2020 Coding and Reimbursement Update

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- [Christy] Time, it is my pleasure to introduce Dr. Kim Cavitt who will discuss the 2020 coding and reimbursement update. Dr. Cavitt was a Clinical Audiologist and Preceptor at the Ohio State University and Northwestern University. Since 2001 Dr. Cavitt has operated her own audiology consulting firm, Audiology Resources. Audiology Resources provides comprehensive operational compliance and reimbursement consulting services to hearing healthcare providers. She is the past President of the Academy of Doctors of Audiology. She also serves as the Chair of the state of Illinois Speech Pathology and Audiology Licensure Board. And she serves on the Audiology Quality Consortium and serves on committees throughout ADA and ASHA. Thank you Dr. Cavitt for being with us again today. At this time I'll hand the mic over to you.

- [Dr. Cavitt] Thank you and thanks to my long time old friends of Audiology Online. And to Christie and to Kim and Caroline and everyone who's so great over there. So let's get started. And we should have time at the end of the webinar. I have allotted time for questions. So, let's first start with our learning activities, our learning outcomes. We're gonna talk about the CPT code changes for 2020. We're gonna describe the MIPS updates for the 2020 payment year. And describe the private insurance policy changes for audiology for 2020. First we always have to have the AMA disclaimer for those of you who don't know. The American Medical Association owns CPT codes. They own their use, their dissemination and their descriptions. And this is just a disclaimer to let you know that they are copyrighted by the AMA. So first, let's talk about the 2020 coding changes. CPT changes always go into effect of January 1st of each year. And in 2020 there were some significant CPT changes for audiology that we'll talk about in a moment. HCPCS changes, that's the code set that is around. CPT is around procedures, HCPCS is around product primarily. And some of the service surrounding that product. Those go into effect also on January 1st of each year. There were no audiology related significant HCPCS changes for 2020. Those changes were last year when we did the BiCROS changes. And then ICD-10, those changes go into effect in October 1st of each year. There were no significant changes that went into effect on October 1st. That should be October 1st not January 1st on that last slide.

There were no significant changes on ICD-10 coding that went into effect in October 1st of 2019. You might see some changes potentially in October 1st of 2020 but definitely for 2021. Let's talk about the changes around CPT. So first let's talk about the changes to posturography. The posturography code used to only be 92548. Now that code has, the descriptor for 92548 as changed and that descriptor has expanded and now another code has been added. So, 92548 is computerized dynamic posturography sensory organization test, CDP-SOT six conditions. And they tell you the six conditions including interpretation and report. If you do not do six conditions either a 92548 or a 92549. You would need to add a 52 modifier. That means that you've reduced the service. You must have a computerized platform to use these codes. And then 92549 is an extension of 92548. It is a computerized dynamic posturography sensory organization test in the six conditions. But it also has the motor control test and the adaptation test as well as the interpretation report. 92626 and 92627 changed significantly. And now they are really what they were always intended to be. Solely around the candidacy testing and the postoperative testing of an auditory prosthetic device. In the world of Medicare and coding auditory prosthetic devices are auditory brainstem implants, cochlear implants, osseointegrated implants and middle ear implants. Anything that isn't surgically implanted, surgically implanted. An ear lance would not count here, it's not surgically implanted.

So this is around that pretesting and determine candidacy and post testing. That's it's only purpose. So, 92626 is evaluation of auditory function for surgically implanted devices, candidacy or post operative status of a surgically implanted device, first hour. I'm going to reword that. It's really technically the first 31 to 60 minutes. You have to spend 31 minutes to bill 92626. And you have to document start and end minutes in the medical record. 92627 is each additional 15 minutes. Again, you would document start and end times. You need to have spent seven minutes or more to count that as 15 minutes. Again, for third party coverage or really now any use. These codes are only for use around implants or prosthetic devices. These codes are not to be used for hearing aid related visits that aren't about candidacy for an implantable device. They're not for

BAHA or cochlear implant fitting or trouble shooting appointments. They're are not for tinnitus evaluations or tinnitus management. They are not for speech in noise testing outside of an implantation eval. And they are not for aided testing outside a cochlear implant candidacy or post operative assessment. They have no purpose outside of an implantable world. Now let's talk about again, around cognitive function. Some rehabilitative and habilitation codes. I need to stress here first. You have to have in your scope of practice that you can do cognitive function management. You have to have that ability. Your licensure board needs to consider that a form of auditory rehabilitation. If they do, you can utilize these codes. Again, when medically necessary and physician order if we're talking about Medicare but when medically necessary. 97129 is the therapeutic intervention that focuses on cognitive functioning. Really teaching, listening and compensatory strategies. Direct one to one patient contact the initial 15 minutes. And again, that would be the initial seven to 15 minutes. And in 97130 is direct one on one. Each additional 15 minutes or each additional seven to 15 minutes. Again, 97130 is like 92627, they're billed with units.

So each unit of 15 minutes you will bill. Like if you did 30 minutes, it'd be two units of 92627 or 97130. They are billed as units. Medicare has a deductible, this seems to be something that is new to folks. But they've always had a deductible. Medicare beneficiaries who have traditional Medicare have a deductible every year in 2020, it's $198. That means that their Medicare coverage will not kick in until they have met their $198 deductible. Those deductibles again, can typically be found in fairly real time through different software systems. Some Medicare Advantage plans. Medicare Advantage plans are the same as Medicare Part C. That is a replacement plan for traditional Medicare. Medicare Advantage plans may also have deductibles, especially if these are HMO plans. So, you need to take a look and determine if a patient has a deductible or not. But traditional Medicare has one. There were some significant changes in the Merit-based Incentive Payment System or MIPS for 2020. MIPS was the replacement for PQRS which was the Physician Quality Reporting System. So MIPS is really about our responsibility to report quality patient outcomes. Audiology

has been eligible for this, to report in MIPS since 2019. Now, some things about MIPS though is the vast majority of audiologists do not meet the low volume threshold which we'll talk about in a minute. That would require you to report. Here is the MIPS resource page. MIPS has a really excellent educational page. I'm gonna go back a slide here. Here are some links at the bottom. Fantastic links that can answer a lot of questions as well. All you national associations are part of the audiology quality consortium. So if you have MIPS questions you should really reach out to your national association you're a member of for further guidance. But here is a resource page. So, first thing is what type of setting do you practice in? If you practice in a hospital, mutli-disciplinary clinic, otolaryngology or physician led practice. You may have different reporting requirements. Methods and guidelines of reporting than someone who works in an audiology clinic. If you work in these situations you need to go in and I'm gonna show you where to go in in a minute. And you need to look at your MPI and see what populates in the system. If something populates and again, I'll show you some examples in a minute. You may need to reach out to your practice administration to determine what your MIPS requirements are. If your practice is enrolled in a Medicare alternative payment model.

