Practice Management Specialty Meeting Office Personnel Workshop

What Is Insurance?
- Mechanism for Reimbursement
- Not a Mechanism of Payment
- Third party contract between the insurance carrier and the patient ONLY!

Insurance...
- should be paid for by the government ensuring “health care for all”
- for Medicare patients should change from age 65 to 72
- there should be a financial “means” test with the government subsidizing premiums
- is not necessarily for everyone... it is survival of the fittest

Types of Insurance Plans
- Public Health Plans
- Military Health System
- Individual, Small & Large Group Plans

HMO, POS, PPO, etc.
- Health Maintenance Organization (HMO): Traditionally “managed” by a gatekeeper, usually the Primary Care Provider (PCP)
- For the patient to see a specialist, a referral may be needed from the PCP
  - Some plans require a referral per visit
  - Some are good for one year of service
  - Some are eliminating the requirement

HMO, POS, PPO, etc. (cont’d)
- Point-of-Service (POS)
  - Mimics HMO plans
  - Patients have a greater choice in seeking out-of-network care
  - Financial incentive to stay in-network
HMO, POS, PPO, etc.

- Preferred Provider Organization (PPO)
  - Currently the most common choice by patients
  - Panel of providers is closed
  - Patients do not need a referral to see a specialist
  - Usually requires a co-pay for office visits
  - Do not necessarily credential audiologists

In the End...

- Insurance is a third party contract between the insurance company and the patient

  IT IS NOT A Healthcare Provider CONTRACT!

- It is okay to bill the patient

Game Plan

FACTS:

- There are procedures performed that either don’t have a procedure code and/or a device code
- There are some codes that the insurance payer deems “not within our provider category” and, therefore, deny payment even though the procedure is within the audiologist’s scope of practice

Game Plan

Action:

- For services not covered, or for those not yet having a code, bill the patient
- Provide an invoice to the patient for each visit
  - List any services that are provided especially those given away for “free” (ex., during the bundled period) and give a dollar amount
    - Ex., you cleaned the hearing aid for free, use V5299 on the invoice with a charge amount, in the adjustment column, credit that amount, but this allows the patient to see the value of the “giveaway”

Coding – HIPAA Compliant Code Sets

- CPT – Procedural codes
  - Owned by the AMA
- HCPCS – Primarily used to identify products such as hearing aids
- ICD-10 – Diagnosis codes (~155,000)
  - First change in 30 years
  - Became effective October, 2015
CPT
• Audiology codes are listed under “Audiology Function Tests”
• Example: 92557 – Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combines); binaural
  – 92553: air and bone
  – 92556: with speech recognition
• Must meet the entire descriptor
• Must use a bundled code if it exists
• Might require a modifier

Bundled Codes
• 92567, 92568
  92550
• 92567, 92568, 92569
  92570
• 92541, 42, 44, 45
  92540
(spontaneous, 4 positionals, DPC, oscillating tracking)

Bundled codes are only used when the entire list of codes is performed.

Healthcare Common Procedure Coding System (HCPCS)
• Standardized coding system primarily used by hospitals and the Veteran’s Administration and private practitioners or facilities billing for product
• Published and revised annually

HCPCS – Level II
• Used primarily to identify products, supplies, and services not included in the CPT-4 codes
• Codes are alpha-numeric: They consist of a single alphabetical letter followed by 4 numeric digits
• Codes are maintained by the Health Insurance Association of America, BC/BS, and CMS

HCPCS – Level II (cont’d)
• Examples include:
  • UB114 – Cochlear Implant device/system
  • V5088 – Hearing Screening
  • V0241 – Repair/Modification of hearing aid
  • V0242 – Hearing Aid, analog, monaural, CIC
  • V12152 – Hearing Aid, programmable analog, binaural, ITE
  • V52811 – Hearing Aid, digital, binaural, BTE
  • V5275 – Ear Impression, each

Hearing services are listed as V5000-V5999

CPT Code Modifiers:
Global Billing vs. Components
• Global Fee: Testing and Interpretation
• -26 Professional Component
  • Used when only interpreting the data
• -TC Technical Component
  • Used when only administering the test
CPT Code Modifiers (cont’d)

- **-22 Unusual Service**
  - Service is greater than its usual descriptor
  - Add to existing CPT® code (testing takes longer or is more comprehensive)
  - Needs supportive documentation and a written report

- **-52 Reduced Services**
  - Partial completion of the designated procedure

- **-53 Discontinued Procedure**
  - Practitioner elects to terminate procedure
  - Example: Patient becomes ill during ENG

CPT Code Modifiers

- **-GY** Service is statutorily excluded or does not meet definition of Medicare benefit
  - Example: Use for denial for secondary insurer when needing a denial for hearing aids

Coding Example

- When a Medicare patient insists that a claim be filed for a statutorily excluded service
  - Example: Billing a hearing test for the purpose of selecting a hearing aid

  92557-GY
  The audiologist can’t bill Medicare, but the patient wants a denial for secondary insurance

Things to Know:

- **92700** – unlisted otorhinolaryngologic service or procedure
  - Used for any procedure that doesn’t have an existing code
  - Requires a written report of justification (literature substantiated)

ICD-10 Coding System

- Compendium of diagnoses grouped by body system
- Updated annually in paperback and computer software formats
- Available from several companies such as AMA and Ingenix
ICD-10-CM Audiology

Appropriate codes found in:

- Alphabetic Index - alphabetical list by disease

  OR

- Tabular List – numeric list of codes divided into 21 chapters according to body system or nature of injury or disease

- Most Audiology codes are located within the Chapter 8: Diseases of the Ear and Mastoid Process

Laterality and Placeholder

- Laterality:
  - The final digit indicates laterality: 1 is for right; 2 for left; 3 for bilateral; 0 or 9 for unspecified

- Placeholder character
  - “X” – Some codes have a placeholder in the 6th digit to allow for future expansion

Symbols of Exclusions

- Excludes1 – Not Coded Here
  - Cannot use this code in conjunction with another in the code grouping (two conditions that can’t be reported together). These are “mutually exclusive” conditions.

