AUDIOLOGYRESOURCESINC

THE THIRD-PARTY ADMINISTRATOR DILEMMA: TO PARTICIPATE OR NOT PARTICIPATE? THAT IS THE QUESTION!

- Kim Cavitt, AuD

- Audacity 2020

LET'S MAKE THIS AS "PRE-COVID" AS IS POSSIBLE

- Get ready to respond to a few polls.
- Depending on how many people are in the course, I will either open up everyone's microphone for questions at the ends of Part 1 and Part 2 or will host breakout rooms for the break!
- You can raise you hand in the course at any time and I will open up you microphone so you can ask a question or, if you are shy, you can send me a question via the chat feature at any time.
  - Want to try to do real-time questions just like in a face to face course.
- If you would normally be in the back of the meeting room talking to a colleague, please do that in my course as well.
  - Heck, it's recorded. You can go back and watch it later!
  - Be social and connected to other attendees.

POLL QUESTION #1

WHAT DO YOU NEED TO ANALYZE A MANAGED CARE AGREEMENT?

- State scope of practice.
- Cost of new customer acquisition.
- Standard of care provided.
- Time scheduled.
  - Need to consider entire patient journey from evaluation to long-term management.
- Value of the time scheduled.
- Contract terms and limitations.
- Allowable rates.

STATE SCOPE OF PRACTICE: WHAT CAN YOU DO?

- How does your state address the following services provided by an audiologist??
  - Evaluation and management?
  - Basic health screenings?
  - Cognition?
  - Telehealth?
  - Cerumen removal?

STATE SCOPE OF PRACTICE

- If not implicitly mentioned in scope of practice (typically listed under "definitions" in statute/law and/or rules/code/regulations), you need to make a written request for a determination.
  - You may need this to appeal to an insurer who will not allow you to bill a patient for a non-covered service (they assign the costs on the EOB to provider responsibility or indicate it is "bundled" into a professional fee).

CUSTOMER ACQUISITION COST

- How much does it cost you to obtain a new patient?
  - Marketing dollars (time and money).
    - This dollar amount has to be considered in any TPA comparison.

STANDARD OF CARE: WHAT DO YOU DO?

- What does your care delivery model include for your general populations, regardless of payer:
  - Cerumen management, when needed or removal of foreign body
  - Audiogram?
    - Air, bone, SRT, WRS, MCL and UCL
  - Other medically necessary diagnostic testing?
    - Immittance testing.
    - Otoacoustic emissions.
    - Evoked potentials.
    - Assessment of tinnitus.
    - Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device.(s)

STANDARD OF CARE

- What does your care delivery model include for your general populations, regardless of payer:
  - Evaluation and Management/communication and functional needs assessment?
    - Inventories.
    - Speech in noise testing.
    - Unaided real-ear measurement.
    - Cognitive screening.
    - Auditory processing screening.
    - Depression screening.
    - Dexterity screening.
    - Falls risk assessment.

STANDARD OF CARE

- What does your care delivery model include for your general populations, regardless of payer:
  - Hearing aid examination and selection?
  - Earmold impression?
  - Hearing aid fitting and orientation?
  - Verification?
  - Earmolds?
  - Accessories?
  - Batteries or battery charger?
  - Auditory rehabilitation?
  - Fitting and orientation of accessories and assistive listening devices.
  - Follow-up visits during evaluation and adjustment period.

STANDARD OF CARE

- What does your care delivery model include for your general populations, regardless of payer:
  - Long-term care post acceptance
    - Bundled and unlimited
    - Pay as you go per visit Service plan
      - Limited
      - Unlimited
    - Loss and damage replacement orders and fitting

THE IMPORTANCE OF DATA IN ANALYZING OUR PRACTICE OPERATIONS

- What does your average patient cost you to evaluate, treat and manage at your given standard of care?
  - How efficient are YOU in evaluating and treating patients?
- The purpose of coding is not just reimbursement; it is data collection.
  - Every patient needs to generate an encounter.
- This data will assist you in making informed decisions and not emotional ones.

