 - Classifies items and their accompanying services, including hearing aids and auditory prosthetic device items and services.
 - ICD-10 (International Classification of Diseases – 10th Revision)
 - Classifies diagnoses and symptoms.
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2018 CODING CHANGES

- There are no significant CPT, HCPCS, or ICD-10 coding changes that pertain to audiology in 2017/2018.
 - ICD-10 coding changes go into effect on October 1 of each year.
 - CPT and HCPCS coding changes go into effect on January 1 of each year.
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WHY WE CODE ITEMS, SERVICES AND DIAGNOSES?

- WE DO NOT CODE FOR COVERAGE!
- We code for data.
 - This data helps a practice make business decisions, rather than emotional decisions.
- We code to reflect productivity.
- We code for reimbursement.
 - Coverage is when a third-party is paying all or part of the cost of the item or service.
 - Lack of coverage does NOT mean a lack of reimbursement.
 - Reimbursement is when you, the provider, receive payment for the cost of the item or service.
- WE NEED TO CARE MORE ABOUT REIMBURSEMENT AND LESS ABOUT COVERAGE!

CODING SCENARIOS

PEDIATRIC TESTING: ATTEMPTED TESTING

- Can bill for testing that is attempted if documentation of:
 - What happened?
 - Why you were unable to complete the testing?
 - Did you spend at least half of the typical test time attempting the procedure?

Documentation is key!

EXAMPLES OF PEDIATRIC TEST SITUATIONS: CHILD LESS THAN TWO YEARS

- VRA (92579) in soundfield or headphones, includes tones and/or speech
- Tympanometry (92567)
- OAEs (92587)
- ABR (92585)

EXAMPLES OF PEDIATRIC TEST SITUATIONS: CHILD TWO TO FIVE YEARS

- Conditioning play audiometry (92582)
- Select picture audiometry (92583) or 92555 (SRT/SAT) or 92556 (SRT/SAT and WRS)
- Tympanometry and reflexes (92550)
- OAEs (92587)

CAPD

- Very hard to do, if participating with third-party payers.
- CAPD evaluation (92620/1).
 - First 31-60 minutes, plus report writing
- Treatment
 - 92633 versus 92700 versus 92507
- Evaluation and management codes?

VESTIBULAR ASSESSMENT

- Basic vestibular evaluation (92540):
 - Gaze (92541).
 - Positionals, minimum of four positions (92542).
 - Hallpike testing is a position.
 - Optokinetic (92544).
 - Oscillating tracking (92545).
- Caloric testing (92537)
- Evaluation and Management codes?

VESTIBULAR ASSESSMENT

- Positional testing, without recording (92532)
 - Could be used for Hallpike in isolation.
- Rotational testing (92546)
 - Must have a rotational chair.
- Use of vertical electrodes (92547)
 - For ENG only (except in Florida).
- Dynamic posturography (92548)
 - Need a platform.
- Saccades, VEMPs, VHiT, SOT, and/or use of goggles (92700)
 - End up being private pay in most cases.

AUDITORY OSSEOINTEGRATED DEVICE

- Need pre-determination in writing, if not clearly listed as a benefit on the patient's contract.
- Never call a BAHA a BAHA.
 - Call it an “auditory prosthetic device”.
- Candidacy testing, if completed (92626).
- Evaluation and Management codes?
- Fitting (L9900 or 92700).
 - Patient pays this amount on the date of the device fitting.
- Troubleshooting/service (L9900 or 92700).
 - Suggest patient be billed and pay privately.

CI CANDIDACY

- Audiogram (92557)
- Tymps and reflexes (92550)
- ABR (92585)
- OAEs (92587 or 92588)
- Caloric testing, per irrigation (92538)
- Evaluation of A/R status (92626/7)
- Evaluation and Management codes?

CI SURGERY

- NRT (92584) or 95940 and 92585 (intraoperative monitoring)

CI INITIAL TUNE-UP

- Programming (92601 if less than 7 years or 92603 if 7 years or older)
 - Could bill as two line items, with RT/LT modifiers or add -50 modifier for bilateral implants
- eSRT (92568)
- Fitting and orientation (L9900 or 92700)
 - Suggest patient pay privately.
- Testing (92626)
 - Add -59 modifier

CI: EVERYTHING ELSE

- Re-programming (92602 or 92604)
- NRT (92584)
 - Remember about the coding edit.
- Soundfield testing (92626)
 - Must spend at least 31 minutes.
- Troubleshooting/service (L9900 or 92700)
 - Suggest patient be billed and pay privately.
- Recommend you send patients to manufacturer for supplies.
 - More time to bill and collect than you actually receive.
 - L codes exist.

CERUMEN REMOVAL

- Impacted (69209 or 69210):
 - Use 69209 if you used lavage or irrigation or use 69210 for use of any other form of instrumentation.
 - Can bill Medicare patients privately.
 - Voluntary ABN.
 - Consult your contract for guidance with other payers.
 - 50 modifier for binaural, although they may only pay for one ear.
- Non-impacted (92700):
 - Inclusive to audiogram if performed on same date of service for Medicare.
 - Can bill Medicare patients privately if done on a separate date of service.
 - Consult your contract for guidance with other payers.
 - Voluntary ABN.

TINNITUS MANAGEMENT

- What does your typical patient look like in terms of test battery, case history, and counseling???
- 92625
- Evaluation and Management?
- This will help you determine the codes you use and the prices you set.
- Will need to screen for depression, as allowed by state licensure, for MIPS.
- Very hard to do, if participating with third-party payers.
- Medicare does not cover tinnitus maskers.
 - Medicare patients are financially responsible for costs.
 - Consult payer guidance for private insurers.
 - V5299.
- Tinnitus rehabilitation (92700 versus 92633).
 - Consult payer guidance for private insurers.
 - Medicare patients are financially responsible for costs.

AURAL REHABILITATION

- 92630 or 92633 or 92507
 - Medicare beneficiaries are financially responsible for the costs.
 - Consult payer guidance for private insurers.

VA, WORKERS COMPENSATION AND MEDICAID CODING

- These entities follow their own, defined coding conventions.
- Following the coding recommendations and requirements outlined by these specific payers.

ICD 10 CODING SCENARIOS

DIFFERENT TYPES OF HEARING LOSS IN DIFFERENT EARS

- H90.A11: Conductive hearing loss, unilateral, right ear, with restricted hearing loss on the contralateral side
- H90.A12: Conductive hearing loss, unilateral, left ear, with restricted hearing loss on the contralateral side
- H90.A21: Sensorineural hearing loss, unilateral, right ear, with restricted hearing loss on the contralateral side
- H90.A22: Sensorineural hearing loss, unilateral, left ear, with restricted hearing loss on the contralateral side
- H90.A31: Mixed conductive and sensorineural hearing loss, unilateral, right ear, with restricted hearing loss on the contralateral side
- H90.A32: Mixed conductive and sensorineural hearing loss, unilateral, left ear, with restricted hearing loss on the contralateral side
 - You would need to select two of the above codes to reflect different hearing losses in different ears.