You could have very different MIPS reporting requirements. You could be in a hospital and you could have been put in a MIPS reporting requirement. And you could potentially be reporting via your electronic health records. Your situations can all be different. There's no way to paint this with one big brush. But I'm gonna walk you through how you do some research about what you're responsibilities may or may not be. So, audiologists are scored on two things. We're scored first on quality. 85% of our MIPS score is our ability to report the six quality measures. Report up to six quality measures on performance. And we can report right now via claims, via registry. Audiology doesn't have its own registry. You would be reporting through potentially an oncology registry or a hospital registry or something else of that nature or through electronic health records. Many of you are gonna report via claims. The other option is, the other thing that we have to report for part of our score is improvement activities.

This is that you have performed something that will yield improved patient outcomes for at least 90 days over the course of the year. And you're gonna document by just attesting. Kind of like we do at a station is what we do mainly with CU's. We tell them that we did it. We say yes, we did it. That's what at a station means and you would just let them know that you did it through their portal. You have to two high weighted activities, one high weighted and two medium or at least four medium. Most of the activities that would apply to us are mediums. So really the rule of thumb is that you would need to do four medium weighted activities. Okay, let's walk through the MIPS steps. First you have to determine eligibility. So you have to determine if you and your MPI are required to report. So, you are going to go to this link above and you're going to insert your. Not your facility national provider identifier. You're going to do your personal one into this window. And it's going to populate what your eligibility is to some degree. Whether your eligible to report as an individual, a group. Like how it's all gonna work for you. Alternative payment models that exist in large hospitals, medical centers and multi-disciplinary clinics could yield a different outcome here which I'll show, again, in a second. I took a lot of screen shots.

So here is, if you follow that link here's what you're gonna see. You're gonna put your MPI number in. Now, this is someone who is a MIPS eligible person. This means that this person, if they do not report and they report successfully. If they don't report successfully on 50% of their patients and they don't attest the improvement activities. They will get a Medicare penalty. If you see this come up this means you need to report. Now, you're gonna see this next one that says well you're not eligible to report because you don't meet the low volume threshold. You would be an opt in clinician. So that means that you aren't required to report but you want to report. I do not recommend people opting in until they have a good personal history of voluntarily reporting. Which we'll talk about in a second. That you voluntarily report for a window of time and you see that you're successful. That you're enrolled in the portal. You can look at your data and you see that you're successful. I would not be opting in until I knew I was a successful reporter because you opt in. That means that you're subject

to the payment and you're subject to the penalty if you don't do it correctly. So I really would voluntarily do a little bit. Look at your data and then make that opt in decision. So here is somebody who's MIPS exempt. That they have been identified that they are not required to participate in MIPS. If this shows up, you would only be somebody who could voluntarily report. You couldn't opt in because you don't meet two of the three criteria to be able to. So, this would be you can't even opt in if you wanted to. Now this is hard to see and you may be able to see it when you look at the slide. But this is somebody that shows that yes, they're not eligible as an individual. But they could be eligible as a group if they wanted to opt to report as a group. Again, before I would opt into group reporting. I would make sure that everyone in your group is a good reporter for a window of time before you opt in. And you put yourself, voluntarily, subject to either incentive or penalty. Some of you, especially the work in big facilities that work in hospitals may see this. That you don't exist in their system. When this populates for you. When is says that you don't exist in their system. You need to reach out to your administrator just to double check. Do you have reporting requirements through an alternative payment model?

Again, some of you may see this. That is says just group. That you might be eligible to report in a group here. Then this again, you need to reach out to your administrator. They may have signed you up for group reporting. So you want to make sure, again, that you're meeting that criteria. So please, if this populates for you. Talk to your practice administration and see how you've been assigned as a group reporter. Now, how they decide. If you are exempt, we're all eligible but if you're exempt from reporting. That means you're not required is two ways. One, if you just enrolled in Medicare for the very first time in 2019. You're exempt from MIPS reporting, you're not required to MIPS report in 2020. Another thing is your what's called the low volume threshold. If you have less than $90,000 in Medicare Part B allowed charges for covered professional services. These are things that are covered. If you provide care or you provide care to 200 or fewer Medicare beneficiaries. Or you provide 200 or fewer covered services under the Medicare fee schedule, you are exempt. That means you

are not required to report. You could if you wanted to opt in as either an individual or a group. Or if you wanted to voluntarily report just to collect data but you are not required to report to the MIPS system. These exemptions are technically called the low volume threshold. 99% of audiologists who are not enrolled in alternative payment model will be exempt in 2020 because most people do not reach that low volume threshold. You do need though, every single one of you needs to go in and type in your MPI or the MPI of your audiologist. Individually to see if anyone exceeds that low volume threshold. Now, you can participate in different ways. If you are not exempt you can participate as an individual. Again, most people are not going to be individual reporters because they're not going to exceed those low volume thresholds. You can participate as a group. That means that you meet enough of the criteria and you have more than two providers under a single EIN. That you could voluntarily, I cannot stress. Could voluntarily report as a group or opt in and report as a group. Again, before I would be opting in I would make sure that I was a good reporter already. You can also report as a virtual group. Although it's too late to join the virtual groups for 2020. In the Spring you could join the virtual group or some of you could actually formally opt in.

Again, before you do any of that I would look at this voluntary participation. You will not formally sign up or enroll. You will though create a profile in the portal. Rumor has it that the portal to get the profile created can be very slow to do at first. But once you're in, you're in. And that will allow you to look at your voluntary data and determine hey, I'm a really great reporter. I'd like to opt in to a program or join a virtual group or report as my practice. We're all great, we want to report as a group. And then you could be potentially eligible for incentives if you all meet the reporting requirements. So here is how you create your QPP account and this is where you would go attest to your improvement activities through the portal. So here is an example of what the measures might look like when you go to look at the measures at the measures link, I gave you that at the beginning. And then here is, again, how you would attest to the improvement activities. And this again, you have to do at least four of these activities over 90 days during the 2020 year and you'll attest via the portal. And here's a like to

the improvement activities as well and you'll see that here. Here are some great QPP resources and NIPS resources here. This link is the audiology quality consortium here at the bottom. That is the stakeholder organizations and audiology who manage that data. Okay, let's talk about the measures that audiologists are eligible to report in 2020. First is documentation of current medications in the medical record. Second, preventative care and screening. Screening for depression or follow up plan. Falls risk assessment. Falls risk plan of care. Referral for otologic evaluations for patients with acute or chronic dizziness. And preventative care and screening tobacco use. Screening and cessation intervention. Those six measures have existed for audiology since we were in PQRS all the way back to 2016. Those were our PQRS measures, we still exist. Those measures still exist for audiology. In 2020 we added three new measures that we are eligible to report. One is elder maltreatment screen and follow up plan. What's important about this one. Many of you may or may not realize that you already have an elder maltreatment requirement in your licensure laws. So, this is actually a really good thing to have in place because you, again, could have this already as a responsibility that you may or may not be meeting. The second is a functional outcome assessment.