DATA YOU NEED (AT A MINIMUM)

- Number of patients seen
- Number of hours scheduled
- Dollars billed
- Dollars collected
- Number of hearing tests completed
- Number of hearing aid candidates (internal code)
- Number of hearing aid evaluations completed
- Number of individual aids fit
- Number of no charge follow-up visits/hearing aid checks
- Number of returns
- Number of exchanges
- Number of loss and damage replacement fittings
- Number of hearing aid repairs
  - In-house
  - Manufacturer
  - Drop-off

STANDARD APPOINTMENT TYPES

- Need standard appointments types and lengths for your practice.
- This establishes how much time is being spent on each procedure or visit and the cost of that "time".
  - Want the minimum required to provide evidence based, patient centered care.
- Appointment types can be established for types of services and/or for individual procedures.
  - With codes tied to them.

STANDARD APPOINTMENT TYPES

- Need standard appointments types for your practice.
  - Need meaningful blocks of "care".
  - Things to consider:
    - Cerumen removal
    - Adult audiometric examination
    - Pediatric audiometric examination
    - Communication and functional needs evaluation
    - Hearing aid examination and selection
    - Hearing aid fitting
    - Hearing aid follow-up
    - Earmold impression

STANDARD APPOINTMENT LENGTHS

- All for your established appointment types need to be assigned standard lengths for all providers for evaluating your average patient.
  - Consider appointment lengths in 15 minute increments.
- Need to work as efficiently as possible.
  - How much time can you afford to schedule for these appointment types based upon your allowable rates?

BREAKEVEN ANALYSIS

- Breakeven analysis is what does your practice needs to bring in, per hour, per full-time equivalent provider to cover your expenses (salary, overhead, calibration, fixed costs, benefits, annual fees, etc.).
  - Hearing aid procurement costs are not here as they are variable.
  - You want to add a "profit" amount to this.
- This is the minimum you can charge.
- This needs to be re-evaluated every year.

POLL QUESTION #2

BREAKEVEN ANALYSIS AND QUICKBOOKS

- Print a Quickbooks Expense Report for a 12 month period of time.
- Take a Black Sharpie and mark through any line item that accounts for goods that are sold (i.e. hearing aids, earmolds, ALDs).
- Add up the remaining expenses (including salaries) from the Report.
  - These are your expenses for the year.
- Divide this amount by 12.
  - This is the amount you need to breakeven per month.
- Divide this amount by the number of full-time equivalent, revenue generating providers.
- Divide this amount by the number of available hours your providers are available to see patients in an average month.
  - No one should see patients 40 hours a week.

OR

BREAKEVEN ANALYSIS AND QUICKBOOKS

- Print a Quickbooks Expense Report for a 12 month period of time.
- Take a Black Sharpie and mark through any line item that accounts for goods that are sold (i.e. hearing aids, earmolds, ALDs).
- Add up the remaining expenses (including salaries) from the Report.
  - These are your expenses for the year.
- Take the number of available hours per week and multiply it by the number of available weeks per year.
- Multiply this number by the number of full-time equivalent providers.
  - This is the total number of available hours for your practice.
- Divide the total expenses for the year by the total number of available hours for your practice.

BREAKEVEN RATE CALCULATION EXAMPLE

Expense	Amount
Salaries	$260,000
Rent	$60,000
Utilities	$4000
Equipment	$6000
Supplies	$4000
Calibration	$3000
Dues and Memberships	$2000
Marketing	$25,000
Telecommunications	$4000
Hearing Aid and Earmold Costs of Goods	$240,000

Audiology Practice Expenses

You employ 3 full-time equivalent revenue generating providers.

Each provider is available to see patients 35 hours a week, 48 weeks a year.

What is the hourly breakeven rate for this practice?