TOXICITY MONITORING FOR CANCER/CHEMOTHERAPY

- Code the cancer as the primary diagnosis.
- Code T36.5X5A Poisoning, adverse effect, aminoglycosides, initial encounter IF they have begun the chemotherapy.
- Code ototoxic hearing loss (if you had a baseline), otherwise code the conditions measured, conditions visualized and/or symptoms reported.

TOXICITY FROM VIAGRA

- H91.02 Ototoxic hearing loss, left ear
- T46.7X5A Poisoning, adverse effect, vasodilators, initial encounter
 - First date you diagnose an ototoxic loss.

ASYMMETRIC HEARING LOSS

- Code the hearing losses themselves and disregard the asymmetry.
- For example, a bilateral asymmetric hearing loss is coded as H90.3 (a bilateral SNHL).

“ROUTINE” HEARING TEST

- There is no CPT or HCPCS code for a “routine” hearing test.
- The best option is ICD 10 codes are Z01.10, Z01.110 or Z01.118.
 - Cannot code a “rule out” condition once you know the condition does not exist.
 - Sometimes, again, it is the patient’s responsibility to fight for coverage.

NORMAL HEARING WITH NO OTHER SYMPTOMS OR CO-MORBIDITIES

- Z01.10 Hearing/vestibular examination without abnormal findings
- or
- H93.2 - - Abnormal auditory perception
 - If they report communication difficulties or have poor speech in noise results.

NORMAL VESTIBULAR

- Z91.81 History of Falling

or

- R42 Dizziness

or

Comorbidities that drove medical necessity.

NEWBORN HEARING SCREENING FOLLOW-UP

- Code pre and post natal conditions or symptoms.
- Code any co-morbidities.
- Code anything you see or measure.
- If they previously failed a hearing screening, code Z01.110.
- Add the -33 modifier to all of the procedures.
- Consider Z05.8 (Observation and evaluation of newborn for other specified suspected condition ruled out).

DIAGNOSING CONDITIONS OUTSIDE AN AUDIOLOGISTS' SCOPE OF PRACTICE

- To support the reason for the test, you may need to include diagnoses for co-morbidities.
- You may receive these diagnoses listed on your order.
- You also may need to reach out to the ordering/attending physician to get the definitive diagnosis and code (diabetes, cancer, multiple sclerosis, etc.).
- Once you have this diagnosis, documented, from a physician or an individual who can, within the own scope, make this diagnosis, you can use it on your claim.
 - This should be documented in your medical record.

HCPCS CODING TIPS

HCPCS “S” CODES

- **Need to determine how each payer recognizes and processes these codes before you use any of the codes.**
- **Not appropriate for Medicare or Medicaid.**
- **Sometimes these codes may be used to represent a service for productivity and not billing.**
- S1001: Deluxe item, patient notified
 - It is listed in addition to the code for the basic item.
 - May help with upgrades.
- S0618: Audiometry for hearing aid evaluation to determine level and degree of hearing loss
 - Some payers may consider this the code to be used for a routine hearing test.

HCPCS “S” CODES

- **Need to determine how each payer recognizes and processes each code before you use any of the codes.**
- S5165: Home modifications, per visit
 - Home falls hazard assessment and modification.
- S9445: Patient education, not otherwise classified, non-physician provider, individual, per session
- S9446: Patient education, not otherwise classified, non-physician provider, group, per session
- S9476: Vestibular rehabilitation program, non-physician provider, per diem
 - Not covered by traditional Medicare.

HCPCS CODES

- V5170: Hearing aid, CROS, in the ear
- V5180: Hearing aid, CROS, behind the ear
 - Receiver and transmitter
- V5210: Hearing aid, BICROS, in the ear
- V5220: Hearing aid, BICROS, behind the ear
 - Transmitter and hearing aid/receiver

Depending on payer, you may be able to bill the CROS/BICROS in this manner:

- As V5257 x 2 units or V5261.
 - Has slight audit risk.
- As CROS/BICROS code plus V5257.
 - If, though, the payer denies the claim, you may be stuck with coverage for CROS/BICROS code only.

MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS)

AUDIOLOGY PHYSICIANS QUALITY REPORTING SYSTEM (PQRS)

- PQRS was retired on December 31, 2016.
- Your practice can still be penalized in 2018 for failure to appropriately report in 2016.
 - The penalty is 2%.
- The replacement program, the Merit-Based Incentive Payment System (MIPS) went into effect on January 1, 2017.
- Most audiologists are ineligible for the MIPS program in 2018.
 - Some audiologists in ACOs MAY have reporting responsibilities.
 - Use <https://qpp.cms.gov/participation-lookup> to determine if you have reporting requirements (hospital and large multi-disciplinary or otolaryngology clinic practice).

PQRS MEASURES FOR AUDIOLOGY THAT STILL EXISTS IN MIPS

- **ALL SIX OF THESE MEASURES STILL EXIST IN THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)**
- **Measure #130: Documentation and verification of current medications in the medical record.**
- **Measure #134: Screening for clinical depression and follow-up plan.**
- **Measure #154: Falls Risk Assessment**
- **Measure #155: Falls Risk Plan of Care**
- **Measure #226: Screening for Tobacco Use/Cessation**
- **Measure #261: Referral for otologic evaluation for patients with acute or chronic dizziness.**
- www.audiologyquality.org for more information about audiology measures.



APPROPRIATE DEPRESSION SCREENING TOOLS

Patient Health Questionnaire (PHQ-9)

- <http://patient.info/doctor/patient-health-questionnaire-phq-9>

Beck Depression Inventory (BDI or BDI-II)

- <http://mhinnovation.net/sites/default/files/downloads/innovation/research/BDI%20with%20interpretation.pdf>

Center for Epidemiologic Studies Depression Scale (CES-D)

- http://www.actonmedical.com/documents/cesd_long.pdf

Depression Scale (DEPS)

- <http://zadz.ch/en/sicknesses/test/depression-self-test-deps/>

Duke Anxiety-Depression Scale (DADS)

- <http://healthmeasures.mc.duke.edu/images/DukeAD.pdf>

Geriatric Depression Scale (GDS)

- http://consultgerirn.org/uploads/File/trythis/try_this_4.pdf

Cornell Scale Screening

- http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf

PRIME MD-PHQ2

- <http://www.oacbdd.org/clientuploads/Docs/2010/Spring%20Handouts/Session%2020j.pdf>