- Excludes2 – Not Included Here
  - Condition is not part of the “main” code-family, but may be acceptable to report if the two conditions occur at the same time. Must be supported with documentation

Abbreviation

- NEC: Not Elsewhere Classifiable
  - Directs to “other specified” codes in the Tabular List
  - Example: Deaf non-speaking (NEC) is indicated not to be used under conductive and sensorineural hearing loss. It directs the coder to a more specific diagnosis (H91.3) which is found under Sudden Idiopathic Hearing Loss

  - H91.3: Deaf non-speaking, not elsewhere classified

- NOS: Not Otherwise Specified
  - Usually interpreted in the Tabular Listing as “unspecified”
  - Unspecified codes in the Tabular list are used when the information in the medical record is insufficient to assign a specific code
  - Usually the fourth or sixth character is a “9” or the fifth character is a “0”
  - Example: H91.20 Sudden idiopathic hearing loss, unspecified ear
ICD-10 Coding Options

H90 Conduction and sensorineural hearing loss
- H90.01 Conduction hearing loss, bilateral
- H90.02 Conduction hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
- H90.03 Sensorineural hearing loss, bilateral
- H90.04 Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
- H90.12 Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
- H90.13 Sensorineural hearing loss, bilateral
- H90.14 Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
- H90.22 Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
- H90.23 Sensorineural hearing loss, bilateral

New ICD-10 Options for 2017

- H90.61 Conduction hearing loss, unilateral, right ear with restricted hearing on the contralateral side
- H90.62 Conduction hearing loss, unilateral, left ear with restricted hearing on the contralateral side
- H90.63 Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side
- H90.64 Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side
- H90.65 Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side
- H90.66 Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side
- H90.67 Pulsatile tinnitus, bilateral
- H90.68 Pulsatile tinnitus, unilateral
- H90.71 Pulsatile tinnitus, right ear
- H90.72 Pulsatile tinnitus, left ear

ICD Coding Principle

- When results of diagnostic testing are NORMAL, code signs or symptoms to report the reason for test/procedure and explain normal result in report
- There is NO ICD code for “normal”

Quiz

- What constitutes a proper diagnosis?
  - Hint: three things
    - History
    - Symptoms
    - Findings

Additional Options

- H90.06 Mixed conductive and sensorineural hearing loss, bilateral
- H90.71 Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
- H90.72 Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
- H90.8 Mixed conductive and sensorineural hearing loss, unspecified

The “Key” - Be specific
- H91.21 Sudden idiopathic hearing loss, right ear
- H83.3X3 Noise effects on inner ear, bilateral
- H93.11 Tinnitus, right ear
- H93.231 Hyperacusis, right ear
- H83.02 Labyrinthitis, left ear
- H91.03 Ototoxic hearing loss, bilateral
- H93.243 TTS, bilateral

Third party payers want specificity which needs to be supported with detailed chart documentation.
Let’s practice:
- Patient has a complaint of sensorineural hearing loss of the right ear with vertigo and tinnitus
- Could use:
  - H91.21 – Sudden idiopathic HL, right ear
  - H82.9 - Vertiginous syndrome. Per ICD-10, it can only be reported as a secondary diagnosis to the underlying disease
  - H93.11 - Tinnitus, right ear

Coding
- A patient reports with the presence of tinnitus, but not sure which ear. All tests are normal
Which code(s) would you use of the following?
- H93.19 Tinnitus, unspecified ear
- H93.13 Tinnitus, bilateral
- H93.12 Tinnitus, left ear
- H93.11 Tinnitus, right ear

Which Are ICD-10, HCPCS, & CPT?
- Audiometry
  - 92507 - Abs
  - 92567 - Tympanometry
  - 92558 - Reflexes
  - 92541 - Spontaneous
  - 92552 - Positional
  - 92573/78 - Colorcts
  - 92516 - Vestibular\n  - 92510 - Dispensing Fee, Binaural
  - 92513 - Digital, Binaural, ITE
- CHS
  - H90.0 conductive, bilateral
  - H90.11 Rt. cond; normal Lt
  - H90.3 SNHL, bilateral
  - H90.41 SNHL, Rt; Lt normal
  - H90.42 SNHL, Lt; Rt normal
  - H90.71 Mixed HL; Normal Lt
- V19.2 Family H/O HL

American Academy of Audiology Tools for ICD-10-CM
- www.audiology.org
- Go to PRACTICE MANAGEMENT
- Then select CODING
- On LEFT side of page, select ICD
1. Editable superbill template for CPT, ICD-10, CPT modifiers
2. Comprehensive listing of audiology related ICD-10 codes with descriptor
   - http://www.audiology.org/search-key-word?ICD-10-ED
   - Comprehensive list of audiology codes:

Getting To Know Medicare
- Centers for Medicare and Medicaid Services (CMS)
- The national health insurance program for:
  - People age 65 years or older
  - Certain disabled individuals under age 65, including blind individuals
  - Children/adults with End-Stage Renal Disease
Office Personnel Workshop

Medicare
• The country is divided into 10 Regions
• Each Region is divided into localities
• Each Region is administered by a Regional Medicare Carrier
  • This Carrier is responsible for processing and reviewing all MC claims
  • Each Regional Carrier has the authority to interpret Medicare law, so reimbursement policies are not always consistent from region to region
• Audiologists credentialed as diagnostic providers

Role of the CMS Regional Office
• Represents CMS on a local level and delivering key messages to and from providers.
• Regional, state and local level implementation of the protective regulations, policy and program guidance developed in central office.
• Monitoring of State Medicaid Agency financial claiming, state survey agencies, Managed Care Plans, Medicare claims processing contractors and peer review organizations, the ROs are the Agency’s front line in monitoring the implementation of CMS policies and regulations.

