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- Call 800-753-2160 (M-F, 8 AM-8 PM ET)
- Email customerservice@AudiologyOnline.com
2020 Coding and Reimbursement Update
Kim Cavitt, AuD
Audiology Resources, Inc.
February 5, 2020

LEARNING OUTCOMES
1) List the CPT code changes for 2020.
2) Describe the MIPS updates for the 2020 payment year.
3) Describe the private insurance policy changes for audiology for 2020.
AMA DISCLAIMER

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2020 Coding Changes

- CPT
  - CPT changes go into effect on January 1 of each year.
  - There were significant CPT changes for audiology for 2020.

- HCPCS
  - HCPCS changes go into effect on January 1 of each year.
  - There were no audiology-related HCPCS changes that went into effect on January 1, 2020.

- ICD-10
  - ICD changes go into effect on October 1 of each year.
  - There were no significant audiology-related ICD changes that went into effect on January 1, 2019.
Posturography

- 92548: Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report
- 92549: Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT).

Auditory Prosthetic Device Testing

- 92626: Evaluation of auditory function for surgically implanted device(s), candidacy or post-operative status of a surgically implanted device(s); first hour.
  - Need to have spent 31 minutes or more to bill 92626.
  - Document minutes in the medical record.
- 92627: Evaluation of auditory function for surgically implanted device(s), candidacy or post-operative status of a surgically implanted device(s); each additional 15 minutes.
  - Need to have spent 7 minutes or more to bill 92627.
  - Document time in the medical record.
  - Billed with units.
Use of 92626/7

- These codes only purpose for third-party coverage is for candidacy determination testing and post operative assessment of a cochlear, middle ear, osseointegrated or auditory brainstem implant.
- This code is NOT to be used for:
  - Hearing aid related visits.
  - BAHA or CI Fitting or troubleshooting
  - Tinnitus evaluation or management.
  - Speech in noise testing outside of implantation.
  - Aided testing outside of implantation.

Rehabilitation/Habilitation Codes

- 97129: Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-to-one) patient contact; initial 15 minutes)
- 97130 (Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-to-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure).
  - 97130 billed with units.
  - As allowed by state licensure laws.
Medicare Deductible

- The 2020 Traditional Medicare deductible is $198.
- Some Medicare Advantage plans may also have deductibles.

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/)
What Type of Setting do you Practice in?

- IF you practice in a hospital, multi-disciplinary clinic, or otolaryngology or physician practice, you MAY have different reporting requirements, reporting methods, and guidelines.
  - In these situations, PLEASE immediately reach out to your practice administration to determine your MIPS requirements.
  - Your practice could be enrolled in an alternative payment model, which has very different MIPS requirements.
MIPS Scoring

Two Performance categories make up the MIPS scores for audiologists.

- **Quality (85%)**
  - This performance category replaces PQRS. This category covers the quality of the care you deliver, based on performance measures created by CMS, as well as medical professional and stakeholder groups.
  - Providers have to be able to report up to six measures of performance.
  - Can be reported via claims, registries, or EHR.

- **Improvement Activities (15%)**
  - 2 high-weighted activities or
  - 1 high-weighted activity and 2 medium-weighted activities or
  - At least 4 medium-weighted activities.
    - Must occur for 90 days or more.
    - Documented by attestation.

MIPS STEP #1: Determine Eligibility

- Go to MIPS Participation Status link or https://qpp.cms.gov/participation-lookup
- Insert your National Provider Identifier in the box provided.
- If, when you check your MIPS eligibility status on the PY2020 tool it indicates that you are eligible to report because of participation in an Alternative Payment Model (APM) OR it does not show your NPI as recognized by the program, please immediately reach out to the practice manager of your facility to determine your specific reporting requirements and mechanisms (as the claims-based reporting option might not be available to you).
  - Typically, APMs only exist in large hospitals, medical centers, and multi-disciplinary clinics.
Quality Payment Program

QPP Participation Status

Enter your 10-digit National Provider Identifier (NPI) number to view your QPP participation status by performance year (PY).

QPP Participation Status includes APM Participation as well as MIPS Participation.

Please note that the QPP Participation Status Tool is only a technical resource and is not dispositive of any eligible clinician’s, group’s, or organization’s status under OPP. For more information, please refer to the Quality Payment Program regulations at 42 CFR part 414 subpart D.

