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

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- [Christy] Welcome back to AudiologyOnline, everyone. I would like to introduce a dear friend to AudiologyOnline, Dr. Kim Cavitt joining us today. She's gonna be discussing Managing Managed Care: Audiology and Hearing Aids in the Third-party World. Dr. Kim 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, Inc. Audiology Resources provides comprehensive operational, compliance and reimbursement consulting services to hearing healthcare providers. Dr. Cavitt is also the past president of the Academy of Doctors of Audiology. She serves as the chair of the State of Illinois Speech Pathology and Audiology Licensure Board. And she also serves on the Audiology Quality Consortium. Thank you, Dr. Cavitt, for being with us today. And at this time, I'll hand the mic over to you.

- [Kim] Thank you, thank you, Christy and Kim, and everyone at AO. Wonderful partners in online education. So let's get started. Today we're gonna talk about Managing Managed Care, again, Audiology and Hearing Aids in a Third-party World. Our learning outcomes is, we're gonna describe how to verify insurance coverage for hearing aids. We're gonna define the term third-party administrator. And we're gonna explain the appropriate use of insurance and upgrade waivers. Really, when it comes to insurance, this is kind of my mantra. I use this in my boot camps and have for years. The pessimist complains about the wind. The optimist expects the wind to change. But the realist adjusts the sails. And that's what we need to do when we're talking about managed care. We need to adjust the sails. So let's talk about managed care agreements. What I find in audiology is many people just get them, sign them, and don't ever read them. But it's really important that you read them before you sign them, and if you've already signed them, that you get them and you read them. And I'll probably bring this up a little bit later. But I'll bring this up now. If you do not have a contract, a copy of a contract that you already signed, ask the the payer for the copy of the most current agreement. Because if you didn't negotiate any of that original

contract, you have probably been amended to what the current agreement is. So it's really important that you read those agreements and that you completely allow the allowable rate schedules. The allowable rate schedules are what the payer is going to pay you for each item or service you provide for each insurance product they offer. So a typical payer may have anywhere from five to 10 different products. They may have a PPO. They may have a POS product. They may have a high-deductible product, an HMO, a Medicare Advantage, or Medicare Part C, a managed Medicaid program. They might have an indemnity plan still. They might have different products, and for each product, they're going to have a different allowable rate schedule for all the items and services covered under that section. So you really need to make sure that those allowable rate schedules address all the CPT and the HCPCS codes with services that you currently provide in your practice or that you might wanna provide. You also need to look closely about how those unlisted codes are addressed, 92700, V5298, V5299.

And again, every pair doesn't just have one allowable rate schedule. They typically have many, and you want to be able to see all of those. UnitedHealthcare, for example, has their allowable rate schedules in their portal. It's in the fee schedule lookup feature. Some Blues have all of their allowable rate schedules behind the firewall in their portal. Some do, some don't. You need to know, how can you access those allowable rate schedules? I also wanna tell you, is this easy to get? No, it's not always easy, especially after you've already signed, to get a copy of the allowable rate schedule. But they are legally required to provide it to you. But they're gonna make you fight for it at times. Insurance isn't trying to make things easy for you. So you really need to, again, ask these questions and keep pushing to get this information. Also, a great deal of information is available on the payer website. Actually, a lot of the contractual things you're obligated to sits in an open portal, or even behind a little bit of a firewall on their website. That's where their medical policies are. That's where administrative guidelines, their provider manuals, those are available on their websites. You need to read those as well. And you need to ask questions to payers when you are unsure, where you want clarification, if there is codes missing on an allowable rate schedule.

List each individual code. And stop trying to do this over the phone. You need to have a paper trail of trying to get this information, 'cause remember, if they won't give it to you, you may have to file complaints with the state, and again, you need this paper trail. So you want to do this via email, via email interactions. When we're talking about managed care, we can't paint every managed care situation with the same brush. Each payer is different, and every practice needs to figure out how to navigate that payer, their individual plans, their products, and their policies. You can't, again, say one rule is gonna apply to everyone. Every payer is different. So what you need to read and read about in your managed care agreement, and these are questions that you need to be able to answer in reading the agreement, the administrative guidance, the policy manuals, provider manuals. What products does this contract obligate your practice to participate with?

Sometimes you can, if you don't wanna participate in their managed Medicaid plan or their Medicare Advantage plan, you can opt out of those individually. Does the payer allow for or require incident to billing if an audiologist works in a medical environment? Medicare and Medicaid, if the audiologist provided the service, require that the audiologist bill for the service under their own NPI. Some private insurances, though, that's not how they work, because they never credentialed the audiologist. They actually don't have an audiology network, maybe, and that you are following under that incident to billing. That is okay in a managed care, in a private insurance world, just not Medicare and Medicaid. Does the payer allow for upgrades for hearing aids? Upgrades, never use the term balance billing. They'll always tell you no. Can they upgrade? Can you offer them something standard or basic, and then the patient chooses that deluxe item? Is there a waiver process for upgrades? Do they need to be notified of the fact they could have gotten something within their benefit, but they've chosen to upgrade? Again, Blue Cross Blue Shield plans want that waiver. United, they don't talk about the waiver, but I would recommend it. Does it recognize or process S1001, that Deluxe item, patient notified? If they do recognize that, that will let the EOB reflect the upgrade. It doesn't change coverage. It just lets the EOB reflect the