FALLS RISK ASSESSMENT

- Falls Risk Assessment Tools:
 - <https://www.youtube.com/watch?v=UhjhBh5gc34&feature=youtu.be>
 - <http://www.mnfallsprevention.org/professional/assessmenttools.html>
 - Get Up and Go:
<https://www.aan.com/Guidelines/home/GetGuidelineContent/273> and
<http://www.rheumatology.org/I-Am-A/Rheumatologist/Research/Clinician-Researchers/Timed-Up-Go-TUG>
 - Tinetti:
http://consultgerirn.org/uploads/File/Tinetti_Assessment_Balance.pdf and
<http://www.bhps.org.uk/falls/documents/TinettiBalanceAssessment.pdf>
 - Berg: http://www.aahf.info/pdf/Berg_Balance_Scale.pdf and
<http://www.unmc.edu/media/intmed/geriatrics/nebgec/pdf/frailelderlyjuly09/toolkits/timberbergbalancescale.pdf>

MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- The Merit-based Incentive Payment System (MIPS) consolidates three existing quality reporting programs: the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VBPM), and meaningful use (MU). The system also adds a new performance category, called improvement activities (IA).
- <https://qpp.cms.gov/>
- <https://qpp.cms.gov/mips/quality-measures>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CPIA-Performance-Category-slide-deck.pdf>

MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND AUDIOLOGY



MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS): WHAT WE DO KNOW

- PQRS like measure reporting will be back.
 - The same codes and measures still exist in MIPS.
- There will also be clinical improvement reporting requirements.
 - Attestation.
- Registry reporting only?
 - Possibly...
 - ASHA is developing an audiology registry as we speak.
 - Details are yet to be released.
- Electronic health record requirements?
 - Maybe....we need to start to prepare for this.

PLANNING AHEAD FOR MIPS

- Basic Health Screenings
 - Body Mass Index
 - https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html.
 - Blood Pressure
 - https://www.cdc.gov/steady/pdf/measuring_orthostatic_blood_pressure-a.pdf
 - Can used automatic cuff.
 - Can be useful with vestibular and pulsatile tinnitus.
 - Pain
 - <https://consultgeri.org/try-this/general-assessment/issue-7.pdf>
 - One of the warning signs of ear disease.

CORE CLINICAL IMPROVEMENT ACTIVITIES

- Expanding practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Achieving health equity
- Integrating behavioral and mental health
- Emergency Response and Preparedness

CLINICAL IMPROVEMENT ACTIVITY EXAMPLES

Expanded hours

Telehealth

Patient satisfaction surveys

Data registry participation

Reports to physicians

Timely communication to
physicians

Electronic health records

Peer led support groups

Enhanced websites

Falls risk screening and
assessment

Humanitarian work

Depression screening

Tobacco screening

PART C COMPLIANCE TRAINING

- Many Medicare Part C (Advantage) programs require providers and staff are trained on compliance.
- This training must be completed within 90 days of a new hire.
- This training must be completed at least annually for all employees and this training must be documented.
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf>

HIPAA UPDATES AND CONSIDERATIONS

THE HIPAA GOLDEN RULE

Do unto others,
as you want
others to do towards you



HIPAA AUDITS

- HIPAA is now being audited by HHS.
- As a result, it is very important that you follow the requirements set forth.
- <http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/>
- <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html>

MOBILE DEVICES AND HIPAA SECURITY

- Use a password or user authentication.
- Install and enable encryption.
- Install and activate remote wiping and/or remote disabling.
- Disable and do not install or use file sharing applications.
- Install and enable a firewall.
- Install and enable security software.
- Keep your security software up to date.

MOBILE DEVICES AND HIPAA SECURITY

- Maintain physical control.
- Use adequate security to send or receive health information over public Wi-Fi networks.
- Delete all stored health information before discarding or reusing the mobile device.
- <https://www.healthit.gov/providers-professionals/how-can-you-protect-and-secure-health-information-when-using-mobile-device>
- <https://www.healthit.gov/providers-professionals/five-steps-organizations-can-take-manage-mobile-devices-used-health-care-pro>

TELEHEALTH AND HIPAA SECURITY

- Telehealth is “the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications”.
 - Store and forward is asynchronous telehealth.
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TELEHEALTH AND HIPAA SECURITY

- Audiologists have to ensure, before they begin providing telehealth, that their transmission systems all meet the HIPAA security requirements that “ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or **transmit**”.
 - Cannot use Facetime, SMS, Skype, or unencrypted email (to store and forward) for telehealth.
 - Please consult an IT consultant when setting up a telehealth program for your practice.
 - http://www.telehealthresourcecenter.org/sites/main/files/file-attachments/hipaa_for_trcs_2014_0.pdf
 - <https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/>
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TRANSFER FROM PAPER TO ELECTRONIC RECORDS

- Consult state medical record retention laws.
- Was it a one to one transfer?
 - If yes, you can properly destroy your paper files.
 - If not, you have to maintain your paper records in accordance with HIPAA and state medical record retention guidelines.

PRIVACY RULE SPECIFICS: TEXTING AND EMAIL

- Email and texting
 - ePHI should be submitted through encrypted/secured service providers ONLY.
 - Your practice needs a policy.
 - Add email and text consent to your patient intake and have a separate acknowledgement.
 - <http://www.hipaajournal.com/hipaa-compliance-for-email/>
 - <http://library.ahima.org/doc?oid=105342#.WYMIA62ZNmA>
 - <http://www.hipaajournal.com/texting-violation-hipaa/>
 - <https://www.fusemail.com/resource-center/white-papers/ensure-email-ephi-hipaa-compliant/>
 - <http://www.healthforum.com/connect/resources/pdf-files/imprivatac-2016-0107-w-cioguide.pdf>

PRIVACY RULE: MARKETING

- The Privacy Rule defines “marketing” as making “a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.”
 - Applies to marketing sent to your database only.
- “An arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.”
- <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/marketing/>

HIPAA AND TESTIMONIALS

- Patient testimonials can be an important part of a practices' marketing strategy.
 - But, in order to do this compliantly, the following must be considered:
 - No PHI can be shared in the testimonial or published review.
 - A patient's written authorization must be obtained prior to public use of their review or testimonial.
 - The Notice of Privacy Practices must outline your policies related to publication or dissemination of testimonials and reviews.
 - Staff must be trained on these policies and that training must be documented.
 - <https://www.solutionreach.com/blog/hipaa-and-patient-testimonials-staying-compliant>
 - <http://www.planethipaa.com/patient-testimonials-putting-hipaa-compliance-risk/>
-

MARKETING VERSUS EDUCATION

- Marketing
 - Requires authorization
 - Is a third-party paying for the communication?
 - Are you trying to get a patient to purchase an item or service?
 - Are you “marketing”:
 - Price
 - Product
 - Promotion

MARKETING VERSUS EDUCATION

- Education
 - Does not require authorization.
 - Informational.
 - Talks about technology, not product
 - No mention of specific products or price.
 - No promotions.
 - To inform patients about new locations, addresses or providers.