You’re a MIPS Eligible Clinician

MIPS Eligibility: INDIVIDUAL

If you’re a MIPS eligible clinician, identified by a unique Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) combination, then you’re required to submit MIPS data. You can report MIPS data at one of the following levels:

- Individual and/or group
- Virtual group (V/G)
- MIPS APM entity

Next Steps

1. Determine if you’re participating as an individual and/or group, virtual group, or MIPS APM entity.
2. Determine if you qualify for any reporting factors that may impact your reporting requirements.
You’re an Opt-in Eligible Clinician

MIPS Eligibility: Individual
Opt-in Option: Opt-in eligible as individual

If you’re an opt-in eligible clinician, identified by a unique TIN/NPI combination, then you’re not required to report as an individual but can opt-in to report as an individual for MIPS.

Alternatively, you can elect to not opt-in and instead voluntarily report or not report at all.

What Happens if I Elect to Opt-in to MIPS?

If you elect to opt-in, you will:

- Be considered a MIPS eligible clinician and be required to report;
- Receive performance feedback;
- Receive a MIPS payment adjustment (positive, negative, or neutral);
- Be eligible to have your data published on Physician Compare and;
- Be assessed in the same way as MIPS eligible clinicians who are required to participate in MIPS and are therefore automatically included.

What If I’m Associated with a Practice That Is Eligible or Opt-in to Report as a Group?

You’re a MIPS Exempt Clinician

MIPS Eligibility: Individual

If you’re exempt from MIPS as an individual clinician, identified by a unique TIN/NPI combination, you’re not required to participate in MIPS. However, if your practice is MIPS eligible or opt-in, and reports to MIPS as a group, you’ll receive a payment adjustment based on that group’s score. You’re also able to voluntarily report if you choose to do so.

What Happens If I Voluntarily Report Data to MIPS?

If you elect to voluntarily report measures and activities for MIPS, you will:

- Receive performance feedback, allowing you to prepare for future years and;
- Be eligible to have your data published on Physician Compare.

If you elect to voluntarily report to MIPS, you will NOT:

- Receive a payment adjustment based on the data submitted, or;
- Be included in the calculation of MIPS measure benchmarks.

Next Steps
Typical Private Practice Audiologist Eligibility Screen

Typical Large Facility Audiologist Eligibility Screen
Typical “Opt-in Eligible” Eligibility Screen

MIPS STEP #2: Determine if you are Exempt

- You are exempt in 2020 if you enrolled in Medicare for the first time in 2019.
- Audiologists are MIPS EXEMPT for participating in the MIPS program if, individually, they:
  - Have $90,000 or less in Medicare Part B allowed charges for covered professional services; OR
  - Provide care to 200 or fewer Medicare beneficiaries; OR
  - Provide 200 or fewer covered professional services under the Medicare Physician Fee Schedule (PFS).
- These exemptions are collectively called the low volume threshold.

99% of individual audiologists in the United States, whose practice is not enrolled in an Alternative Payment Model (APM), will be exempt from MIPS reporting in 2020.
Merit Based Incentive Payment System (MIPS) Participation Options

- **Participate as an individual**
  - An individual is defined as a single clinician, identified by their individual National Provider Identifier (NPI) tied to a single Taxpayer Identification Number (TIN).
  - If you report only as an individual, you'll report measures and activities for the practice(s)/TIN(s) under which you are MIPS-eligible and be assessed across 2 performance categories at the individual level. Your payment adjustment will be based on your Final Score derived from the 2 MIPS performance categories.
  - **In this reporting option, almost all of you will be subject to the low volume threshold and reporting will be VOLUNTARY!**

- **Report as a Group**
  - A group is defined as a single TIN with 2 or more clinicians (at least one clinician within the group must be MIPS-eligible) as identified by their NPI, who have reassigned their Medicare billing rights to a single TIN.
  - If you report only as a group, you must meet the definition of a group at all times during the performance period and aggregate the group’s performance data across the 2 MIPS performance categories for a single TIN. Each MIPS-eligible clinician in the group will receive the same payment adjustment based on the group’s performance across 2 MIPS performance categories.
  - **If you CHOOSE to report as a group, you could be subject to payment penalties and incentives.**
MIPS Step #3: Determine if you Want to Report

Exempt audiologists (audiologists who do not meet the low volume threshold) may decide to voluntarily participate in the MIPS program. This can be accomplished by several means:

- Report as a Group (if eligible).
- Join a virtual group: https://qpp.cms.gov/mips/individual-or-group-participation
- Voluntary Participation:
  - Audiologists will not formally sign up/enroll in this type of reporting.
  - Audiologists can participate via the same mechanism they reported Physician Quality Reporting Systems (PQRS) Measures.
  - Reporting G-Codes via Medicare Part B claims.
  - Audiologists will also “attest” to the Improvement Activities (IA).
- Opt-In Participation:
  - Audiologists will officially and formally “opt in”.
  - Everyone is not “opt in eligible”.
  - Audiologists can participate via the same mechanism they reported Physician Quality Reporting Systems (PQRS) Measures.
  - Reporting G-Codes via Medicare Part B claims.
  - Audiologists will also “attest” to the Improvement Activities (IA).
  - Audiologists would be eligible for payment incentives and payment reductions, based upon their overall MIPS score and performance.