BREAKEVEN RATE CALCULATION EXAMPLE

- Let's do the math
  - $368,000 in total expenses for one year.
  - $30, 666.67 for each month.
    - Divide 368,000 by 12
  - $10,222.22 per provider per month must be collected to cover expenses.
    - Divide 30666.67 by three
  - $73.02 per provider per hour to breakeven.
    - Divide 10222.22 by 140 hours

BREAKEVEN RATE CALCULATION EXAMPLE

- Let’s do the math
  - $368,000 in total expenses for one year.
  - 5040 hours available for three providers in one year.
  - Divide 368000 by 5040

BREAKEVEN RATE CALCULATION EXAMPLE

$73.01 or $73. 02

(depended on

rounding and calculation)

BREAKEVEN RATE

The Breakeven Rate is the MINIMUM you can charge for a window of time to cover your expenses!

PROFIT

- This is the percentage or fixed amount that is added to every item or service to create profitability.
- Here is how you consider profit:
  - What would your highest third-party payer reimburse you for a specific service?
  - What are the socioeconomics of your area?
    - What hourly rate can the market bear?
  - What is easily divisible?

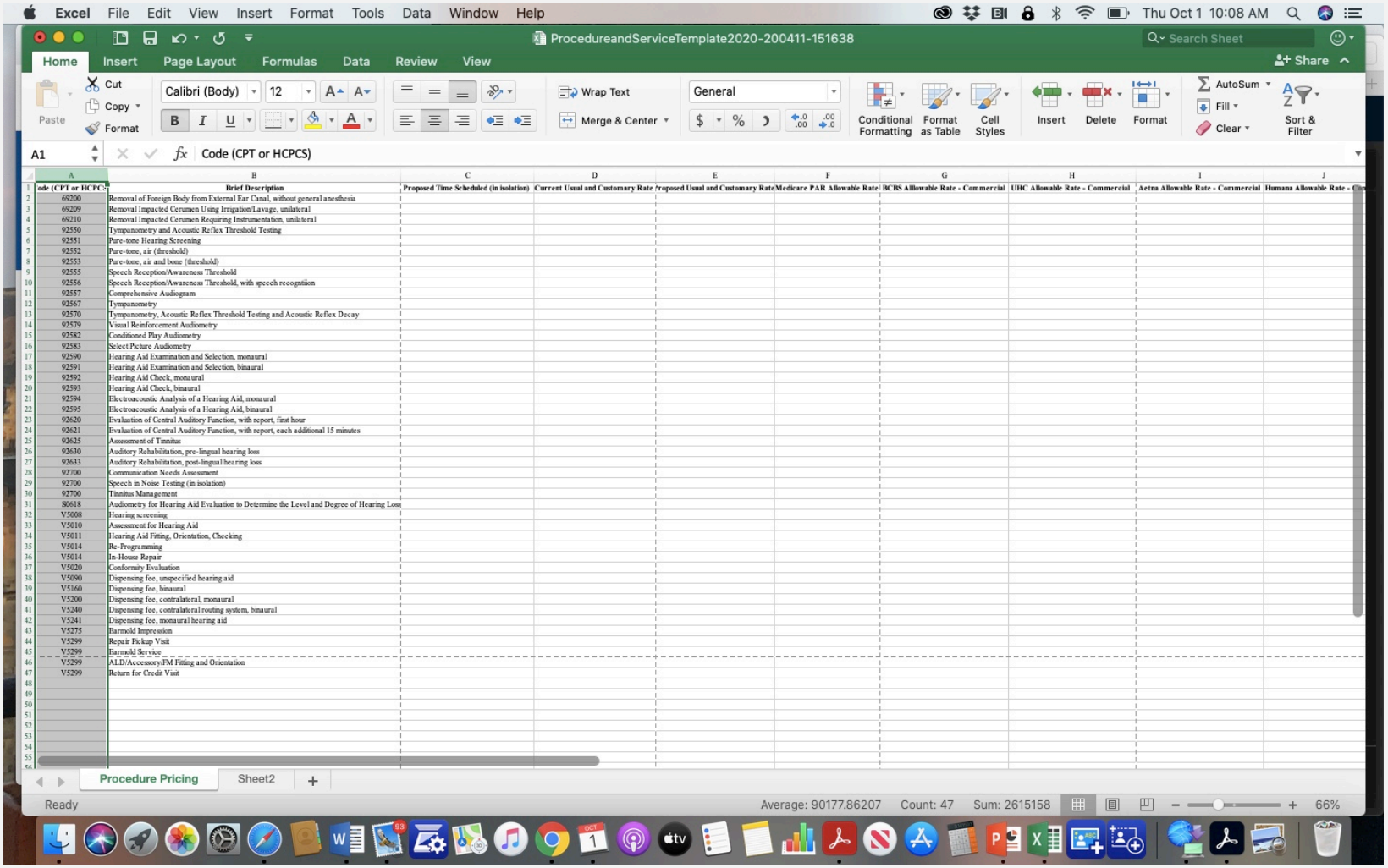
ESTABLISHING USUAL AND CUSTOMARY SERVICE PRICING

- List, in a spreadsheet, of every appointment type and every procedure or service you provide (or possibly hope to provide).
  - X axis
- Code each of these appointment types, procedures, and/or services with the most appropriate CPT and HCPCS code.
  - Column A
- Description of each appointment type, procedures, and/or services.
  - Column B.
- Estimate the approximate appointment length for each appointment type, procedure and service if the service were provided in isolation.
  - Column C.

ESTABLISHING USUAL AND CUSTOMARY SERVICE PRICING

- List your current usual and customary rate for each procedure or service.
  - Column D.
- Calculate your usual and customary rate by multiplying the breakeven plus profit rate by the estimated length of service, procedure or visit.
  - Column E.
- List the Medicare allowable rate for each procedure and service.
  - Column F.
- List the allowable rates for each procedure or service for each payer you are contracted with.
  - Columns G+..