PRIVACY RULE: MARKETING DECISION MATRIX POLL

- Do you co-op marketing with a third-party?
- Are you an equity member of a buying group whose products you market?
- Do you have a lease or loan from a third-party vendor of products you market?
- Do you have a business development fund for products you market?
- Do you go on vendor-funded trips for products you market?

If you answered “yes” to any of the above questions, you need a long-form marketing authorization if you continue to market those products.

LONG FORM VS. SHORT FORM MARKETING AUTHORIZATION

- Short form
 - No remuneration, in cash or in kind, exchanges hands in any form for products you market.
 - You pay for all of your own marketing communications, in full, that are sent to your database.
 - Example:
 - *By initialing this section and signing below, I authorize Clinic A to send me educational and/or marketing information on the products and services offered by Clinic A. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.*

LONG FORM VS. SHORT FORM MARKETING AUTHORIZATION

- Long form
 - Remuneration, in cash or in kind, occurs regarding a product or service you are marketing.
 - The form discloses this to the patient.
 - The vendor is paying in whole or in part for the communication.
 - One page document.
 - Need assistance of legal counsel to draft.

FOOD AND DRUG ADMINISTRATION (FDA)

FDA REQUIREMENTS

- Requirements:

- <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?fr=801.420>
- <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?FR=801.421>
- Receive a User Brochure
- Medical Clearance or Medical Waiver
 - Needed for each fitting of a child under the age of 18 years of age.
 - If over 18 years of age, may sign a medical waiver.
 - The FDA will NOT be policing the lack of use of a medical waiver/clearance.
 - Either needs to be in FDA language.

FDA REQUIREMENTS

- “The U.S. Food and Drug Administration today (December 7, 2016) announced important steps to better support consumer access to hearing aids. The agency issued a guidance document explaining that it does not intend to enforce the requirement that individuals 18 and up receive a medical evaluation or sign a waiver prior to purchasing most hearing aids. This guidance is effective immediately. Today, the FDA is also announcing its commitment to consider creating a category of over-the-counter (OTC) hearing aids that could deliver new, innovative and lower-cost products to millions of consumers”.
- <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm532005.htm>
- **You need to find out where your state dispensing board falls on the issue of the medical clearance and medical waiver.**
 - This will all be modified when the Over the Counter Hearing Aid Act of 2017 provisions are determined.

FDA REQUIREMENTS

- Many state laws still reference the FDA Referral Red Flags:
 - Active drainage within previous 90 days.
 - History of sudden or rapidly progressive hearing loss.
 - Unilateral hearing loss.
 - Conductive hearing loss or air-bone gap.
 - Impacted cerumen or foreign body in the ear canal.
 - Pain or discomfort.
 - Visibly congenital or traumatic deformity of the ear.
 - Acute or chronic dizziness.

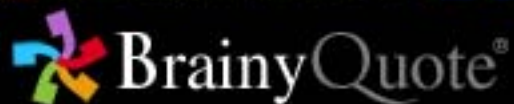
FDA AND STATE DISPENSING LAWS

- Just because the FDA has indicated that they will not enforce the medical waiver or medical clearance requirement does NOT mean that your state will immediately remove it from your state dispensing laws.
- It is **IMPORTANT** that, before you discontinue use of the medical clearance and medical waiver for adults, that you contact your state dispensing and/or audiology licensure boards, in writing, and determine if the requirement remains in your state.



**The pessimist complains about the
wind; the optimist expects it to
change; the realist adjusts the sails.**

William Arthur Ward



MANAGING MANAGED CARE

COVERAGE VERSUS REIMBURSEMENT

- Coverage is when a third-party is paying all or part of the cost of the item or service.
- Reimbursement is when you, the provider, receive payment for the cost of the item or service.
 - Reimbursement can come from third-party payers or from the patient.
- Lack of coverage does NOT mean a lack of reimbursement.

WE NEED TO CARE MORE ABOUT REIMBURSEMENT AND LESS ABOUT COVERAGE!

MEDICARE REVALIDATION

- This is Medicare's attempt to update your enrollment.
- <https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/revalidations.html>
- <https://data.cms.gov/revalidation>
- This WILL occur every three to five years.
- You have 60 days to re-validate.
- ONLY do it online via PECOS at <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>

WHICH THIRD-PARTY PAYERS SHOULD MY PRACTICE CONTRACT WITH?

- Providers need to do a market analysis.
 - What are the socioeconomic factors of your community?
 - What insurers represent the major employers in your area?
 - What insurances do your referral sources and local hospitals accept?
 - Some referral sources cannot, by contract, refer to out of network providers.
 - What insurers offer lucrative hearing aid benefits?

STEP #1 TO CONTRACTING: REQUEST INFORMATION FROM THE PAYER

- Begin the process with a Google search.
- Most payers have excellent websites that contain useful information regarding provider enrollment and guidance.
 - Take a look at their medical policies, provider manuals and/or administrative guidance.
- You can often begin the application request/enrollment process directly from the payer website.
 - Provider/enrollment/healthcare professional section of the website.

STEP #2: YOU WILL RECEIVE A REPLY FROM THE PAYER

- Once your application/enrollment request is completed, you will receive a reply from the payer. This can include:
 - Rejection:
 - Closed Network.
 - They can and do say “no.”
 - Provider Agreement and, possibly, Payer Fee Schedule.

HOW TO HANDLE REJECTION

- Reach out to the human resources department of the employer providing these benefits to their employees.
 - Have data to illustrate how many of their members are seeking your services, how underserved your community is (if a patient has to drive more than 5 miles to see an in-network provider), or how your practices offers services or products not provided by other in-network providers (such as auditory processing, vestibular or tinnitus evaluation or management, pediatrics or implants).

HOW TO HANDLE REJECTION

- Periodically, attempt to re-enroll if participation with this payer is lucrative for your business.
 - Have data to illustrate how many of their members are seeking your services, how underserved your community is (if a patient has to drive more than 5 miles to see an in-network provider), or how your practices offers services or products not provided by other in-network providers (such as auditory processing, vestibular or tinnitus evaluation or management, pediatrics or implants).

HOW TO HANDLE REJECTION

- Have your patients advocate for your inclusion in the plan.
 - Encourage them to contact customer service or the human resources department of their employer.

HOW TO HANDLE REJECTION

- Purchase a practice that is in-network with the payer in question.

Again, you will need an attorney and an accountant to assist you in insuring that your type of business purchase enables you to retain their managed care agreements.

HOW TO HANDLE ENROLLMENT: CAQH

- Credentialing clearinghouse.
- Can use this to enroll with multiple payers.
- Free.
- <http://www.caqh.org/>
- To participate:
 - Must be a contracted provider with a least one of the CAQH participating payers.
 - Must be invited by CAQH once registered.

