Solutions for the Most Common and Problematic Coding and Reimbursement Issues

Kim Cavitt, AuD
Audiology Resources, Inc.

Indiana Speech and Hearing Association
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CPT Tips

- Always have the coding legitimately represent all of the procedures that were completed on each individual patient on a given date of service
- Make sure you are using the most up to date codes
- Make sure you have a 2013 CPT Manual in your office
- It is legitimate to bill for attempted procedures with the appropriate documentation
- Use modifiers when needed

Use of 92700

- To classify procedures that do not have CPT codes
- Individually reviewed
- ABN required
- If reporting 92700, submit report with:
  - Copy of Patient Report
  - Description of procedure
  - Clinical Utility of the Procedure
  - Time
  - Skills of Tester
  - Equipment used
  - Benefit to patient
  - Usual and Customary Fee

Modifiers

- -22: Increased procedural service
  - Some examples to consider are clicks and tone burst ABR, middle and late latency response ABR, high frequency audiometry
  - Could select 92700 instead
- -33: Preventative service
  - When billing for follow-up newborn hearing screening only

Modifiers

- -52: Reduced service
  - Only tested one ear
  - Did not meet all of the components of a code
- -59: Distinct procedural service
  - Use when unbundling portions of a bundled code, such as 92540 or 92557

Modifiers

- -RT: Right ear
- -LT: Left ear
  - Use with hearing aids, cochlear implants, and auditory osseointegrated devices

Modifiers

- -GA: Required waiver of liability on file
  - Required ABN completed
    - Order in place but medical necessity not met
    - Testing frequency outside the norm
    - Use of 92700
    - Local coverage determination in place

Modifiers

- -GX: Voluntary waiver of liability on file
  - Voluntary ABN completed
    - Routine or annual audiologic testing where medical necessity was not met
    - Hearing aids or testing for the sole purpose of obtaining a hearing aid
    - Treatment services such as cerumen removal, canalith repositioning, tinnitus management and aural rehabilitation
    - Tinnitus maskers and devices
    - Evaluation and Management codes
    - Audiologic and/or vestibular testing where a physician order was not obtained prior to testing
    - Audiologic evaluations that were the result of solicitation (i.e. reminder cards, marketing events)
    - Audiologic and/or vestibular testing that was completed by a student in the absence of 100% personal supervision by an audiologist or physician
    - Audiologic testing that requires the skills of an audiologist or physician but was completed by a technician
    - Screenings

Modifiers

- -GY: Item or service statutorily excluded or does not meet the definition of a Medicare benefit
  - You want a Medicare denial
  - Used with –GX modifier only

ICD10: A Preview

- Scheduled to go into effect October 1, 2014
- HIPAA 5010 was created to allow for ICD10 conversion

Differences between ICD9 and ICD10

- 69,000 plus codes
- Addition of information
- Expanded injury codes
- Creation of diagnostic/symptom codes
- Code length up to 7 characters
- Greater specificity allowed
- V and E codes changed to 7 character code
- Alphanumeric (except letter U)

Purpose of ICD10

- Establishes medical necessity
- Translates written terminology and descriptions into universal, common language used over most of the world
- Provides data for statistical analysis

What You Need To Know About ICD 10 Today….

- Your practice needs to be HIPAA 5010 compliant NOW
- You need to read the e-blasts from the national associations you are a member of to keep abreast of changes in compliance and educational opportunities
- You will need to educate your self in 2013/14 at the latest

What You Need To Know About ICD 10 in 2014:

- You and your entire staff will need to be fully educated
- Purchase needed software or manuals
- Avoid "crosswalk" materials
  - Look up each code you use in ICD9 and look up the equivalent codes for ICD10 YOURSELF
- Create a encounter form that contains the new codes

HCPCS Tips

- V codes represent hearing aid assessment, devices, parts, accessories, earmolds, batteries, ALDs, and services
- No code for any tinnitus devices or maskers, streamers
- There are some "duplicates" across CPT and HCPCS codes
  - V5010 vs. 92590/1
  - V5014 vs. 92592/3 and 92594/5

HCPCS Tips

- Use the code covered in your insurance contract, which has the highest reimbursement in your fee schedule, or which is required by the insurance benefit
- In order to utilize all of the HCPCS codes, practices must create an unbundled hearing aid cost package for use with certain carriers.
- Do not forget all of the codes that would encompass this unbundled pricing package.
- Remember, there is one code for each type of aid (digital BTE, monaural) and it does not take into account level of technology

