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- Clear browser cache using these instructions
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Still having issues?

- Call 800-753-2160 (M-F, 8 AM-8 PM ET)
- Email customerservice@AudiologyOnline.com

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Managing Managed Care: Audiology and Hearing Aids in a Third-party World

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Audiology Resources, Inc.

1

CONTINUED

Learning Outcomes

After this course, participants will be able to:

- Describe how to verify insurance coverage for hearing aids.
- Define the term "third-party administrator".
- Explain the appropriate use of insurance and upgrade waivers.

2

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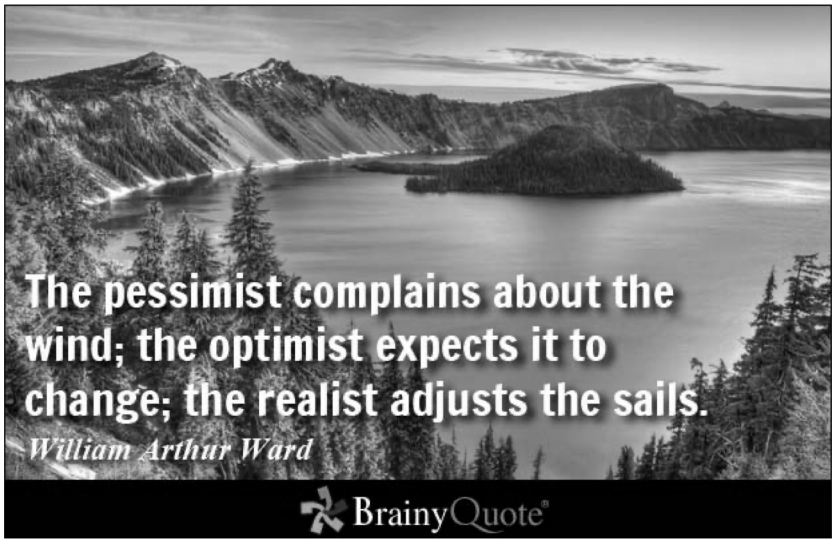

3

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Understanding a Managed Care Provider Agreement

- Read the entire agreement and review the allowable rate schedule.
- The most important thing to review is the allowable rate schedules.
  - Allowable rate schedules TYPICALLY lack all of the codes.
    - You need each allowable rate schedule to include every HCPCS and CPT for the items and services you currently provide or might want to provide.
    - You need to know how unlisted codes (92700, V5298, and V5299) are processed.
  - There will be a different allowable rate schedule for each product you are contracted with for each payer.

4

Understanding a Managed Care Provider Agreement

- Things to consider:
  - A great deal of information is available on the payer website.
  - Ask questions when you lack understanding.
    - You want answers to any clarification questions IN WRITING ONLY!
  - STOP TRYING TO DO ALL OF YOUR COMMUNICATION WITH PAYERS BY PHONE!!!

5

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.

6

Understanding a Managed Care Provider Agreement

- What products does this contract obligate the practice to participate with: Medicare Advantage? Medicaid? HMOs?
  - You can often opt out of Managed Medicaid and Medicare Advantage programs.
- Does the payer allow for or require "incident to" billing if the audiologist is the rendering provider?
- Does it allow for patient upgrades for hearing aids?
  - Does the practice have to offer a "basic" or "standard" device first?
  - Is there a required waiver process for upgrades?
  - Does it recognize or process S1001 (Deluxe item, patient notified)?
    - How does this "upgrade" reflect on the EOB the patient receives?

7

Understanding a Managed Care Provider Agreement

- Does the payer allow for hearing aid rentals?
  - If yes, does it require specific modifiers?
- Does the agreement require patients complete notices of non-coverage before non-covered services are provided?
  - This is VERY common.
- Is the hearing aid benefit inclusive of all of the items and services associated with the dispensing fees, fittings, batteries and repair services?

8

CONTINUED

Understanding a Managed Care Provider Agreement

- Can student externs or technicians see members of this plan for covered services?
  - If yes, are there supervision requirements?
- Can hearing aid dispensers see members of this plan for covered services?
- Can audiology assistants see members of this plan?
  - If yes, are there supervision requirements?
- Is hearing aid coverage contingent on receipt of a medical clearance?
  - Does it have to be from an ENT?
    - Does the patient have to be physically seen by the ENT?
    - What evidence needs to be provided of that ENT visit?