upgrade. Does the payer allow for rentals? If they allow for hearing aid rentals, is there modifiers? Does the agreement require that patients sign a notice of non-coverage before being billed for any non-covered services? Just an FYI, very common in a managed care agreement. Is the hearing aid benefit inclusive of certain items or services, or all items or services, around dispensing, fitting, batteries, and repair services? Sometimes, there are things included in that benefit and things that can be billed separately. You need to know what is inclusive to that fixed benefit. Can student externs or technicians see members of this plan for covered services? I'm gonna tell you, I'm seeing plans now where the answer is no, that anyone unlicensed cannot see any of their members. But if they do allow it, are there supervision requirements? Can hearing aid dispensers see members of this plan for covered services? Can audiology assistants see members of this plan for covered services. Again, sometimes the answer is no. Is the hearing aid coverage contingent on the receipt of a medical clearance.

Does that medical clearance have to be from an ENT? Does the patient physically have to be seen by an ENT? And what evidence needs to be provided that the patient was seen? That actually exists in some hearing aid benefits. So you need to know what exists for you, because if you can't produce this documentation, you bill it and you can't produce this documentation, they'll deny your claim, and you cannot recoop payment from the insurer until you can secure these things. And you might not even be able to secure it after the fact if the dates don't line up. Can certain services be carved out of the contract? That means, can we take certain services and not have them included? That used to be very common in a managed care agreement. Now, pretty much anything you provide to your general population under this EIN, or tax ID number, is all part of this contract. In order to carve something out now, you really have to create a separate business entity with a separate EIN. What are the termination terms? What are the renegotiation terms? Again, renegotiation, what I tell people is, follow the guidance for termination, but instead, request in writing that you wanna renegotiate. For hearing aids, is a practice required to supply a manufacturer's invoice?

Very common now, and again, give it to them. In the old days, they didn't, I would not recommend that. Now all these insurers know what the invoice price is. They're all part of third-party administrators. They know exactly what the price is. You're not keeping any secrets from them. So again, do you have to create the invoice? What's the renewal terms? Is this contract gonna automatically renew, or what's known as evergreen? Does the payer cover telehealth provided by an audiologist? What specific services can be provided for coverage for telehealth? Does the payer require a telehealth modifier? Are there specific requirements in terms of security or systems or patient notification? How is medical necessity defined? How do they define what they consider to be medically reasonable and necessary? That's gonna vary payer by payer. What are the requirements for standard processes and procedures, a standard chargemaster? A general rule of thumb is that insurance companies will say that you cannot treat my members differently than you treat your general population, and that you cannot charge me for things that you give away to your general population at no charge.

So everyone needs to be treated the same. But can you bill MSRP rather than usual and customary? Can the practice bill differently to this payer, bill MSRP, than they bill to their general population? Typically, the answer is no. But you need to ask those questions. Find out in the review of the agreement and all of their associated resources. How are they gonna notify you of substantive changes to the agreement? How are you going to know? Is it from a bulletin? Is it from an email? Is it going to be posted on their website? How are you gonna know when they change their contracts, which they do all the time? What are the timely claims filing requirements? So what that means is, how many days do you have from the date of service to submit what's called a clean claim, or a perfect claim, that doesn't have any errors? How many days from the date of service do you have to submit a clean claim in order to get payment? I've seen as short as 60. I've seen as long as 18 months. Medicare is 365 days from the date of service to submit a claim and have it covered, a clean claim, one that doesn't have errors. So how many days, because that's what you're working with. And

that clock starts at of the date of service. Are there any other claims filing requirements? Like, for example, do they accept paper claims? What are your clinic hour requirements? So many audiologists have signed contracts that will say that you're open, or you're available 24 hours a day, seven days a week. Again, is that how your practice works? You to look at those requirements in a contract. What are their medical record retention requirements? Medical record retention is typically outlined by state law, by HIPAA first, and then by state law. But a payer could have different medical record retention requirements for them that would exceed state or federal guidelines. What are they, or do they exceed? Does the payer allow for or cover evaluation and management services provided by an audiologist? If not, does it allow for the financial responsibility to be assigned to the patient, especially in states where an audiologist has in their scope of practice that they can evaluate and manage? Do they require hearing aid patients to be referred to a third-party administrator for dispensing? If yes, for all hearing aids or for only those with certain products or plans?

