KENTUCKY ACADEMY OF AUDIOLOGY 2024: TOPICS IN COMPLIANCE, BILLING, CODING, AND MANAGED CARE

Kim Cavitt, AuD

Audiology Resources, Inc.

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NO SURPRISES ACT - KENTUCKY

- Kentucky
  - https://insurance.ky.gov/ppc/Documents/nsa%20-%20consumer%20bulletin%2012-2021.pdf
- Federal
  - https://www.cms.gov/nosurprises

In the most conservative sense, if you are not submitting a claim to a third-party of the item or service AND you are scheduling the individual more than three days or more away, you need a good faith estimate.

Estimates must be within $400 of final bill or updated before provision of care.

INFORMED CONSENT

- Audiologists are required, in many instances and in many states, to obtain informed consent prior to the provision of care.
- A patient must be informed, and acknowledge in writing, all of the potential benefits, risks, and alternatives involved in any medical procedure or other course of treatment.
  - In a nutshell, you must obtain the patient's written consent to proceed, prior to the provision of care and, separately, for telehealth.
  - Kentucky Regulations
    - https://www.chfs.ky.gov/agencies/dph/dpqi/hcab/Documents/consentforservices.doc
    - https://law.justia.com/codes/kentucky/chapter-311/section-311-5975/#:~:text=2023%20Kentucky%20Revised%20Statutes%20Chapter%20311%20%2D,Board%20to%20promulgate%20administrative%20regulations.%20Universal%20Citation:.

AMA DISCLAIMER

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AUDITORY OSSEOINTEGRATED DEVICE PROGRAMMING CODES

- **Went into effect January 1, 2024.** Hint
- 92622: Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
  - Does not require implantation.
  - Must spend at least 31 minutes without a 52 modifier. (reduced service)
  - Document minutes in medical record.
- 92623: Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (list separately in addition to code for primary procedure
  - Must spend at least 8 minutes.
  - Must document minutes in medical record.
- **These codes ARE NOT FOR COCHLEAR IMPLANT SERVICES!**
- Neither code can be reported with 92626 or 92627.
  - Evaluation of auditory function for surgically implanted device(s), candidacy or post-operative status of a surgically implanted device(s)
- **These are post fitting/activation codes ONLY.**
- Can be billed with AB modifier.

CERUMEN MANAGEMENT

- 69200: Removal of foreign body from external auditory canal; without general anesthesia
  - Not covered by traditional Medicare if provided by an audiologist.
  - Can be billed "incident to" a physician.
- 69209: Removal of impacted cerumen using irrigation/lavage, unilateral
- 69210: Removal impacted cerumen, with instrumentation, unilateral
  - Non-covered by traditional Medicare.
  - Can be billed "incident to" a physician.
  - While can be billed with a -50 modifier, it typically only is reimbursed as one unit.

CERUMEN MANAGEMENT

- "Impacted cerumen was defined in *CPT Assistant* October 2013, page 14, as having any of the following:
  - Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
  - Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc..
  - Inflammatory considerations: Associated with foul odor, infection, or dermatitis.
  - Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills".

CERUMEN MANAGEMENT – MEDICARE/MEDICAID

- As a result of the **Medicare/Medicaid** coding edits, clearinghouses and payers reject the use of 69209 or 69210 for the removal of impacted cerumen on the same date of service as any audiometric testing.
  - CMS deems ALL cerumen removal inclusive to the audiometric testing if removed by an audiologist.
  - May NEVER apply to commercial insurers so bill normally to all payers.
- The edit cannot be overridden by a 59 modifier.
- You cannot bill the patient privately for the cerumen removal when a coding edit exists.
- Only option: Perform audiometric testing on separate date of service.

92700

- To classify procedures that do not have CPT codes.
- Could be replaced by an E/M code.
- **Must be submitted to health plan for claims processing.**
- **A physician order is required for traditional Medicare.**
- Coverage is limited.
- Individually reviewed.
- Advanced Beneficiary Notice (ABN) required for traditional Medicare beneficiaries.
  - Patient should pay usual and customary rate at date of service.
  - It will ALWAYS require a physician order.
- Notices of non-coverage required for other payers.
  - Patient should pay usual and customary rate at date of service.
- Initially can be submitted electronically, but most payers request additional information on initial denial.

92700

- If reporting 92700, submit report with:
  - Copy of Patient Report documenting medical necessity.
  - One page info sheet specific to procedure
    - Description of procedure
    - Clinical utility of the procedure
    - Procedure it is similar to.
    - Time required to perform.
    - Skills of tester
    - Equipment used
    - Peer reviewed research links
    - Usual and customary fee

92700

- Communication and Functional Needs Assessment High-frequency audiometry
- Behavioral observation audiometry
- Eustachian tube function testing
- Use of goggles
- Saccade testing
- Sensory organization test
- Speech in noise testing
- Removal of incidental cerumen, independent of audiometric testing
- Fistula testing
- VHit
- Vestibular Autorotation Test (VAT)
- Fukada
- Acceptable noise level
- Auditory prosthetic device evaluation and selection

HEARING PROTECTION/HEARING AID

- When the individual has normal hearing (for hearing protection) Hint
  - V5274
    - Bill as units or as separate line items with RT and LT modifiers.
- When the individual has an aidable hearing loss (for hearing protection and amplification)
  - V5298
    - Bill as units or as separate line items with RT and LT modifiers.

BILLING LYRIC

- The most appropriate code is V5298, as two lines items, each with a RT and LT modifier.

NO CHARGE ITEMS

Do not charge a health plan for an item or service your received at no charge.