9

CONTINUED

Understanding a Managed Care Provider Agreement

- Can certain services be carved-out of the contract?
- What are the termination terms?
- What are the renegotiation terms?
- For hearing aids, is the practice required to supply a manufacturer's invoice?
- What are the renewal terms?
  - "Evergreening" of contract.

10

CONTINUED

Understanding a Managed Care Provider Agreement

- Does the payer cover telehealth services provided by an audiologist? Are there only specific services the payer covers via telehealth? Does the payer require a modifier? Are there specific requirements?
- How is medical necessity defined?
- What are the requirements for standard processes and procedures for all patients? A standard chargemaster?
  - Can we bill MSRP rather than UCR for hearing aids?
  - Can the practice bill differently to the payer than they bill their general population?
    - Typically the answer is “no”.

11

CONTINUED

Understanding a Managed Care Provider Agreement

- What are the means of provider notification of substantive changes to the agreement?
- What are the timely claims filing requirements?
- Are there any other claims filing requirements.
  - Can the practice file paper claims?

12

CONTINUED

Understanding a Managed Care Provider Agreement

- Are there clinic hour requirements?
- What are the medical record retention requirements?
- Does the payer allow for and cover evaluation and management services to be provided by an audiologist?
  - If not, does it allow for the financial responsibility to be assigned to the patient?
- Do they require hearing aid patients be referred to a third-party administrator for dispensing?
  - If yes, for all hearing aids or only those offered by some products/plans?
- Do the allowable rate schedules address all of the items and services you provide?

13

CONTINUED

Understanding Allowable Rates

- What the payer allows, per contract, for each specific item and service you provide for each specific product you are contracted to provide.
  - Never accept less than you can afford to receive unless you will have significant volume.
    - Need to know your breakeven plus profit amount per hour to properly analyze this.
    - Do the benefits of participation outweigh the costs?
  - What codes are pushed to patient responsibility versus provider liability when non-covered?
  - What does "IC" (individual consideration) mean to this payer?
    - Common with BCBS plans.
    - This varies practice to practice and payer to payer.

14

Understanding Allowable Rates

- Be careful of:
  - Third-party administrator involvement.
  - Required physician recommendations or clearances.
  - Inclusive hearing aid coverage benefits.
  - Restrictions on number of line items allowed.
  - Large hearing aid discounts (percentages of dollars billed).
  - "Fitting fee only" or Invoice plus arrangements.
    - Requirements to provide the manufacturer invoice.
    - Sometimes you do not buy the aid in this equation.

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

15

Additional 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 allowable rate schedules.
- They can also be found in Provider bulletins.
  - These meet the criteria for notification of substantive changes to the agreement.

16

Payer Guidance and Medical Coverage Policies

- Aetna: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#
- BCBS:
  - Google "BCBS Medical Policies (add you state here).
- Cigna: https://www.cigna.com/health-care-providers/coverage-and-claims/policies/
- Humana: http://apps.humana.com/tad/tad_new/home.aspx?type=provider
- UHC
  - https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html

17

Third-party Medical Policies 2020 – UHC Commercial

- https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/hearing-aids-devices-including-wearable-bone-anchored-semi-implantable.pdf
- "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.

18

How Would you Bill a UHC Commercial Hearing Aid Claim

- The claim should be itemized.
  - If you are bundled, the total itemized fee must equal the usual and customary fee of the same type, style, and technology of aid if it were provided to a private pay patient.
  - You also must offer the same level and length of care and service.
- The costs for batteries, accessories, accessory fitting and orientation, and dispensing fees should be billed separately.
  - This will most likely push to patient responsibility.
- The patient should be informed, via a notice of non-coverage of these potential out of pocket expenses and should pay for them on the date of fitting.

19

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".

