ADA 2023 Coding and Reimbursement Update

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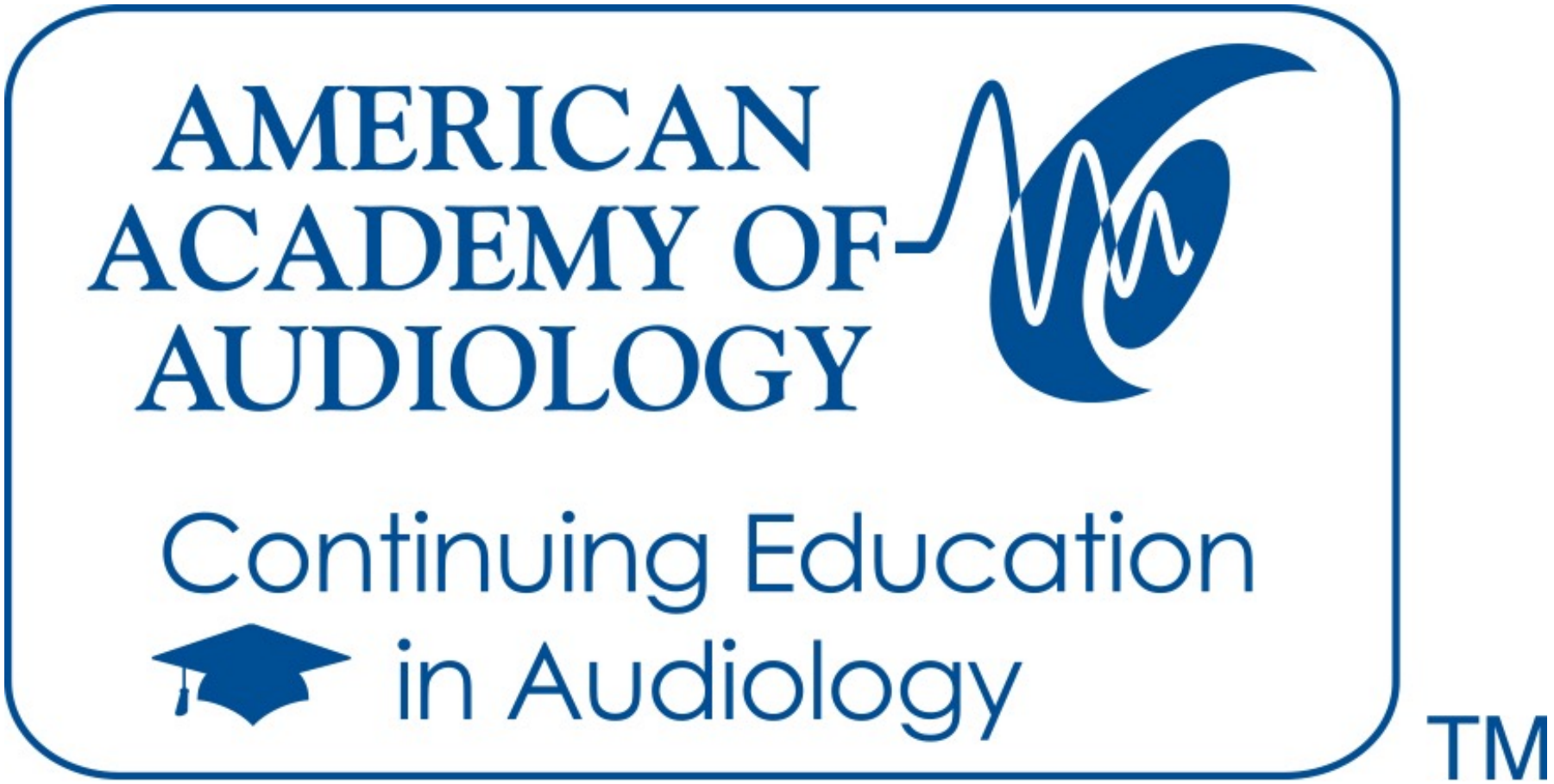
AUDIOLOGY RESOURCES INC.
YOUR GUIDE TO PRACTICE MANAGEMENT SINCE 2001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No Surprises Act/Good Faith Estimate