STEP #3: UNDERSTANDING THE PROVIDER AGREEMENT

- Read the entire agreement and review the fee schedule.
 - Fee schedules TYPICALLY lack all of the codes.
- Things to consider:
 - You want answers to any clarification questions **IN WRITING ONLY!**
 - What products does this contract obligate the practice to participate with: Medicare Advantage? Medicaid? HMOs?
 - If Medicare Part C, what are the organizational pre-determination requirements?

STEP #3: UNDERSTANDING THE PROVIDER AGREEMENT

- Does it allow for patient upgrades for hearing aids?
 - Does the practice have to offer a "basic" or "standard" device first?
 - Is there a required waiver process for upgrades?
 - Does it recognize or process S1001 (Deluxe item, patient notified)?
 - How does this "upgrade" reflect on the EOB the patient receives?
- Does the payer allow for hearing aid rentals?
 - If yes, does it require specific modifiers?
- How many line items are allowable on a hearing aid claim?
- Does the agreement require patients complete notices of non-coverage before non-covered services are provided?
- Is the hearing aid benefit inclusive of all of the items and services associated with the dispensing fees, fittings, batteries and repair services?

STEP #3: UNDERSTANDING THE PROVIDER AGREEMENT

- Can student externs or technicians see members of this plan for covered services?
 - If yes, are there supervision requirements?
- Can hearing aid dispensers see members of this plan for covered services?
- Can audiology assistants see members of this plan?
 - If yes, are there supervision requirements?
- Is hearing aid coverage contingent on receipt of a medical clearance? Does it have to be from an ENT? Does the patient have to be physically seen by the ENT? What evidence needs to be provided of that ENT visit?
- Can certain services be carved-out of the contract?
- What are the termination terms? Renegotiation terms?
- For hearing aids, is the practice required to supply a manufacturer's invoice?
- What are the renewal terms?
 - “Evergreening” of contract.

STEP #3: UNDERSTANDING THE PROVIDER AGREEMENT

- Does the payer cover telehealth services provided by an audiologist? Are there only specific services the payer covers via telehealth? Does the payer require a modifier? Are there specific requirements?
- How is medical necessity defined?
- What are the requirements for standard processes and procedures for all patients?
- What are the means of provider notification of substantive changes to the agreement?
- What are the requirements for standard fee schedule/charge master?
 - Can the practice bill differently to the payer than they bill their general population?
- What are the timely claims filing requirements?
- Are there any other claims filing requirements.
 - Can the practice file paper claims?

STEP #3: UNDERSTANDING THE PROVIDER AGREEMENT

- Are there clinic hour requirements?
- What are the medical record retention requirements?
- Does the payer allow for and cover evaluation and management services to be provided by an audiologist?
 - If not, does it allow for the financial responsibility to be assigned to the patient?
- Do they require hearing aid patients be referred to a third-party administrator for dispensing?
- Should binaural hearing aids be billed as binaural, two units of monaural, or two line items of monaural?
- Does the fee schedule address all of the items and services you provide?
 - Every HCPCS and CPT for the items and services you currently provide or might want to provide.
 - How are unlisted codes (92700, L9900, V5298, V5299) processed?

STEP #4: UNDERSTANDING THE FEE SCHEDULE/CHARGEMASTER

- What the payer allows, per contract, for each specific item and service you provide for each specific product you are contracted to provide.
 - Never accept less than you can afford to receive unless you will have significant volume.
 - Need to know your breakeven plus profit amount per hour to properly analyze this.
 - Do the benefits of participation outweigh the costs?
 - Be careful of:
 - Inclusive hearing aid coverage benefits.
 - Restrictions on number of line items allowed.
 - Large hearing aid discounts (percentages of dollars billed).
 - “Fitting fee only” or Invoice plus arrangements.
 - Requirements to provide the manufacturer invoice.
 - Sometimes you do not buy the aid in this equation.

Sometimes it is a better business decision to be out-of-network providers as patients pay you in full on the date of service and can often, still, access some of their benefits.

THIRD-PARTY ADMINISTRATORS (TPA)

- TPAs (third-party administrators) are becoming more and more prolific in the audiology space.
- They exist to:
 - Allow payers a single point of contact and payment for hearing aid related items and services.
 - Defined risk for the payer.
 - Cost containment for the member.
 - An established standard of care for the member.

Audiologists helped create the need for these programs and help maintain their existence through their participation.

CONSIDERING TPA PARTICIPATION

- Before you agree to participate, please consider the following:
 - Can I afford to provide the level of care, at the agreed upon rates, required by the plan?
 - Is the plan offering a funded or unfunded (discount) benefit?
 - Is your practice bundle or unbundled?
 - Can you create a competitive product offering?
 - What is my responsibility in informing the patient of their benefits, either funded or unfunded?
 - In MOST cases, you have no contractual obligation to notify someone of their TPA benefit unless the plan refers the patient to your office.
 - What are the ethical implications?

CONSIDERING TPA PARTICIPATION

- Do any of their policies conflict with my other managed care agreement terms?
 - The “free” hearing test, for example
- What products does the plan offer?
 - What if the member wants a product that is not in the program?
- How many patients do you stand to potentially lose if you do not enroll in the program?

CONSIDERING TPA PARTICIPATION

- Can I charge the patient or their healthcare insurer for a hearing test?
- What items and services are included in the fitting fee?
 - If it is not included in the fitting fee, are there limits to what I can charge?
 - Do I have to notify patients of these costs, in writing, upfront?
- Do I receive a greater fitting fee if I am a member of a specific buying group or membership organization?

CONSIDERING TPA PARTICIPATION

- How long is the trial period?
- What do I receive if the patient returns the aids for credit?
- How long do I have to manage the patient for the fitting fee?
- Are their limits as to what I can charge for service outside of the fitting fee window?

BEFORE YOU INITIALLY SIGN ANY AGREEMENT...

- Make a copy of the entire contract and fee schedule and SAVE IT.
- Ask questions, in writing, when you lack answers.
 - Don't sign until you get your answers!
- Do not be afraid to negotiate.
 - The worse they can do is say “no.”
- What are the pros versus cons of contracting with each payer?
- If unsure of some of the contract terms, hire an consultant and/or attorney to assist you.

IF YOU HAVE ALREADY SIGNED: RENEGOTIATION

- It is NOT the payers responsibility to have a copy of your contract.
- If you cannot locate it, request, in writing, a copy of their current agreement and review any bulletins, medical policies, administrative guidance and/or provider manuals on their websites.
- Request, in writing, a copy of the current fee schedules or access to the current fee schedule.

RENEGOTIATION

- You have more leverage the more services you bring to the payer and the more locations you offer.
- Know what you want and defend why you deserve it.
 - Have a knowledge of your current agreement and your Medicare fee schedule for your area.
- Follow the guidance in the contract on termination but, instead of sending a termination letter, send a request for renegotiation.
- You must also be willing to walk away in negotiation or you have no power or leverage.
- Follow the same contract evaluation process you would follow if you were signing up for the first time.