THIRD-PARTY COVERAGE

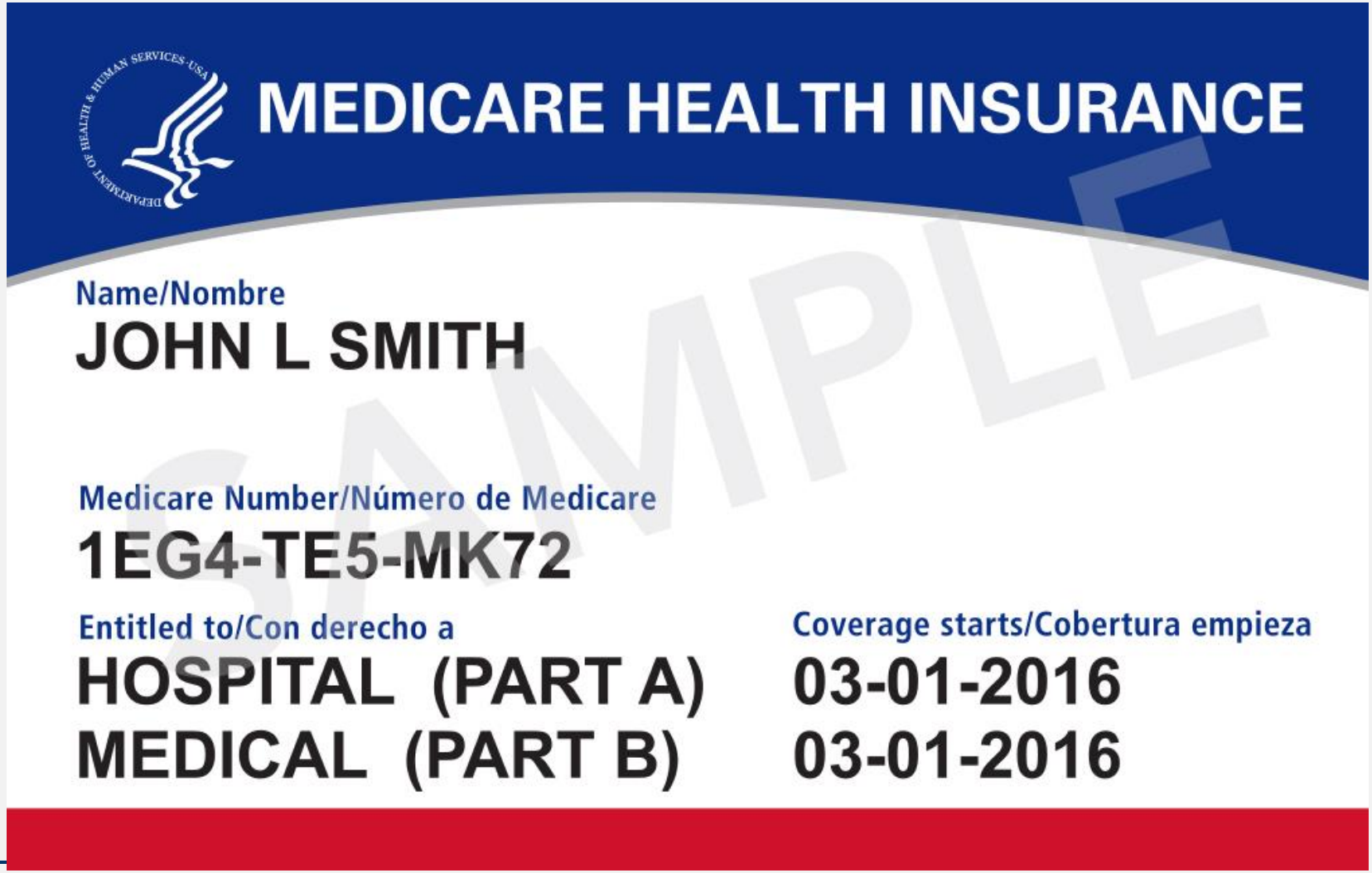
Medical Necessity = Coverage

Document, document, document.

Why did you do what you did?

Why do that need that make, model, and style of hearing aid and its associated features?

INSURANCE CARD EXAMPLES – TRADITIONAL MEDICARE



TRADITIONAL MEDICARE

- Advanced Beneficiary Notices can apply here.
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ABN-Tutorial/formCMSR131tutorial111915f.html
- Ask about Medicare Supplement (Medi-Gap).
  - Covers 20% co-insurance.
  - Could include "discounted" hearing aid benefits through third-party.

MEDICARE FEE SCHEDULE

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

MEDICARE HAS A DEDUCTIBLE

- Traditional Medicare deductible for 2024 is $240.
  - Who is responsible for the deductible (supplement, secondary, or beneficiary) varies patient to patient.
    - Typically, the beneficiary is responsible for the deductible.
- Some Medicare Part C plans have deductibles and some do not.
  - Can find out if go online or call to check eligibility and benefits.

THE LIST OF AUDIOLOGIC PROCEDURES THAT CAN BE PROVIDED FOR NON-ACUTE CONDITIONS WITHOUT A PHYSICIAN ORDER ONCE EVERY 12 MONTHS

- https://www.cms.gov/files/zip/audiology-code-list-updated-7522.zip

MEDICARE PHYSICIAN ORDER CHANGES

- Effective January 1, 2023
- Technically, audiologists can provide non-acute hearing assessment unrelated to disequilibrium or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids once every 12 months without a physician order.
- This applies to traditional Medicare beneficiaries. Medicare Advantage plans, generally, do not require a physician order (unless specified in your agreement).
- Vestibular services (92517-92519 and 92537-92549) and 92700 will always require a physician order for traditional Medicare coverage.

MEDICARE PHYSICIAN ORDER CHANGES

- It is recommended that practices either utilize an Advanced Beneficiary Notice, prior to assessment, or secure a physician referral If their practice has:
  - 1) no record of the use of the AB code (and associated testing), by their or another practice within the past 12 months,
  - 2) does not have a physician order AND
  - 3) are planning, as a result of the lack of a physician order, to utilize the AB modifier.

Again, this is another example where triage at scheduling can be invaluable. We also encourage audiologists to reach out to their Electronic Health Record/Electronic Medical Record (EHR/EMR) vendors to determine what internal verification processes might exist.

MEDICARE PHYSICIAN ORDER CLAIM INFORMATION

- If you do not have an order:
  - Leave qualifier, name of referring provider and referring provider NPI fields blank.
  - Add an AB modifier to every Medicare covered service line item on the claim.
  - Vestibular services, 92700 and the services associated with an acute diagnosis ALWAYS requires an order.
  - Do not put services that were not ordered on the same claim as services that require an order.
    - Everything on the claim should either be ordered or not ordered.

INSURANCE CARD EXAMPLES – MEDICARE SUPPLEMENT (MEDI-GAP)

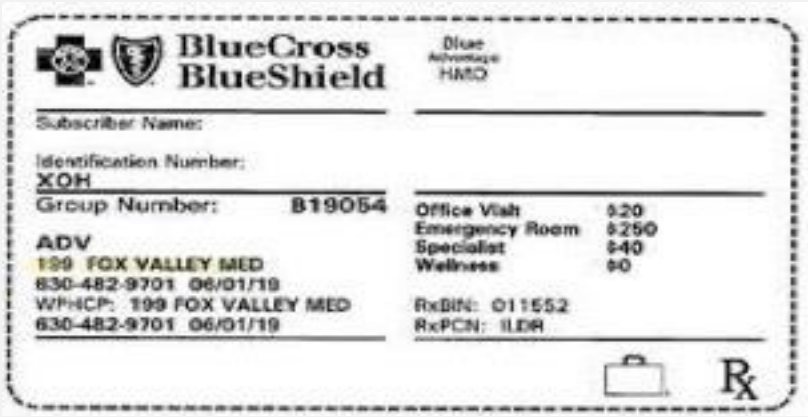
MEDICARE SUPPLEMENT

- Its primary role is to cover the Medicare 20% co-insurance.
  - Most do not cover the deductible (except Plan F).
- Its associated hearing aid "benefits" are discount, unfunded benefits through hearing benefit plans/third-party networks.