20

CONTINUED

Third-party Medical Policies 2020 – Tricare

- TRICARE only covers hearing aids and hearing aid services if you have hearing loss that meets specific criteria.
  - Adults with: Hearing threshold of at least 40 dB HL in one or both ears when tested at 500, 1,000, 1,500, 2,000, 3,000, or 4,000Hz; or hearing threshold of at least 26 dB HL in one or both ears at any three or more of those frequencies; or speech recognition score less than 94%.
  - Children with: hearing threshold level of at least 26dB HL in one or both ears when tested at 500, 1,000, 2,000, 3,000, or 4,000Hz.
- TRICARE doesn't cover hearing aids and hearing aid services for retired service members and their families. However, they may be able to obtain hearing aids through other government programs. This includes:
  - The Department of Veterans Affairs (VA)
  - The Retiree-At-Cost Hearing Aid Program (RACHAP)
- https://tricare.mil/CoveredServices/IsItCovered/HearingAids
- https://www.military.com/benefits/veteran-benefits/hearing-aids-for-military-retirees.html
- http://militaryaudiology.org/rachap-rhapp-locations/

21

CONTINUED

Third-party Medical Policies 2020 – FEHP

- https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/
- FEHP hearing aid benefits are not "one size fits all".
- Allowable rates are payer dependent.
- 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 $2500.

22

Managed Care Entity Communications

- Payers 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!!!

23

Third-party Provider Networks

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

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

They are also NOT uniformly bad for audiology or your practice.

24

Considering Provider 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?
    - This is where, again, you need to know your breakeven rate.
  - Is the plan offering a funded or unfunded (discount) benefit?
    - If unfunded, easier to create a competitive offering, especially if your practice is unbundled.

25

Considering Provider 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?

26

Considering Provider Network Participation

- Can I charge the patient or their healthcare insurer for a hearing test?
  - If the answer is “no”, I strongly suggest having the agreement reviewed by legal counsel.
  - Is the TPA billing the hearing test to the payer and just not reimbursing you separately for it?
- 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?

27

Considering Provider 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?

28

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)
- Communication Needs Assessment (92700)
- Electroacoustic analysis of the hearing aid (92594/5)
- Auditory rehabilitation (92630/33)
- Conformity evaluation/verification (V5020)
- Earmold/insert (V5264/5)
- Diagnostic testing beyond 92557
- Accessories/FM and the fitting/dispensing of such accessories (V5299)

29

Billing and Reimbursement Fundamentals

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

30

The Role of Scheduling

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

31

Insurance Verification

- VERIFICATION IS EASIER AND FASTER WHEN YOU KNOW YOUR ALLOWABLE RATES AND MEDICAL POLICIES.
- Cannot get allowable rates or codes in phone verification process.
- Do as much as possible online.
  - Portals
    - UHC:
      - Shows coverage, eligibility, benefits and allowable rate schedules.
    - Availity and Navinet:
      - Show coverage and eligibility.
      - Will still need to verify, with payer, benefits.

32

Insurance Verification

- Use a form and ask all of the questions.
  - Who did you call? At what number? Do they have a reference number?
  - **Is the benefit or discount only available through a specific third-party administrator? GIVE NAMES!**
  - Is the patient eligible on this date of service?
  - Have they met their deductibles?
    - They can sometimes be larger than the cost of the hearing aids.
    - Unmet deductibles and co-insurance amounts should be collected on the date of the fitting!

33

Insurance Verification

- Do they have out-of-network benefits? (You ask this if you are an out-of-network provider).
- Does the patient have a hearing aid benefit? Allowance?
  - Allowance is dollars "towards".
- Dollars?
  - A fixed defined dollar amount or an "up to" amount
    - "Up to" generally means your allowable fee for the device itself.
- Is this a funded (the payer is covering all or a portion of the costs of the device) or unfunded (discount) benefit?

34

Insurance Verification

- How frequent is the benefit available?
  - X number of months or years
- Is this an inclusive benefit?
  - Does the benefit include all services related to the evaluation and fitting of the device?
  - If yes, what are those services?