Pediatric Testing

- Can bill for testing that is attempted if:
  - What happened?
  - Why were you unable to complete the testing?
  - Did you spend at least half of the typical test time attempting the procedure?
  - Documentation is key!
- There are no "method" codes

Examples of Pediatric Test Situations: Child Less Than Two Years

- VRA (92579) in soundfield
- OAEs (92587)
- ABR (92585)

Examples of Pediatric Test Situations: Child Less Than Two Years

- Maybe…
  - Pure-tone, air (92552)
  - Tymps and reflexes (92550)
  - SAT (92555)
    - If point to body parts
  - Pure-tone, air (92552) under headphones using VRA
    - Separate procedure

Examples of Pediatric Test Situations: Child Two to Five Years

- Conditioning play audiometry (92582)
- Select picture audiometry (92583)
- OAEs (92587)

Examples of Pediatric Test Situations: Child Two to Five Years

- Maybe….
  - Tymps and reflexes (92550)

CAPD

- Very hard to do if participating with third-party payers
- CAPD evaluation (92620/1)
- Treatment (92507 versus 92633)
  - 92507 cannot be used with Medicare
  - Know your contract terms and fee schedules
- Team meeting with patient (99366) and team meeting without patient (99368)
- Evaluation and management codes

Vestibular Assessment

- Basic vestibular evaluation (92540)
  - Gaze (92541)
  - Positionals, minimum of four positions (92542)
    - Hallpike testing is a position
  - Optokinetic (92544)
  - Oscillating tracking (92545)
- Caloric testing, per irrigation (92543 x 4)

Vestibular Assessment

- Positional testing, without recording (92532)
  - Could be used for Hallpike in isolation
- Rotational testing (92546)
  - Must have a rotational chair
- Use of vertical electrodes (92547)
  - For ENG only (except in Florida)
- Dynamic posturography (92548)
  - Need a platform
- Saccades or use of goggles (92700)

Auditory Osseointegrated Device

- Need pre-determination in writing if not clearly listed as a benefit on the patient's contract
- Candidacy testing, if completed (92626)
- L8690 (implantation with surgery) vs. L8692 (without surgery)
- Fitting (L8699)
  - Patient pays this amount on the date of the device fitting
- Troubleshooting/service (L9900)

CI Candidacy

- Audiogram (92557)
- Tymps and reflexes (92550)
- ABR (92585)
- OAEs (92587 or 92588)
- Caloric testing, per irrigation (Calorics x 2)
- Evaluation of A/R status (92626/7)
- Team meeting with patient (99366) versus team meeting without patient (99368)

CI Surgery

- Intraoperative Monitoring (95920 and 92585)

CI Initial Tune-up

- Programming (92601 if less than 7 years or 92603 if 7 years or older)
- Testing (92626)

CI: Everything Else

- Re-programming (92602 or 92604)
- Testing (92626)
  - Must spend at least 30 minutes or add a -52 modifier
- Troubleshooting/service (L9900)
  - Suggest patient be billed and pay privately
- Recommend you send patients to manufacturer for supplies
  - More time to bill and collect than you actually receive
  - L codes exist

Cerumen Removal

- Impacted (69210)
  - Can bill Medicare patients privately
    - Voluntary ABN
  - Consult your contract for guidance with other payers
- Non-impacted (92700)
  - Inclusive to audiogram if performed on same date of service for Medicare
  - Can bill Medicare patients privately if done on a separate date of service
  - Consult your contract for guidance with other payers
    - Voluntary ABN

Tinnitus Management

- Very hard to do if participating with third-party payers
- Medicare does not cover tinnitus maskers
  - Medicare patients are financially responsible for costs
  - Consult payer guidance for private insurers
  - V5299
- Tinnitus rehabilitation (92700 versus 92633)
  - Consult payer guidance for private insurers
  - Medicare patients are financially responsible for costs

Aural Rehabilitation

- 92630 or 92633
  - Medicare beneficiaries are financially responsible for the costs
  - Consult payer guidance for private insurers

Facts About Documentation

- Think beyond the ear…
- If it is not documented, it did not happen
- An audiogram in and of itself does not constitute sufficient documentation, specifically as it relates to medical necessity
- Needs to be complete and legible
- It needs to be dated
- Must document name and professional identity

Medicaid

- Varies greatly state by state
  - Know the guidelines and follow it!
  - http://provider.indianamedicaid.com/general-provider-services/manuals.aspx
  - Medical necessity always applies here
- Ask yourself why are you participating????
- Medicaid is NOT a revenue generating business!
- Know how to handle non-covered services and do not provide them for free!