Like UnitedHealthcare, for example, Medicare Advantage is through UHC Hearing. UHC commercial is still directly through UnitedHealthcare. And do the allowable rate schedules address all the items or services that you provide in your practice? When it comes to these allowable rate schedules, this is what the payer allows per contract, per product, for each specific item or services you provide. So you need to know what your breakeven plus profit is to be able to really look at this contract and to think about volume. And when it comes to certain tests, does that lead to other things that have a higher coverage amount? You wanna be careful of accepting less than you can afford to receive, again, unless you're gonna have significant volume, or it's going to lead you to other services. Do the benefits of participation outweigh the costs? Because if you're out of network, the patient would pay you your usual and customary rate in full. On the date of service, you could submit as a courtesy. And then the patient's gonna get reimbursed any out-of-network benefits they have. So is participation good when you're looking at these allowable rate schedules? What codes are pushed to patient responsibility versus provider liability when non-covered? You need to distinguish.

Some of them, they may just tell you that you can't bill the patient for them. That sometimes happens with evaluation and management. So you need to find what happens, what is being pushed for patient responsibility versus provider liability? Some Blues use something called IC, or individual consideration. When IC is on that allowable rate schedule, what does that mean? I can tell you, from a lot of years of experience, that IC is not uniform within a given state and not uniform within a given product. So the IC for all Medicare Advantage isn't x. Different providers have different ICs, maybe that they negotiated. So you need to know what that IC means. You also need to be careful when you're looking at these allowable rate schedules of third-party administrator involvement, required physician recommendations or clearances, inclusive hearing aid benefits, that it's including a lot of things in this benefit, and that there's less that you can bill separately, large hearing aid, restrictions on the number of line items allowed, that the payer will only allow you on a claim to cover two line items, and anything beyond that is non-covered. Large hearing aid discounts, so large percentages off of dollars billed, but they're only gonna pay you 40% of dollars billed, or fitting fee only or invoice plus, that they're gonna pay you invoice plus 10%, invoice plus 20%. You have to be careful of those.

You're always gonna have to supply the manufacturer's invoice there. And if now you've got an inclusive benefit with an invoice-plus arrangement, are you going to be able to, and you're still a bundled practice, so you've gotta treat everyone the same, can you afford to be in network for that plan? Because again, sometimes it's a better decision to be out-of-network rather than be in network, 'cause you can't afford to be in network and offer hearing aid services. So there's also additional payer guidance and medical coverage policies that are actually extremely valuable to read and review. You can access the UHC hearing aid coverage and benefits online through their portal. So if you are in network for UnitedHealthcare, please have portal access, because their coverage and benefits is all there, as are their allowable rate schedules. Every payer has a website. Look up every item or service. When you're looking at medical policies, go to their medical policy link. Or if they're in alphabetical order, look through every

single one to see if there's anything that you, provider, might wanna provide outlined in medical policies. These policies vary payer by payer and state by state. Some are housed beyond a portal. Some portals also have co-insurance and deductibles there. And some have allowable rate schedules. You can also find a lot of information and provider bulletins. Please read those when they come out every month. Some of them are posted on their, typically posted on their websites as well. And these oftentimes meet that criteria for notification substitutive changes. So I have given you links for medical policies. Aetna, Cigna, Humana, and United have medical policies that really go across the country. Blue Cross Blue Shield has different medical policies for different states. So how you would find your medical policy for Blue Cross Blue Shield, literally type in BCBS medical policies and your state, and it will typically get you to a link where you can access those medical policies if they exist.

So I'm gonna show the UnitedHealthcare medical policy for their commercial product. That means people, commercial typically means people who are still employed. It's part of an employee-employer plan. And this is valid right now in 2020. There is the link. It is in quotes because I'm showing you exactly how the policy reads. It's actually on page six. Standard plans include coverage for wearable hearing aids that are a result of a written recommendation by a physician. So before you fit hearing aids, you need to have a written recommendation. That's what your form needs to say, a written recommendation, and it needs to be a physician, not a nurse practitioner, not a physician's assistant, a physician. You need that before, you need to have that. You don't submit with a claim. You just have that available if they request it. Benefits are provided for hearing aids and for charges for the associated fitting and testing. A wearable hearing aid benefit does not include batteries, accessories, or dispensing fees. So if you were, if you're bundled, these can be itemized out, as long as your total equals your private pay total. For those of you that are unbundled, these are things that are unbundled that you can charge a patient for separately, outside their benefit. And this is where now United, this next paragraph, where they're letting you know that a patient can upgrade. If more than one type of hearing aid can meet a member's

functional needs, benefits are only available for the hearing aid that meets the minimum specification of member's needs. If the member purchases a hearing aid that exceeds these minimum specifications, UnitedHealthcare will only pay the amount that it would have paid for hearing aid that meets the minimum specifications, and the member will be responsible for paying for the difference in cost. I would recommend using a waiver here that the patient understood that they could have gotten something within their benefit, and they've chosen to upgrade. But it is not required, but it is something I would strongly recommend. How would I bill UnitedHealthcare commercial? The claim should be itemized. If you're bundled, the total itemized fee must equal the usual and customary for the type and style of aid if it was through a private pay patient. And you also must offer the same level and length of care and service as you would to a private pay patient in this whole bundle delivery. The cost for batteries, accessories, accessory fitting and orientation, dispensing fees could be billed separately. And this will most likely push that responsibility to the patient. The patient should be informed, again, via the notice of non-coverage of those potential out-of-pocket costs. They should be informed of, again, in full transparency before the fitting.