Role of Medicare Administrative Contractors (MAC)
• “a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.”
• MACs serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements, training for providers, and the receipt, processing and payment of Medicare claims.
Local Coverage Determinations

- LCD’s help providers define medical necessity for providers.
- CRC monitors newly created LCD’s to make sure they are accurate for current standards of care.
- The Academy’s Coding and Reimbursement Committee reviews changes to LCDs on a monthly basis.

To find LDC’s and NCD’s

https://www.cms.gov/medicare-coverage-database/

Example of vestibular LCD
Slide 53

KKH3  are we directly attention to anything in particular here?
Kristiina Huckabay, 7/21/2016

Slide 54

KKH4  same question as previous slide
Kristiina Huckabay, 7/21/2016
Medicare Learning Network

- Articles
- Web based training videos
  - Diagnosis coding using the ICD-10-CM
  - Understanding the remittance advice for professional providers
  - World of Medicare
  - Your office in the world of Medicare
- Free Educational Materials

Medicare Part A: Covered Services

- Hospitalization
- Nursing Care
- Home Health Care
- Hospice Care
- Blood

🌟 Audiologic services performed in a hospital setting for in-patients

Medicare Part A (cont’d)

- Note: Audiologic services performed on in-patients are reimbursed under the DRG (Diagnosis Related Group) system. Reimbursement goes to the hospital (and hospital-employed audiologists)

Private practice audiologists will not be reimbursed for any inpatient services

Medicare Part B: Covered Services

- Medical Expenses
- Home Health Care
- Clinical Laboratory Services
- Outpatient Hospital Services
- Blood
- Ambulatory Surgical Services

🌟 Audiologic services performed in ANY outpatient setting

Medicare Part C

- Medicare Advantage Plan
  - Has minimum coverage requirements
  - Coverage for other items and services not in the FFS Medicare program
- Benefits of a Medicare Advantage Plan would be items not covered by traditional Medicare such as:
  - Hearing Aids
  - Dental
  - Vision
  - Routine and preventative care
Medicare Part D

- Prescription Drug Benefit

Medicare
- Defines covered and non-covered services
- Defines the circumstances of coverage for the Medicare program.
- There are legal exclusions for coverage

Medicare does NOT
- Define a professional’s scope of practice.
- Many clinicians including physicians provide items and services that Medicare (like any other insurance) does not cover.
- No requirement to adhere to the fee schedule

Mandatory Reporting Requirement
1. Physicians and suppliers must complete and submit claims for beneficiaries.
2. Beneficiaries should not be asked to file their own claims.
3. The claims filing requirement applies to all suppliers who provide covered services to Medicare beneficiaries.
4. Providers are not required to accept assignment for claims unless they fall under the category of mandated claims.

*Mandatory requirement does not require a provider to treat Medicare patients.

Medicare: Primary or Secondary?
- Medicare is Primary Unless:
  - Pt. has automobile liability insurance/No-Fault
  - Disability insurance is being invoked
  - Employee Group Health Plan (EGHP) applies
  - 65 Years of age or older, still employed
  - Employer Supplemental Insurance
  - Federal Black Lung Act
  - Veterans Affairs
  - Worker’s Compensation

Medicare: Primary or Secondary?
- Medicare is secondary when:
  - Individual or spouse currently employed & covered under EGHP
  - Company has 20 or more employees
  - Pt. is on MC disability & company has 100 or more employees
  - There is end-stage renal disease when an EGHP applies
Getting Started... Medicare Enrollment

National Provider Identifier (NPI)

- The standard unique health identifier for health care providers
- 10-digit number that is permanently linked to the provider (replaced the PIN/UPIN)
- Audiologists MUST use his/her own NPI when billing Medicare

Medicare Enrollment

- Where do I start?
  - Centers for Medicare Services (CMS) website info on enrollment.
  - Find info from your local Medicare contractor’s website here
  - Provider Enrollment Chain & Ownership System (PECOS)
    - Electronic enrollment system
    - https://pecos.cms.hhs.gov/pecos/login.do#headingLv1
    - Used in lieu of Medicare enrollment application, i.e. paper CMS-855

PECOS

- Submit an initial Medicare enrollment application
- View or change your enrollment information
- Track your enrollment application through the web submission process
- Add or change a reallocation of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate an existing enrollment record
- Withdraw from the Medicare Program
- Submit a Change of Ownership (CHOW) of the Medicare-enrolled provider
PECOS

- Benefits:
  - Faster than paper-based enrollment (45 day processing time in most cases, vs. 60 days for paper)
  - Tailored application process means you only supply information relevant to YOUR application
  - Gives you more control over your enrollment information, including reassignments
  - Easy to check and update your information for accuracy
  - Less staff time and administrative costs to complete and submit enrollment to Medicare

Maintain the “Status” Quo?

- Provider Status Options:
  - Participating Provider (Par): Accept Assignment (AA)
    - Medicare payment sent directly to the provider
  - Non-Participating Provider (Non-Par):
    - Medicare payment sent to the patient
    - Limiting Charge under Non-Par:
      - Non-Par is 5% less than Par (AA)
      - Limiting Charge is 10% more than Par (AA)
  - Opt Out
    - No contractual agreement with Medicare
    - Audiologists can’t opt out

Audiologists Can’t OPT Out, So…

- CMS requires that covered services must be submitted for Medicare beneficiaries (Mandatory Reporting Requirement)
- To bill Medicare, you must be enrolled in Medicare (can’t opt out)
  - Approximately 30 days to have provider status

Audiologists Can’t OPT Out, So… (cont’d)

- Does not apply to non-covered services
  - Hearing aids and related testing
  - Non-physician referral
  - No medical necessity
- However, if a beneficiary believes that a service may be covered, a formal Medicare determination must be granted.