INSURANCE CARD EXAMPLES – MEDICARE PART C (ADVANTAGE)

UHC

BCBS



MEDICARE ADVANTAGE

- Also known as Medicare Part C
- 30+ options in Kentucky.

Hint

- Encompasses Medicare Part A, Part B, Part D (typically) and Medi-Gap under a single plan.
- HMO plans MAY require co-pays and prior authorization.
  - Can learn this from plan documents.
- They are not all created equal.
  - Some mimic premier commercial insurance and others mimic Medicaid.

MEDICARE ADVANTAGE - KENTUCKY

- Most common plans (change every November 1 and go into effect January 1)
  - Aetna Medicare
  - Anthem Blue Cross and Blue Shield
  - Cigna Healthcare
  - Essence Healthcare
  - Humana
  - Paramount Elite Medicare Plans
  - Passport Advantage
  - UnitedHealthcare
  - Wellcare
    - Type in zip code to review plan options and covered benefits.

MEDICARE ADVANTAGE (PART C)

- General Rule of Thumbs:
  - Read the plan documents, which are available online.
  - If in-network with the Advantage plan
    - Do not collect anything on the date of service but applicable unmet deductibles, applicable co-insurance, applicable co-payments, and usual and customary costs of prior notified non-covered services.
    - Complete an organization predetermination for non-covered services that are not listed on the non-covered or exclusion list (when using 92700).
  - If out of network with the Advantage plan
    - Have patient complete notice of non-coverage prior to provision of care.
    - Collect unmet deductibles, applicable co-insurance, applicable co-payments, Medicare Limiting Charge on the date of service for covered services (anything medically necessary and meeting coverage allowances) and and usual and customary costs of prior notified non-covered services.
    - Reimburse the patient in accordance with remittance.

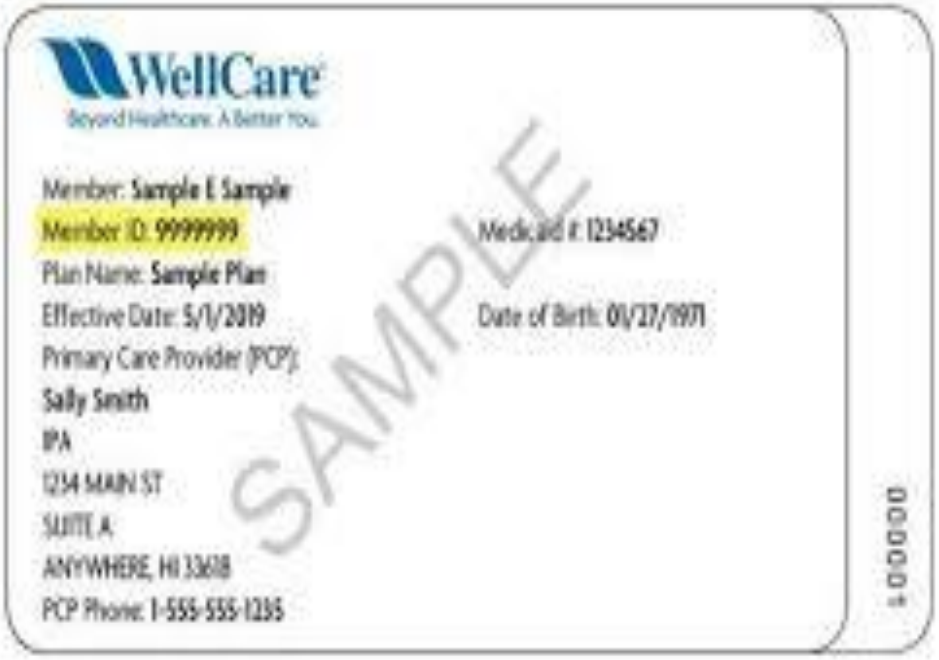
MEDICARE ADVANTAGE (PART C)

- Hearing Aid "Benefit" Tips:
  - These are typically discount programs, unless union/employee/retiree Advantage plan or a state coverage mandate exists.
  - Hearing aid "benefits" are typically ONLY available through Hearing Benefit Plans/Third-Party Networks.
    - Most will not have any access to out of network benefits.
  - Calling to verify benefits may trigger the plan contacting the member.

ROUTINE HEARING TESTS

- Medicare Advantage may cover routine HEARING testing.
  - This only includes 92552-92557.
  - There may be co-payments, which you should collect at the time of visit.
    - This is outlined in the plan document.
- There is no code specific to routine testing.
- "Routine" in healthcare typically refers to screenings or basic testing.
  - Hearing Screening (92551 or V5008)
  - Pure-tone, air (92552)
  - Audiometry for hearing aid evaluation to determine the level and degree of hearing loss (S0618)

MEDICAID


WellCare
Beyond Healthcare. A Better You.
Member: Sample E Sample
Member ID: 9999999
Plan Name: Sample Plan
Effective Date: 5/1/2019
Primary Care Provider (PCP):
Sally Smith
IPA
1234 MAIN ST
SUITE A
ANYWHERE, HI 33618
PCP Phone: 1-555-555-1235
Medicaid #: 1234567
Date of Birth: 01/27/1971
SAMPLE
000000

MEDICAID

- The insurance card will typically say Medicaid somewhere on the card.
- They do not cover routine testing.
- Prior authorization is common.
  - Cannot be retroactively obtained.
- If out of network:
  - There are not typically out of network benefits. They must see an in-network provider to access their benefits.
  - Can typically see a Medicaid patient (state dependent) as a cash pay patient once they receive a good faith estimate (if scheduled over 3 days in advance) AND a notice of non-coverage.

KENTUCKY MEDICAID

- Covers children and adults.
- "Eligible services are medically necessary, limited to one complete hearing evaluation per the calendar year and may include a hearing instrument evaluation which includes three follow-up visits:
  - Within the six-month period immediately following fitting with a hearing instrument; and
  - Related to the proper fit and adjustment of the hearing instrument including one additional follow-up visit at least six months following the hearing instrument fitting and related to the proper fit and adjustment of the hearing instrument.
- Referral by a physician to an audiologist is required. The department will not cover an audiology service without a referral from a physician.
- Additional services may be included if the beneficiaries' health care provider demonstrate that an additional hearing instrument evaluation is medically necessary
- Audiologist service providers must meet the coverage provisions and requirements of 907 KAR 1:038 to provide covered services. Any services performed must fall within the scope of practice for the provider. Listing of a service in an administrative regulation is not a guarantee of payment. Providers must follow Kentucky Medicaid regulations. All services must be medically necessary".