CMS Audiology Policies

- Update to Audiology Policies
  - October, 2008
- Revision and Re-Issuance of Audiology Policies
  - September, 2010
- ABN
  - January, 2012
- PQRS

CMS Audiology Policies

- "Incident to billing"
- Required physician orders
- Treatment services
- Supervision requirements
- Computerized audiometry
- Role of technicians and their supervision requirements
- Role of students, including but not limited to, the final year extern and their supervision requirements
- Medical necessity
- Billing of technical and professional components
- Use of 92700
- Opt out provision
- Billing in comprehensive outpatient rehabilitation facility
- Mandatory claims submission

Medical Necessity

- "Under any Medicare payment system, payment for audiological diagnostic tests is not allowed by virtue of their exclusion from coverage in section 1862(a)(7) of the Social Security Act when:
  - The type and severity of the current hearing, tinnitus or balance status needed to determine the appropriate medical or surgical treatment is known to the physician before the test; or
  - The test was ordered for the specific purpose of fitting or modifying a hearing aid".

Medical Necessity

- "Examples of appropriate reasons for ordering audiological diagnostic tests that could be covered include, but are not limited to:
  - Evaluation of suspected change in hearing, tinnitus, or balance;
  - Evaluation of the cause of disorders of hearing, tinnitus, or balance;
  - Determination of the effect of medication, surgery, or other treatment;
  - Reevaluation to follow-up changes in hearing, tinnitus, or balance that may be caused by established diagnoses that place the patient at probable risk for a change in status including, but not limited to: otosclerosis, atelectatic tympanic membrane, tympanosclerosis, cholesteatoma, resolving middle ear infection, Meniere's disease, sudden idiopathic sensorineural hearing loss, autoimmune inner ear disease, acoustic neuroma, demyelinating diseases, ototoxicity secondary to medications, or genetic vascular and viral conditions;
  - Failure of a screening test (although a screening test is non-covered);
  - Diagnostic analysis of cochlear or brainstem implant and programming; and
  - Audiology diagnostic tests before and periodically after implantation of auditory prosthetic devices".

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Documentation

- "Documentation for Orders (Reasons for Tests).
  - The reason for the test should be documented either on the order, on the audiological evaluation report, or in the patient's medical record. (See subsection C. of this section concerning reasons for tests.)
- Documenting skilled services. When the medical record is subject to medical review, it is necessary that the record contains sufficient information so that the contractor may determine that the service qualifies for payment. For example, documentation should indicate that the test was ordered, that the reason for the test results in coverage, and that the test was furnished to the patient by a qualified individual.
  - Records that support the appropriate provision of an audiological diagnostic test shall be made available to the contractor on request".

Physician Order Requirements

- Needed for each incident of care
- Does not guarantee medical necessity
- Should state "audiologic and/or vestibular evaluation"
  - Should avoid the term "hearing aid"
- For audiologists, tests do not need to be individually listed
- Delivery methods:
  - Hand delivered, faxed or mailed
  - E-mailed
  - Telephone
    - Avoid this option

Audiology Physicians Quality Reporting System (PQRS)

- PQRS is a program designed to improve the quality of care to Medicare beneficiaries.
- Audiologists who bill Medicare Part B beneficiaries must participate in 2013 to avoid deductions in reimbursement in 2015.

How PQRS works…

- Audiologists can begin any time
- Until December 31, 2014, a 0.5% bonus will be given for all Medicare eligible cases when reporting on 50% of eligible measures

What Happens in 2015 Matters Now…

- Beginning January 1, 2015, the voluntary incentive program is slated to end and a reimbursement adjustment will be made if eligible professionals (such as audiologists) do not report on at least one PQRS measure.
- The 2015 reduction is based on reporting in 2013
  - In 2015, the reduction is 1.5% of all 2013 eligible claims
  - In 2016, the reduction is 2.0% of all 2014 eligible claims

Are There Quality Measures That Audiologists Can Report On?