So here is a Aetna medical policy. Excuse me. What we have to be careful about Aetna is, you have to meet these criteria for them to consider the hearing loss great enough to warrant their coverage. So for example, Aetna isn't going to pay for hearing aids for tinnitus management if the patient doesn't have a hearing loss. So these are the requirements that you must have for Aetna to cover hearing aids. This is the degree of hearing loss. And you're noticing the ors, there's nothing and. You're noticing the ors. TRICARE, TRICARE has similar guidance for coverage of hearing aids as does Aetna, that they, again, they have to have a hearing loss. It can't just be used for tinnitus masking. TRICARE doesn't cover hearing aids for retired service members or their families. But there are options about how retired military can access hearing aid benefits, whether it's through the VA, or whether it's through a program called Retiree-At-Cost. And I've provided the links here for more information. FEHP, it's really important when we're talking about FEHP, which is a Federal Employee Health Plan.

This is for all government and civil service employees. So what's important to know is that there are hundreds of options for federal health benefits. It's not just Blue Cross Blue Shield. Blue Cross Blue Shield is the most common, but there are lots of other plans available. So this link that I have here at the top will, if you click on it, there'll be a map. Then you can click on your state. Then you'll see all the plans that are available. And the beauty of this link is every plan bulletin sits there. So if you wanna see if they have hearing aid coverage benefits, you can actually see it in the plan bulletin. You're gonna have to dig through it. It's not gonna just jump right out at you. But all of the plan benefits are there. But the allowable rates, again, are payer dependent. There's not, like, everybody doesn't have, every federal employee doesn't have 2,500. That's gonna vary by the plan.

But the most common is the Blue Cross Blue Shield FEHP plan. Here are there hearing aid benefits, hearing aids for children up to age 22, limited at $2,500 per calendar year. Hearing aids for adults over 22, it's 2,500 every three calendar years. And the benefit is inclusive of dispensing fees, fittings, batteries, and repair services. That is what is inclusive to that benefit. So that's why you have to be careful that you, if the patient has FEHP and you access that benefit for a repair, you've probably exhausted their whole benefit for three years. It's not a bank that you just get to go up to. It's when you access it that typically you've exhausted it. And then the patient is, again, responsible for costs that exceed 2,500. And please have an upgrade waiver in place that they understand that. Again, payers need to communicate with you when they have significant changes to their provider agreement. You need to find out what that is. Again, it's typically provider bulletin sent by email, website updates, and medical policy updates. You need to read the communications that are being sent to you from the managed care entities that you're contracted with. Let's talk about third-party provider networks or third-party administrators. And third-party administrator is a person or an entity within--Between the provider and an employer. Okay, a third-party network is closer to a middle person or middle entity between an insurance plan and a provider.

So these exist, and they're much more prolific in our space than they ever were before. They exist to allow payers a single point of contact in payment for hearing aid-related items and services. They define risk for the payer. The payer knows exactly what they're paying all the time for items and services. It contains costs for the member. And it establishes a plan of care or delivery for that member. Audiologists help create the need for these programs and maintain their existence through participation and through shenanigans. So when you are upgrading every single patient, when no one saw an upgrade waiver, when you were charging insurance companies differently than you were charging your private pay patients, when you were 10,000, $12,000 to insurance, they got tired of it. And so these went through these networks now that can control that. But those networks need you, the audiologist, to enroll for them to exist. But I will tell you that not all of them are created equal, and they're not all uniformly bad.

Some actually were better than contracting direct with the insurer. So you have to look at each one of them through their own lens. Now we have to look at, what do you look at with a provider network? You need to, again, know your breakeven plus profit. Can I afford to provide the level of care at the agreed upon rates required by the plan? This is, again, you have to look at it through the lens of your own breakeven plus profit. Is the plan offering a funded, that means the insurance company or employer is kicking in whole or in part, or unfunded, where it's merely a discount plan? If it's unfunded or discount and you were unbundled, you could create a competitive offering that you could compete directly against it, because those plans, for the most part, are unbundled. So that's what you need to look at. Is it mainly, in your area, is it funded or a discount? Do any other policies conflict with other managed care agreement terms or legal things, such as that free hearing test? And you need to start asking questions about that hearing test. Was it free? Was it really free? And what I mean is, is the administrator or network billing the payer or employer on the back end for the hearing test? That means it really wasn't free. It's just that they're representing it to you in a

bundle. So that's one of the things that you need to dig into. What products does the plan offer? If the member wants a product that's not in the program, how does it work? Like Lyric, if a patient wants a Lyric, how does that work in the plan? How many patients do you stand to potentially lose if you don't participate? And are you okay that those people are going to go somewhere else, and their family members, and they become a ripple? Can you afford to lose those people? Can I charge the patient or their health insurer for that hearing test? Again, we're back to that hearing test. If their answer is no, you wanna have your agreement reviewed by legal counsel. And again, is that TPA billing on the back end? What items and services are included in that fitting fee? If it's not included in the fitting fee, are there limits to what I can charge? Do I have to notify the patient of these costs in writing up front? And do they have the right the opt out?