STEP #4: Create a QPP Account

- You will attest Improvement Activities through this portal.
MIPS Voluntary Participation Step #5: Complete and Attest to improvement Activities

- MIPS also has a category known as Improvement Activities.
- Improvement activities are activities designed to improve clinical practice.
- Each audiologist must complete at least four of these activities listed above and each activity must be performed for 90 days or more during 2020.
- Audiologists will attest to their performance of these improvement activities at the QPP site at https://qpp.cms.gov/login.
- Audiologists can learn more about improvement activities at:
  - https://qpp.cms.gov/mips/improvement-activities
Resources

- [https://qpp.cms.gov/about/resource-library](https://qpp.cms.gov/about/resource-library)
- [https://qpp.cms.gov/about/webinars](https://qpp.cms.gov/about/webinars)
- [https://qpp.cms.gov/about/help-and-support](https://qpp.cms.gov/about/help-and-support)
- [www.audiologyquality.org](http://www.audiologyquality.org)
2020 Audiology Quality Measures

- Documentation of Current Medications in the Medical Record
- Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Falls: Risk Assessment
- Falls: Plan of Care
- Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness
- Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Elder Maltreatment Screen and Follow-Up Plan
  - Already a requirement of many state audiology licensure acts.
- Functional Outcome Assessment
- Falls: Screening for Future Falls Risk
  - This measure has limited reporting options for audiology.

Elder Maltreatment

- Report at least once per calendar year for 50% of eligible patients.
- Requires care plan.
- CPT Codes:
  - 92540, 92541, 92542, 92550, 92557, 92567, 92570, 92587, 92588, and 92625
- ICD 10 Codes
  - None specified (so all included)
What is Elder Maltreatment:

- **Physical Abuse**
- **Psychological Abuse**
- **Neglect**
  - By a caregiver or family member; not self neglect
    - Active – Behavior that is willful or when the caregiver intentionally
      withholds care or the neglect may be motivated by financial gain or
      reflect interpersonal conflicts.
    - Passive – Situations where the caregiver is unable to fulfill his or her
      care giving responsibilities as a result of illness, disability, stress,
      ignorance, lack of maturity, or lack of
- **Sexual Abuse**
- **Elder Abandonment**
  - Desertion of an elderly person by an individual who has assumed
    responsibility for providing care for an elder, or by a person with
    physical custody of an elder.
- **Financial or Material Exploitation**
- **Unwarranted Control**
  - Controlling a person’s ability to make choices about living situations,
    household finances, and medical care.

Elder Maltreatment

- **G8733**: Elder maltreatment screen documented as positive
  AND a follow-up plan is documented.
- **G8734**: Elder maltreatment screen documented as negative, follow-up is not required.
- **G8735**: Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of the encounter.
  - Patient refuses to participate and has reasonable decisional capacity for self-protection.
  - Patient is in an urgent or emergent situation.
- **G8941**: Elder maltreatment screen documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan at the time of the encounter.
- **G8536**: No documentation of an elder maltreatment screen, reason not given.
- **G8735**: Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given.
Appropriate Elder Abuse Screening Tools

- Including but not limited to:
  - Elder Abuse Suspicion Index (EASI)
  - Vulnerability to Abuse Screening Scale (VASS)
  - Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)
    - https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/HS_EAST.pdf

Elder Maltreatment

- Follow-Up Plan –
  - Have a plan if your patient is in immediate, life threatening danger.
    - Call 911.
  - Must include a documented report to state or local Adult Protective Services (APS) or the appropriate state agency.
- Resources:
  - National Adult Protective Services Association:
  - ElderCare locator:
    - https://eldercare.acl.gov/Public/Index.aspx
  - National Center on Elder Abuse:
    - https://ncea.acl.gov/
Functional Outcome Assessment

- Report at least once per calendar year for 50% of eligible patients.
- Requires care plan.
- CPT Codes:
  - 92540, 92541, 92542, and 92548
- ICD 10 Codes
  - None specified (so all included)