- Measure #188: Congenital or traumatic deformity of the ear
- Measure #261: Referral for otologic evaluation for patients with acute or chronic dizziness
- Measure #130: Documentation and verification of current medications in the medical record
- Measure #134: Screening for clinical depression and follow-up plan
  - Avoid reporting this one

Eliminations

- Measures #189 (active drainage) and #190 (sudden or rapidly progressive hearing loss) will be permanently retired in 2013.
- **Do not report on these measures as of January 1, 2013!**

How Would An Audiologist Report On These Measures?

- These measures are reportable via the CMS 1500 claim form or your electronic billing system. The audiologist would add Medicare directed, CPT Category II or G-Codes, which are available in the HCPCS system, to the claim to report the measures to CMS. These codes must be reported on the same claim as the patient diagnosis and diagnostic procedure to which the PQRS code applies.

How Does Participation Work?

- The audiologist must be a Medicare provider. This means that in addition to having one's own NPI number, the audiologist must have completed the Medicare form 8551 for formally registering with Medicare as a provider and, if necessary, an 855R form to inform Medicare where regular payments should be directed.
- The incentive payment is calculated after the end of the year based on all qualifying claims submissions throughout the year.

Why Is PQRS Important For Audiology?

- PQRS is important for many reasons
  - Focuses audiology's place in the Health Care arena
  - Recognizes audiology as providing significant influence on the quality of health care we provide
  - Offers 0.5% bonus payment on the qualifying submitted procedures at year end for 2013 and 2014
  - Accepted measures focus on problems and disorders that go beyond routine issues and focus on those that have significant impact on long-term outcomes and quality of life.

PQRS Reporting Step #1: Review the Measures and Their Codes

- Measure #188: Congenital or traumatic deformity of the ear
- Measure #261: Referral for otologic evaluation for patients with acute or chronic dizziness
- Measure #130: Documentation and verification of current medications in the medical record
- Measure #134: Screening for clinical depression and follow-up plan
  - Avoid reporting this one

PQRS Reporting Step #2: Review the Codes for Each Measure

- Each measure is reportable via the CMS 1500 claim form using the International Classification of Diseases Ninth Revision, Clinical Modification (ICD-9-CM) codes, Current Procedural Terminology (CPT) codes, and G-codes.
  - CPT Codes
    - Indicate the procedure performed on the patient.
    - This is what drives whether or not you report a measure.
    - Represents the measures' *denominator (the eligible patients for a measure) in conjunction with the ICD-9-CM codes.*
  - ICD-9-CM codes
    - Indicate the diagnosis of the patient.
    - Represent the measures' *denominator (the eligible patients for a measure) in conjunction with CPT codes.*
  - G-Codes
    - Represents the measures' *numerator (action required by the measure for reporting and performance) as well as when the action does not occur because the patient fits into the denominator exclusion (patient that fits into the denominator but is not eligible for the measure).*
    - Some measures have CPT Category II codes to represent the numerator as well as when the action does not occur because the patient fits into the *denominator exclusion. When there are no CPT Category II codes for a measure, CMS creates temporary G-codes.*

Codes for Referral for Congenital or Traumatic Deformity of the Ear

- **CPT Codes**
  - 92550, 92557, 92567, 92568, 92570, 92575
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - 744.01, 744.02, 744.03, 744.09, 380.00, 380.01, 380.02, 380.03, 380.10, 380.30, 380.31, 380.32, 380.39, 380.51, 380.81, 380.89, 380.9
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

Codes for Referral for Congenital or Traumatic Deformity of the Ear

- G8556
  - *Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation*
- G8557
  - *Referral not performed because patient is not eligible (denominator exclusion) (e.g., patients for whom an assessment of the congenital or traumatic deformity of the ear has been performed by a physician (preferably a physician with training in disorders of the ear) within the last 6 months, patients who are already under the care of a physician (preferably a physician with training in disorders of the ear) for congenital or traumatic deformity of the ear, etc.*
- G8558
  - *Referral not performed, but reason not specified.*

Codes for Referral for Acute or Chronic Dizziness

- **CPT Codes**
  - 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - 780.4 OR 386.11
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

Codes for Referral for Acute or Chronic Dizziness

- G8856: Referral to a physician for otologic evaluation
- G8857: Patient is not eligible for the referral for otologic evaluation (i.e. patients who are already under the care of a physician for acute or chronic dizziness)
- G8858: Referral to a physician for an otologic evaluation not performed, reason not specified