ADA Member Resources

- https://audiologist.org/resources/communications/in-the-news/item/ada-no-surprises-act-nsa-webinar-and-key-resources-now-available-for-members-on-demand?highlight=WyJnb29kIiwiZmFpdGgiLCJnb29kIGZhaXRoIl0=

No Surprises Act/Good Faith Estimate

https://www.cms.gov/nosurprises

- Audiologists should consult their healthcare attorney for a definitive answer as to their rights and responsibilities for their practice and situation.
- If in an independent contractor relationship, consult legal counsel, specifically an attorney who specializes in healthcare and regulatory matters, as to implications of state and federal surprise billing legislation and have this addressed in any independent contractor agreement.
- All uninsured patients (lack any health plan coverage) must receive a good faith estimate (GFE) prior to the provision of care.
- The estimate must be within $400 of the final bill or it need to be provided again.

No Surprises Act/Good Faith Estimate

If you are an in-network provider:

- Have patient sign an advanced beneficiary notice (ABN; for traditional Medicare only) or notice of non-coverage (NONC), prior to the provision of care, for all non-covered or potentially non-covered services, AND
- Collect all unmet deductibles, applicable co-payments and co-insurance, and the usual and customary rate (UCR) of non-covered services, AND
- Submit claims, for all items and services provided, to the insurer for claims processing OR
- Complete a detailed GFE three days before the items and services are provided.

No Surprises Act/Good Faith Estimate

If you are an out of network provider:

- Have patient sign a notice of non-coverage (NONC), prior to the provision of care, for all non-covered or potentially non-covered services, AND
- Collect UCR for all items and services provided, AND
- Submit claims, for all items and services provided, to the insurer for claims processing OR
- Do not accept assignment on the claim.
- Complete a detailed GFE three days before the items and services are provided.

No Surprises Act/Good Faith Estimate

Hearing Aid Utilization

- Hearing aid patients, who are not being fit with amplification the same day, should always be receiving a GFE (price quote), which outlines evaluation, fitting, and long-term care costs, as well as all non-refundable fees.
  - The bill of sale should also meet all of the legal requirements of your state.
  - The GFE can be avoided ONLY by submitting claims for all covered hearing services to the patient's insurer. In the cases where the patient has insurance, but a specific service/item is not covered, the audiologist should provide a notice of non-coverage.
- Phone triage, during the scheduling process, is invaluable in determining what needs services need to be scheduled and then contained in the GFE.
  - The practice should develop office policies and processes for providing this estimate three days prior to the appointment.

No Surprises Act/Good Faith Estimate

State Implications

- https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act#map
- Some states have their own balance billing regulations that are more stringent than the federal No Surprises Act.

FDA: Establishing OTC

- https://www.fda.gov/news-events/press-announcements/fda-finalizes-historic-rule-enabling-access-over-counter-hearing-aids-millions-americans
- https://www.federalregister.gov/documents/2022/08/17/2022-17230/medical-devices-ear-nose-and-throat-devices-establishing-over-the-counter-hearing-aids

FDA: Establishing OTC

OTC

- “Output limits.
  - We are finalizing lower output limits than we proposed. The general limit will be 111 decibels of sound pressure level (dB SPL), with 117 dB SPL allowable for devices while input-controlled compression is activated.
- Gain limit.
  - We did not propose, and are not finalizing, a separate gain limit.
- Design requirements.
  - We have revised the allowable insertion depth. The most medial (innermost) component of an OTC hearing aid must be reasonably expected to remain at least 10 millimeters (mm) from the tympanic membrane (eardrum). We are also requiring that all OTC hearing aids have a user-adjustable volume control”.

FDA: Establishing OTC

OTC

- "Labeling.
  - We have improved phrasing throughout the labeling to make it more understandable for hearing aid users (non-experts).
- Conditions for sale.
  - We are not requiring age verification for the sale of OTC hearing aids. Prescription hearing aid sales will be subject to the requirements in § 801.109 (21 CFR 801.109), including that they be sold only to or on the prescription or other order of a practitioner licensed by law to use or order the use of (prescribe) the devices (which is as proposed).
- Scope and definitions.
  - Perceived mild to moderate hearing impairment remains the scope of the intended use of OTC hearing aids, and we are declining to require measurements of hearing loss to establish prospective users' qualification to purchase OTC hearing aids.
- OTC category and self-fitting air-conduction hearing aid classification.
  - We are not requiring that OTC hearing aids be self-fitting devices, and we have provided clarification on the difference between customization and fitting.
- Quality System requirements.
  - OTC hearing aids will be subject to the requirements under part 820 (21 CFR part 820), which describes a quality management system appropriate for medical devices".