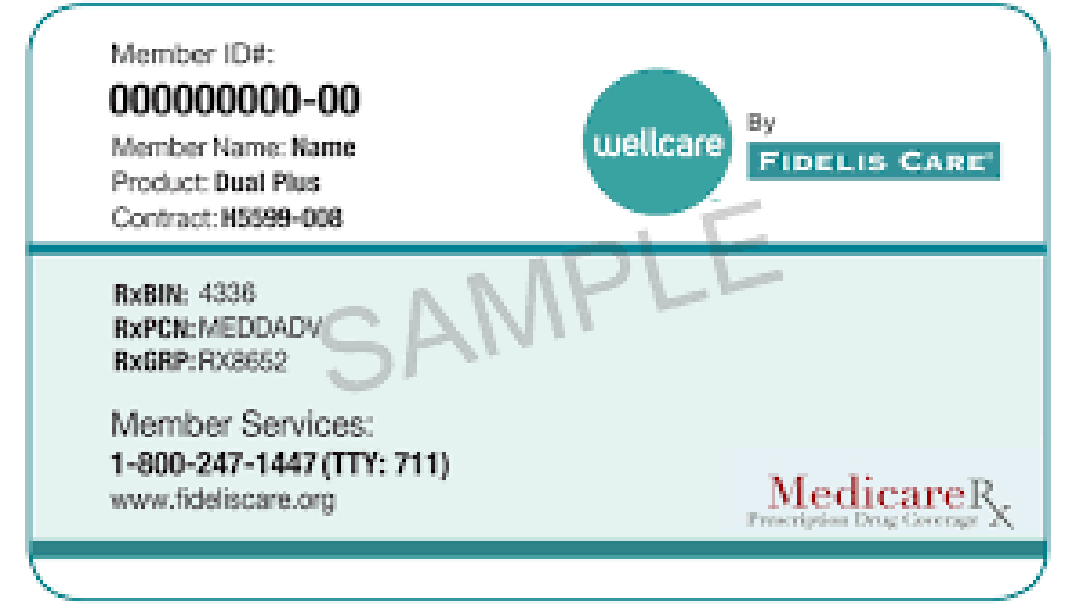
KENTUCKY MEDICAID

- Hearing Program Manual: https://www.chfs.ky.gov/agencies/dms/dpo/bpb/Documents/HearingServicesManual103107.pdf
  - Does not yet reflect adult coverage.
- Hearing Program Provisions: https://apps.legislature.ky.gov/law/kar/titles/907/001/038/
- Hearing Program Reimbursement Provisions: https://apps.legislature.ky.gov/law/kar/titles/907/001/039/
- Fee Schedule: https://www.chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/2024AudiologyFeeSchedule.pdf
- Audiology Provider Summary: https://www.chfs.ky.gov/agencies/dms/DMSProviderSummaries/AudiologistPT70.pdf
- Audiology Group Provider Summary: https://www.chfs.ky.gov/agencies/dms/DMSProviderSummaries/AudiologistPT70.pdf

KENTUCKY MEDICAID

- Itemization is required.
  - Reimburse separately for:
    - V5008
    - 92590-92595
    - V5010
    - V5011
      - Six-month check
    - V5020
    - V5090 or V5160
    - V5264
    - V5275
      - Must include invoice.
    - Code for hearing aids
      - Must include invoice.

INSURANCE CARD EXAMPLES – DUAL ELIGIBILITY MCO



MEDICARE DUAL PLAN

- **Individual has Medicare and Medicaid.**
- Even if Non-Par Medicare Provider or Out of Network, you must accept assignment on these claims.
- Cannot collect Medicare payment upfront when an ABN is utilized.
- Many programs (QMB) do not allow providers to collect unmet deductibles or co-insurance from the patient.
- Out of network coverage and benefits may vary.
  - Complicated.
  - Please verify benefits.
  - Many services, especially hearing aids, require prior authorization.
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf
- **If out of network, recommend referring these individuals to in-network, participating providers.**

INSURANCE CARD EXAMPLES – COMMERCIAL INSURANCE

BSBS

UHC

COMMERCIAL INSURANCE

- Employer or private coverage for those under 65 years of age or for retiree benefits of those over 65 years of age.
- May cover routine **hearing** testing.
- Hearing aid coverage is typically directly through the health plan.
  - Some exceptions:
    - Cigna uses Amplifon for their hearing aid benefits.
    - UHC uses UHC Hearing for some of their benefits (specifically for unfunded, discount "benefits").

PAYER GUIDANCE AND MEDICAL AND COVERAGE POLICIES

- Many third-party payers do not cover amplification for the treatment of tinnitus in the absence of hearing loss.
- Aetna: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#
- Anthem of Kentucky: https://www.anthem.com/provider/policies/clinical-guidelines/?cnslocale=en_US_ky
- Cigna: https://www.cigna.com/health-care-providers/coverage-and-claims/policies/
- Humana: http://apps.humana.com/tad/tad_new/home.aspx?type=provider
- UHC
  - https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html
  - Also search subsidiaries, such as Optum and Oxford, separately.
- VA Community Care
  - https://vacommunitycare.com/provider

THIRD-PARTY MEDICAL POLICIES – UHC COMMERCIAL 2024

- https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/hearing-aids-devices-including-wearable-bone-anchored-semi-implantable.pdf
- Removed the requirement for a written recommendation from a physician.
- "Refer to the member specific benefit plan document to determine if coverage applies.
- Standard plans include coverage for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- Benefits are provided for the Hearing Aid and for charges for the associated fitting and testing.
- The wearable Hearing Aids benefit does not include batteries, accessories, or dispensing fees.
- For certain plans, benefits are also provided for certain U.S. Food and Drug Administration (FDA) approved over-the-counter Hearing Aids for Covered Persons age 18 and older who have mild to moderate hearing loss.
    - Benefits for over-the-counter Hearing Aids do not require any of the following:
        - A medical exam.
        - A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
        - A written prescription or other order.
- If more than one type of Hearing Aid can meet the member's functional needs, benefits are available only for the Hearing Aid that meets the minimum specifications for the member's needs. If the member purchases a Hearing Aid that exceeds these minimum specifications, UnitedHealthcare will pay only the amount that it would have paid for the Hearing Aid that meets the minimum specifications, and the member will be responsible for paying any difference in cost".
    - I would recommend a waiver that clearly reflects this fact.