SPREADSHEET EXAMPLE



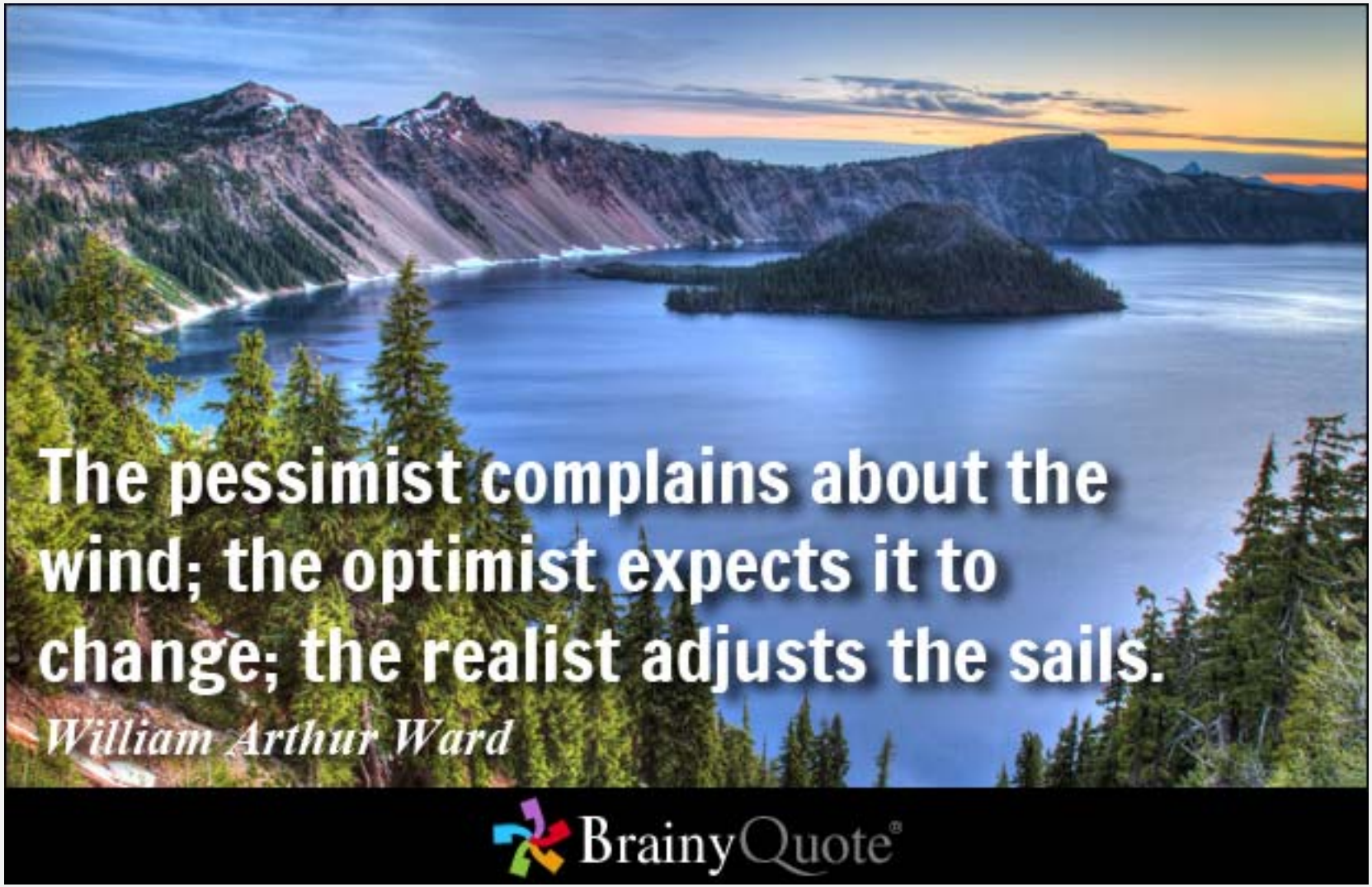
Code (CPT or HCPCS)	Brief Description	Proposed Time Scheduled (in isolation)	Current Usual and Customary Rate	Proposed Usual and Customary Rate	Medicare PAR Allowable Rate	BCBS Allowable Rate - Commercial	UHC Allowable Rate - Commercial	Aetna Allowable Rate - Commercial	Humana Allowable Rate - Commercial
69200	Removal of Foreign Body from External Ear Canal, without general anesthesia								
69209	Removal Impacted Cerumen Using Irrigation/Lavage, unilateral								
69210	Removal Impacted Cerumen Requiring Instrumentation, unilateral								
92550	Tympanometry and Acoustic Reflex Threshold Testing								
92551	Pure-tone Hearing Screening								
92552	Pure-tone, air (threshold)								
92553	Pure-tone, air and bone (threshold)								
92555	Speech Reception/Awareness Threshold								
92556	Speech Reception/Awareness Threshold, with speech recognition								
92557	Comprehensive Audiogram								
92567	Tympanometry								
92570	Tympanometry, Acoustic Reflex Threshold Testing and Acoustic Reflex Decay								
92579	Visual Reinforcement Audiometry								
92582	Conditioned Play Audiometry								
92583	Select Picture Audiometry								
92590	Hearing Aid Examination and Selection, monaural								
92591	Hearing Aid Examination and Selection, binaural								
92592	Hearing Aid Check, monaural								
92593	Hearing Aid Check, binaural								