Again, this is around the vestibular. And the third is a falls risk screening future falls risk. That particular measure has very limited reporting options for audiology. So most of us will not have access to that measure. It requires, it really requires you to be reporting via hospital systems. So, those of you in a hospital scenario might have access to that but it's extraordinarily limited for us to report in 2020. Let's talk, we're only gonna talk today about the two new measures. Elder maltreatment and functional outcome assessment. So elder maltreatment, you would need to report at least once per calendar year for 50% of patients. Who you performed one of these procedures below. That's a vestibular evaluation. Spontaneous gaze, positional, tips and reflexes and audiogram, temps, temps reflexes and decay, OAEs and assessment of tinnitus. And that's irrespective of diagnosis code. So, what is elder maltreatment? Elder maltreatment can be any of these things listed below. Physical abuse that you can see

that the patient has wounds or bruises or things of that nature. Psychological abuse, if you feel like the patient is being taken advantage of. Neglect by a caregiver or family member, not self neglect of the patient. So it could be active, that means that they're purposely withholding care. But it could be for financial gain or inner personal conflicts or passive. That's when that caregiver is unable to fulfill the responsibilities of being a caregiver. Sexual abuse, elder abandonment. That means that a patient was supposed to have a caregiver but that caregiver has abandoned them. The financial or material exploitation that you feel like they're being stolen from. This is the one that's actually the most common. That we'll see is that financial material exploitation or again, unwanted control is also very common. The more common, I wouldn't say very common. When you see elder abuse, that it's controlling the ability. Someone's controlling their ability to make choices for themselves. That is elder maltreatment. And again, a lot of these responsibilities exist in licensure law. So here is how you would report it. First code, elder maltreatment screen documented as positive and you create a follow up plan.

So let's talk about the follow up plan. We all need to have a plan of attack if we believe that one of our patients is being abused. Whether it's a child, whether it's a senior. We need to have policies in place in our practice. So, that's what your follow up plan would be part of. The next one is an elder maltreatment screen was documented as negative and a follow up plan was not required. Both of those are positive reportings. They would meet your criteria of reporting. The third is an elder maltreatment screen was not documented. You would document the patient is not eligible for an elder mal screen at the time of encounter. That means they refused to participate or they were in an urgent or emergency situation. That still counts as a positive reporting. The next, G8941 is that you documented a positive but you didn't do a follow up plan. And the documentation are not eligible for a follow up plan. Again, if they are positive you need to document a follow up plan. That would not be a positive reporting. One is that you didn't document an elder maltreatment screen. And the final is an elder maltreatment screen is documented as positive but the follow up plan not documented and the reason not

given. So, that we should be screening when we're doing. Testing their patients to make sure that people are not being abused. So, how do we screen people? Here are some three very quick and easy ways for someone to be screened. This could be actually in your intake paperwork that a patient is filling out. To determine if they are. That they fill out themselves. You want this to be filled out by themselves not a caregiver. That they fill this out and they can document or you can ask them if you feel. If you feel like that you might suspect abuse you could ask that person to step out of the room and you could ask these questions verbally as well. But they can be done in a paper format. So your follow up plan is if they're in a life threatening situation you want to contact 911. You also must include a documented report to state or local Adult Protective Services or the appropriate state agency. And here's some great resources of places that you can learn about reporting or learn about who to report to, great resources on elder abuse.

The next measure is, the next possible measure is functional outcome assessment. You're gonna report this at least one per calendar year on any eligible patients. Anybody you do vestibular assessment on. Irrespective of their diagnosis. Here are some functional outcome assessments that you can use. One is the dizziness handicap inventory. That's probably something that we should all be using when we see someone is dizzy. Again, it can be done in the intake paperwork. There's the Berg activities specific balance confidence scale and the PROMIS. All of these here are available, I've given all these links. This is a good time to tell you I'm doing a large event tomorrow. All these links three weeks ago functioned. So, I can't control after something that three weeks ago everyone of these links functioned. But if you have any difficulties just Google the name and you'll be able to find an alternative resource. Again, here's how you would report the functional outcome assessment. Here the first one is that it's documented as positive and you've created a care plan based upon the functional outcome assessment. That you have taken into account what you found like in the dizziness handicap inventory and create a new care plan. Irrespective of your vestibular test results. That's a really important part here. This is supposed to exist

outside your test results. That they have a handicap. So even if you don't. You get a normal vestibular assessment you still need your care plan to address what was in their functional outcome assessment and that's super important. The second one that the standardized tool was document but they don't have any functional, functional deficiencies. The third is that you did a functional outcome assessment. We documented 30 days in a care plan. And based upon identified deficiencies on the date of the functional outcome is documented. That something was done. That they've already had one done previously within the last 30 days. And so you don't need and maybe in another. Somewhere else in your facility that you don't need to do it again. Still, a positive function but your care plan needs to take into account what you found from that. The next one is that it's not that you didn't do a functional outcome assessment but they were eligible. Maybe they weren't norm for the paperwork. They couldn't complete the paperwork for some reason, they were in emergent condition. Those first four measures from 8939 through 85, 8539 through 8540 are all right there, positive reportings. Now, G9277, that means you didn't do it. Now, that's still a positive reporting as well because they refused, they were unable. Still positive. G8541, it means you didn't do it. Reason not given or, the worst one. Is that you got a positive functional outcome but you didn't document your care plan.

Those bottom two are negative reportings. And again, I would rather not report those two things actually. Again, screening falls risk, future falls risk is not applicable to most audiologist given its reporting limitations. But it may be applicable in group report via registry or electronic health record. Okay, if you want a sample of how to submit the MIPS via CMS 1500 form. Here is an example here on the quality consortium page. And the reporting options change with group reporting. Now let's get into why you're all probably really here is to talk about insurance. So, this is one thing that you all need to understand. Especially in the world of social media. You cannot paint every payer and insurance situation with the same brush. Each payer is different and actually each payer is different in each state for the most part. Because those of you who don't know every insurance plan needs to go through the filter of the Department of Insurance in

your state. So, in two states it can be slightly different. Especially in the world where there are mandates in your state. So, don't just because somebody said something on social media that it is okay for you. Every practice needs to learn how to navigate each individual managed care plan, product and policy in their state for their practice. And I also have to stress about their practice because some of your colleagues may have been savvy and negotiated contracts that are unique to themselves. So just because someone else can do it in their contract or just because somebody's allowable rate is X doesn't mean your allowable rate is X. You have to do the homework for you. Is this easy? No it isn't. Will it happen quickly? No it will not. It could take for some people years. Is it possible? Yes, but you have to devote some time and treasure to really digging into these managed care situations. And if you don't want to do that you should consider being out of network. Because then you're not obligated to any of these terms or conditions. You can do whatever you want within the licensure laws in your state.