So I receive a greater fitting fee is I'm a member of a specific buying group or a membership association that's associated with this network? 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 that patient for that fitting or professional fee? And are there limits as to what I can charge for service outside that fitting fee window? So things that you need to ask about that might be bundled into that dispensing fee are things that you, again, you have to provide these things in order to be able to ask. But can these things be, are they inclusive to that professional fee? And if not, can I charge a patient privately for them? So that's the hearing test. A communication needs assessment, a true evidence-based communication needs assessment is diagnostic in nature. Because it's creating a whole patient care plan. And a hearing aid may or may not be in that care plan. It could be an implant. It could be an accessory. It could be OTC. What is that? What is in that care plan? That's diagnostic, it comes before. It's not just, we're gonna pick a hearing aid. This is a diagnostic to get whether or not they're a hearing aid candidate. Electroacoustic analysis, it's running hearing aids in a HIT box. Auditory rehabilitation and conformity evaluation or verifications, or real ear measurement, speech mapping, your ear mold or your insert or your dome, diagnostic these beyond

the audiogram, and accessories or FM and their fitting of that. Again, audiologists need to start charging for fitting accessories. And fitting accessories, that phone is an accessory. So doing this connectivity, if I owned a practice today, I would do it once, 'cause I would be unbundled. If they had a service plan, it would be included in their service plan for me to reconnect. If not, they would be, again, needing to pay. That would be a service visit. So we need to start thinking about, is that included in the third-party administrator or third-party network bundle? So now let's talk about policies and procedures. Because really, reimbursement starts at scheduling. That's when it starts. Coverage and reimbursement starts right there. And so you need to have a process in place and policies and accountability for everyone along. And that's called revenue cycle. For everyone along your revenue cycle chain, what's everyone's roles and responsibilities?

Scheduling, your scheduler needs to be trained on insurance. They need to know the basic things that they need to be asking about. They need to phone triage questions about the eight warning signs of ear disease plus tinnitus to determine if medical necessity is likely met, and how to schedule the appropriate type and length of appointment. If the patient says that they think they might have hearing loss, then the next is, do you think you might to be further evaluated for hearing aid candidacy at that visit? That would be your communication needs assessment. You wanna inform your patients of your network status, if you're in or out of network. You inform the patient. You can't get the order, the Medicare order, for them, because you can inform them of need of the order, or the need of a prior authorization from Medicaid or an HMO. You're gonna get their basic demographic information, name, address, email, cellphone number. You wanna get their insurance information if they are interested in doing things that are bigger, vestib, hearing aids, implants. Because you wanna get, and you also, in that, need to get the name and date of birth of insured so that you can verify benefits long before they come in. You wanna inform the patient of potential out-of-pocket costs. So for you know that your vestibular program has so many dollars that, because you're doing VEMPs or saccades that aren't covered, you should inform

them of that then. You wanna ask about any mobility or communication issues. Are they in a wheelchair? Do they need an interpreter? Do they have any mobility or communication issues? You wanna let them know your financial policies, that payment is due at the time of visit. And again, link them to your site, where all of that information is available. You should have all your policies, your forms, everything should be available on your website so people can literally fillable-PDF it, and send it off to you, or print it up if they want. And then you schedule the appointment. If they are going to come in to fill out forms, tell them, come in early to fill out forms. So now your patient gave you their demographic information. They think they have a hearing loss, and they need to verify benefits. This is when you should do the verification process. Verification is so much easier when you know your allowable rates and medical policies. I, back in the day, when I used to verify literally hundreds of benefits, I knew all my contracts very well.

So I could actually verify benefits 95% of the time, 90, 95% of the time, in five minutes or less. The rest were an hour or more. But if you know what your allowable rates are, it's very simple and easy to know how to work within it for, you just need, all you're really calling about, the only thing that an insurance company can give you in a verification is about the patient's benefits. They cannot tell about your contract. That is a separate department. They can't tell you, is this covered, is this covered? No, you're only verifying the patient's coverage and benefits. You can do as much as possible online through portals. There is UHC, their portal is very all-inclusive. Availity or NaviNet, or I think it's called NantHealth now, NaviNet, show coverage and eligibility. And again, you're still going to need to call, though, to verify that very specific patient's hearing aid benefits. You wanna use a form, and you wanna ask all the questions on the form. So when I had a form, all those questions were there for a reason, because they were important in verification. So you need to use a form and ask all the questions. Who did you call? And this would be what would be on my form. Who did you call, at what number, and do they have a reference number? The very first thing you need to ask, if you know that in your community, Blue Cross Blue Shield does a lot

of work with a specific third-party administrator, ask, is the benefit or discount only available through x? Don't say TPA, don't say network. Is it available through x? Give them the name. Is the patient eligible on this date of service? Have they met their deductibles? It's important to know deductibles, because sometimes now they're so much larger than even the cost of the hearing aid. Patients need to pay unmet deductibles and co-insurance at the date of service, or the date of fit. So you wanna know what these deductibles are. Do they have out-of-network benefits? If you're an out-of-network provider for the patient's plan, that would be the thing I would ask, really, up at the top. Do they have any out-of-network benefits? A lot of people with HMOs or managed Medicaid plans do not have any sort of out-of-network benefits. Does the patient have a hearing aid benefit or an allowance?