92594	Electroacoustic Analysis of a Hearing Aid, monaural								
92595	Electroacoustic Analysis of a Hearing Aid, binaural								
92620	Evaluation of Central Auditory Function, with report, first hour								
92621	Evaluation of Central Auditory Function, with report, each additional 15 minutes								
92625	Assessment of Tinnitus								
92630	Auditory Rehabilitation, pre-lingual hearing loss								
92633	Auditory Rehabilitation, post-lingual hearing loss								
92700	Communication Needs Assessment								
92700	Speech in Noise Testing (in isolation)								
92700	Tinnitus Management								
S0618	Audiometry for Hearing Aid Evaluation to Determine the Level and Degree of Hearing Loss								
V5008	Hearing screening								
V5010	Assessment for Hearing Aid								
V5011	Hearing Aid Fitting, Orientation, Checking								
V5014	Re-Programming								
V5014	In-House Repair								
V5020	Conformity Evaluation								
V5090	Dispensing fee, unspecified hearing aid								
V5160	Dispensing fee, binaural								
V5200	Dispensing fee, contralateral, monaural								
V5240	Dispensing fee, contralateral routing system, binaural								
V5241	Dispensing fee, monaural hearing aid								
V5275	Earmold Impression								
V5299	Repair Pickup Visit								
V5299	Earmold Service								
V5299	ALD/Accessory/FM Fitting and Orientation								
V5299	Return for Credit Visit								