FDA: Establishing OTC

Prescription

- “Prescription hearing aids are prescription devices and as such, they are subject to § 801.109. Under § 801.109(a), a prescription device is a device that is:
  - (1) either in the possession of a person, or his agents or employees, regularly and lawfully engaged in the manufacture, transportation, storage, or wholesale or retail distribution of such device or in the possession of a practitioner, such as physicians, dentists, and veterinarians, licensed by law to use or order the use of such device and
  - (2) is to be sold only to or on the prescription or other order of such practitioner for use in the course of his professional practice”.

If YOU want to ensure that FDA provisions are appropriately addressed in your State

- Join your State audiology or speech and hearing association.
- Volunteer.
- Donate.
- Join ADA State Leaders Network.
  - Reach out to sczujahewski@audiologist.org.

HIPAA Changes

Look ahead for significant changes in 2023.

- HIPAA created in 2003 and significantly updated in 2013.

Medicare Local Coverage Determinations

Local coverage determinations mean the use of a required ABN.

Local Coverage Determinations by State

- Vestibular and Auditory Testing
  - Novitas
- Cerumen Removal
  - CGS
- Evoked Potentials
  - Novitas
- Intraoperative Monitoring
  - Novitas
  - WPS
- Vestibular Testing
  - First Coast Options
  - Palmetto

2023 Medicare Part B Deductible

$226

Medicare Physician Order Changes

Effective January 1, 2023

- Technically, audiologists can provide non-acute hearing assessment unrelated to disequilibrium or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids once every 12 months without a physician order. This applies to traditional Medicare beneficiaries. Medicare Advantage plans, generally, do not require a physician order (unless specified in your agreement).
- Vestibular Services (92517-92519 and 92537-92549) will <u>always</u> require a physician order for traditional Medicare coverage.

CPT Code	Short Descriptor
92550	Tympanometry & reflex thresh
92552	Pure tone audiometry air
92553	Audiometry air & bone
92555	Speech threshold audiometry
92556	Speech audiometry complete
92557	Comprehensive hearing test
92562	Loudness balance test
92563	Tone decay hearing test
92565	Stenger test pure tone
92567	Tympanometry
92568	Acoustic refl threshold tst
92570	Acoustic immitance testing
92571	Filtered speech hearing test
92572	Staggered spondaic word test
92575	Sensorineural acuity test
92576	Synthetic sentence test
92577	Stenger test speech
92579	Visual audiometry (vra)
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92587	Evoked auditory test limited
92588	Evoked auditory tst complete
92601	Cochlear implt f/up exam <7
92602	Reprogram cochlear implt <7
92603	Cochlear implt f/up exam 7/>
92604	Reprogram cochlear implt 7/>
92620	Auditory function 60 min
92621	Auditory function + 15 min
92625	Tinnitus assessment
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
92640	Aud brainstem implt programg
92561	Aep hearing status deter i&r
92562	Aep thrshld est mlt freq i&r

The list of audiologic procedures that can be provided for non-acute conditions without a physician order once every 12 months.

Medicare Physician Order Changes

- Triage will be invaluable at scheduling to determine the appropriate need for a physician order. You will need to screen the individual for the warning signs of ear disease and any complaint, symptom or condition that is recent (in last 90 days), or which involves disequilibrium (dizziness, vertigo, imbalance) should be referred to a physician or non-physician practitioner, prior to testing, to secure a physician order.
- Audiology practices, especially at the outset, will need to be wary of the use of acute diagnoses such as sudden idiopathic hearing loss, acute otitis media, or vestibular diagnoses (dizziness, labyrinthitis, neuronitis) on claims without a physician order. We recommend you obtain a physician order when receiving a referral from a physician, specifically an otolaryngologist (even if you are employed by the same business entity), for assessment of an acute otologic conditions. In these situations, it is better to err on the side of caution and obtain a physician order, even if you are employed by the same business entity.