So again, can't paint every picture with a brush. I'm gonna try to give you some generalities and things today but it's not all one size fits all. Insurance verification is extremely important. Especially at the beginning of the year. Insurance verification is not verifying your contract. They cannot tell you what your allowable rates are. They can't tell you what codes they recognize. They can't tell you anything about your contract. They can only tell you about the patients benefit. So you need to ask questions solely about the benefit and not about your contract. So, when you verify at the beginning of the year. You need to ask what changes if any exist in that hearing and delivery space? So, payers have really really excellent websites, fantastic websites. You need to start, get on the phone and you need to start looking at their websites first. That's where medical policies land. Fairly easy to find in most cases. The only way you're gonna find out about your contract is by sending emails to either contracting, credentialing or provider relations. Wherever that falls a that particular payer. Or if you have a contact there or you have a customer service person. You want to email them your questions in writing. They cannot tell you things over the phone.

The phone is what you did in the 90s. Now people use portals and ask questions through their portal or they email them. You need to find out what products or payers have transitioned to a third party administrator. A general rule of thumb. This is very general, very very general. Is if it's a Medicare Advantage Plan you need to rule out that it's through a third party administrator first. Because of a lot of Medicare Advantage hearing aid benefits are through Advantage plan. That's more common than it being direct through the insurer. So rule out the third party administer involvement first and then if it's ruled out move on to the insurer. What products and what do I mean by products? Every insurance plan offers multiple products. They will have a product that's commercial. They'll have a commercial PPO. Commercial POS, Point of Service Plan. They might have a commercial HMO. They might have a commercial high deductible plan. They might have a commercial Health Savings Account Plan. They might have a commercial Flexible Savings Account Plan. So they could have multiple plans, they'll have a Medicare Advantage. They might have a Medicare Advantage HMO. They might have a Medicare Advantage PPO. They might have a managed Medicaid. They might have any number of different products.

So every product has its own policies and has its own guidelines and has its own allowable rate schedule. So your allowable rate schedule for insurance company A for their managed Medicaid and their Medicare and their commercials are all different. So, you could have upwards of five to 10 allowable rate schedules for a single insurer. So it's important for you to be aware of all the products you're contracted with. And know any new policies or guidelines associated with that product or policy. Another thing to know is they often times tell you now. Notify you of substantive changes via their provider bulletins, via eblasts or via medical policies changes. You just have to be diligent at looking at their site and reading things they send you or emails they send you, it's very important. And it's also important for insurance verification at the beginning of the year, that deductible started new. Remember some people have high deductible plans. That the cost of the hearing aids while they may have a hearing aid benefit. The cost of the hearing aids are so great. I mean their deductible is so great

that it exceeds the cost of the hearing aids. In that case the patient would pay the allowable rate cost on the date of fit because their deductible is not met. Another general rule of thumb. Things that you can collect on the date of service. You can collect co-payment and in audiology co-payments are typically only around evaluation of management codes. You can collect co-insurance. That's the patients 20%, 10% that they're responsible for. You can collect unmet deductibles and you can collect the charges of non-covered services. That's the only thing you can collect at time of visit if you are a participating in network provider.

So let's talk about some differences in terms. First term is an allowance and this is why you need to know these 'cause you need to ask it differently in verification. An allowance is money towards the cost of the hearing aids but it's not intended to cover the entire cost of hearing aids and related services, it's dollars towards. That's an allowance, you need to know if the benefit is an allowance. The next one is a benefit. That's something that's funded in whole or in part by the payer. It's typically a fixed dollar amount. Like the FEHP, $1,250 a year or up to amount. Up to $2,500 does not necessarily mean 2,500. It means your allowable rate for that specific insurance product. You need to be able to understand that. Up to 2,500 is not 2,500. You may never be able to reach the benefit. You might, again, with the itemization but up to does not mean the amount. The allowable rate is considered payment in full except for United Healthcare Direct or Blue Cross Blue Shield which allow for upgrades. But they allow for upgrades after you've offered the patient in writing a product within their benefit. And the patient has acknowledged that they are willing to upgrade and pay any differences. That's important that you have that in writing. And you need to be offering people a product within their benefits before you upgrade. Third option is a discount plan. This is common with these Medicare Advantage plans. It's negotiated by the insurer or the employer but not funded really by either. If you were unbundled you can compete many times, not every time but many times with a discounted plan. Good thing to say here is you cannot be unbundled just to them. If you are going to be unbundled you're unbundled with all your patients. You can't discriminate against a

patient just because they have insurance. So, if you go unbundled it gives you some flexibility but it has to be available to all your patients not just these restricted ones in the insurance plan. 'Cause remember, you're a voluntary participant managed care. Other than Medicare you don't have to participate. So if you are gonna participate you need to participate by the rules they've laid out in front of you. If you don't want to follow those rules then don't participate. Then there's the inclusive benefit. The inclusive benefit, this is a funded hearing aid benefit where the specific hearing aid related item or services are included in the fixed dollar amount. So what's included is gonna vary payer by payer and plan by plan but it's typically outlined in the benefit. What is inclusive to that benefit? I'll give you some examples here in a minute. Then again the up to, this is a benefit where the payment is solely based on the allowable rate. Up to X does not mean X. It means the allowable rate for that specific CPT and or HCPCS code.

So, payer guidance and coverage policies. You can access United Healthcare hearing aid coverage and benefits via their provider portal. So you can pull up patients benefits directly online through their portal for United Healthcare. You have to enroll in their portal though. Every payer has a website that outlines these policies. Oh, let's go back to United Healthcare portal. The only reason, you won't get access to the portal if you're not a United Healthcare provider. So, it's only available in network providers. Now, everybody has a website that outlines their policies. You want to look up every item or service you provide in the medical policy links. These are gonna vary payer by payer and state by state. Sometimes they're housed behind the portal. These portals also list co-insurance and deductibles. And some contain fee schedules depending on the state. You want access to every insurance plan that you're contracted with. You want access to their online portals. Also you can find a lot of information provider bulletins and these typically meet the criteria for the notification substantive changes to your signed contract or agreement. Here are some links to portal access. So, here's UHC. Here's Availity. Availity is a portal that is typically used by a lot of Blues. There is a no charge and a charge version of it that you can access. And the same with Navinet

or what's now called Nant Health. That does a lot of work with Aetna and Signa. So, when you go in to look up medical coverage policies look up the key words for all the services you provide. I've given you the links to the coverage policies. Some are national but let's use UHC as an example. Read in the upper right hand corner. It will tell you if there are exceptions like it doesn't apply to New York or this is only for New York or this only for California. It will tell you what that availability, who it applies to. So, here's the link for Aetna. For Blue Cross Blue Shield you want to enter literally BCBS of your state medical policies. And they will populate almost 100% of the time. Have I looked up all 51 states in the territories, no? Have I looked up 30 or more, yes? And it populated every time but one. So, there's a lot available. Very readily available online.