FINALLY, WE ARE READY TO ANALYZE A CONTRACT

QUESTIONS AND DISCUSSION

BREAK

YOU ARE WELCOME TO LEAVE YOUR MICROPHONES OPEN AND CHAT IN THE CLASROOM, CHAT IN THE CHAT FEATURE OR GO TO A BREAKOUT ROOM (IF THERE ARE LOTS OF YOU ATTENDING)


The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails.
William Arthur Ward
BrainyQuote®

NAVIGATING MANAGED CARE

- Cannot paint every third-party administrator or 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.

POLL QUESTION #3

THIRD-PARTY PROVIDER NETWORKS

- Third-party administrators/networks 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 managed care "shenanigans".

WHAT THE TPA DOES FOR THE PROVIDER

- Market benefits to members.
- Refer members to your practice.
- Purchase the hearing aids from the manufacturer.
- Outline coverage and benefits options.
- Pay the provider on a fixed date.

WHAT THE TPA DOES NOT DO FOR THE PROVIDER

- Allow the provider to collect their usual and customary, private pay fee for every item and service.
- Fully unbundle care.
- Allow the provider to fit outside of the plan if they are a participating provider and the patient was referred by the plan.
- Allow the purchase of the hearing aids from the manufacturer.
- Clearly outline coverage and benefits options.
- Allow for negotiation.
- Allow the provider charge their usual and customary rate for non-covered/non-inclusive services.

MAJOR PLAYERS IN AUDIOLOGY

- American Hearing Benefits
- Amplifon Hearing Health Care
- Audionet
- Hearing Care Solutions
- TruHearing
- UnitedHearing Care
  - Subsidiary of United Healthcare.
- Your Hearing Network

Some entities are owned by hearing aid manufacturers.

CONSIDERING PROVIDER NETWORK PARTICIPATION

- Read the Provider Agreement and Provider Handbook.
- LEARN what you are agreeing to provide,
- ASK QUESTIONS in writing when needing clarification!

GENERAL RULE OF THUMB:

When you agree to participate with a TPA, you agree to provide care to the same standards you provide care to your private pay patients.

CONSIDERING PROVIDER NETWORK PARTICIPATION

- Before you agree to participate, please consider the following:
  - How will patients be referred to you and your practice?
  - What is the TPAs referral protocol?
    - If corporate owned clinic is also close to the patient, do they receive priority for the referrals?
  - What if an existing patient of your practice has access to this benefit?
    - Do I have to refer them through the program?
    - Do I have to notify them of the existence of this benefit if they are unaware?
      - What if they only have access to an unfunded benefit?

CONSIDERING PROVIDER NETWORK PARTICIPATION

- What dispensing or professional fees am I agreeing to accept if I agree to participate?
  - What items and services, from evaluation to long-term follow-up care are included in this fee?
    - This fee typically varies by level of technology.
    - 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?
- Is the plan offering a funded or unfunded (discount) benefit?
  - If unfunded, easier to create a competitive offering, especially if your practice is unbundled.