THIRD-PARTY MEDICAL POLICIES – ANTHEM COMMERCIAL 2024

https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html

"Air conduction hearing aid devices are considered **medically necessary** for the treatment of hearing loss when **ALL** of the following criteria are met (A and B):

The hearing loss is due to one of the following etiologies:

- Sensorineural hearing loss; **or**
- Mixed hearing loss; **or**
- Conductive hearing loss which has been:
  - unresponsive to medical interventions; **and**
  - unresponsive to surgical interventions or not amenable to surgical correction; **and**

The degree of hearing loss is confirmed by audiometry or other age-appropriate testing to be greater than or equal to 26 decibels (dB)".

THIRD-PARTY MEDICAL POLICIES – ANTHEM COMMERCIAL 2024

"Binaural air conduction hearing aids are considered **medically necessary** when BOTH of the following criteria are met (A and B):

- Both ears meet the criteria listed above in A and B; **and**
- Binaural testing shows improved speech recognition using bilateral devices.

Air conduction hearing aid devices with advanced technology models and features (for example, in-the-ear and in-the-ear-canal models with digital signal processing, directional microphones, multiple channels/memories) are considered **medically necessary** when the technology enhancement is needed to improve the hearing quality for the wearer.

Replacement of an air conduction hearing aid device that is out of warranty and no longer functioning adequately to support activities of daily living is considered **medically necessary** when the device is malfunctioning and cannot be refurbished or repaired sufficiently to resume its original functionality".

THIRD-PARTY MEDICAL POLICIES – ANTHEM COMMERCIAL 2024

"Air conduction hearing aid devices are considered **not medically necessary** when the above criteria are not met.

> Air conduction hearing aid devices with advanced technology models and feature enhancements (for example, in-the-ear and in-the-ear-canal models with digital signal processing, directional microphones, multiple channels/memories) are considered **not medically necessary** when provided solely for the convenience of the wearer or to improve his/her cosmetic appearance.

Replacement of a currently functional air conduction hearing aid device that is still under warranty for the sole purpose of obtaining a device with updated technology, (commonly referred to as an "upgrade"), is considered **not medically necessary** unless the new updated device will provide a significant functional advantage over the device that was originally issued".

- Upgrade Example: https://providernews.anthem.com/maine/article/billing-for-deluxe-hearing-aids

THIRD-PARTY MEDICAL POLICIES 2024 – AETNA

http://www.aetna.com/cpb/medical/data/600_699/0612.html

- "Air conduction hearing aids are considered medically necessary when the following criteria are met:
  - hearing thresholds 40 decibels (dB) HL or greater at 500, 1000, 2000, 3000, or 4000 hertz (Hz); *or*
  - hearing thresholds 26 dB HL or greater at three of these frequencies; *or*
  - speech recognition less than 94 percent".
- "Aetna considers the following procedures experimental and investigational because the effectiveness of these approaches has not been established:
  - Air conduction hearing aids for improvement of balance
  - Hearing aids and semi-implantable hearing aids for all other indications (including for improvement of depression and cognitive decline in the elderly)
  - Use of free-floating piezoelectric microphone in an implantable hearing aid".

THIRD-PARTY MEDICAL POLICIES 2024 – AETNA

”Aetna considers the Bose Hearing Aid and other FDA-cleared hearing aids available over the counter without a prescription as medically necessary equally effective alternatives to hearing aids available only by prescription for persons whose hearing has been evaluated and meet medical necessity criteria for air conduction hearing aids, and the member has a prescription for the hearing aid from a physician or provider licensed to prescribe hearing aids.

- State dispensing laws will matter here.

For plans that do not exclude hearing aids, either OTC and prescription hearing aids are eligible for coverage if they are cleared by the FDA and prescribed by a qualified healthcare provider and medical necessity criteria for hearing aids above are met”.

THIRD-PARTY MEDICAL POLICIES – ANTHEM COMMERCIAL 2024

https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html

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- Upgrade Example: https://providernews.anthem.com/maine/article/billing-for-deluxe-hearing-aids

THIRD-PARTY MEDICAL POLICIES 2024 – TRICARE

- TRICARE only covers hearing aids and hearing aid services if you have hearing loss that meets specific criteria.
  - Adults with: Hearing threshold of at least 40 dB HL in one or both ears when tested at 500, 1,000, 1,500, 2,000, 3,000, or 4,000Hz; or hearing threshold of at least 26 dB HL in one or both ears at any three or more of those frequencies; or speech recognition score less than 94%.
  - Children with: hearing threshold level of at least 26dB HL in one or both ears when tested at 500, 1,000, 2,000, 3,000, or 4,000Hz.
- https://www.tricare.mil/CoveredServices/IsItCovered/HearingAids
- https://www.military.com/benefits/veteran-benefits/hearing-aids-for-military-retirees.html

THIRD-PARTY MEDICAL POLICIES 2024 – FEHP

https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/

- FEHP hearing aid benefits are not "one size fits all".
- Allowable rates are payer dependent.

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- https://www.fepblue.org/our-plans/medicare/compare-plans#:~:text=Hearing%20Aids&text=Prior%20approval%20will%20be%20required,aids%20and%20hearing%20aid%20supplies.
- FEP Hearing Aid 005
- FEP Standard plan beneficiaries can received covered services at out of network providers. FEP Basic and Blue Focus beneficiaries have no out of network coverage.

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- **Prior authorization is required in 2024.** Hint
- **Documentation of medical necessity has ALWAYS been required.**
- Request prior authorization through Availity or via fax to 1-800-732-8318
- There is the option to call (if you must) to 1-800-860-2156

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- Minimum test battery:
  - Air conduction testing
  - Bone conduction testing
  - Speech reception threshold
  - Speech recognition testing

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- Recommended documentation for hearing aid prior authorizations:
  - All audiometric test results required by the State.
    - Three and four frequency pure-tone average.
    - Results of medically necessary audiometric testing and otoscopy.
  - Results from a standardized inventory (i.e. HHI, COSI, SAC, etc.)
  - Speech in noise results.
  - Unaided real ear (to illustrate that the aided ear cannot meet NAL targets)
  - Results of any screenings (i.e. cognitive, APD, dexterity, mobile proficiency, speech/language).
  - Findings from patient interview regarding audiologic and communication needs.
  - Copies of any medical referrals/orders/findings/evaluations.
  - Medical clearance/waiver, if required by a State.
  - Prescription for make, model and style of hearing aid being prescribed (as allowed).
  - Documentation of medical necessity for the type, style, and features of hearing aid being prescribed, including peer reviewed research supporting necessity.

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- BCBS FEHP plan:
  - This is an allowance benefit.
  - "Hearing aids for children up to age 22, limited to $2,500 per calendar year.
    - Here is a rationale for an unbundled delivery.
  - Hearing aids for adults age 22 and over, limited to $2,500 every 5 calendar years. Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above."
  - The patient is responsible for all costs which exceed $2500.