Medicare Physician Order Changes

- When the chief complaint is non-acute hearing assessment and unrelated to disequilibrium or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids AND the audiologist is providing one or more of the 36 procedures listed in Table A, the audiologist can assess this patient once per calendar year without a physician order.
- When a physician order is not required and not obtained, no ordering physician will be listed on the claim. Instead, the AB modifier (Audiology service furnished personally by an audiologist without a physician/NPP order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary) must be added to every procedure code performed on that date of service.

Medicare Physician Order Changes

- Generally, the services billed on a traditional Medicare claim, will all either be physician ordered (where the name and national provider identifier of the ordering physician or non-physician practitioner is listed on the claim) or not ordered (non-acute hearing assessment and unrelated to disequilibrium or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids where the AB modifier is added to every item and service listed on the claim). One exception may be when billing for some services to obtain the required Medicare denial. In this case, the GY modifier (item or service statutorily excluded or does not meet the definition of a Medicare benefit) would be added to those items and services which are non-covered by Medicare. Failure to document an ordering physician AND failure to add an AB modifier to every service on a claim (that was provided without an order) will result in a claims denial.
- It is recommended that practices either utilize an Advanced Beneficiary Notice, prior to assessment, or secure a physician referral If their practice has 1) no record of the use of the AB code (and associated testing), by their or another practice within the past 12 months, 2) does not have a physician order AND 3) are planning, as a result of the lack of a physician order, to utilize the AB modifier. Agdin, this is another example where triage at scheduling can be invaluable. We also encourage audiologists to reach out to their Electronic Health Record/Electronic Medical Record (EHR/EMR) vendors to determine what internal verification processes might exist.

Medicare Physician Order Changes

- Practices will need to obtain a physician order for ANY medically necessary procedure on the audiology code list and/or that is listed in Table A once the beneficiary has undergone audiologic testing and utilized the AB modifier, for any service, within the past 12 months.
- This will be a large learning curve for audiologists, their staffs, EHR/EMR vendors, clearinghouses, and Medicare Administrative Contractors (MACs). Education and patience will be important, especially in the first quarter of 2023. Per CMS, in the Final Rule:
- "Aligning our final policy to use modifier AB…necessitates multiple changes to our claims processing systems, which will take some time to operationalize, possibly until mid-year 2023. Until such time, audiologists may use the AB modifier that is available for dates of service on and after January 1, 2023, to provide services/tests to beneficiaries who have directly accessed their services. Audiologists who furnish these services without an order are expected to follow our policy and safeguards built into the AB modifier, as above and in the code descriptor below. As we noted above, we plan to communicate to audiologists via provider education and other guidance, including the Audiology Services webpage page at https://www.cms.gov/audiology-services".

Traditional Medicare Coverage of Hearing Tests

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r84BP.pdf

- "It is appropriate to pay for audiological services for patients who have sensorineural hearing loss and who wear hearing aids if the reason for the test is anything other than evaluation of the hearing aid. For example, there may be a perceived change in hearing or tinnitus that makes testing appropriate and covered. Such testing might rule out other reasons for the symptoms (auditory nerve lesions, middle ear infections) and result in subsequent evaluation of the hearing aid (not covered) or aural rehabilitation by a speech-language pathologist (covered)".
- When a test reveals information that is not known to the physician prior to the test, that information cannot be used to deny payment. For example, a test ordered due to a reported change in hearing may not be denied when the results reveal there is no change in hearing but the audiologist also finds a hearing aid malfunction. However, if no hearing change is reported but the physician is aware that the patient's hearing aid is broken, a test cannot be ordered solely for the purpose of fitting a new hearing aid.
- In general, contractors shall pay for audiological diagnostic tests based on the reason for the test and not on the person who ordered it. However, tests must be "for the purpose of obtaining information necessary for the physician's diagnostic medical evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem". If a physician orders a test but has no appropriate diagnostic or medical use for the results, then the reason for the test may be questioned".

CPT and HCPCS

- There are no 2023 CPT, HCPCS or ICD 10 changes that are significant to audiology.

Deleted CPT Codes

- 92559: Audiometric testing of groups
- 92560: Bekesy audiometry; screening
- 92561: Bekesy audiometry; diagnostic
- 92564: Short increment sensitivity index (SISI)

Modifiers

- AB: Audiology service furnished personally by an audiologist without a physician/NPP order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary.
- XU: Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service.
  - Used when performing 92601-92604 and 92626/7 or 92584 or 92568 on the same patient on the same date of service.