CONSIDERING PROVIDER NETWORK PARTICIPATION

- Can I charge the patient or their parent healthcare insurer for additional, medically necessary diagnostic audiologic and vestibular testing?
  - If the answer is "no", I strongly suggest having the agreement reviewed by legal counsel.

POLL QUESTION #4

CONSIDERING PROVIDER NETWORK PARTICIPATION

- Can I charge the patient or their parent healthcare insurer for additional, medically necessary diagnostic audiologic and vestibular testing?
  - Is the TPA billing the hearing test to the payer On the back end) and just not reimbursing you separately for it?
  - Where do they stand on billing evaluation and management services, if allowed by state licensure, and part of my standard of care?
  - How are other diagnostic services, beyond 92551-92557, handled?
    - Are there limits as to what I can charge?
    - Who do I submit these charges to?

CONSIDERING PROVIDER NETWORK PARTICIPATION

- How does this program mesh with hearing aid mandate language that may exist in certain states?
- How does this program mesh with state hearing aid dispensing laws?
- Does your state have an insurance mandate that is administered by a TPA?
- How am I compensated for the evaluation if:
  1) The patient is not a hearing aid candidate?
  2) The patient does not opt to proceed with amplification on the date of service?

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?
- Do I receive a greater fitting fee if I am a member of a specific buying group or membership organization that is tied to the TPA?

CONSIDERING PROVIDER NETWORK PARTICIPATION

- How are accessories and accessory fitting fees managed?
- How long is the evaluation and adjustment/trial period?
  - What do I receive if the patient returns the aids for credit?
- Do they allow for coverage for services provided via telehealth (as allowed by state law)?
- How long do I have to manage the patient for the fitting/dispensing fee?
  - If it is based upon number of visits, what visits are inclusive to the fitting and what count separately?

CONSIDERING PROVIDER NETWORK PARTICIPATION

- Do they allow (as allowed by state law) for care to be provided by:
  - Hearing aid dispensers?
  - AuD students?
  - Audiology assistants/technicians?

SERVICES PROVIDER NETWORKS DO NOT SEEM TO "BUNDLE" INTO THE DISPENSING FEE

Determine how these services, which may or may not be inclusive to the dispensing fee, are addressed (this goes back to your standard of care):

- Hearing test (92557 or S0618)
- Diagnostic audiologic and vestibular testing beyond 92552, 92553, 92555, 92556, and 92557.
- Evaluation and management services (99201-99213)
- Screenings such as cognitive, auditory processing, depression, falls risk, and dexterity
- Communication and Functional Needs Assessment (92700)
- Electroacoustic analysis of the hearing aid (92594/5)
- Conformity evaluation/verification (V5020)
- Earmold/insert (V5264/5)
- Accessories/FM and the fitting/dispensing of such accessories (V5299)
- Auditory rehabilitation (92630/33)

Do Not Charge if You Do Not Provide or Do Not Bill These Things to Your Private Pay Patients!

Before charging patients privately for these services, please consult your individual agreement with this entity as well as their policies and guidelines.

"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, as allowed by contract, 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.