NON-PARTICIPATION AS AN OPTION

- Again, other than Medicare, you are a voluntary participant in managed care.
- It is an option to not participate in third-party, managed care plans and be an out of network provider.
- But, once you terminate, you may not be able to get back into the plan if you change your mind.

NON-PARTICIPATION AS AN OPTION

- Analyze your situation before terminating.
 - How many patients are represented by this payer?
 - How many dollars are represented by this payer?
 - How many referral sources are represented by these patients who are represented by this payer?
 - Does this payer contractually allow for hearing aid upgrades?
 - Does the payer offer lucrative, audiology direct, hearing aid coverage and benefits?
 - Does the payer utilize a TPA for their hearing aid coverage and benefits?
 - What are the socioeconomics of the area?

NON-PARTICIPATION AS AN OPTION

- When out of network, the patient pays in full on the date of service.
- One exception is Medicaid QMB/dual eligibility recipients.
 - Many of these situations do not let you collect the Medicare co-insurance or deductible if you are non-participating with the Medicaid plan.
- Another exception can be when seeing Medicare Part C (Advantage) patients.
 - Many of these plans do not let you collect any more than the Medicare limiting charge.
 - The explanation of benefits will guide you in these situations.

NON-PARTICIPATION AS AN OPTION

- Your office can submit claims to the payer as a courtesy to the patient.
- The patient is reimbursed, from the payer, their out of network benefits.
- You often see this in mental health, dental and optometry offices.

COVERAGE VERSUS REIMBURSEMENT

- Coverage is when a third-party is paying all or part of the cost of the item or service.
 - Lack of coverage does NOT mean a lack of reimbursement.
- Reimbursement is when you, the provider, receive payment for the cost of the item or service.

WE NEED TO CARE MORE ABOUT REIMBURSEMENT AND LESS ABOUT COVERAGE!

BILLING AND REIMBURSEMENT FUNDAMENTALS

- It is ALL about PROCESS, POLICIES AND ACCOUNTABILITY.
 - Every staff member has responsibilities along the accountability chain.
- Coverage and reimbursement processes BEGINS at scheduling.

SCHEDULING

- Scheduler needs to be well trained on insurance.
- Scheduler needs to:
 - Ask phone triage questions to determine if medical necessity likely met and to assist in scheduling the appropriate appointment type and length.
 - Inform patient of your network status.
 - Inform patient of need for order, prior authorization, etc.
 - Obtain demographic information.
 - Obtain insurance information, including name and date of birth of insured.
 - Inform patient of potential out of pocket costs.
 - Especially, if medical necessity has not been met.
 - Inform patient of financial policies (payment due at time of visit).
 - Inform patient of resources available on your website (policies, forms, etc.)
 - Schedule the appointment.
 - Have them come in early to complete forms.

INSURANCE VERIFICATION

- KNOW YOUR CONTRACTS!!!
 - This is so much easier if you have a working knowledge of the allowable rates FIRST.
- Do as much as possible online.
- Use a form and ask all of the questions.
 - Who did you call? At what number? Do they have a reference number?
 - Is the benefit or discount only available through a specific third-party administrator?
 - Is the patient eligible on this date of service?
 - Have they met their deductibles?
 - They can sometimes be larger than the cost of the hearing aids.

INSURANCE VERIFICATION

- Do they have out-of-network benefits? (You ask this if you are an out-of-network provider).
- Does the patient have a hearing aid benefit? Allowance?
- Dollars?
 - A fixed defined dollar amount or an “up to” amount
 - “Up to” generally means your allowable fee for the device itself.
- Can the patient have out-of-pocket expense? Can they upgrade?
- Is this a funded (the payer is covering all or a portion of the costs of the device) or unfunded (discount) benefit?
- Can the claim be billed with more than two lines items?
- Do they want binaural hearing aids billed as binaural, two, monaural with modifiers or two units of a monaural?
 - If do not know, always bill as binaural first.

INSURANCE VERIFICATION

- Does the HL have to be related to accident, illness or injury?
- How frequent is the benefit available?
 - X number of months or years
- What services are covered?
 - Literally, provide the codes 92591, 92593, 92595, V5011, V5020, and V5160.
- Is this an inclusive benefit?
 - Does the benefit include all services related to the evaluation and fitting of the device?

PROVIDER RESPONSIBILITIES

- Providers:
 - Complete the testing, evaluation or treatment.
 - Complete documentation by the close of each business day.
 - Fill out the superbill or enter charges into the EMR/OMS.
 - Complete an EMR/OMS encounter (or superbill) on every patient you see, even no-charge visits.
 - Data is allows for business decisions, not emotional ones.
 - Fit within the verified benefit AND allowable rates.
 - Collect patient financial responsibilities at the time of visit.

BILLING STAFF RESPONSIBILITIES

- Someone has to collect patient responsibility on the date of service.
 - This individual needs to never be undermined.
 - Billing costs YOU money!!!
- Office staff takes:
 - The superbill/EMR/OMS information and submits the claim within two business days of the date of service.
 - Posts payments each day.
 - Monitors payments, especially accounts receivable outside of 90 days.
 - Files appeals for denials or incorrect payments within two business days of receipt of the EOB.
 - Monitors accounts payable.

OFFICE MANAGER/DIRECTOR/OWNER RESPONSIBILITIES

- Administration should:
 - Purchase training and billing resources for themselves, their providers and their staffs.
 - Have a strong, working knowledge of the managed care agreements, Medicare and Medicaid.
 - Create policies and procedures.
 - Train their staff on policies and procedures and document training.
 - Evaluate and update pricing on, at least, an annual basis.
 - Monitor claims payments, accounts payable and accounts receivable on, at least, a monthly basis.
- The financial policies also apply to LEADERSHIP OR OWNERSHIP!
 - These policies should be in writing, readily available and acknowledged by the patient at initial intake.
- No one should be able to write-off sums over \$100 other than the manager or owner.
- Stop seeing patients who owe you money without making payment arrangements.

HOW PRACTICES END UP IN INSURANCE HELL

- **YOU put yourself there, not the Insurer!**
 - You do not ask the right questions at scheduling and intake.
 - You sign ANYTHING without reading or negotiating it.
 - You do not have a working knowledge of the agreement YOU agreed to.
 - You do not verify an individual patient's coverage and benefits EVERY time.
 - You insist everyone needs top of the line products.
 - You insist on remaining in a bundled delivery model and expect coverage, up front, of long-term service that may or may not occur.
 - You do not charge patients privately for non-covered services and to notify them in writing of their out of pocket expenses.
 - You do not collect patient responsibility (co-pays, deductibles and co-insurance) at the time of the visit.