Did You Know…?

- Must use CMS 1500 form and submit electronically
  - Unless the facility is a “Small Provider”
  - Performs no electronic services at all
  - Has fewer than 10 full-time equivalent (FTE) employees
- Physician referral and “Medical Necessity” required; referral must not be “solicited”
- So, with physician referral, some diagnostic services can be billed to Medicare even if the evaluation results in a recommendation for hearing aids
- 20% Co-pay MUST always be collected

What does Medicare cover as a benefit?
Medicare pays for diagnostic tests that are considered reasonable and necessary for the diagnosis or treatment of an illness or injury that fall within a statutorily defined benefit category to improve the functioning of a malformed body part or covered preventative services.

To be eligible for coverage under Medicare:

All diagnostic tests must be ordered by a physician or NPP (non-physician provider)

This includes diagnostic procedures that are being performed by a physician.

Medicare Requirements:

“Audiology services”

- Two elements required to bill a hearing evaluation
  - Physician [MD, DO, ND] order for evaluation
    - Non-physician provider (NPP): physician assistant, nurse practitioner, clinical nurse specialist
  - Medical necessity
    - Hearing loss, tinnitus, aural pain, pressure, dizziness, change in hearing, sudden loss

Medicare does NOT cover

- Screening
- Procedures that do not meet the guidelines for coverage (i.e. excluded services such as hearing test for purpose of a hearing aid)
- Routine exam (no new signs or symptoms)
- Services without a physician’s order
- Procedures not covered by particular practitioner (e.g. students)
- Services denied as bundled or included in basic allowance of another service

Things to Know: Can you bill?

- Cerumen Management
  - For Managed Care patients – Yes
  - For Medicare – No, because CPT 69210 is a treatment code

IMPORTANT

“Does not cover” ≠ “cannot perform”

~The patient is responsible. Don’t give your professional services away for free
Advanced Beneficiary Notice of Non-Coverage (CMS-R-131)
- ABN and Notice of Exclusion of Medicare Benefits (NEMB) are on the same page
- Patient directs how the claim is to be filed
  - 3 options:
    1. Bill Medicare
    2. Don’t bill Medicare
    3. Patient declines suggested procedure

CPT Code Modifiers
- GA Signed ABN on file
  - Used when service might be covered if performed by another provider under different circumstances
  - Patient is responsible for payment if Medicare denies reimbursement
- GY Service is statutorily excluded or does not meet definition of Medicare benefit
  - Example: Use for denial for secondary insurer when needing a denial for hearing aids

Medicare Audiology Policies
- Medicare Benefit Policy Manual Chapter 15 Section 80.3
- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- Transmittals

In summary
- Medicare is an insurance program for 65 and older (and some other situations)
- Medicare does not dictate an audiologist’s scope of practice
- Federal Law requires services that are covered are submitted to Medicare for payment
- Audiologists must enroll in Medicare in order to submit claims

Audits: Fraud & Abuse
Medicare: Defining Fraud & Abuse

Unlike Medicare fraud, which involves an intentional deception or misrepresentation, Medicare abuse occurs when physicians, providers, or suppliers mistakenly bill for items or services.

Fraud

- Fraud involves an intentional deception or misrepresentation, for example:
  - Submitting an intentionally fraudulent claim in which the provider has actual knowledge of the falsity of the claim
  - The provider has a duty to know what the billing staff is doing. The provider is ultimately responsible for claims billed, regardless of who is completing the forms.

Medicare Fraud: Examples

- Billing for services not performed
- Misrepresenting the diagnosis to justify payment
- Soliciting, offering, or receiving a kickback
- Unbundling a CPT code
- Falsifying medical necessity, plans of treatment, or medical records to justify payment

Abuse

- Abuse occurs when physicians, providers, or suppliers mistakenly bill for items or services

Illegal To Bill Medicare For:

- Anything not medically necessary
- What is medical necessity?
  - Needed for the diagnosis, direct care and treatment of the patient’s medical condition
  - Meets the standard of good health practice (for defined diagnostic purpose: not annuals)
  - Is not for the convenience of the patient or health care practitioner
- If unsure, consult your Local Coverage Determination Policy
- It is illegal for an audiologist to bill “incident to” (billing services performed with a physician’s NPI)
Local Coverage Determinations (LCD)

- >90% of coverage & payment decisions occur at the local level
- CMS gives authority to the local contractors to determine under what conditions a service is considered medically necessary and claims may be denied if not appropriate.
- In most states the CMD has the ultimate authority to determine medical necessity

Direct Access

- Although audiologists have their own NPI and are credentialed by CMS under the Diagnostic Provider category, audiology services can only be billed to Medicare with a physician referral.
- Medicare will not pay the audiologist unless the referring physician is part of the PECOS (Internet-based Provider Enrollment, Chain and Ownership System)

Questions

- What are the three coding systems used for processing claims?
- Do I have to collect the 20% Medicare co-insurance?
- Is it legal to bill Medicare for annual hearing tests as long as the patient obtains a physician referral?

Questions

- Is it okay to bill non-Medicare patients less than Medicare patients for an equivalent service?
- What do you do if secondary insurance will pay for something Medicare, as the primary, deems an uncovered benefit?

The Medical Record

- Enables clear communication between treating medical professionals
- Is required for determining reimbursement
- Serves as a legal document
- Is utilized when performing quality assessment reviews

Thorough Documentation

- Requisite for avoiding and/or surviving an audit
- Having an organized chart is part of best business practices
- The practice “owns” the chart
Components of the Chart: Reason for the Appointment

- Referring physician
  - **Mandatory** for Medicare patients to be reimbursed for medically necessary tests
- Chief complaint: reason for "today’s" visit
- Brief history of problem
  - What are the symptoms and when did they begin?
  - What makes it better or worse?