Codes for Documentation of Current Medications

- **CPT Codes**
  - 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - None specified (so all included)
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

Codes for Documentation of Current Medications

- G8427: List of current medications (includes prescription, over the counter, herbals, vitamin/dietary supplements) documented by the provider, including drug name, dosage, frequency, and route
- G8430: Provider documentation that patient not eligible for medication assessment
- G8428: Current medications (includes prescription, over the counter, herbals, vitamin/dietary supplements) with drug name, dosage, frequency, and route not documented by provider, reason not specified

Codes for Screening of Clinical Depression

- **CPT Codes**
  - 92557, 92567, 92568, 92625, 92626
  - Patients that have any of these CPT codes (as well as the ICD-9-CM codes above) fit into the measure's *denominator (the eligible patients for a measure)*
- **IDC-9 Codes**
  - None specified (so all included)
  - Patients that have any of these IDC-9-CM codes (as well as CPT codes below) fit into the measure's *denominator (the eligible patients for a measure)*

Codes for Screening of Clinical Depression

- G8431: Positive screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented
- G8510: Negative screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented
- G8433: Screening for clinical depression using an age appropriate standardized tool not documented, patient not eligible/appropriate
- G8432: No documentation of clinical depression screening using an age appropriate standardized tool
- G8511: Positive screen for clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified

PQRS Reporting Step #3: Fill Out the HCFA 1500 Claim Form

- A sample 1500 claim form is available on the CMS Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2012PQRSMadeSimple_PrevCareMGs_PMBR_01-30-2012_508.pdf.
  - ICD-9 codes are placed in box 21
  - CPT codes are placed in box 24D
  - G-codes are placed in box 24D following the CPT code

MOST IMPORTANT THING TO NOTE:

- **<u>Do not recommend any reporting of the Screening of Clinical Depression Codes</u>**
  - This screening may or may not be within your state defined scope of practice
  - Audiology community is working to get Audiology removed from this measure.

MOST IMPORTANT THING TO NOTE:

- **EVERYTIME** YOU PERFORM 92557 ON A MEDICARE PART B PATIENT THERE IS AT LEAST ONE MEASURE TO REPORT ON!!!!
- **THIS IS REGARDLESS OF THEIR CHIEF COMPLAINT AND CASE HISTORY**

MOST IMPORTANT THING TO NOTE:

- **EVERYTIME** YOU PERFORM 92540 AND YOUR REPORT DIZZINESS OR BPPV ON A MEDICARE PART B PATIENT THERE IS AT LEAST ONE MEASURE TO REPORT ON!!!!
- **THIS IS REGARDLESS OF THEIR CHIEF COMPLAINT AND CASE HISTORY**

PQRS Reporting Step #4:
Make Sure You Meet the CMS Minimum Reporting Requirements

- CMS requires that PQRS participants report on at least 50% of eligible patients to be eligible for the **incentives** in 2013 and 2014.
  - Therefore, an audiologist would need to report on 50% of the patients they see that fit into any of the available measures

PQRS Reporting Step #4:
Make Sure You Meet the CMS Minimum Reporting Requirements

- CMS requires that PQRS participants report on at least one measure in 2013 and 2014 to not be penalized in 2015 and 2016.

Billing 101: The Facts

- Providers complete the testing, write the report and fill out the superbill
- Someone has to collect patient responsibility on the date of service
  - Billing costs YOU money!!!
- Office staff takes the superbill information, submits the claim, and monitors payment

Billing 101: The Facts

- Claims should be posted within two business days
- Payments should be posted daily
- No one should be able to write off sums over $100 other than the manager or owner
- Stop seeing patients who owe you money

Billing 101: The Facts

- You must invest in staff training and materials
  - Office management or billing software
    - The days of paper claims are almost over!!!
  - Manuals
  - Training
- You must have consistent, no exceptions financial policies
  - STOP GIVING IT AWAY!!!!
  - Should be in writing and available

Billing Checks and Balances:

- Owners and managers, regardless of your work setting, must monitor accounts receivable and accounts payable
  - Monthly, at a minimum
  - Collect patient responsibility on date of service
    - Credit card on file is an option as well

Facts by Insurance

- Other than Medicare, you are a VOLUNTARY participant in managed care
- Must be credentialed before you can bill a payer as an in-network provider
  - Otherwise, you are an out-of-network provider and patient should pay in full for any item or service they receive on the date the item or service is provided
  - The patient should be informed of your network status (as it pertains to their insurance) prior to making an appointment and be informed of their financial obligations