Okay, let's talk about the United Healthcare policy. And this is the commercial policy. This is for patients typically who are still employed and have commercial insurance through their employer. I have given you the link here to this policy. This policy is still in effect in 2020, at least right now in 2020. This policy could change though at any time as they try to integrate more of UHC hearing into all of their insurance products. UHC hearing right now is, that their third party administrator plan. And that is typically surrounding, at the moment, Medicare Advantage plans. But this is their commercial policy. It is in quotes for a reason because it's directly from the policy. Standard plans include coverage for wearable hearing aids that are purchased as a result of a written recommendation by a physician. So, if you want United Healthcare commercial to cover hearing aids. You need a written recommendation not a medical clearance and medial clearance language. You need it to be worded as a written recommendation for hearing aids. That's what you need for United Healthcare because they are asking frequently for a copy of this written recommendation. They are not requiring them at submission. They are randomly requesting the written recommendation so you must have one. Benefits are provided for the hearing aid and for charges for the associated fitting and testing. The wearable hearing aid benefit does not include batteries, accessories or dispensing fees. So, if you are a bundle to your general population. You could bill these separately to your United Healthcare beneficiaries. As long as you are

also billing your private pay patients for the same things. So if you provide batteries at no charge. You can't bill United Healthcare people for batteries. You can't treat them differently than you treat your general population. Here is where they have allowed for the upgrade. If more than one type of hearing aid can meet the members functional needs. Benefits are available only for the hearing aid that meets the minimum specifications for the members needs. If the member purchases a hearing aid that exceeds minimum specifications. United Healthcare will only pay the amount that it would have paid for the hearing aid that meets the minimum specifications. And the member will be responsible for paying the difference in cost. That means that the patient can upgrade above the allowed rates. Now, I while they do not require a waiver that reflects that I would have one. I would have a waiver in place that said you could have found something within your benefit. But you have chosen to upgrade and accept financial responsibility. So, because that's a great protection to have in case if a patient pushes back. And says they never offered me anything in my benefit. So it's important that you do that and you do that in writing. Here is the Aetna policy for 2020 on hearing aids.

This is important to note as well. Air conduction hearing aids are considered medically necessary when the following criteria are met. See the following criteria. The patient has to have a hearing loss. They have to have what Aetna would be considered an aidable hearing loss. So they do not cover, Aetna does not cover hearing aids for the sole purpose of tinnitus treatment. When the hearing loss requirements listed there are not met. They do not cover hearing aids for the sole purpose of tinnitus treatment. Here's FEHP. So, it's important to note I think people believe that the only insurance the federal government offers to its employees is insurance that has been provided by Blue Cross Blue Shield. That is not true. Actually, there are literally. Probably hundreds of insurers that offer FEHP benefits in different states. So you're gonna see this link here. This link will take you to a map. At the map you can click on your state and you will see all the available products that a federal employee can select from. What's great about this site is all the plan brochures are there. So, because all the plan brochures

are there you can see who has hearing aid benefits and who doesn't. Every FEHP plan does not have a hearing aid benefit. So, if you want to always make sure to take a look at their card and verify benefits accordingly. But if they're a federal employee. You can see all the plan brochures online at this link. Now let's say they are Blue Cross Blue Shield, FEHP plan holder. This is what FEHP covers. It's hearing aids up to 22, limited $2,500 per calendar year. Hearing aids for adults age 22 or over, limited $2,500 every three years. Benefits for hearing aid dispensing fees, batteries, fitting and repair services are included in the limits described above. So if it exceeds the $2,500 limit, the patient is responsible. They are not going to pay separately for fitting and batteries and repairs. They're not gonna pay itemized anything over $2,500. They're only gonna pay up to $2,500 and the patient is responsible for anything above and beyond that. But again, because it's Blue Cross Blue Shield. If you're doing these upgrades please make sure that you offer the patient something within the $2,500 limit. And that if they chose to upgrade that they're acknowledging that in writing.

So, managed care entity communications. Payers and third party administrators contractually are obligated to communicate with you regarding significant changes to their provider agreement or payment policies. How this information is gonna be disseminated to you is a question you need to ask. Again, social media has its place but asking the hive all these questions is not useful because in every state it's different. You could have your state association go in and ask these questions, that would make sense. But going in and taking that. Someone was told somewhere else. You don't even know how they asked it. When I ask questions, which I do a lot. I give them a scenario. I explain the patient scenario and ask them to comment on it accordingly. So, you need to ask two payers in writing how they're gonna communicate to you. The typical means of communications are provider bulletin sent by email. Or provider bulletins posted on their website, website updates and medical policy updates. You want to read all the communications for managed care entities that you're contracted with. HiHealth Innovations and EPIC have now merged under the UHC umbrella and are known as UHCHearing. They are a wholly owned subsidiary of United Healthcare.

They are owned by United Healthcare. So they operate under different set of rules to some degree then third party administrators that are owned by another entity. You want to consult your United Healthcare EPIC provider relations contact for detailed program information for your state. State hearing aid mandates can have a huge influence over the program and how it's implemented in your state. So that's why it's important to find our from your state. Also, when we talk about state associations. You should all be members of your state associations. And state associations, just an FYI, or national associations that you're not a member of have no obligation to inform you. So if you expect that your state association is gonna keep you up to date on things and you're not a member of the state association. They're not going to. You need to be responsible for that. If you want to know what's happening you should be a member of your state and nation associations. So, before you agree to participate in a third party administrator. Everyone's really wanting know what questions should you ask?

So the first thing you need to do is you need to analyze your own financial data and your own practice patterns. What your standard of care looks like. And you need to determine can I afford to provide the level of care that I provide to my general population at the agreed upon rates required by the plan? We all need to be careful to not be treating these patients differently, you're in network. If you agreed in your contract I guarantee you that you are going to treat them like you treat our general population. So before you start rationing and saying I'm only gonna see so many of these. Make sure your contract allows you to ration, many contracts do not. You want to make sure that you are following the terms of the agreement you signed. If you're unsure, you need to seek the advice of legal council or the advice of a consultant who can help you. But you need to, cannot afford do 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 it's unfunded or discount you can compete against that in many ways if you are unbundled. Do any of the policies conflict with other managed care agreement terms? Like that free hearing test. Let's talk about UHC hearing for a minute though. UHC hearing tests, while they are paying you in a bundled manner. On the back end it

is being billed to the Advantage Plan. So it is not technically free. They are just not paying it to you as a separate line item. So that's a question that you need to ask. All of these plans, is the hearing test? Are you the third party administrator billing the hearing test? And you're just bundling payment to me. You want to know what hearing aid products the plans offer and you want to know what do you do if the product that the patient wants, like a Lyric, isn't offered in the program. You need to determine how many patients that you have that are in your database have this plan? And how many patients you potentially lose if you don't enroll in the program? You want to know can you charge for that hearing test separately, either the third party administrator or their insurer. And if they say no, is it being billed separately by the administrator? If the tell you no, they're not billing it separately. You need to seek the advice of legal council depending on your other managed care commitments. You want to know what items or services are included in the fitting fee. And if it's not included in the sitting fee are there limits to what I can charge or do I have notification requirements to notify the patients? You want to ask what's included in this continuum that you provide in your standard of care.