THE DECISION TO PARTICIPATE OR TO NOT PARTICIPATE

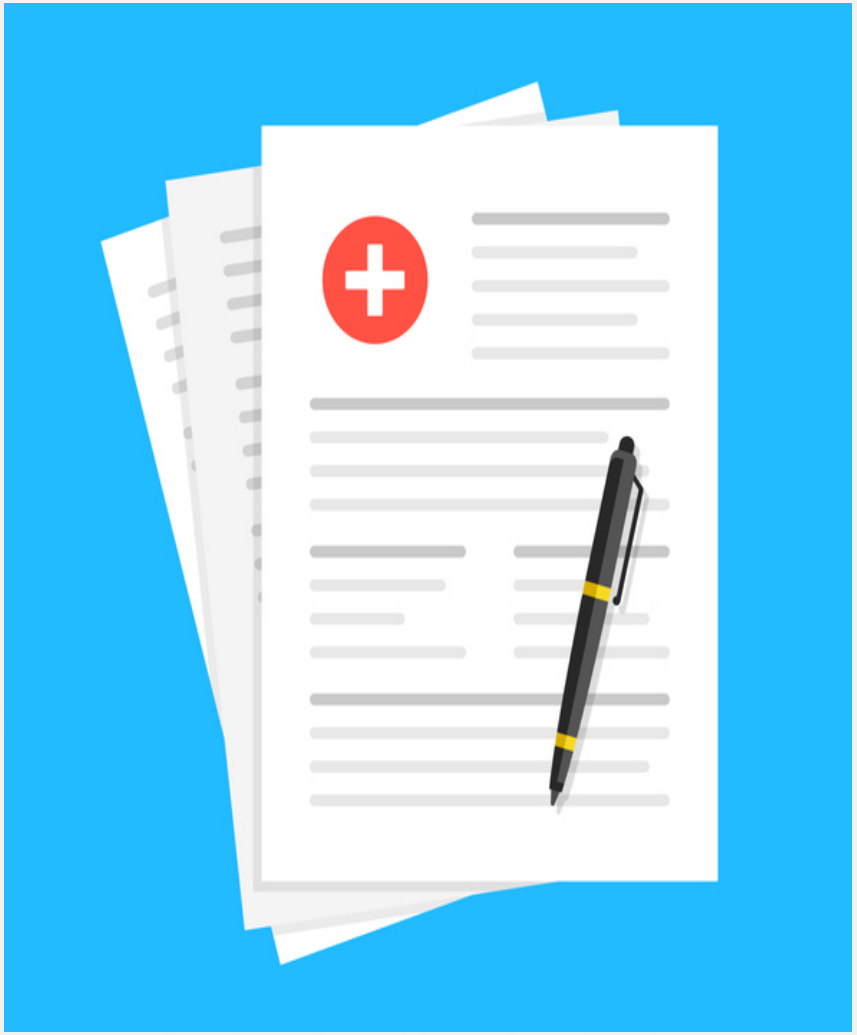
- Can I afford to provide my standard of care, at the agreed upon rates, required by the plan?
- Are there any out of network benefits available if you opt not to participate in the program?
- How many patients (and dollars) do you stand to potentially lose if you do not enroll in the program?
- Can you create a competitive product offering?
  - If you are unbundled and the benefit is unfunded.

BEFORE YOU INITIALLY SIGN ANY MANAGED CARE AGREEMENT…

- Ask questions, in writing, when you lack answers.
  - Don't sign until you get your answers!
- Do not be afraid to try to negotiate.
  - The worse they can do is say "no."
- What are the pros versus cons of contracting with each payer?
- If unsure of some of the contract terms, hire an consultant and/or attorney to assist you.

HOW TO GET ANSWERS FROM TPAS

You only want contract and process questions addressed IN WRITING



TPA COMMUNICATIONS

- Save a copy of the entire agreement, allowable rate schedules and communications with the TPA.
- Pose all questions via email with their professional relations person.
- Clearly clarify, in writing, your rights and responsibilities.
- Determine how you will be notified of substantive changes to the program.

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.
    - Have them come in early to complete forms.

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.

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?
    - Does a deductible apply for this service?
      - Deductibles 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!

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?

INSURANCE VERIFICATION

- Do they have out-of-network benefits? (You ask this if you are an out-of-network provider).
  - Typically do not exist with TPA plans.
- 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?

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).

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.
  - This is a legal document and must be carefully worded.

HOW PRACTICES END UP ANGRY AND 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 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.

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 and reconsider annually as their policies and pricing evolves.
- KNOW your contracts and agreements!
- Nothing is free!
- Collect payment at time of visit.

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!

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.

POLL QUESTION #4

QUESTIONS AND DISCUSSION

THANK YOU

AUDIOLOGYRESOURCESINC

(773) 960-6625

AudiologyResources.com

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