Allowance is dollars towards. Those are the ones you'll often see that it's $600, $500. It's dollars towards. Or do they have a fixed benefit? Or is it to the allowable? If it's dollars, if it's a fixed dollar amount, like the FEHP, Blue Cross Blue Shield FEHP of $2,500 every three years, or is it an up to? If they tell you up to 1,500, it's not 1,500. It is the allowable rate for the device itself. Is it a funded or an unfunded benefit? What's the frequency of the benefit, the number of months or years? Is it inclusive, and what's it inclusive of? Have them read you the whole benefit word for word. And again, 'cause you wanna know what those inclusive services are. That, they can read you, what that benefit says. So now you've had benefits verified, patients scheduled, benefits that's been verified, what's the provider's responsibility? So providers need to complete the testing, the evaluation, and the treatment. They need to complete documentation by the close of each business day. You should be writing reports. There's all sorts of systems. It's a lot of touch and click that you can do it very quickly. But you should have this done at the end of the day. Because your billers may need access to this information in order to appropriately bill. You need to fill out your superbill or enter your charges into your EHR/EMR/OMS if you're electronic. You should be entering data for every visit and for everything you did, even if it's no charge. Because that data is really business metrics. And business metrics help us make business decisions and not

emotional ones. You also need to fit within the benefit and the allowable rates. So if it's an up-to plan, that's really with Aetna, Humana, you have to fit within that benefit. The patients can't upgrade in those cases. You have to fit within the benefit. And again, insurances are not responsible to provide streaming. They're not responsible to provide 22 channels. They are responsible to provide the minimum the patient needs to fit their hearing loss. It's not personal comfort, it's not deluxe. So you're going to need to fit within the benefit. So now you've submitted your, entered in your charges or submitted your claim. So your billing staff now, their responsibilities kick in. Someone has to collect patient responsibility when they check out. This individual never needs to be undermined ever.

So if you're a provider that's constantly trying to give things away but your office policy is that you don't, then you should not talk to these people. Let your billing staff talk to the patient. And you also don't wanna be one that just is constantly having things billed out. If you were gonna bill out batteries, you should've just given the batteries away. Because that billing is going to cost you as much as the batteries cost. So you wanna have, again, where patients are paying via instant Venmo or Zelle or PayPal, or whatever mechanism you're, Square, whatever you're using to take in patient quick payment, well, you can invoice them, and then, again, they pay you. You ship it out, and you charge for shipping. Your office staff is going to take that information and post the claim. They should really be doing within two business days of the date of the service, because remember, you're working in a timely claims-filing window. Payments should be posted every day. They should be monitoring payments, especially accounts receivable outside of 90 days. They really need to be on top of your accounts receivable. They need to file appeals for denials or incorrect payments within two business days of receipt of that EOB. They need to stay on top. Because remember, you're in a timely claims-filing window. And you need to monitor accounts payable. Did you get all of your no-charge rushes or no-charge courtesy, just outside of warranty services? Did you get the discounts that you were supposed to? That's what's monitoring accounts payable is for. Now you have office manager/director/owner

responsibilities. The administration should purchase training and billing resources for theirselves, their providers, and their staff. Everybody needs to watch these webinars, not just one person. Everybody needs to be trained. That leadership needs to have a strong working knowledge of their managed care agreements, Medicare and Medicaid. They need to create policies and procedures, and they need to stick to them for everyone. They need to train their staff on those policies and procedures, and document their training, and have consequences. They need to evaluate and update their pricing at least on an annual basis. And they, too, need to monitor claims payments, accounts payable and accounts receivable at least monthly. The easiest thing for a biller to do is make something go away.

So like in my case, I had a report for anything, that anything that got zeroed out would trigger to report to me so I could understand why it was zeroed out. You need to monitor things. The financial policies apply to the leadership or ownership. They should be in writing and readily available to all of your patients. No one should be able to write off sums of more than $100, other than a manager or the owner. And you need to stop seeing patients that owe you money without putting in place payment arrangements. They need to start, you need to stop adding my money into the mix. And you should stop servicing people who haven't technically, really paid for their hearing aids. You need to, again, have payment arrangements in place. And it can very, I mean, we're not talking that you want to pay it in full. Arrangements, they need to set up a payment plan or something of that nature. Things you need to stop doing immediately, you should not be billing, staff should not just randomly bill out repairs, follow-up visits, loss and damage deductibles, replacement aids, ear molds, batteries, tinnitus, without the audiologist's or owner's knowledge, or within weighing the consequences with the patient. Remember, if you bill a package of batteries to a patient's insurance, that may exhaust their benefit with a $20 purchase. Just, you have to know about what you're dealing with. Don't just randomly bill things out. Because most patients exhaust their hearing aids for a fixed amount of time. Any time you access the benefit, it's not, again, a bank. So you need to work with that patient as to, how do you wanna, you're really