Merit Based Incentive Payment System (MIPS): What We Do Know

No Change for 2023

- Low Volume Threshold (2022)
  - Dollar Amount ($90,000) or
  - Number of Beneficiaries (200) or
  - Number of Covered Professional Services (200)

Are YOU Required to Report in 2023?

CHECK YOUR PARTICIPATION STATUS HERE

2023 Audiology MIPS Measures

- Documentation of Current Medications in the Medical Record
- Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Falls: Plan of Care
- Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness
- Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Elder Maltreatment Screen and Follow-Up Plan

  Already a requirement of many state audiology licensure acts.
- Functional Outcome Assessment
- Falls: Screening for Future Falls Risk*
- Screening for Social Drivers of Health
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

  - *This measure cannot be reported via claims.

OTC and Insurance

OTC implies self-fitting

- Most health plans will not cover OTC hearing aids provided by audiologists.
  - Patients should purchase the OTC hearing aids and submit themselves for reimbursement, even if you are in-network.
  - Aetna covers FDA approved OTC hearing aids.
- The most appropriate code is V5298.

Insurance Card Tips

Types of Coverage

- Traditional Medicare (Part B)
  - No hearing aid coverage.
- Medicare Part C (Advantage)
  - Medicare Parts A, B and supplemental combined.
  - Follows Medicare coverage guidelines.
  - Typically offers access to an unfunded, “discount” hearing aid benefit through a TPN (except in Illinois).
- Medicare Parts E-K (Supplemental)
  - Follows Medicare coverage guidelines.
  - Covers Medicare 20% co-insurance.
  - Typically offers access to an unfunded, “discount” hearing aid benefit through a TPN.

Insurance Card Tips

Types of Coverage

- Medicare Dual
  - Medicare/Medicaid combined.
  - If out of network, can only collect Medicare Limiting charge, less the co-insurance and unmet deductible.
- Medicaid
  - State administered and managed care organization (MCO).
  - Often covers auditory rehabilitation and hearing screenings.
  - Governed by policies.
  - Often requires prior authorization.
- Commercial health plans
  - Often PPO, POS, or HMO.
  - Governed by medical policies.

Know the Medical Policies

Resources

- Many third-party payers do not cover amplification for the treatment of auditory processing or tinnitus in the absence of hearing loss.
- You do not have legitimate coverage if you do not follow the medical policies.
- Look up potential policies for every item and service you offer.
- 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).
  - May be under Anthem, Empire, Excellus, Regence names.
- 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
  - Also search subsidiaries, such as Optum and Oxford, separately.
- VA Community Care
  - https://vacommunitycare.com/provider
  - https://www.va.gov/COMMUNITYCARE/revenue_ops/Fee_Schedule.asp#current

UHC Commercial Medical Policy

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”.

Anthem Commercial Medical Policy

https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html

- "Air conduction hearing aid devices are considered **medically necessary** for the treatment of hearing loss when **ALL** of the following criteria are met (A and B):
- The hearing loss is due to one of the following etiologies:
  - Sensorineural hearing loss; **or**
  - Mixed hearing loss; **or**
  - Conductive hearing loss which has been:
    - unresponsive to medical interventions; **and**
    - unresponsive to surgical interventions or not amenable to surgical correction; **and**
- The degree of hearing loss is confirmed by audiometry or other age-appropriate testing to be greater than or equal to 26 decibels (dB)".

Anthem Commercial Medical Policy

https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html

- "Binaural air conduction hearing aids are considered **medically necessary** when BOTH of the following criteria are met (A and B):
  - Both ears meet the criteria listed above in A and B; **and**
  - Binaural testing shows improved speech recognition using bilateral devices.
- Air conduction hearing aid devices with advanced technology models and features (for example, in-the-ear and in-the-ear-canal models with digital signal processing, directional microphones, multiple channels/memories) are considered **medically necessary** when the technology enhancement is needed to improve the hearing quality for the wearer.
- Replacement of an air conduction hearing aid device that is out of warranty and no longer functioning adequately to support activities of daily living is considered **medically necessary** when the device is malfunctioning and cannot be refurbished or repaired sufficiently to resume its original functionality".