HOW DO YOU GET YOUR PRACTICE OUT OF INSURANCE HELL

- Have a strong scheduling and intake process.
- Run your practice like your dentist, optometrist, chiropractor, or podiatrist runs theirs.
 - Be comfortable and unapologetic about collecting patient responsibility.
- All business is not good business.
 - Weigh the pros and cons of each for YOUR PRACTICE AND SITUATION before joining.
- KNOW your contracts!
- Nothing is free!
- Collect payment at time of visit.
- Fit the patient, with something audilogically appropriate, within their benefit.
 - <http://www.harlmemphis.org>

MANAGING DENIALS

- Who is in the right?
 - If you:
 - Send evidence (copy of written benefit, LCD, copy of report, copy of coding manual, etc)
 - Resubmit claim with supporting documentation and return monies paid, if any.
 - If payer:
 - Only denied or paid incorrectly because you billed it out incorrectly.
 - Send a corrected claim and return monies paid, if any.

NO SHOW APPOINTMENTS

- Medicare may bill patients for missed appointments.
 - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5613.pdf>
 - Medicare does not cover missed appointments.
- Medicaid programs, generally, do not allow patients to be billed for no show fees.
- Need to consult private payer agreements to determine if they allow patients to be billed for no show fees.
 - Payers do not cover no show fees.

“INCIDENT TO” BILLING

- This is when an item or service is billed to the payer, not under the NPI of the rendering provider, but, instead under the NPI of the attending physician or audiologist.
- Medicare does not allow technical services to be billed incident to an audiologist and does not allow audiology services provided by an audiologist to be billed incident to a physician.
 - Technician services can be provided, under direct supervision of the physician, by an appropriately trained technician, hearing aid dispenser, or student incident to the attending physician.
 - Can only provide services with a TC/PC split.
- Audiologists need to determine if private third-party payers or Medicaid allow for services provided by technicians, hearing aid dispensers or audiology assistants can be billed incident to an audiologist.
- Some private third-party payers do not contract audiologists separately from their physician employers (or independent contractors).
 - In this case, services are billed incident to the attending physician.
 - The audiologist's NPI is not on the claim.

THIRD-PARTY COVERAGE

Know the terms of your third-party contracts and fee schedules.

- Good reimbursement begins and ends with you.
 - Starts from the minute the patient calls.
- Accountability is key.
- You can learn from EOBs.
 - “Experimental” billing.
- Verification is required EVERYTIME!
 - Have to ask the right questions.
 - Hearing aids.
 - BAHA.
 - Cochlear implants.

THIRD-PARTY COVERAGE

- Third-party coverage of diagnostic and hearing aid services is the result of an agreement between the PATIENT and the INSURER.
- The patient selected their plan and its benefits, not you.
- Sometimes patients have out of pocket expenses and financial responsibility for non-covered or denied coverage for services.
- Sometimes the fight for payment is a fight between the patient and the payer and NOT you!

SO I VERIFIED BENEFITS? NOW WHAT?

- You must treat managed care patients as you would treat a private pay patient.
- The date you bill is the date you fit!
 - Date of service is the day the item is dispensed or the service is provided.
- Can the patient upgrade?
 - If no, you must fit within the benefit.
 - Itemization can help in these situations, unless it is an inclusive benefit or line item restricted.
 - If yes, you need to offer them a product within their benefit.
 - If they choose to “upgrade”, then they need to be notified in writing, prior to fitting, of the fact that they could have received a product at no-charge (except for co-pays, co-insurance and deductibles) but, instead, they have opted to upgrade and their financial responsibility is X.

SO I VERIFIED BENEFITS? NOW WHAT?

- Is it an “up to” benefit or a fixed dollar amount?
 - “Up to X” does not mean “X”
 - “Up to” typically means your allowable.
 - Fit a entry level product.
 - You will need to fit within the benefit.
 - Itemization can help in these situations, unless it is an inclusive benefit or line item restricted.

HEARING AID INSURANCE EXAMPLE #1:

- The patient has a BCBS hearing aid benefit, with a \$2500, inclusive benefit every 36 months.
- The patient has met \$100 of his \$1000 deductible.
- The patient also has a 10% co-insurance.
- The patient can upgrade, as long as he is notified in writing, of his out of pocket expenses and is offered something first within his benefit.
- The aids can only be billed two a limit of two lines items.
- Binaural aids should be billed using binaural codes.
- Your practice offers a bundled hearing aid delivery.

HEARING AID INSURANCE EXAMPLE #1:

- If patient opts to be fit within his benefit:
 - Must fit hearing aids whose UCR is less than \$1250 per ear.
 - Let's say you select binaural, digital BTEs at a UCR of \$1200 each.
 - Aids are billed using V5261 and V5265 x 2 units.
 - On the date of fit, the patient owes:
 - \$900 for the deductible, at least, \$250 for the co-insurance, and , possibly, the reduced or UCR cost of the earmolds (if not allowed by contract).
 - Your allowable rate might be less than \$1200 per ear, so you may owe the patient a refund for the co-insurance unless you collect the exact amount.

HEARING AID INSURANCE EXAMPLE #1:

- If the patient opts to upgrade:
 - Can fit anything.
 - Let's say you select binaural, digital BTEs at \$3000 each.
 - Aids are billed using V5261 and V5265 x 2 units.
 - On the date of fit, the patient owes:
 - \$900 for the deductible, at least, \$250 for the co-insurance, possibly, the reduced or UCR cost of the earmolds (if not allowed by contract) and the \$3500 upgrade amount.
 - Patient must complete an upgrade waiver at the date of the fitting.

HEARING AID INSURANCE EXAMPLE #2:

- The patient has a UHC hearing aid benefit, with a \$5000, inclusive benefit every 36 months.
- The patient has met \$500 of his \$650 deductible.
- The patient also has a 20% co-insurance.
- The patient CANNOT upgrade. The patient is only financially responsible for co-payments, co-insurance, deductibles and the costs of non-covered services.
- Binaural aids should be billed using binaural codes.
- Payer allows for 92591, 92595, V5011, and V5020.
- Your practice offers a bundled hearing aid delivery.

HEARING AID INSURANCE EXAMPLE #2

- I strongly encourage you to be honest with the patient about the situation (i.e. “the negotiated rate is less than my cost for more advanced products”).
- The patient then has four options:
 - Get a more basic hearing aid paid in full by their third-party payer. This is what most patients prefer.
 - Refer the patient to EPIC, if you are contracted with EPIC, since they allow the patient to upgrade.
 - Send the patient elsewhere and try to find another provider who will do this for them (in many cases out of network providers would be allowed to balance bill the patient).
 - Have the patient sign a completed insurance waiver. In this case, they are waiving their insurance coverage and you, as the provider, will not be submitting a claim to their carrier. Please ensure that the patient gets an original copy of their bill or sale and the insurance waiver in the event they attempt to bill their carrier themselves.
- If the patient proceeds with the first bullet, the patient should pay any co-insurance amounts (based upon usual and customary rates) and deductible amounts (up to the usual and customary cost of the aids) on the date of the fitting.