CAQH

- Credentialing clearinghouse
- Free
- http://www.caqh.org/
- To participate:
  - Must be a contracted provider with a least one of the CAQH participating payers
  - Must be invited by CAQH once registered

Provider Agreement from Payer

- Read the entire agreement and review the fee schedule
  - Things to consider:
    - Does it allow for balance billing or patient upgrades for hearing aids?
    - Termination terms
    - Renewal terms
      - "Evergreening" of contract
    - Medical necessity
    - Means of provider notification of substantive changes to the agreement
    - Claims filing requirements
    - Requirements related to consistency in pricing and policies
    - Clinic hour requirements
    - Does the fee schedule address all of the items and services you provide?

Third-Party Payer Fee Schedule

- What the payer allows, per contract, for each specific item and service you provide
  - Never accept less than you can afford
    - Do the benefits outweigh the costs
  - Be careful of:
    - Large hearing aid discounts
    - Invoice plus arrangements
    - Requirements to provide the manufacturer invoice
  - Sometimes it is a better business decision to be out-of-network providers

Third-Party Reimbursement

- Know the terms of your third-party contracts and fee schedules
- Good reimbursement begins and ends with you
  - Starts from the minute the patient calls
- Accountability is key
- Verification is required EVERYTIME!
  - Have to ask the right questions
  - Hearing aids
  - BAHA
  - Cochlear implants

Before You Sign a Payer Contract…

- Make a copy of the entire contract and fee schedule and SAVE IT
- Ask questions when you lack answers
- Do not be afraid to negotiate
  - The worse they can do is say "no"
- What are the pros versus cons of contracting with this payer?
- If unsure of some of the contract terms, hire an consultant and/or attorney to review

The Down Low on Waivers/Patient Notification

- CANNOT USE IF NOT ALLOWED BY CONTRACT!!!
  - Otherwise, you will be in violation and, if a patient pushes back, you will have to refund them
  - Think about ethics here
- Patient Notification
  - Use to notify and bill patient for non-covered services
- Upgrade Waiver
  - BCBS
  - Must provide an aid (standard) at no charge to patient
  - Patient can upgrade if they so choose and pay the difference between the allowable and usual and customary

The Down Low on Waivers/ Patient Notification

- Insurance Waiver
  - Patient waives their insurance benefit
  - They do not bill their insurance and you do not bill their insurance
  - Rarely happens

Hearing Aid Verification Scenarios:

- **Scenario 1: You contact the third-party payer and completes the insurance verification form in full. Per the third-party payer, you are allowed to balance bill the patient for the difference between the insurance coverage/allowable amount and the your usual and customary charge.**
  - **This one is easy!!!**

Scenario 2: You contact the third-party payer and complete the insurance verification form in full. Per the third-party payer, you are not allowed to balance bill the patient for the difference between the insurance coverage/allowable amount and your usual and customary charge.

- You must restrict product cost to an aid whose invoice cost is less than $250-350 per aid maximum.
- The patient has no out of pocket expense in this scenario (except for unmet co-pays or deductibles).
- You must accept the negotiated rate as payment in full.

Scenario 2: Continued

- I strongly encourage you to be honest with the patient about the situation (i.e. "the negotiated rate is less than my cost for more advanced products").
- The patient then has three options:
  - Get a more basic hearing aid(s) paid in full by their third-party payer. This is what most patients prefer.
  - Refer the patient to a third-party administrator you is contracted with, such as HearPO or Epic, that IS a contracted provider for this plan, is allowed to bill the funded portion of their plan and is also allowed to balance bill the patient.
  - Go elsewhere and try to find another provider who will do this for them (in many cases out of network providers would be allowed to balance bill the patient).
  - Have the patient sign a completed insurance waiver. In this case, they are waiving their insurance coverage and you, as the provider, will not be submitting a claim to their carrier. Please ensure that the patient gets an original copy of their bill or sale and the insurance waiver in the event they attempt to bill their carrier themselves.
- If the patient proceeds with Option #1, the patient should pay any co-insurance amounts (based upon usual and customary rates) and deductible amounts (up to the usual and customary cost of the aids) on the date of the fitting.