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- BCBS FEHP medical necessity:
  - "**Medical necessity** shall mean healthcare services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:
    - In accordance with generally accepted standards of medical practice in the United States; and
    - Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
    - Not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and
    - Not part of or associated with scholastic education or vocational training of the patient; and
    - In the case of inpatient care, able to be provided safely only in the inpatient setting".

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- BCBS FEHP plan requires documentation of medical necessity for all hearing aids, including initial fittings:
  - "Must be FDA-approved
  - Dispensed by prescription from a licensed healthcare provider..
  - Hearing aid purchase within 6 months of the date of prescription.
  - Hearing loss determined and documented by audiometric testing (hearing test) completed in the 6 months prior to hearing aid purchase.
  - Moderate hearing loss of 40 dB or greater (based on pure tone average tone-conduction detection threshold) for:
    a. conductive hearing loss unresponsive to medical or surgical interventions
    b. sensorineural hearing loss
    c. mixed hearing loss (combination of conduction hearing loss and sensorineural hearing loss)"

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- BCBS FEHP plan replacement device, whether in years three to five or after five years of age:
  - "Documentation of medical necessity for replacement hearing aid to include:
    - Member's past history of hearing aid use
    - Pertinent medical history, description of functional status, relevant prior treatment
    - Comprehensive audiometric testing: date, type of testing and results that demonstrates the hearing loss and need for a replacement hearing aid
    - The currently used device is no longer functioning adequately and has been determined to be non-repairable and is not under warranty, OR
    - Significant change in the person's hearing that requires a different hearing aid (at least a 15 dB change in at least one frequency between 500 and 4000 Hz)
    - Recommendation for type of replacement device
    - Follow-up plan for assessing effectiveness/outcome of use of the replacement hearing aid
      1. Trial period
      2. Warranty information"

THIRD-PARTY MEDICAL POLICIES 2024 – BCBS FEHP

- BCBS FEHP non-covered items and services list:
  - "Accessories which are for convenience and not medically necessary
    - While many hearing aids are now Bluetooth compatible, below are examples of additional tools that are considered not medically necessary (this list is not all inclusive:
      - Streamer remote/TV adapter (for connection to multiple audio sources such as a home theater system or smartphone)
      - Phone clip (allow hearing aid to become a wireless stereo headset)
      - Remote control (change volume/programs and control other accessories)
      - Remote microphone
      - Apps
  - Hearing aids that have been returned for a refund during the trial/adjustment period
  - Repair of hearing aid performed under warranty
  - Repair or replacement of hearing aids due to loss, misuse or abuse
  - Over-the-counter hearing aids/ hearing assistive devices/ personal sound amplification products (PSAPs) available without a prescription".

HEALTH PLANS MAY ASK YOU FOR

- Prescription
- Prior authorization or prior authorization number
- Medical clearance, possibly even from an ENT
- Documentation of medical necessity
- Invoice
  - They have the contractual right to this.

These requests will be outlined on denial remittance.

INSURANCE VERIFICATION PROCESS

1. Obtain health plan information from the patient at scheduling.
2. Send a Good Faith Estimate.
3. Verify eligibility, coverage and benefits prior to patient visit.
4. Document and communicate coverage and benefits to provider.
5. Make a copy of the patient's insurance cards at intake.
6. Openly discuss coverage and benefits and their limitations with the patient and their family.
7. Have patient complete any required upgrade waivers or notices of non-coverage.

INSURANCE VERIFICATION

- VERIFICATION IS EASIER AND FASTER WHEN YOU KNOW YOUR ALLOWABLE RATES AND MEDICAL POLICIES.
- Cannot get allowable rates, medical or coverage policies, or coding guidance in phone verification process.
  - These are CONTRACTING questions.
  - Can get this from provider relations/representatives.
- Do as much as possible online.
  - Portals
    - UHC:
      - Shows coverage, eligibility, benefits and allowable rate schedules.
    - Availity and Navinet:
      - Show coverage and eligibility.
      - Will still need to verify, with payer, benefits.

INSURANCE VERIFICATION

- Call to verify hearing aid coverage and benefits before the patient's appointment.
  - **Never use the term "balance bill" if in-network provider.**
    - Ask about "upgrades to a deluxe item from a standard item" or "top up".
    - Do not need to ask UHC or BCBS FEHP.
    - Ask them to READ the benefit on the screen (what they see) word for word.
    - Hearing aid benefits may be listed separately from audiologic evaluation benefits.
  - Research Medicare Advantage plan documents, coverages and third-party involvement.
    - Calling can trigger the third-party contacting the patient directly to schedule with an in-network provider.
    - Typically, if a third-party is involved there is no out of network coverage and ben

INSURANCE VERIFICATION

- Important tips
  - Commercial health plans
    - At every visit, ask patients if they have had any changes in their insurance coverage, especially if they have had a spousal death, retired, gotten divorced (or, if child, if their parents have gotten divorced), had their 26th birthday (which kicks them off their parent's coverage) or had a change in employment.
      - If you have verified benefits AND they have had any of the above changes, you need to reverify benefits before providing care.
    - If you verified benefits in one calendar year and you are fitting the patient in another calendar year, you need to reverify benefits for the year the patient is being fit.
  - Medicaid
    - Some of these plans and member eligibility change month to month.
    - Please verify eligibility and benefits for the month you are providing care.
  - Medicare
    - Benefits change every January 1.
    - If you verified benefits in one calendar year and you are fitting the patient in another calendar year, you need to reverify benefits for the year the patient is being fit.
    - Medicare Advantage plans, unless employer sponsored or in Illinois, are generally unfunded, hearing aid discount programs through HBP/TPNs.

INSURANCE VERIFICATION

- Funded or unfunded.
- Inclusive.
- Upgrade possible
  - BCBS association commercial plans
  - UHC commercial plans
    - Must offer a patient an option within their benefit.
- Funded HA benefit options:
  - Allowance.
  - Fixed, negotiated allowable rates.
  - Fixed dollars amount.
  - Invoice plus.
  - Percentage of allowable rate.
  - Percentage of dollars billed.
  - “Up to” (allowable rate).
- Frequency of benefit.
  - Months or years
    - Exhaust benefit typically at fitting.

HEARING AID BENEFIT TYPES

- Unfunded
  - A "benefit" where the health plan negotiated "discounts" on hearing aids and related items and services.
  - The patient pays in full for the costs of the items and services.
  - Administered through a hearing benefit plan/third-party network.
- Funded
  - The health plan is paying in whole or in part for the cost of the item of service.
  - Can be administered directly by the health plan or a hearing benefit plan/third-party network.
- Inclusive
  - What items and services are included in the hearing aid benefit.
  - Often defined by medical policy or allowable rate schedule.