HEARING AID INSURANCE EXAMPLE #2

- Must fit hearing aids whose UCR is less than \$2500 per ear.
 - Let's say you select binaural, digital BTEs at a UCR of \$2500 each.
- Aids are itemized and billed using V5261, 92591, 92595, V5011, V5020 and V5265 x 2 units.
 - The total amount billed equals your UCR for the same aid, with the same delivery terms, for your general population.
- On the date of fit, the patient owes:
 - \$150 for the deductible, at least, \$1000 for the co-insurance, and , possibly, the reduced or UCR cost of the earmolds (if not allowed by contract).
 - Your allowable rate might be less than \$2500 per ear, so you may owe the patient a refund for the co-insurance unless you collect the exact amount.

PRE-DETERMINATION

- In writing.
 - Need to send letter and medical records (report).
- Not a guarantee of payment.
- This should be used when:
 - Coverage is contingent on hearing loss being due to accident, illness or injury.
 - Auditory prosthetic devices (when not clearly indicated in coverage or exclusions).

WHEN DEALING WITH HEARING AIDS IN A THIRD-PARTY WORLD, PLEASE CONSIDER:

- The insurance verification form and process is completed prior to the hearing aid evaluation. If possible, the insurance information should be gathered at the time the hearing aid evaluation is scheduled.
- Please also make sure that the patient pays all outstanding deductibles, co-pays, and percentages of responsibility (co-insurance) on the date of fitting, as well as any charges for non-covered services.
 - You want to be in a position to refund money and not trying to collect outstanding monies from the patient.
 - These are all of the monies you can collect on the date of order or fit if you are an in-network provider.

WHEN DEALING WITH HEARING AIDS IN A THIRD-PARTY WORLD, PLEASE CONSIDER:

- Do not discount hearing aids billed in whole or in part to third-party carriers.
 - Have all marketing provide a disclaimer to this effect.
- You must get your cost of goods as low as possible.
 - No manufacturer is irreplaceable.

WHEN DEALING WITH HEARING AIDS IN A THIRD-PARTY WORLD, PLEASE CONSIDER:

- The payer may have coverage requirements, such as:
 - Medical clearance.
 - Evidence of medical evaluation, by an otolaryngologists, prior to fit.
 - Pre-authorization.

There is no coverage if the coverage requirements are not met.

BILLING HEARING AIDS VIA THIRD-PARTY ADMINISTRATORS

- They each have their own processes.
- The general process is this:
 - TPA refers patient to your practice.
 - Your practice sees the patient and recommends amplification.
 - You fax, email or submit via their portal the required paperwork to order and/or acknowledge fitting of the device.
 - The TPA pays for the device and, often, the earmold, if needed.
 - After the end of the trial period, you are paid a fitting fee.
 - You manage the patient, at no additional cost to the patient or the plan, for a fixed time period or number of visits.

THE REALITY OF WAIVERS/PATIENT NOTIFICATION

- YOUR PRACTICE CANNOT USE WAIVERS UNLESS EXPLICITLY ALLOWED BY CONTRACT!!!
 - Otherwise, you will be in violation and, if a patient pushes back, you will have to refund them.
 - The patient will also receive an EOB that will reflect patient responsibility different than what you charged them.

PATIENT NOTIFICATION OF NON-COVERAGE

- Typically required by private managed care contracts and third-party administrators.
- This means your practice needs to have a patient acknowledge, in writing, their understanding and acceptance of the costs associated to items or services not covered by their insurance carrier.
- This needs to be in place before the service is rendered or the item is dispensed.

UPGRADE WAIVER

- Upgrade Waiver
- BCBS.
- Must offer a basic aid (standard) at no-charge to patient.
- Patient can upgrade if they so choose and pay the difference between the allowable and usual and customary.
 - The provider needs to have a form to reflect this and this needs to be completed prior to the hearing aid fitting.
- Does the payer recognize S100I (deluxe item, patient notified)?
 - If yes, this can help reflect patient responsibility on the EOB.

INSURANCE WAIVER

- Patient waives their insurance benefit.
 - Allowed by HIPAA Omnibus.
- The patient does not bill their insurance and you do not bill their insurance.
 - There needs to be a form to reflect this that is signed prior to fitting.
 - Rarely happens.

BILLING SITUATIONS


- Need a Medicare denial and do not have an ordering physician.
 - MOST (but not all) Medicare contractors recommend that the audiologists' name and NPI are placed in the “referring physician” (Box 17) section.
- Need a Medicare but are not enrolled in Medicare
 - You have to be enrolled in Medicare to submit to Medicare, even for a denial.
- “Incident to” billing
 - The attending physician's NPI should be placed in the “rendering physician” section (24J).

MEDICARE CARD


- Every patient will be getting a new Medicare card that does not contain their social security number.
- “CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, we said that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, we referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, we will refer to this project as the New Medicare Card”.
- Please ask patients for copies of all Medicare cards.
- <https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html>

MEDICARE CARD

Current Medicare Card

MEDICARE			HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)				
NAME OF BENEFICIARY JANE DOE				
MEDICARE CLAIM NUMBER 000-00-0000-A		SEX FEMALE		
IS ENTITLED TO HOSPITAL (PART A)		EFFECTIVE DATE 07-01-1986		
MEDICAL (PART B)		07-01-1986		
SIGN HERE → <u>Jane Doe</u>				

New Medicare Card

		MEDICARE HEALTH INSURANCE	
Name/Nombre JOHN L SMITH			
Medicare Number/Número de Medicare 1EG4-TE5-MK72			
Entitled to/Con derecho a PART A		Coverage starts/Cobertura empieza 03-03-2016	
PART B		03-03-2016	

ADVANCED BENEFICIARY NOTICES

- Form changed in 2017.
- The valid ABN form has an effective date of June 21, 2017.
- The new ABN has an expiration date of March 2020.

<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>

MEDICARE DATA ON YOU

- Google yourself and many of you will find that your Medicare claims data is available online to consumers.
- <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-provider-charge-data/physician-and-other-supplier.html>
- <http://graphics.wsj.com/medicare-billing/>

MEDICARE DATA ON YOU

Mon Jan 22 4:36 PM

Kim

graphics.wsj.com/medicare-billing/#/name=&special=Audiologist (billing independently)&city=&state=

BEHIND THE NUMBERS

Medicare Unmasked

See Medicare's payments to over one million medical providers from 2012 to 2015, and how doctors and other providers compare with peers in their state and nationwide.

EXPLORE THE DATA
Search doctors and other providers who received Medicare payments.

Physician or Provider

Ex: Smith
Last Name / Company

Audiologist (billing indepen...
Specialty / Facility Type

Location

Ex: Denver
City

All locations
State / Territory

SEARCH

RESET

QUESTIONS

I answer questions, at no charge, until April 1, 2018.

THANK YOU



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