The Purpose of Documentation: List Procedures and Findings

- After detailing the history and physical exam, date and record the diagnostic tests performed along with the findings
- Include cerumen management and other non-diagnostic care
  
  **Notes should support the CPT and ICD-10 codes used in the billing process**

Access to the Chart

- The facility "owns" the chart
- Under HIPAA, the patient/family has the right to examine the chart or obtain a copy within “a reasonable timeframe”
- Thirty days is considered "reasonable"
  
  **Pearl:** Never give the chart to the patient – give a copy

Access to the Chart (cont’d)

- The patient may question chart notes and request an amendment
  - A written authorization is needed to obtain a copy of the chart
  - In the case of divorce, either parent may access the chart if there is joint custody

Access to the Chart (cont’d)

- State laws stipulate length of time to maintain medical records
  - Adult – usually 7-8 years (?????)
  - Minor – usually 7-8 years after reaching majority (???????)
- Check state laws to ensure what applies for your practice

Access to the Chart (cont’d)

- Under HIPAA, legal authorities may access the chart without authorization if needed for “the common good”
  - If subpoenaed, carefully read whether the original must be sent (or a copy)
  - Do not alter the chart notes in any way
Insurance Audits: What Triggers an Investigation?
• Too-frequent billing of same CPT codes
• Too many patient visits in a single workday, week, or month
• Excessive billings for patients in a nursing facility
• Patient complaints
• “Whistle-blower”

SOAP: Is Your Chart “Clean”?
• Subjective – Patient’s description of the problem
• Objective – Physical findings on exam
• Assessment – Evaluation/findings
• Plan – Recommendation(s)

Method for standardizing charting within a facility

...and So It Is Said
• If it is not written, it didn’t happen!

Electronic Health Record (EHR)
Electronic Medical Record (EMR)
• Completely computerized - “paperless chart”
• To be legally acceptable:
  – Notes must contain an electronic signature, a means of authenticating the user
  – Notes must not allow editing after the electronic signature is affixed
• Back-up often; keep a copy off-site
• Business Operating Systems (BOS)

Health Care Laws: Compliance
STARK Law
Medicare/Medicaid Anti-Kickback
HIPAA

STARK Law
• Named after Congressman Pete Stark (CA)
• Prohibits a physician who has a “financial relationship” with an entity from referring patients to the entity for “designated health services” covered by Medicare, unless an exception is available. Where no exception is available, the entity performing the services is prohibited from submitting a claim for the services to Medicare program or billing any individual or third-party payer
• Limited applicability for audiologists
  – Designated Health Services (DHS) include hospital inpatient/outpatient services + CPT codes 92507 & 92508 (SLP codes)
**Anti-Kickback Statute**

- 42 U.S.C. 1320a-7b(b)
- Prohibits individuals or entities from directly or indirectly, knowingly and willfully offering, paying, soliciting or receiving remuneration in order to induce business reimbursed under Medicare or State health care programs.
- Certain Safe Harbors exist
- Violations result in criminal penalties

**For More Information**

- Fraud compliance guidance constantly changing, evolving
- See OIG Compliance Roadmap at: [https://oig.hhs.gov/compliance/physician-education/](https://oig.hhs.gov/compliance/physician-education/)

**Privacy Rule Objectives**

- Gives patients more control over their health information
- Sets boundaries on the use and release of health records
- Establishes appropriate safeguards that healthcare providers and others must achieve to protect the privacy of health information

**Privacy Rule: Exception**

- Treatment, Payment, and Operations (TPO)
  - Doctors, hospitals, or other health care providers do not need to obtain a patient’s consent before using or disclosing the patient’s Protected Health Information (PHI) or electronic PHI (ePHI) to carry out TPO

**Notice of Privacy Practices (NPP)**

- A document that reflects dedication to privacy and is given to all patients
- Informs patients that PHI won’t be used or released except as stated in the NPP
- Explains the patient’s privacy rights
- States that you are required to abide by the terms of your NPP under HIPAA
Notice of Privacy Practices (NPP) (cont’d)

• Discusses office policies about fax, mail, electronic messaging, leaving voice mail messages, etc.
• Providers must attempt to obtain (and record) an acknowledgment from each patient that he/she has received the NPP
• Needs to be posted on the practice web site

Notice of Privacy Practices (NPP): Fact or Fiction?

• If a patient refuses to sign the NPP, then the patient can’t be seen?
• A patient can file a complaint for leaving a voice mail reminding him/her of an upcoming appointment?
• A patient can file a complaint when a practice leaves a voice mail that a hearing aid is back from repair?
• A patient’s full name can’t be used when being called in to see the provider?
• Sign-in sheets can list the patient’s name?

HIPAA, HIPAA, Hooray: Correcting the Myths, and Securing The Facts

HIPAA Compliance:

• Updates to the Health Insurance Portability and Accountability Act (HIPAA) are found within
  ◦ PRIVACY
  ◦ SECURITY
  ◦ ENFORCEMENT
  ◦ BREACH NOTIFICATION
• The Department of Health and Human Services (HHS) provided modifications to HIPAA
• The Health Information Technology for Economic and Clinical Health Act (HITECH) addresses Electronic Health Record (EHR) and broadens the scope of HIPAA

What’s “UP”?