35

Provider Responsibilities

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

36

Billing Staff Responsibilities

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

37

Office Manager/Director/Owner Responsibilities

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

38

CONTINUED

Things to Stop Doing Immediately

- Staff should NEVER bill things like repairs, follow-up visits, accessories, loss and damage deductibles, replacement aids, earmolds, batteries, or tinnitus devices, without the audiologist's or owner's knowledge and without weighing the consequences.

- Most patients exhaust their hearing aid benefits for a fixed period of time at their fitting. As a result, they have no additional coverage until they are again eligible.
  - Items and services should not be billed by staff, to a payer, without the provider's knowledge.
- If the patient is eligible AND you access their benefits for things like repairs, follow-up visits, accessories, loss and damage deductibles, replacement aids, earmolds, and batteries, this may exhaust their new eligibility and new benefit.
  - Weigh the pros and cons with the patient before proceeding.

39

CONTINUED

"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.
  - Transparency and prior notification is important here.
- We also do not rethink this strategy because a small percentage of patients complain.
  - The squeaky wheel should not be greased!
  - Every patient is right for you and your practice.

40

How Practices End Up in Insurance Hell

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

41

How Do You Get Your Practice Out of Insurance Hell

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

42

Managing insurance Denials

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

43

Third-Party Coverage

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

44

Third-Party Coverage

- Third-party coverage of diagnostic and hearing aid services is the result of an agreement between the PATIENT and the INSURER.
  - Patients, in some cases, are being misled by payers, TPAs, and insurance brokers.
  - We need to be transparent (not judgmental) with the patient about their coverage and benefits.
  - If a patient is unhappy with the factual accounting of their insurance coverage and benefits, encourage them to complain to their employer/union, Medicare (if a Part C plan), the state department of insurance and the state AG.

45

So I Verified Benefits? Now What?

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

46

So I Verified Benefits? Now What?

- Is it an "up to" benefit or a fixed dollar amount?
  - "Up to X" does not mean "X"
    - "Up to" typically means your allowable rate.
      - Fit a entry level product if you do not know what that rate is.
  - You will need to fit within the benefit.
    - Itemization can help in these situations.
    - It can push some costs to patient responsibility.

47

So I Verified Benefits? Now What?

- Be VERY careful of accessing a patient's benefit (when they are eligible for hearing aids and related services) over anything other than new hearing aids.
  - Accessing their benefits, at all, typically exhausts ALL of these benefits for the eligibility period.
    - Remember these are "up to" dollar amount benefits and, for most payers, they are NOT allowances or amounts that can be drawn from, leaving the remaining dollars for future use.
    - Medicaid is the exception.

48

CONTINUED

When Dealing with Hearing Aids in a Third-Party World, Please Consider:

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

49

CONTINUED

When Dealing with Hearing Aids in a Third-Party World, Please Consider:

- Payers can and do make coverage rules and it is YOUR responsibility to know what they are and follow them.
- You must get your cost of goods as low as possible.
  - No manufacturer is irreplaceable.
  - No hearing aid is curative.

50

When Dealing with Hearing Aids in a Third-Party World, Please Consider:

- The payer may have coverage requirements, such as:
  - Providing invoice.
    - VERY common now.
  - Medical clearance.
  - Written physician recommendation.
    - UHC
  - Evidence of medical evaluation, by an otolaryngologist, prior to fit.
  - Pre-authorization.
  - Degree of hearing loss limitations (greater than 40dB).

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

51

The Reality of Waivers/Patient Notification

YOUR PRACTICE CANNOT USE WAIVERS UNLESS EXPLICITEDLY ALLOWED BY CONTRACT!!!

- Otherwise, you will be in violation and, if a patient pushes back, you will have to refund them.
- The patient will also receive an EOB that will reflect patient responsibility different than what you charged them.

52

Patient Notification of Non-Coverage

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

53

Upgrade Waiver

- BCBS and UHC.
- Must offer a basic aid (standard) at no-charge to patient.
- Patient can upgrade if they so choose and pay the difference between the allowable and usual and customary.
  - The provider needs to have a form to reflect this and this needs to be completed prior to the hearing aid fitting.
- Does the payer recognize S1001 (deluxe item, patient notified)?
  - If yes, this can help reflect patient responsibility on the EOB.

54

Insurance Waiver

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

55

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.

56