And do I receive a greater sitting fee if I'm a member of a specific buying group or member organization that might be tied in to that third party administrator? You want to know how long the trial period is? What do I receive if the patient returns the hearing aid for credit? How long do I have to manage the patient for the sitting fee? And are there limits on what I can charge for the service outside the sitting fee window? You need to know all those things. You also need to consider in this calculation what is your cost of acquiring a new patient? Because some of these patients that you would get if you joined these plans would be new to you. So you also need to think about what would be the cost? I didn't have to pay to acquire this patient. And figure that into those financial arrangements. Now, some services that provider networks do not seem to always bundle into the dispensing fee. But, I should have bolded this. Before charging patients privately for these services. Please consult you individual agreement with each specific entity as well those policies and guidelines. And if it's not clear ask

them in writing if this is something that can be billed privately to the patient. These are things like the hearing test 92557. Diagnostic testing beyond 92557. Communication needs assessment which in my world is the diagnostic. It precedes a hearing aid. So, this is diagnostic because the results of the needs assessment may not actually be the outcome being a hearing aid. So, is that something? An ear mold impression, electroacoustic analysis, auditory rehabilitation. Conformity or verification, real ear measurement, earmolds or inserts or accessories and or the fitting of such accessory. Those are things you need to determine. Are they included in that fee? And you don't just assume they're not because it's not mentioned. It doesn't mention that you can't do surgery either but you need to ask in writing. You need to ask in writing. You want to again, pose all questions via email with their professional relations person. As someone who used to be the professional relations person of one of these people. One of these plans, I really really request that you submit question via email and let them answer you. Will it happen instantaneously? No, but I have seen for the most part over the last few weeks that people are responding within a day or two. It's not been or what I mean by responding.

Sometimes they're responding back saying we have to dig into this a little bit more and we'll get back to you. That is still a response. So they are responding. You want to clearly clarify your rights and responsibilities. And you want to know how they're going to notify you of substantive changes and give them scenarios when you can. Again, non-participation is always an option. Other than Medicare you're a voluntary participant managed care. It's always an option to not participate in managed care plans and be out of network. But please know once you terminate you may not be able to get back in a plan once you change your mind. That panel may be closed to new providers and you may not be able to get back in. And some referral sources may stop referring to you because their contracts say that they're supposed to refer first and foremost to an in network provider. Before you terminate you want to know how many patients are represented by this payer. And that's including a third party administrator. How many dollars? How many referral sources? How many payers contractual offer

hearing aid upgrades? Does the payer offer lucrative audiology, audiology direct, hearing aid coverage and benefits? Those are few and far between but they still exist in some places. Does the payer utilize a provider network for their coverage and benefits? And what are the socioeconomics of the area? Because remember, most HMO plans and third party administrator plans do not have out of network benefits. That you have to see an in network provider.

So, before you just say no. Really do an analysis of your practice. And it's data to make, and really make a business decision. Again, when out of network and they have out of network benefits. The patient's gonna pay in full on the date of service. One exception is if you don't accept Medicaid and the patient is dually eligible Medicare and Medicaid. In these situations Medicare, you can't collect the Medicare co-insurance that Medicaid would have paid. You can't collect that from the patient. That's something you would have to eat. Another exception is if you're out of network to a Medicare Advantage insurance plan for diagnostics. In those cases you're only allowed to collect from the patient the limiting charge. Which is like if you were a non-participating provider with Medicare. Your office, which I do recommend people do when they're out of network, can submit claims to the payer as a courtesy to the patient. The patient is then typically reimbursed from the payer, their out of network benefits. And this is something that you see a lot of mental health, dental and optometry offices that are out of network and this is how they work it in their world. This is really important that audiologist start to realize. That non-covered does not mean not reimbursable. Third party payers don't cover everything. Physicians, dentists, chiropractors, optometrists, physical occupational therapists have a lot of things that they charge people privately for. I know, I paid them. Seniors pay them. Remember, Medicare doesn't cover dental or vision either. So these seniors that you're to no charge for things are paying optometrists and opticians for readily and dentists. And it's significant dollar amounts, think of dental implants. These are significant dollar amounts that they're just paying and no one's giving away anything for free. So, these providers unapologetically bill their patients. They notify them in advance of these

costs and they routinely get paid without incident. We need to charge patients for non-covered services and we need to stop giving away free. As we're gonna talk about in a minute. What are you gonna do when hearing aids go OTC and people have no intention of ever purchasing a hearing aid from you. They just want to come for evaluation and you're gonna give it away for free. That is going to be unsustainable. You really have to get away from that free world. And again, we also need to always rethink strategies based upon a small amount of people who will complain. Again, when people make this transition most people. People will throw out numbers of 80, 90% of people. No one blinked when they started charging people. A small percentage complained. And most of those people if you do really great service will come back. Even though they say they're not going to, they'll be back. Trust me, I've done it twice. So, they will come back. You just have to, again. We need to have a different mindset away from the free. Cash discounts, this is something that I'm seeing a lot of people. There are managed care agreements where contract language would prohibit cash discount to private pay situations. If you're not gonna offer that same cash discount in managed care situations. Please, please have an attorney before you start offering cash or private pay discounts. Please review your contract language and discuss this with legal council.

You also need to think about the fairness of this. There are large deductible healthcare plans. Five, $10,000 deductible plans that people are paying completely out of pocket for. And they don't have access to the cash discount. So, this is why you really need to have this reviewed by council before you start offering cash or private pay discounts. Now let's talk a little bit about. Let's talk a little bit about OTC. OTC was signed by President Trump on August 18th, 2017. The FDA has no later than three years after the date of enactment of the act to create and release the proposed rules. So technically they have until August 18th of 2017 to release the proposed rules. So what happens in government, there's rules that are proposed. Then there'll 120 to 160 day comment period. And then after the comment period they will create final rules. So, the FDA has until August to create the proposed rules. But again, it's supposed to be moving fast

which you'll see in a minute. No state or local government shall establish or continue in effect any regulation that is applicable to hearing products that would restrict or interfere with the servicing, marketing, sales, dispensing, use, customer support or distribution of over the counter hearing aids. So those of you who thought you could go out and create a state law that's gonna make this not possible. Or our state laws are not gonna make it possible are incorrect. All of our dispensing laws in all 50 states and the territories are going to need to be updated to address the new OTC regulations when they're finalized. So, we can't have any state laws that restrict the ability of a consumer to purchase things OTC. In October of 2018, that was about a year after signage. The FDA announced these rules would be a priority on their Fall 2018 agenda. And would be able to deliver the proposed rules well in advance of the August 2020 statutory deadline. Proposed rules were slated then to be released in November of 2019. But in the same month the FDA indicated that those proposed rules were going to be delayed to the first quarter. Well, Senator Grassley and Senator Warren did not really like that.