Anthem Commercial Medical Policy

https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html

- "Air conduction hearing aid devices are considered **not medically necessary** when the above criteria are not met.

  Air conduction hearing aid devices with advanced technology models and feature enhancements (for example, in-the-ear and in-the-ear-canal models with digital signal processing, directional microphones, multiple channels/memories) are considered **not medically necessary** when provided solely for the convenience of the wearer or to improve his/her cosmetic appearance.
- Replacement of a currently functional air conduction hearing aid device that is still under warranty for the sole purpose of obtaining a device with updated technology, (commonly referred to as an "upgrade"), is considered **not medically necessary** unless the new updated device will provide a significant functional advantage over the device that was originally issued".
- Upgrade Example: https://providernews.anthem.com/maine/article/billing-for-deluxe-hearing-aids

Federal Employee Health Plans

https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/

- Options exist beyond BCBS.
  - Hearing aid benefits will vary.
- BCBS Standard versus basic
  - The deductible does not apply to the standard plan, but does apply to the basic plan.

Commercial Insurance Tips

Verifying the Hearing Aid Benefit

- Hearing aid benefit or allowance amount.
  - Allowance is dollars “towards”.
  - Fixed dollars.
  - Percentage of allowable.
  - Percentage of dollars billed.
  - “Up to” (allowable rate).
  - Invoice plus.
    - Inclusive.

Commercial Insurance Tips

When does itemization typically help coverage

- Type of hearing aid benefit:
  - Medicaid.
  - State funded plans for special populations.
  - VA Community Care.
  - Vocational rehabilitation.
  - Worker's compensation.
  - Commercial health plan benefits.
    - Percentage of allowable.
    - Percentage of dollars billed.
    - "Up to" (allowable rate).
    - Invoice plus.

Reverification of Benefits

When you must reverify benefits:

- Medicaid
  - Can change monthly.
- At the beginning of each year.
- Change in employment.

What Not To Do

- Do not provide free hearing tests (any aspect of 92557) to some patients and then bill a health plan for the same hearing tests.
  - If the service is free to one individual, it should be free to all individuals. This has been clearly documented (https://www.asha.org/practice/reimbursement/medicare/audiology-medicare-prohibitions-faqs/). The ONLY exceptions are indigence or if your practice were to ONLY bill insured patients (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf).
  - The solution: Bill the patient or their health plan for all services rendered and items dispensed and stop providing free care.
- Do not bill a health plan for hearing aids that have yet to be fit.
  - This is an example of a false claim (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf; https://www.bcbs.com/healthcare-fraud; https://www.uhc.com/fraud/faqs). There are no loop holes around this (i.e. fitting a patient with a loaner or demo set of hearing aids).
  - The solution: Verify coverage and benefits, fit within the hearing aid benefit, applicable medical policies, and coverage allowances and bill hearing aids on the date of dispensing.

What Not To Do

- Do not fit stock hearing aids on a patient and bill the hearing aids to a health plan.
  - Medical necessity for the item being dispensed must be documented in the medical record. Many payers, in their coverage and benefits language, medical policies, or contract language require a manufacturer's invoice be submitted when requested. Also, some health plan's allowable is based upon a percentage of the manufacturer's invoice cost and, as a result, the invoice must be submitted as part of the claims process. This invoice must reflect the actual invoice cost (and not single unit or MSRP), be dated after the date of the hearing aid evaluation and should contain the name of the patient.
  - The solution: Select and order hearing aids for each specific patient from the manufacturer following the communication needs assessment/hearing aid evaluation when a health plan is paying in whole or in part of the item.
- Do not bill a health plan for an item you received at no charge.
  - This is a potential violation of false claims and anti-kickback legislation (https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf) and has been well documented in healthcare (https://www.justice.gov/opa/pr/united-states-settles-false-claims-act-allegations-cochlear-americas-880000; https://www.justice.gov/usao-edmo/pr/united-states-reaches-291288-civil-settlement-dr-sherry-ma-and-aima-neurology-llc).
  - The solution: If the item was free, provide it to the patient for free .