happy with your hearing aids. Do you wanna access it for a repair? Do you wanna access it for an accessory? That's gonna exhaust your benefit. And let them be part of that, part of the conversation and the decisioning rather than you just making that decision for them. Non-covered does not mean non-reimbursable. Third-party payers don't cover everything. Third-party administrators, third-party networks, they don't cover everything. So we need to be comfortable in charging patients for those services. All of these physicians, dentists, chiropractors, optometrists, our patients are paying all of these people for non-covered services. We also have to be comfortable in charging people for things that falls outside their coverage and benefits. We, like dentists and optometrists and physicians and PTs and OTs and chiropractors, need to be unapologetic for the evidence-based, necessary care that we're providing, but it's just non-covered. We need to charge patients something for the non-covered care we provide. You could have a different fee schedule, a sliding schedule for Medicaid for the uninsured. You can have those. You just need to charge people something. And transparency and prior notification is really valuable here.

And again, we don't wanna rethink this strategy just because one person complains. The squeaky wheel should not be greased. Change your policies. Will you lose some people? Yes, but when I did this, I'm gonna tell you, and when my other colleagues I've had have done this, most people actually said, "I always wondered why you didn't charge me," than the people who complained. You have to do what is right for you and your practice. You have to determine that. And you just have to be able to communicate that to your patients in a transparent, honest way. How practices end up in insurance hell, in my now almost 30 years in this space, I'm gonna tell you that in the most case, the providers put themselves there, not the insurer. They didn't ask the right questions at intake. They signed any contract, never read it, never reviewed it, and then are mad because they don't like the terms. They didn't have a working knowledge of the contract. They don't verify coverage and benefits every time. They bill everything to insurance first, and then get payment later. They insist on top of the line products for everyone. They insist on remaining bundled and expect coverage up

front for service that may or may not occur. They don't charge patients privately for non-covered services and notify them in writing of their out-of-pocket responsibilities. And they don't collect patient responsibility at the time of visit. But you can get yourself out. You can have strong scheduling intake processes like we've already talked about. You can run your practice like other doctoring professions and be comfortable and unapologetic of collecting patient responsibility. All business is not good business. You've gotta weigh the pros and cons of every managed care agreement, every third-party network or administrator agreement, and decide, do I wanna be in this? Or do the pros outweigh the cons? You need to know your contracts. Nothing is ever free in your practice. We've gotta get away from free. Collect payment at the time of visit. And fit the patient with something audiologically appropriate within their benefit. There's a link here to the great folks at HARL. Jani Johnson, the late Robyn Cox wrote some amazing work, all double-blind, evidence-based studies to show that patients don't know the differences in performance or satisfaction between some of these products, high end and low end.

So please, again, fit within the benefit. When you get a denial from an insurance, you need to find out who is in the right. If it's you, that you were right, prove it. Send evidence, a copy of the written benefit, the local coverage determination if it's Medicare, a copy of the report, a copy of the coding manual, copy of Medicare policies. And resubmit the claim with supporting documentation. And I have always had more success if I return all the monies for that claim. Send the whole thing back, and we're starting over. If the payer, if it only denied or paid incorrectly 'cause you billed it out incorrectly, I, again, would send those monies back, any monies that they paid, because it's very hard to get partial monies back. It's better to send it back and start over with a corrected claim. Again, third-party coverage for diagnostic and hearing aid services is a relationship, really, as well, not just between us and an insurer but between the patient and their insurer. The patient selected their plan and benefits, not you. They selected it. Sometimes patients have out-of-pocket expenses and financial responsibility for non-covered or denied services. And sometimes that fight for

coverage or payment, especially when you're an out-of-network provider, it's a fight between the patient and the payer, and not a fight between you and the payer. So if the payer isn't paying something, and they're pushing it to patient responsibility, get the patient involved, and let them also fight. Once they get that invoice, they will start fighting with you. Patients are sometimes in these third-party networks, or insurance plans are being misled by brokers, by payers, by the plans themselves. We need to be transparent and not judgmental, just honest and transparent about what their actual coverage and benefits are. If the patient is unhappy with the factual accounting of how their insurance work and what those coverage and benefits are, you want them to complain to who's ever administering those. So it might be the employer. Complain to their union. They could complain to Medicare, if it's around a Medicare Advantage plan.