And so Senator Grassley and Senator Warren, although he was the leader on this action. He's the one who released statements with the regard. He pressed them, the FDA over lack of action or writing of rules to allow for the sale of OTC hearing aids. He gave them till December 19th 2019 to address what the status of the OTC hearing aid rules regulations are. And when do they expect finalizing the OTC hearing aid rules? No one knows yet the outcome of that letter. Did he actually hear from the FDA? Okay, I have allotted plenty of time for questions. And I see some question over here in the bio side and not in the Q and A side. But if anybody has any questions. Chrissy, are you gonna read the questions or do you want me to read the questions? I can, oh. You are telling me, okay. So, can we have codes? Slide 11, can 92627 be used in a hospital setting? Can a hospital audiologist billing under facility enroll in a TPA? Let's take these two at a time, one at a time. Can 92627 be used in a hospital setting? Yes, but how you're reimbursed can vary based upon whether or not you bill via the hospital outpatient perspective payment system or OPPS. Or whether your services are billed

two part via directly. So that you could be paid, if you're under OPPS. It's all, all your codes are paid in like a bundle. Not all of them. There's a bucket of codes that are paid in a bundled manner. Based upon a facility fee. So yes, that code is something that could be billed in a hospital setting. How you are covered, how you're covered will depend on how you bill the Medicare system. Can a hospital audiologist billing under facility enrollment in TPA? Oh, that's a question to ask your hospital contracting and legal team. They're going to decide, not me and not the TPA either. They are going to decide whether that contract is acceptable to them. And those are acceptable to them and that it can really only be handled by your hospitals legal and contracting teams. Okay, MIPS. How do you alert CMS of a change in my job? My new associate went from working in a hospital to a private practice. So our QPP participation still shows her previous position and that she's eligible to report. Okay, so when she came to you she needs to go into PECOS.

So, she should have gone into PECOS and but I'm gonna answer this in a second to make you not worry. So she should always go into PECOS and update her Medicare enrollment. So she'll go in, get rid of her old employer. Unless she still's doing PRN or moonlighting or something there. She'll move out her old employer and only have you there as someplace she works. Now, remember if somehow she got penalized, doing air quotes. If somehow she got penalized from her old employer you would not get penalized. Because it's tied to the EIN that those claims were billed out under. So it's not gonna have any impact on her today because it's all about her reporting before. That's who gets a penalty. She would only be, this is why you need to fix her PECOS enrollment. She will only be with you from the date she's with you and remember, it's always two years ahead. So, any penalties for anything she does in 2020 won't be assessed until 2022. So, that's kind of how that whole thing works. So you just need to update her PECOS enrollment. Can audiologist bill for the QuickSend? Okay, let's talk about the difference between billing and coverage. You can bill for the QuickSend. The most appropriate code for billing for the QuickSend is 92700, the unlisted. The oenological item or service. It would require an ABN or notice of non-coverage

because they're individually reviewed. You can bill electronically. They might ask for additional documentation. Typically that additional documentation, you need to make a sheet on the QuickSend. What it is. What it means. How you use it? It's gonna be utility. All of that 'cause it's all about diagnostic, not about rehabilitative. It's all about diagnostic. And you would charge the patient privately at the date of service because most uses of 92700 are the financial responsibility of the patient. So, in other words can you bill it? Yes, when you get coverage. Very rarely no, but that doesn't mean that you shouldn't do it. And it shouldn't mean that you shouldn't have people pay privately for it. I've had people paying privately, including myself for literally decades. So, you'll just have to charge people privately for it to show them its value. What is the language the recommendation by a physician for UHC? Can audiologist provide a document with this correct language for a physician to sign? Yes, just like you would have a document for a medical clearance. You should have a document for the UHC to sign. And you should say essentially that I, John Smith MD am recommending amplification for patient name, patient date of birth. There are no medical contra indications for hearing aid use. And you want to title the form Written Recommendation for Hearing Aids. That would be kind of the language that you would be looking for.

Oh, what is PECOS? Okay, P-E-C-O-S. PECOS is where you enroll. It's the electronic place that you enroll and update enrollments for Medicare. This is where you go to enroll. This is where you go to update your enrollment. Update changes in address. Update changes of employment. When they want you to revalidate, you'll go there. This is the Medicare portal for enrollment and management of credentialing for Medicare. And P-E-C-O-S. You can Google that and it will come right up. With so much info, great. How does this apply to the VA? Oh, the VA. So, when you've been to one VA you've been to one VA. So, what I would say about the VA. None of this really, for the most part, applies to the VA. When it comes to coding, you want to talk to your chief at your VA to see what the coding guidance that they are supplying for you. 'Cause VA's can use very different codes in very different ways and they're completely allowed to do so. So you really want to start with your chief and then Judy Shaffer who

works at the central office. She is also a great resource for how to code things. So, when it applies to the VA you want to really talk to your chief and Judy Shaffer or Rachel McCurdle at central office. Can an audiologist bill for an office visit? Okay, let's back up. An office visit, evaluation and management codes. That is a physician office visit. Can you bill for an office visit? Did you meet the criteria? Let's start first. 'Cause we're gonna talk about has no utility. An evaluation management codes have no utility for a hearing aid visit. None, zero, nada. Hearing aids have a code for follow up. It's called 92592 or 92593 hearing aid check. This would be about diagnostic visits. So the first thing is can an audiologist in your state by licensure evaluate and manage? Because you need to know that because if a payer says well we don't allow audiologist who use these codes and you can't bill the patient. If you can evaluate and manage in your state. You need to be pushing back and going, oh. I can evaluate and manage and I should be able to access these codes because the code set says it's by state, scope or practice, it's by scope or practice. So, you need to know in your state can you evaluate and manage?