HEARING AID BENEFIT OPTIONS

- Allowance
  - Dollars towards.
  - Patient can pay the difference between the allowance and the usual and customary rate of the hearing aids and related services.
  - Examples: BCBS FEHP
- Fixed, negotiated allowable rate.
  - Based upon your practice's allowable rate schedule.
  - 100% of allowable for…
  - Itemization is vital here.
  - Examples: Some BCBS association commercial plans.
- Fixed dollar amount.
  - The benefit is a fixed number and not based upon your allowable rate schedule.
  - Itemization may push things to patient responsibility.
  - Example: UHC commercial and its $2500 per ear benefit.

HEARING AID BENEFIT OPTIONS

- Invoice plus
  - This is where you must submit an invoice for coverage.
  - The health plan pays the hearing aid invoice plus a percentage.
  - Itemization is vital here.
  - Example: BCBS of Georgia
- Percentage of allowable rate
  - The health plan covers a percentage of the allowable rate for hearing aids and related services.
  - The remaining percentage is co-insurance and should be paid at the time of visit.
  - Itemization is vital here.
  - Example: Some BCBS Association plans

HEARING AID BENEFIT OPTIONS

- Percentage of dollars billed
  - The health plan covers a percentage of the dollars billed for hearing aids and related items and services.
    - Often 50-70%
  - VERY hard to operationalize and meet the contract requirements of standard pricing.
    - May need documentation from health plan, in writing, allowing for cash pay discounting.
  - Unbundled delivery is difficult with this type of benefit.
  - Rarer benefit type.
- "Up to"
  - The health plan covers "up to" a fixed dollar amount for the hearing aid and related items and services.
  - They do not cover $X for the hearing aid; they cover a maximum of $x dollars for the hearing aid and related services.
    - Hearing aid and related services paid at allowable rate.
  - Itemization is vital here.
    - It's the only way to truly maximize the benefit.

THINGS NOT TO DO

- **Do not provide free hearing tests (any aspect of 92557) to some patients and then bill a health plan for the same hearing tests.**
  - If the service is free to one individual, it should be free to all individuals. This has been clearly documented (https://www.asha.org/practice/reimbursement/medicare/audiology-medicare-prohibitions-faqs/). The ONLY exceptions are indigence or if your practice were to ONLY bill insured patients (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf).
  - *The solution: Bill the patient or their health plan for all services rendered and items dispensed and stop providing free care.*
- **Do not bill a health plan for hearing aids that have yet to be fit.**
  - This is an example of a false claim (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf; https://www.bcbs.com/healthcare-fraud; https://www.uhc.com/fraud/faqs). There are no loop holes around this (i.e. fitting a patient with a loaner or demo set of hearing aids).
  - *The solution: Verify coverage and benefits, fit within the hearing aid benefit, applicable medical policies, and coverage allowances and bill hearing aids on the date of dispensing.*

THINGS NOT TO DO

- **Do not fit stock hearing aids on a patient and bill the hearing aids to a health plan.**
  - Medical necessity for the item being dispensed must be documented in the medical record. Many payers, in their coverage and benefits language, medical policies, or contract language require a manufacturer's invoice be submitted when requested. Also, some health plan's allowable is based upon a percentage of the manufacturer's invoice cost and, as a result, the invoice must be submitted as part of the claims process. This invoice must reflect the actual invoice cost (and not single unit or MSRP), be dated after the date of the hearing aid evaluation and should contain the name of the patient.
  - *The solution: Select and order hearing aids for each specific patient from the manufacturer following the communication needs assessment/hearing aid evaluation when a health plan is paying in whole or in part of the item.*
- **Do not bill a health plan for an item you received at no charge.**
  - This is a potential violation of false claims and anti-kickback legislation (https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf) and has been well documented in healthcare (https://www.justice.gov/opa/pr/united-states-settles-false-claims-act-allegations-cochlear-americas-880000; https://www.justice.gov/usao-edmo/pr/united-states-reaches-291288-civil-settlement-dr-sherry-ma-and-aima-neurology-llc).
  - *The solution: If the item was free, provide it to the patient for free .*

THINGS NOT TO DO

- **Do not bill services provided by unlicensed or non-credentialed provider to a health plan under another provider's national provider identifier.**
  - Recent graduates are unlicensed providers. They cannot see any patient, regardless of payer, until they are licensed (unless their state has clear provisional or temporary licensure or privileges, which is not common). The newly licensed and new employees cannot see patients and bill the items and services to a health plan until the audiologists are credentialed providers for the health plan (with few exceptions). Otherwise, this is a false claim (https://www.fbi.gov/scams-and-safety/common-scams-and-crimes/health-care-fraud; https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf).
  - *The solution: Do not begin employment as an audiologist until licensure is conferred and do not allow audiologists to see patients where insurance claims are being submitted for covered services until the provider has been credentialed with the health plan.*
- **Do not market to existing patients that they are "due" or "eligible" for new hearing aids.**
  - This can be seen as a solicitation or as potential fraud, abuse or waste when medical necessity for the replacement device has not been clearly documented (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf). Some health plans, including most state Medicaid programs, have medical policies that clearly require documentation of medical necessity (not just that the eligibility date has arrived) for replacement devices (https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html).
  - *The solution: Recommend, fit and bill health plans for replacement hearing aids when it is medically reasonable and necessary to replace existing hearing aids.*

THINGS NOT TO DO

- **Do not assume an item or service is non-covered just because the treatment plan includes hearing aids and, as a result, charge the beneficiary privately for the service.**
  - While Medicare does not cover "examination for the purpose of prescribing, fitting, or changing hearing aids" or "routine" services (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf), coverage of audiometric testing is not automatically precluded JUST because the patient is a hearing aid user or because the treatment plan includes hearing aids. The Update to Audiology Policy (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r84BP.pdf) indicated: "It is appropriate to pay for audiological services for patients who have sensorineural hearing loss and who wear hearing aids if the reason for the test is anything other than evaluation of the hearing aid. For example, there may be a perceived change in hearing or tinnitus that makes testing appropriate and covered. Such testing might rule out other reasons for the symptoms (auditory nerve lesions, middle ear infections) and result in subsequent evaluation of the hearing aid (not covered) or aural rehabilitation by a speech-language pathologist (covered)". So, in other words, if the testing is physician ordered and medical necessity has been documented, Medicare will cover the testing. The patient should not be held financially responsible.
  - *The solution: Allow the patient to access their health plan benefits by reviewing the patient's case history, documenting medical necessity for the services provided, and billing the health plan for medical necessary services.*