• HIPAA Privacy and HIPAA Security are separate rules found within HIPAA under "Administrative Simplification Provisions"
• The PRIVACY RULE – essentially controls the use and disclosure of Protected Health Information (PHI)
  ◦ Much of it is common sense, but there are a some complex protocols
• The SECURITY RULE – monitors the relationships between covered entities and business associates to protect and safeguard PHI transmitted in electronic form
  ◦ Access to the network, storage of data, and how it is handled

HIPAA Glossary

• Business Associate (BA) – Person or entity that is not a member of your facility who uses or discloses “your” ePHI to perform its business function.
• Covered Entity (CE) – a healthcare provider, health plan payer, clearinghouse that conducts transactions covered by HIPAA electronically (claims billing, verification of eligibility...)
• Access- ability to read, write, or modify ePHI that is created, maintained or transmitted
Security Rule

- Three primary security safeguards:
  - Administrative
  - Physical
  - Technical
- The security standards are intended to support the protection of electronic information covered by the Privacy Rule.
  - Required implementation specifications
  - Addressable implementation specifications
- Security language is broad: more flexible than the Privacy Rule. It provides a CE more leeway in how to comply.

General Obligations of the CE or BA Under the Security Rule

- Ensure the confidentiality, integrity, and availability of all ePHI whether created, received, maintained, or transmitted.
- Protect against threats or hazards to the security or integrity of ePHI.
- Protect against non-permitted disclosures required under the Privacy Rule.
- Ensure compliance with the Security Rule by members of the workforce.

3 Primary Safeguards

- Administrative: procedures to protect, prevent, detect, contain, and correct security violations of ePHI (includes personnel management).
- Physical: procedures to protect computer systems, buildings, and equipment from natural causes (ex. fire), environmental hazards, and intrusion.
- Technical: processes to control and monitor access to ePHI such as passwords, access to data transmitted over the internet, email, computer, etc. (does not apply to fax or telephone).

Standards: Addressable versus Required

- There are 41 compliance specifications:
  - 21 are addressable and 20 are required.
- The REQUIRED are more rigid in their design and application; they must be IMPLEMENTED.
- The ADDRESSABLE must SATISFY:
  - Review specifications to see if they are reasonable and appropriate for a facility.
  - Document why it doesn’t apply and/or how it is otherwise being met.

Note: as facilities “evolve”, some specifications may change from addressable to required.

HIPAA and State Laws

- As a general rule, state laws regarding the security of health information are honored over the federal HIPAA law if/when they are more stringent.
- Every facility is strongly advised to consult with an attorney who specializes in state laws that relate to security.
Security Rule Definition: Business Associate

- Any person or entity required by a CE to complete business activities and functions including billing and collections, hearing aid manufacturers, marketing, and technology services (ex., computers)
- CE/BA agreements signed when HIPAA was enacted in 1996 with compliance effected in 2003 (needed to be renewed in September 2014!)
- BA agreement “releases” the CE from the legalities of a breach of PHI by the BA

Marketing: “Financial Remuneration”

- Financial remuneration to a CE (audiologist) by a BA (hearing aid manufacturer) for the purpose of marketing requires patient written authorization whether or not the remuneration is direct (share or underwrite cost of marketing) or indirect (product discount specific to product sold from the marketing)
- The marketing to an audiologist’s patients promoting the manufacturer’s products

Marketing: “Financial Remuneration”

- SO, if there is no exchange of financial remuneration between the CE and the BA, patient authorization is NOT needed
- Generic purchased patient lists (ex., zip code lists), DON’T require authorization even if one of your patients may be part of this list
- Audiologists with dedicated marketing funds from a manufacturer, will need patient authorization if the marketing is paid for with these funds

Question

Which of the following is accurate:
A) Financial remuneration to a CE (audiologist) by a BA (hearing aid manufacturer) for the purpose of marketing requires patient written authorization
B) Even when there is no exchange of financial remuneration between the CE and the BA, patient authorization is still needed
C) Patient authorization is always necessary when marketing a patient

“Same Old News”: What Hasn’t Changed?

- In the absence of financial remuneration, patient authorization is still not required for:
  - Treatment, Payment, and Operations (TPO) – educating the patient about product, securing payment either with the patient or with a third party payer and the operational communications necessary for achieving TPO

“Same Old News”: What Isn’t Marketing?

- Face-to-face communications between practitioner and the patient even if manufacturer materials are supplied
- Promotional gifts of nominal value
- Communications for case management including alternative health-related products or services
  - Hearing aids, ALD’s, Aural rehab, alternative treatment
Office Personnel Workshop

**Quiz: As part of treatment...**
- Your quarterly newsletter is paid for by "HUH" Hearing Aid Company because the content of the newsletter promotes its unique product. You have patients that have not been successful in noisy environments. This new patented disruptive technology guarantees hearing in the presence of noise due to its outstanding SNR. You are sending this newsletter to all of your established patients
  - T or F – as part of TPO within HIPAA, a patient authorization is not needed for this update

**Quiz: Myth or Fact**
- HIPAA Security rule prohibits a patient from being called by his/her full name when other patients are in the waiting room?
  - HIPAA Privacy Rule prohibits the use of a patient sign-in list

**Quiz: Myth or Fact**
- A Life Insurance company wants patient information. They have enclosed a signed patient authorization for release of information. Your facility still needs to have the HIPAA authorization signed by your patient
  - An insurance company is denying reimbursement for a patient visit. The patient needs to sign HIPAA Authorization in order to communicate with the insurance company

**Quiz: Myth or Fact**
- If a patient asks for the treatment notes from a date of service, only health information from that patient encounter should be disclosed. Simply, don’t send the entire chart. This would be Minimum Necessary
  - When sending mail to patients (including reminders), it is acceptable to have the return address and the name of the organization on the envelope

**Breach of HIPAA Security**
- The new Security Rule has expanded protocols to secure a patient’s PHI
  - The rule identifies what is a breach of PHI, what security standards must be in place to avoid a breach, who is responsible should a breach occur, and most importantly, lists the mandated procedures should a breach be identified
  - The HIPAA Security officer is responsible for following HIPAA policy should a Breach arise. Every workforce member is responsible to report a Breach to the Security officer

**Quiz: Myth or Fact**
- As a general rule, if someone is part of the workforce of a practice/facility, he/she doesn’t need to sign a Business Associate agreement
  - No information other than to have the patient call back, can be left on voicemail or an answering machine

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Quiz: Myth or Fact

- If a patient wants a copy of his/her medical record, the organization is allowed to charge the patient.
- If a patient wants access to his/her medical record, this has to be granted at the time of the request.
- A patient wants you to send a report of summary to the referring physician. HIPAA patient authorization needs to be signed before sending the report.