Second, do you know what those codes mean and how they're used? They have case history and exam and documentation requirements that you have to meet. So, can you, yes? Should you, maybe? It depend on what. First, can you buy licensure? Do it. Second, do you know what the codes mean and how they should be used? 'Cause it's not about time. And the code set as it exists right now today. That's gonna change next year but as it exists today. And finally do the payers that you are contracted with? Do they recognize it and do they allow it to be pushed to patient responsibility? It can only be pushed to patient responsibility go full circle if you're allowed, let's say a licensure, to evaluate and manage. And again on a hearing aid claiming check, the code 92592 or 92593. If a patient chooses to upgrade out of their plan how to you bill insurance? Okay, again the question is does their plan allow for an upgrade? That's the first question. United Healthcare and Blue Cross Blue Shield allow for upgrades if you offer them something within their benefit first. You would bill it as its usual and customary fee of the whole devices in service. All would be billed in your usual and

customary private pay fee. And then on the claim you would reflect how many dollars you collected from the patient at time of visit. So again, that's how you could reflect it on the claim. Not the amount only recognized by the insurance payer, no. You want to have it be your total amount and actually document how many dollars you've collected. I have a contract that reads a hearing aid benefit is global and everything is included. Okay, now I have a question. I've never seen something say global. What does everything mean? So I would push back in writing to that payer of what does global mean? What does everything mean? I need for you to tell me what codes or procedures are included in global or everything? We're not asking people on the phone, we're not. We're emailing people and we're asking questions in writing. And is there hope with negotiating with the IPA? No one likes when I say this but I want to always be transparent with you guys. If you are a single or two provider practice. And you primarily do hearing aid work. Your ability to negotiate will be very slim. Especially, unless you live somewhere very rural where you're the only game in town. You're negotiating power will be fairly slim because, you know.

So you drop out, there's other people that can see their beneficiaries. This is why you don't see physicians anymore in single or two provider practices. This is why they merge together is because of negotiation. So, is there hope? Maybe but again, I would tell you that that hope is not great. If you're a small practice or a practice that's primarily in hearing aids. If you do a lot of different things. Implants and vis dib and tinnitus, kids. Oh, they love people who do kids. If you do a lot of different things you're much more attracted to the payer and you're meeting their needs. Remember, it's all about supply and demand. It's all about meeting their needs and their members needs. What do we got here? Can a non-medical office? Can a non-medical office bill CPT codes? I'm sorry, I wish I understood that question. I don't know what non-medical means. So you're gonna need to clarify. You're gonna need to clarify that for me. And billed CPT codes to whom and for what? I want to go back to the question and I'm sorry I can't roll down that one. A few years ago I was told by my hospital financial people that United Healthcare does not allow for non-covered service hearing aid

upgrades. But by what you said it sounds like it's changed. Yeah, you got it in writing right there. I gave you the link to the medical policy. Do they have their own form or can I use my own hospital's form? Actually, they don't even require a form. I'm just really recommending a form because I've seen bad things happen when people don't use one. So, you can use your own form. But make sure your form says they could have gotten something within their benefit and they've chosen to upgrade. But you have the link to the medical policy to show that this is allowed now. That wasn't doesn't have a question.

Okay, I'm still trying to read this one. I hope I answered the question about the upgrade. How do you bill insurance? I hope I answered that. If I didn't, please write again. And is there a basic coding workshop you recommend for university clinic that's beginning to bill through the university hospital? We've previously been self pay. So, first of all your national associations and sometimes your state associations do offer coding courses. I actually have, I try not to promote myself. But I just have to be honest. I'm audiological mind, I have a whole series of courses that are covered under your $99 benefit outside of this one. We're actually rerecording, oh gosh. I think we're recording five or six hours in March and we will be doing two text courses. So there's a lot of coding sources available on Audiology Online. I also so, as do other associations. I think Audigy does a lot of coding things as well. I do workshops. I'm actually doing one tomorrow for two days. So, you're just gonna need to find a workshop that's really focused on coding. And when you do it, have your students come. It's really important that your students are educated on coding. Okay, did I answer everyone's questions? Thank you so much for being in attendance. Okay, we have two more questions. And I've got five more minutes. Regarding evaluation management codes. I have sent payers denying evaluation management care due to not allowed for payer of this type to the state of Illinois. The state of Illinois, that's when they discovered practice. They continue to deny. It's not about denial. Can it push to patient responsibility? First of all, insurances don't have to cover evaluation management provided by audiologists. But if it's in your scope of practice they should be required to allow to bill the patient. So

that's the difference. Can you bill the patient? It's not about do they allow for coverage. Many of them do not allow for coverage. But can you then bill the patient for the evaluation management service? If you, again, meet the criteria of the code. Can you bill the patient for that service? That's the question you want to know. I apologize for my cough. How do you know what the patient paid on a $1,500 when billing for an upgrade? Oh, gosh. 'Cause the patient paid you. You would know what the patient gave you. So let's say it's a federal plan, it's $2,500. They got $5,000 worth of hearing aids. You would bill out $5,000 in either an itemized or bundled manner to the insurer. That's what would go out on the claim but then in the box for patient paid amount. And I don't know the box number off the top of my head. You would reflect that in the amount on either the CMS 1500 form or your 837 format, the dollars the patient paid. That's always a line item on a claim form.

Can one bill patient seen in retirement communities? Can one bill for patients seen in retirement communities help centers? Bill what? I'm not sure what you're trying to bill. I'm not sure, do you have orders? Do you have physician orders? Are they medically necessary? What are you billing? You have to change your place of service away from office to whatever that place of service is for that facility. But I don't have enough information to be able to answer that question. Um and... Oh, testing or services. Okay again, I'm sorry. I'm not trying to be invasive. Can you bill there? You can bill in retirement facilities, health centers, if you change your place of service code on the claim. If you have physician orders. If the testing is medically reasonable and necessary. And you follow the Medicare rules of billing and reimbursement that exists. Can I explain what assignment means on a HCFA form and the ramifications are saying yes or no? Okay, are you a Medicare participating? Are you enrolled as a Medicare participating or Medicare non participating provider? If you are a Medicare participating provider you are always accepting assignment. If you are Medicare non participating provider you could accept assignment on a claim by claim basis. So that's why they're asking you on this case I would like to accept this assignment. Assignment means that you're accepting the Medicare allowable as payment in full.

And this is gonna be our last question. Does it have to reflect on your contract that you can see patients in your homes? No, but let's do some but's. You have to change the place of service code. And you really should talk to your liability, your malpractice and liability insurance vendor about, you know. Does your malpractice coverage cover you seeing people in the home? And you need an emergency plan when you're in someone's home. You need to have what is your emergency plan? But as long as your state dispensing laws don't have rules that you have to have a booth or anything of that nature. This should not be an issue. You just have to change the place of service to a place of service at home. And one final note. I want to thank everyone at Audiology Online and thank everybody for being here. If you posted in the window that you wanted me to email you. I don't see this window ever again after today. So, I don't see it at all. So everyone, you can email me. You can Google me and you can find me fairly easily. If anyone has any questions I offer no charge guidance to members of the Academy's of Doctors of Audiology, Michigan Audiology Coalition members. And to anyone who's attended one of my training events in the last 30 days to six months. So, I hope this was helpful to everyone who's listening now and later. And thank you and have a really great day.