Including, but are not limited to:
- Berg Functional Balance Scale
- Dizziness Handicap Inventory (DHI)
  - http://www.rehab.msu.edu/_files/_docs/Dizziness_Handicap_Inventory.pdf
- Activities Specific Balance Confidence Scale (ABC)
- Patient-Reported Outcomes Measurement Information System (PROMIS)
  - http://www.healthmeasures.net/explore-measurement-systems/promis/obtain-administer-measures
- Select measure(s) that are appropriate for your patient population.
Functional Outcome Assessment

- G8539: Functional outcome assessment documented as positive using a standardized tool AND a care plan based on identified deficiencies on the date of the functional outcome assessment, is documented.
- G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required.
- G8942: Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented.
- G8540: Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter.
- G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter.
  - Patient refuses to participate.
  - Patient unable to complete questionnaire.
  - Patient is in an urgent or emergent medical situation.
- G8541: Functional outcome assessment using a standardized tool not documented, reason not given.
- G8543: Documentation of a positive functional outcome assessment using  

Falls: Screening for Future Falls

- Not applicable for most audiologists given its reporting limitations.
- May be applicable if you report via a registry or EHR.
Submitting MIPS Quality Measures

- A sample CMS 1500 claim form or its electronic equivalent, with MIPS, is available at: www.audiologyquality.org.
- Reporting options change with group reporting.

Navigating Managed Care

Cannot paint every payer and insurance situation with the same “brush”.

Each payer is different and every practice needs to learn how to navigate each, individual managed care plan, product, and policy.
2020 Insurance Verification Tips

- What changes, if any, exist in the hearing aid delivery space.
  - Payers have excellent guidance on their websites and portals.
- What products or payers have transitioned to a TPA?
- What products have new policies or guidelines?
- Deductibles start anew.

Know the Terms

- Allowance
  - This is money TOWARDS the cost of hearing aids, but not intended to cover the entire cost of hearing aids and related services.
- Benefit
  - Funded, in whole or in part, by the payer.
  - This is typically a fixed dollar amount or “up to” amount.
  - The allowable rate is considered payment in full, except for UHC and BCBS, which allow for upgrades (after you offer the patient, in writing, a product within their benefit).
- Discount
  - Common with Medicare Part C (Advantage)
  - Negotiated by the insurer or employer but not funded by the payer.
  - Can compete against these plans, in many cases, with unbundled delivery.
Know the Terms

- **Inclusive**
  - This is a funded hearing aid benefit where specific hearing aid related items and services are included in the fixed dollar amount hearing aid benefit.
  - What is included varies payer by payer and plan by plan.

- **Up to**
  - This is a benefit where the payment is based solely on the allowable rate.
  - Up to X does not mean X; it means the allowable rate for the specific CPT and/or HCPCS code.

Payer Guidance and Medical Coverage Policies

- You can access UHC hearing aid coverage and benefits online, via their provider portal.
- EVERY payer has a website that outlines these policies.
  - Look up EVERY item and service you provide in the medical policies links.
  - These vary payer by payer and state by state.
  - Some are housed behind a portal.
    - These portals also list co-insurance and deductibles.
    - Some contain the fee schedules.
- They can also be found in provider bulletins.
  - These meet the criteria for notification of substantive changes to the agreement.
Portal Access

- UHC
  - https://www.uhcprovider.com/
- Availity
  - https://www.availity.com/
- Navinet/Nant Health

Payer Guidance and Medical Coverage Policies

- Look up key words for ALL of the services you provide!
- Aetna: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#
- BCBS: Google “BCBS of (enter the name of your state) Medical Policies
  - Some are behind a portal.
  - Contact me if you cannot locate the policies for your state.
- UHC
Third-party Medical Policies 2020 –
UHC Commercial 2020 Hearing Aid Policy

- “Standard plans include coverage for wearable Hearing Aids that are purchased as a result of a written recommendation by a Physician.
- 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.
- 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 2020 –
Aetna

- http://www.aetna.com/cpb/medical/data/600_699/0612.html#dummyLink2
- “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”.
    - No coverage of hearing aids for treatment of tinnitus when hearing loss not present.
Third-party Medical Policies 2020 – FEHP

- [https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/](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.
- BCBS FEHP plan:
  - “Hearing aids for children up to age 22, limited to $2,500 per calendar year.
  - Hearing aids for adults age 22 and over, limited to $2,500 every 3 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 $2,500.

Managed Care Entity Communications

- Payers and TPAs need to communicate with you regarding significant changes to their provider agreement or payment policies.
- How this information is disseminated should be gleaned from the payer.
- Typical means of communications:
  - Provider bulletins send by email.
  - Website updates.
  - Medical policy updates.