Scenario 2: Continued

- Do not discount aids billed to third-party carriers. Have all marketing provide a disclaimer to this effect.
- Please ask the third-party payer if you are to bill "usual and customary" or MSRP for this case.
- Consider unbundling the charges as it may push about $200-300 to patient responsibility. Have the patient pay the cost of the hearing aid evaluation and earmold at the date of fitting.
- If a carrier states that they pay a "maximum of x dollars" but do not specifically define a benefit amount, assume the $500 rule as, on many occasions, they will not actually pay the maximum (the maximum would typically apply to a digital CIC).

Scenario 3: You contact the third-party payer and completes the insurance verification form in full. The carrier states that either the dispensing fee and/or hearing aid evaluation can be billed as a separate charge and/or they request that the claim be submitted unbundled.

- The patient should also pay any co-insurance amounts (based upon usual and customary rates) and deductible amounts (up to the usual and customary cost of the aids) on the date of the fitting.
- You need to unbundle the cost of the hearing aid in this situation. You can unbundle differently for different payers, based upon what is allowed in each contract, as long as the total package always equals the same amount!

Scenario 3: Continued

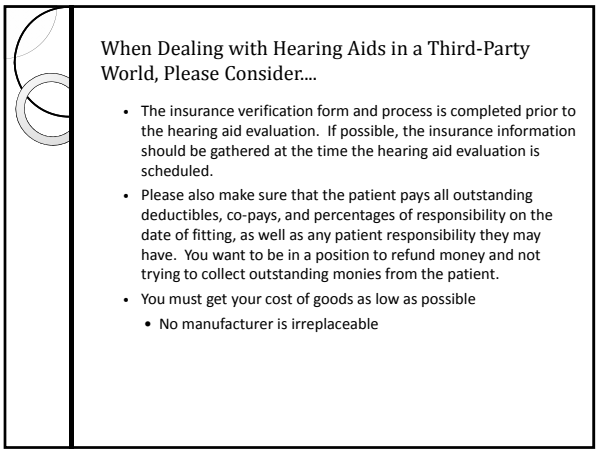
- Hearing aid (V5…)
- Dispensing Fee (V5…; if allowed)
- Hearing aid evaluation (92590/1)
- Hearing aid check (92592/3)
- Electroacoustic analysis of aid (92594/5; if performed)
- Fitting and Orientation of aid (V5011)
- Conformity Evaluation (V5020; if performed)
- Earmold, if applicable (V5264)
- Earmold Impression, if applicable (V5275)
- Batteries (V5266)
- Accessories (V5267; if provided)

Scenario 4: You contact the third-party payer and completes the insurance verification form in full. Per the third-party payer, you are not allowed to balance bill the patient for the difference between the insurance coverage amount and your usual and customary charge AND the reimbursement is a percentage of the dollars billed (50%, for example).

- The patient has no out of pocket expense in this scenario (except for unmet co-pays or deductibles). You must accept the negotiated rate as payment in full.
- The patient should also pay any co-insurance amounts (based upon usual and customary rates) and deductible amounts (up to the usual and customary cost of the aids) on the date of the fitting.
- Restricting the product is of no use in this scenario. You just need to ensure that your cost of goods is low and your usual and customary charge is high enough so that you can make a profit.
- Unbundling should be evaluated but, in some situations, may result in diminished overall reimbursement.

Scenario 4: Continued

- Please ask the third-party payer if you are to bill "usual and customary" or MSRP for this case. Please ask the third-party payer if you can bill separately for the hearing aid evaluation and earmold, if applicable.
- Try to negotiate a special price for these patients with your hearing aid vendors for these cases.
- If a carrier states that they pay a "maximum of x dollars" but do not specifically define a benefit amount, assume the $500 rule as, on many occasions, they will not actually pay the maximum (the maximum would typically apply to a digital CIC).
- Do not discount aids billed to third-party carriers. Have all marketing provide a disclaimer to this effect.


When Dealing with Hearing Aids in a Third-Party World, Please Consider....
• The insurance verification form and process is completed prior to the hearing aid evaluation. If possible, the insurance information should be gathered at the time the hearing aid evaluation is scheduled.
• Please also make sure that the patient pays all outstanding deductibles, co-pays, and percentages of responsibility on the date of fitting, as well as any patient responsibility they may have. You want to be in a position to refund money and not trying to collect outstanding monies from the patient.
• You must get your cost of goods as low as possible
• No manufacturer is irreplaceable