What Not To Do

- Do not bill services provided by unlicensed or non-credentialed provider to a health plan under another provider's national provider identifier.
  - Recent graduates are unlicensed providers. They cannot see any patient, regardless of payer, until they are licensed (unless their state has clear provisional or temporary licensure or privileges, which is not common). The newly licensed and new employees cannot see patients and bill the items and services to a health plan until the audiologists are credentialed providers for the health plan (with few exceptions). Otherwise, this is a false claim (https://www.fbi.gov/scams-and-safety/common-scams-and-crimes/health-care-fraud; https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf).
  - The solution: Do not begin employment as an audiologist until licensure is conferred and do not allow audiologists to see patients where insurance claims are being submitted for covered services until the provider has been credentialed with the health plan.
- Do not market to existing patients that they are "due" or "eligible" for new hearing aids.
  - This can be seen as a solicitation or as potential fraud, abuse or waste when medical necessity for the replacement device has not been clearly documented (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf). Some health plans, including most state Medicaid programs, have medical policies that clearly require documentation of medical necessity (not just that the eligibility date has arrived) for replacement devices (https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_c185384.html).
  - The solution: Recommend, fit and bill health plans for replacement hearing aids when it is medically reasonable and necessary to replace existing hearing aids.

What Not To Do

- Do not assume an item or service is non-covered just because the treatment plan includes hearing aids and, as a result, charge the beneficiary privately for the service.
  - While Medicare does not cover "examination for the purpose of prescribing, fitting, or changing hearing aids" or "routine" services (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf), coverage of audiometric testing is not automatically precluded JUST because the patient is a hearing aid user or because the treatment plan includes hearing aids. The Update to Audiology Policy (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r84BP.pdf) indicated: "It is appropriate to pay for audiological services for patients who have sensorineural hearing loss and who wear hearing aids if the reason for the test is anything other than evaluation of the hearing aid. For example, there may be a perceived change in hearing or tinnitus that makes testing appropriate and covered. Such testing might rule out other reasons for the symptoms (auditory nerve lesions, middle ear infections) and result in subsequent evaluation of the hearing aid (not covered) or aural rehabilitation by a speech-language pathologist (covered)". So, in other words, if the testing is physician ordered and medical necessity has been documented, Medicare will cover the testing. The patient should not be held financially responsible.
  - The solution: Allow the patient to access their health plan benefits by reviewing the patient's case history, documenting medical necessity for the services provided, and billing the health plan for medical necessary services.

What Not To Do

- Do not uniformly upgrade hearing aid technology from a basic or standard item to a deluxe item without documentation of medical necessity for the deluxe item, without first offering a patient a standard item within their benefit, without having the patient acknowledge, in writing, their rights and responsibilities prior to dispensing, and, most importantly, without ensuring that the health plan contractually allows for upgrade.
  - Every health plan does not allow for upgrade from a standard item to a deluxe item. As a result, the audiologist could be violating their payer agreement by having the beneficiary pay, privately, for anything other than unmet deductible, applicable co-insurance or co-payments, or for prior notified non-covered services. This capacity for upgrade is determined by the health plan and your agreement with that health plan. If the health plan does not allow for an upgrade, the patient is not allowed to upgrade.
  - The solution: The practice needs to educate themselves on each payer agreement and medical or payment policies, create verification processes and policies and implement upgrade forms and processes.

What Not To Do

- Do not fit hearing aids on normal hearing individuals and bill the health plan, unless explicitly allowed by medical policy.
  - Many health plans, including state Medicaid programs, Aetna and Tricare, have degree of hearing loss requirements for hearing aid coverage and/or have medical policies restricting coverage of hearing aid for treatment of tinnitus or auditory processing disorders or for hearing protection purposes (for example https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html, https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html, and https://www.tricare.mil/CoveredServices/IsItCovered/HearingAids#:~:text=TRICARE%20doesn't%20cover%20hearing,aids%20through%20other%20government%20programs.).
  - The solution: When the audiologist is in-network provider, the provider should educate themselves on the contracts terms and applicable medical policies governing coverage.
- Do not bill health plans differently than you bill your private pay patients for the same items or services.
  - Billing in excess of your usual and customary rate to a health plan can be construed as abuse (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf).
  - The solution: Bill insurance the same rate as you bill your general population for the same item or service.

- Kim Cavitt will be traveling from December 17, 2022 through January 22, 2023.
- She will be unable to accept phone calls or schedule video meetings during this time frame.
- She will available via text, Facebook message, or email during much of this trip.

Questions?

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