Coding Scenario Exercise

What ICD-10 code do we use for asymmetric sensorineural hearing loss?

- When sensorineural loss presents in both ears but is greater in one ear than the other, we would recommend using H90.3, bilateral sensorineural hearing loss.
- If the hearing loss is unilateral, use the codes that address unrestricted hearing on the contralateral side.

Examples:
- H90.4 SNHL, unilateral with unrestricted hearing on the contralateral side
- H90.41 SNHL, unilateral, right ear, with unrestricted hearing on the contralateral side
- H90.42 SNHL, unilateral, left ear, with unrestricted hearing on the contralateral side

What ICD code do you report when results are normal?

- Coding for diagnostic tests should be consistent with the following guidelines:
  - Code for the result of the diagnostic test.
  - In the case of a normal result, the next choice would be to choose a diagnosis code that reflects the reason for the referral and/or the chief presenting complaint.
  - It is helpful to include other secondary diagnosis codes that will help paint a clear clinical picture of why the test(s) are being performed.

What code can I use to bill for speech-in-noise testing (e.g. QuickSIN, HINT, BKB-SIN)?

- Speech-in-noise testing could be included in Comprehensive Audiological Evaluation (92557) or as part of Speech Audiometry with Speech Recognition (92556) evaluation.
- Alternatively, it could be billed as an unlisted otorhinolaryngological procedure code 92700, with documentation & explanation of the procedure. Audiologists should consult payer guidelines for submitting the unlisted code.
- CPT code 92700 should not be filed to Medicare if utilized as a predictor of hearing aid performance in noise.

ICD-10: A patient comes in with the complaint of hearing loss. After completing an evaluation, all test results are normal. Is there an ICD-10 code that I can use to show that I was “ruling out” hearing loss? Can I code for the suspected type of hearing loss?

- When the results of the exam are normal, the next codes that should be looked at are signs, symptoms or reason for referral.

Examples:
- Patient was referred due to tinnitus, or vertigo. If there aren’t signs and symptoms that could be reported, there are some encounter codes that can be reported.
- For example, you could look at using Z01.10 or Z01.110 (depending upon if there was a failed hearing screening initially).

Listing of these codes, in addition to many other audiology specific codes available here.
Must both ipsilateral and contralateral acoustic reflex thresholds be obtained to bill CPT codes 92568, 92550 and 92570?

- Yes! To appropriately bill for acoustic reflex testing, the audiologist must perform both contralateral and ipsilateral reflexes. If you are only performing ipsilateral reflexes, you must append the -52 modifier to indicate reduced services.
- A reduced-services modifier is not required for incomplete stimulus frequencies, as long as there is a combination of the four test conditions that are necessary to obtain the complete diagnostic information.
- However, if one or more of the test conditions is not performed (e.g., a two-contralateral stimulation and one ipsilateral stimulation or two contralateral stimulations only), then use modifier -52 only. This modifier means that the basis protocol for the procedure has not been altered, but the entire procedure has not been performed. (CPT Assistant, June 2009).
- An ipsilateral acoustic reflex screening at 1000 Hz does not meet the coding criteria for 92568, because the protocol for this procedure requires obtaining the threshold level for the acoustic reflex and not simply observing the presence or absence of an acoustic reflex at a single intensity level.

I know many audiology codes are bilateral. If the audiologists only tests one ear, what modifier do I use to indicate unilateral testing? -50, -52, or do I just specify right ear (RT)/left ear (LT)?

- Audiologic Function Tests (Codes 92550 through 92700) include the testing of both ears.
- If only one ear instead of two ears is tested, the -52 modifier (Reduced Services) should be utilized.

What HCPCS code do I use for Hearing Aid, Monaural, RIC?

- There are no HCPCS codes specifically for RIC. We suggest BTE codes for RIC devices.
- You may want to check with individual payers to see what codes they will accept, as payer policies may vary.
- Example: codes like VS257 Hearing aid, digital, monaural, BTE; or V5060 hearing aid, monaural, behind the ear.

Do technicians need to be supervised by physicians for the services to be reimbursed by Medicare?

- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. These services may not be furnished under the supervision of an audiologist.
- Further, there are codes with a professional component (PC)/technical component (TC) split.
- Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.

Our office has an audiology assistant who performs tympanometry and DPOAEs. Can I bill for the services she performs under my Medicare NPI if I am on the premises when she performs these tests?

- Medicare does not allow audiology assistants to use their NPI number to bill for "incident to" services completed by technicians.
- Audiology services must be personally furnished by an audiologist, or non-physician practitioner (NPP).
- Physicians may personally furnish audiology services, and technicians or other qualified staff may furnish those parts of a service that do not require professional skills under the direct supervision of physicians.
- Important Resources:
  - Link to Physician Fee Schedule
  - Chapter 11 of the Medicare Benefit
  - Policy Manual also address who may perform audiology services (see page 103).

I have a patient who wished to have a hearing test in order to potentially get hearing aids. She did not wish to get a referral from her doctor and presented on a self-referral basis. Would a voluntary or required ABN be necessary in this situation? Or would a -07 modifier be more appropriate for a voluntary ABN was not signed as the purpose of the exam was to determine hearing aid candidacy?