THINGS NOT TO DO

- **Do not uniformly upgrade hearing aid technology from a basic or standard item to a deluxe item without documentation of medical necessity for the deluxe item, without first offering a patient a standard item within their benefit, without having the patient acknowledge, in writing, their rights and responsibilities prior to dispensing, and, most importantly, without ensuring that the health plan contractually allows for upgrade.**
  - Every health plan does not allow for upgrade from a standard item to a deluxe item. As a result, the audiologist could be violating their payer agreement by having the beneficiary pay, privately, for anything other than unmet deductible, applicable co-insurance or co-payments, or for prior notified non-covered services. This capacity for upgrade is determined by the health plan and your agreement with that health plan. If the health plan does not allow for an upgrade, the patient is not allowed to upgrade.
  - *The solution: The practice needs to educate themselves on each payer agreement and medical or payment policies, create verification processes and policies and implement upgrade forms and processes.*

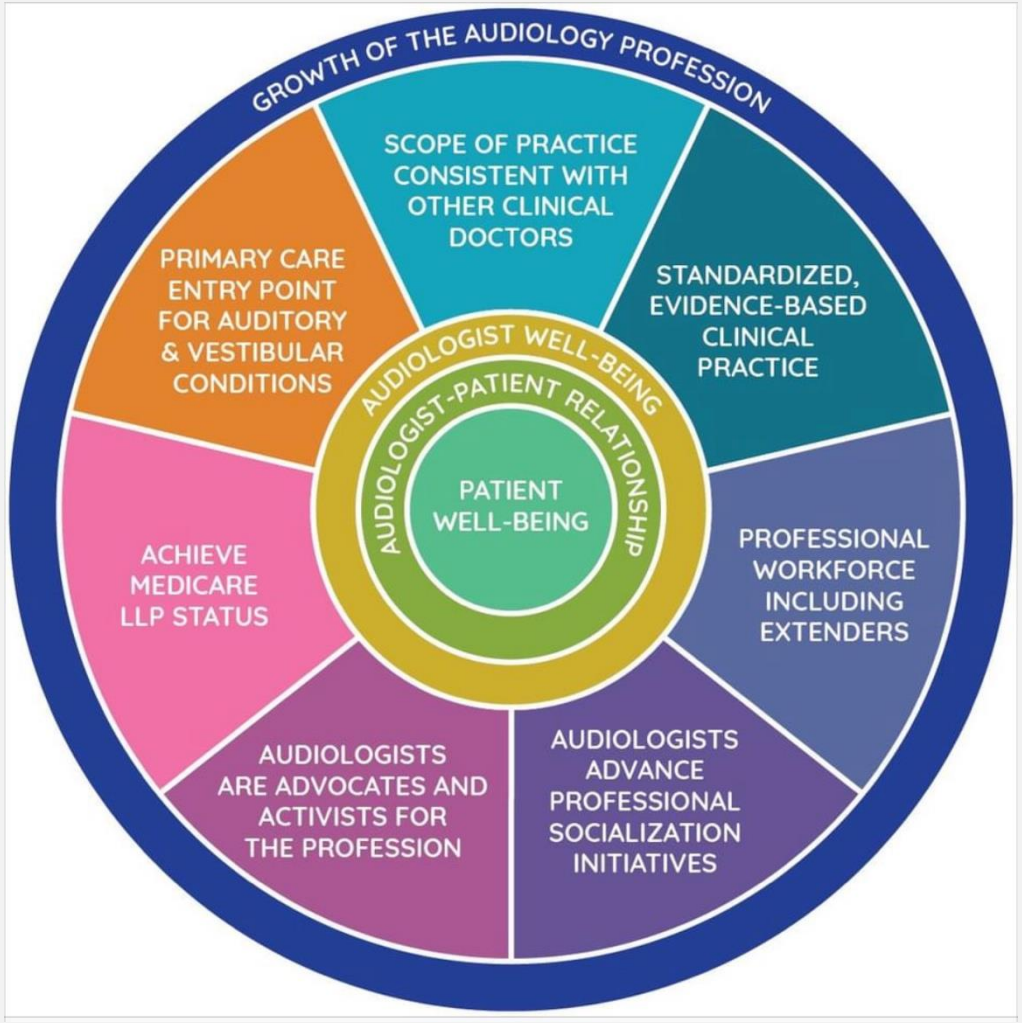
THINGS NOT TO DO

- **Do not fit hearing aids on normal hearing individuals and bill the health plan, unless explicitly allowed by medical policy.**
  - Many health plans, including state Medicaid programs, Aetna and Tricare, have degree of hearing loss requirements for hearing aid coverage and/or have medical policies restricting coverage of hearing aid for treatment of tinnitus or auditory processing disorders or for hearing protection purposes (for example https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html, https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html, and https://www.tricare.mil/CoveredServices/IsItCovered/HearingAids#:~:text=TRICARE%20doesn't%20cover%20hearing,aids%20through%20other%20government%20programs.).
  - *The solution: When the audiologist is in-network provider, the provider should educate themselves on the contracts terms and applicable medical policies governing coverage.*
- **Do not bill health plans differently than you bill your private pay patients for the same items or services.**
  - Billing in excess of your usual and customary rate to a health plan can be construed as abuse (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf).
  - *The solution: Bill insurance the same rate as you bill your general population for the same item or service.*

THINGS NOT TO DO

- **If you are fitting a patient with a CROS/BICROS system (two devices) do not bill the devices as a hearing aid plus a "contralateral routing device, monaural", either on a single date of service or separate dates of service.**
  - This constitutes a false claim (https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf), unless the health plan, in specific medical policy or payment guidance, allows for this coding scenario.
  - Just because it processed and paid does not mean that the health plan could not come back, at a later dates, and legitimately request these monies.
  - *The solutions:*
    - *Bill CROS/BICROS systems on the same date of service using the "contralateral routing system, binaural" codes.*
    - *Attempt to renegotiate your allowable rates for the CROS/BICROS code set.*
    - *Appeal payment decisions by sharing invoice information, illustrating how the devices are invoiced to your practice.*
    - *Itemize your claim to the health plan.*
- **Do not get your advice on billing, coding, or managed care solely from social media or manufacturers.**
  - All of the scenarios from this "what not to do" section were created because someone, on social media, recommended this to their colleagues.
  - **The solution: Reach out to state and national audiology associations, industry experts (myself, AAPC, Zupko, etc..) and health plan education and guidance when you have questions.**

IF AUDIOLOGISTS WANT TO HAVE MORE, WE HAVE TO DO MORE: ADA'S AUDIOLOGY 2050



QUESTIONS:

I answer questions at no charge for KAA attendees ONLY until October 18, 2024

Current Academy of Doctors of Audiology (ADA) have unlimited access to me for questions as a value-added benefit of membership.

THANK YOU

Email:

kim.cavitt@audiologyresources.com

Phone or text:

(773) 960-6625

Calendly:
https://calendly.com/audiologyresources

Website:

www.audiologyresources.com