Or if it's around a plan that's being offered, Blue Cross Blue Shield is offering a plan with a third-party administrator, and the third-party administrator is misleading people, complain to Blue Cross Blue Shield. You can also complain to your state department of insurance and your state attorney general's office. And have the patients complain. Have them drive this. They have a much bigger voice in these venues than sometimes the provider has, where we look like sour grapes. Again, so you verified benefits, now what? You must treat your managed care patients like you would treat your private pay patient. The date you bill is the date you fit, the date of services, the date the item dispensed or the services provided. Can they upgrade? If no, it's not balance billing. Never use that term. They'll always say no. Can they upgrade? And the only third-party payers right now, in 2020, that allow for upgrades uniformly are Blue Cross Blue Shield and UnitedHealthcare. And that is for, again, their commercial products. But can they, if you can't upgrade, you need to fit within the benefit. Itemization can help. If they can upgrade, you need to offer them something within their benefit, have them sign an upgrade waiver that they understand they could have gotten something within their benefit and they've chosen a deluxe item to upgrade. And have them pay the difference between their benefit amount and your usual and customary for the

upgraded device on the date of service. Again, up to x doesn't mean x. It typically means your allowable rate. So if you don't know what that is, the best rule of thumb is to fit an entry-level product. Fit within that benefit, that itemization. Or, if you're still bundled, unbundling it into pieces that the total equals the total cost of a private pay can sometimes help push some cost-to-patient responsibility as well. You wanna be careful, again, about accessing their benefits for things other than new hearing aids, because again, not a bank, not something you can draw from. Medicaid is the exception to that rule. Again, when dealing with hearing aids in the third-party world, you need to do that verification process every time for hearing aids, every single time. Even if it's a husband and wife, you've gotta verify both of them. You wanna do that long before they ever show up in your office. Also, you wanna make sure that the patient always pays their patient responsibility, co-payments, co-insurance, deductibles, non-covered services, on the date of service. You wanna be in the role of the refunder and not in the role of a collector.

But, the but here, you cannot collect all of payment in full at the time of visit, if you're in network. You can if you're out of network. But if you're in network, you can only collect at the time of visit, co-payments, co-insurances, deductibles, and the cost of non-covered service, not payment in full. Payers can and do make coverage rules, and it's your responsibility to know what those are. You have to get your cost of goods as low as possible. No manufacturer is irreplaceable, because there's no hearing aid that's curative. You have to get your cost of goods down and have a product for these situations where you have to fit within the benefit. The payer, again, will have coverage requirements about providing invoice, medical clearance, written physician recommendations, evidence of medical evaluation by an otolaryngologist prior to being fit, pre-authorization, common for Medicaid and HMO, and degree of hearing loss. Technically, if you don't have these things, at least in your medical record, there's no coverage if it's not met. If those requirements exist, you need to make sure that you're meeting those requirements. Let's talk about waivers and patient notification. You cannot use waivers unless allowed by contract or by payer. Otherwise, you're gonna

be in violation of a payer agreement. Most payer agreements say that you can't enter into a relationship with a patient if you have them sign something for you that conflicts with the terms of the managed care contract. So if that patient were then to submit that claim and it get processed, you would get a nasty-gram, and that patient pushes back when they show patient responsibility of zero. You will get the nasty-gram from the insurance, and you will be refunding money. Remember, the patient gets an EOB as well. So do not be using waivers or upgrade things unless you're allowed to do so. Most insurances typically do require what's called a notice of non-coverage. This is actually becoming more and more prolific. This is actually part of that whole legislation around surprise medical bills. So if your contracts say you need to notify patients of their, not their deductibles or co-insurance, but non-covered services, you need to have them sign and acknowledge that in writing.

Again, it needs to be in place before the service is rendered or the item is dispensed. And it is really, can be really valuable in out-of-network situations so you can avoid those state balance billing regulations and those state, again, surprise medical bill legislation. Blue Cross Blue Shield and UnitedHealthcare, again, right now, in 2020, are the only payers that really uniformly allow for upgrades. And again, that's for their commercial products primarily. You must offer a standard product at no charge to the patient or within their benefit amount. The patient can upgrade if they so choose and pay the difference. But again, the patient needs to understand that could've gotten something within their benefit, and they've chosen to upgrade. And then the next question is, do they recognize that S1001 so that the explanation of benefits will reflect that the patient understood that they were upgrading and that this was their out-of-pocket responsibilities? An insurance waiver is allowed by HIPAA, by HIPAA Omnibus, that a patient doesn't want you to bill their insurance. They don't wanna access their insurance benefit. Now, in this case, the patient isn't gonna bill their insurance nor are you. So you're going to need to have a form that it very clearly indicates the patient had benefits, they've chosen not to access them, that you're not gonna bill the insurance, and the patient's not gonna bill the insurance. You need to have a legal form

that really outlines this. Cash discounts, again, these are managed. There are managed care agreements where contract language will prohibit a cash discount. So before you start offering cash discounts, have your legal counsel review your contract and determine if the cash discount is, again, allowed within the framework of those managed care agreements that you participate with. You also need to think, be the patient and think about fairness. Because some patients have large deductible plans. So they don't have access to your cash discount, but they have a $5,000 deductible. So they still have to pay in full, just because they had insurance but with this huge deductible. Yet someone who doesn't have insurance gets a discount. So you really have to think about that fairness or ethics around that. Our hour together is up. I hope that I gave you some things to consider in dealing with third parties. Please, if you have further questions, please reach out to the state or national associations or buying groups that you're a member of for additional guidance and support. And again, please know that this module was not meant to be viewed in isolation of other modules around coding or insurance that may exist in the boot camp series here on AudiologyOnline. Thank you so much, and have a wonderful day.