READ ALL COMMUNICATIONS FROM MANAGED CARE ENTITIES YOU ARE CONTRACTED WITH!!!
HiHealth Innovations and EPIC have merged under the UHC umbrella and are now known as UHCHearing.

Please consult your UHC or EPIC provider relations contacts for detailed program information for your state.
- State hearing aid mandates can influence the programs.

Considering Third-Party Administrator/Network 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?
  - If unfunded, easier to create a competitive offering, especially if your practice is unbundled.
Considering Third-Party Administrator/Network 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?

- Can I charge the patient or their healthcare insurer for a hearing test?
  - If the answer is “no”, is the cost of the audiogram being billed by the TPA to the payer and just not paid separately to you, the provider?
  - I strongly suggest having the agreement reviewed by legal counsel.
- What items and services are included in the fitting fee?
  - If it is not included in the fitting fee, are their 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 Third-Party Administrator/Network 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?

Services Provider Networks do not Seem to “Bundle” into the Dispensing Fee

- Before charging patients privately for these services, please consult your individual agreement with this entity as well as their policies and guidelines.
  - Hearing test (92557)
  - Diagnostic testing beyond 92557
  - Communication needs assessment (92700)
  - Earmold impression (V5275)
  - Electroacoustic analysis of the hearing aid (92594/5)
  - Auditory rehabilitation (92630/33)
  - Conformity evaluation/verification (V5020)
  - Earmold/insert (V5264/5)
  - Accessories/FM and the fitting/dispensing of such accessories (V5900)
TPA Communications

- Pose all questions via email with their professional relations person.
- Clearly clarify, in writing, your rights and responsibilities.
- Determine how you will be notified of substantive changes.

Non-Participation as an Option

- 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.
  - Some physicians may stop referring to you.
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 provider network for their hearing aid coverage and benefits?
  - What are the socioeconomics of the area?
    - Most HMO and TPA plans do not have out of network benefits.

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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.
    - 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.
    - 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.

“Non-covered” Does not Mean “Non-reimbursable”

- Third-party payers DO NOT cover everything.
  - Physicians routinely collect payment for elective or experimental procedures.
  - Dental insurance usually caps coverage at $1500 maximum per year. Their patients routinely pay above and beyond that for extractions, crowns, implants, and braces.
  - Most chiropractic care is non-covered by third-party payers.
  - Optometrists, like us, often receive full coverage for testing but only see limited coverage of glasses and contacts and their “special” features.
  - Physical and occupational therapists often charge privately for deluxe items.
- These providers UNAPOLOGETICALLY bill patients and patients ROUTINELY pay these providers without incident.
- We need to charge patients something for the non-covered care we provide, regardless of their payer source.
- We also do not rethink this strategy because a small percentage of patients complain.
  - The squeaky wheel should not be greased!
Cash Discounts

- There are managed care agreements where the contract language would prohibit applying cash discounts to private pay situations and not offering the same cash discount to a managed care situation.
  - Please review your contract language before implementing a cash discount program.
    - Discuss this with legal counsel.
  - Think about fairness to patients with large deductible plans.
    - Paying out of pocket for UCR but not able to access cash discount just because they have insurance.

OTC Update

- Signed by President Trump on August 18, 2017.
- The Food and Drug Administration (FDA) has no later than 3 years after the date of enactment of the Act to promulgate proposed regulations.
- No State or local government shall establish or continue in effect any law, regulation, order, or other requirement specifically applicable to hearing products that would restrict or interfere with the servicing, marketing, sale, dispensing, use, customer support, or distribution of over-the-counter hearing aids.
- In October of 2018, the FDA announced these rules would be a priority on their Fall 2018 Unified Agenda and would be able to deliver the proposed rules well in advance of the August 2020 statutory deadline.
- Proposed rules were slated to be released in November 2019.
- In this same month, the FDA indicated that the release of the proposed rules would be delayed until the first quarter of
OTC Update

- Senate Finance Committee Chairman Chuck Grassley (R-Iowa) and Sen. Elizabeth Warren (D-Mass.) are today pressing the Food and Drug Administration (FDA) over its lack of action on writing rules to allow the sale of over-the-counter hearing aids.
  - Gave them until December 19, 2019 to address:
    - What is the status of the OTC hearing aid rules and regulations?
    - When do you expect to finalize the OTC hearing aid rules?
    - No one knows yet the outcome of that letter.

THANK YOU!