- Performing a hearing test for the purpose of determining candidacy for hearing aids is not a covered benefit and therefore, a mandatory ABN would not be required. You may utilize a voluntary ABN if desired.
- Generally, an ABN is only deemed mandatory when an alternative service is included which is not covered by Medicare.Further, there is no compatible reason or necessity.
- ABN’s are not mandatory when an item or service is included (never covered) or does not otherwise meet the technical coverage criteria of the Medicare benefit.
- Examples of when a voluntary ABN could be used:
  - Tests not ordered by a physician or NPP (routine tests, or test related to hearing aids and hearing aid related services).
  - The -07 modifier is typically used when a patient has a secondary insurer plan that covers hearing aids and in order to access this benefit, they need a denial from Medicare.
Does Medicare pay for annual hearing tests? What if I think hearing tests every 2-3 years are in the best interest of my patient?

- Audiologists can perform routine or annual tests, we just cannot ask Medicare to pay for them.
- Medicare audiology coverage is part of the “other diagnostic tests” benefit and the performance of diagnostic tests requires an order from a physician as well as medical necessity.
- Medicare does not cover annual or routine hearing evaluations or those evaluations for the purpose of selecting hearing aids. This can also foster a discussion of standard of care versus coverage, etc.

When requesting an e-mail address on a patient intake sheet are there any legal restrictions or other considerations for using this e-mail address for communication with the patient?

- HIPAA requires that when using e-mail to send patients’ health information, the e-mail must be secure and encrypted.
- HIPAA guidance also says that to reasonably safeguard the individual’s privacy, covered entities should take care to limit the amount of information disclosed.

I know that a physician order is required for Medicare patients. Does this order need to be on the physician’s script pad specifically? Is the signed order required in the patient’s medical record?

- No signature is required. An e-mail or telephone call by the treating physician/NPP or his/her office to the testing site is sufficient if the physician/office and the testing site document the communication in their respective copies of the beneficiary’s medical records.
- The Academy has a helpful Medicare FAQ document that specifically addresses the requirements for a physician order. This FAQ also references the requirements found in the Medicare Benefit Policy Manual.

If the patient comes to the office strictly wanting new hearing aids or a patient comes into the office without a physician referral, how are we supposed to get paid? From what I have been reading, it would not be lawful to bill Medicare for the cost of the test, nor would it be lawful to just have the patient be self-pay. What is the legal thing to do to get the test paid for?

- Hearing tests for the sole purpose of fitting a hearing aid or tests that are not ordered by a physician for treatment of a medical condition are not covered by Medicare and the claim should not be sent to Medicare for reimbursement.
- These two scenarios are never covered by the Medicare benefit and are the responsibility of the patient; therefore, the patient should be charged for these services.

Some of our payers are now including hearing aid coverage, but they require a Medicare denial first. What is the best way to get this Medicare denial?

- We recommend that you use the –GY modifier when completing the Medicare claim form.
- This modifier states that the provider is aware that the service is not covered by Medicare.
- The –GY modifier is typically used when a patient has a secondary insurance plan that covers hearing aids and in order to access this benefit, they need a denial from Medicare.

Insurance contracting and hearing aid benefits
Medicare

- Medical Necessity: purpose of preventing, evaluating, diagnosing or treating illness, injury, disease or its symptoms
- Physician Referral
- Hearing aids and testing for the purpose of obtaining hearing aids are statutorily excluded from Medicare coverage

Hearing Aid Benefits

- Pos
- Cost

Types of Hearing Aid Benefits

- Traditional Insurance Coverage
  - In-network
  - Out-of-network
- Allowance Toward Total Cost
  - Defined fixed benefits
  - Medicare Advantage Plans
- Discount Plans
  - Hearing Aid Savings

Third Party Hearing Networks

- Examples
  - TruHearing
  - TruHearing Solutions
  - HearingCare
  - HearUSA
  - ZipHearing
  - Epic
  - Amplifon

Problems with Traditional Insurance

- In most cases, discounting is expected (in-network)
- HCPCS code set for amplification is antiquated
- No standardized method for billing
- Claims are manually processed
- Traditional delivery model for hearing aids does not correlate with how insurance works (insurance doesn't reimburse for life of instrument care and follow-up)

Important Insurance Terms

- Billed amount: The amount charged to a patient or insurance for a service item
- Usual and Customary: An amount or range that the insurer determines to price an item or service
- Allowed amount: The total amount that the insurance company determines should be paid for an item or procedure per contract
- Balance billing: Charging the patient the difference between the billed amount and the allowed amount. This is typically not allowed for in-network providers.
**Important Insurance Terms**

- Deluxe Upgrade: Item that is beyond a standard medically necessary device.
- In-network provider: Provider who is part of an insurance network and has agreed to accept the insurance company's contracted rates. The patient incurs less out-of-pocket expense when seeing a provider who is in-network.
- Out-of-network provider: Provider who is not part of an insurance network and not entered into a contractual agreement with the insurance company to accept their contracted rates.

**In-Network vs. Out-of-Network**

- **In-Network**: A contracted provider for the insurance plan.
- **Out-of-Network**: A provider who does not have a contract with the insurance plan.
  - The patient incurs less out-of-pocket expense when seeing a provider who is in-network.
  - Greater co-insurance applies when going out-of-network.

**CONTRACTING**

- Insurance Fee structure:
  - Will it cover expenses? What is allowed amount?
    - Obtain fee schedule for procedure you perform.
  - How many patients are in the plan?
  - Call for benefit verification.

**Beware**

- Will you be required to share invoices?
- How does the insurance carrier reimburse for "unvalued" codes?
- Can you bill as out-of-network provider for hearing aids? Diagnostics?
- Is the technology restricted? Specific manufacturers?
- Does the patient have to keep the hearing aids for a set amount of years before the benefit becomes eligible once again?
- Does the benefit include repairs (how long?), batteries (how long?), free trial period, programming (how long?)?

Never agree to accept an insurance reimbursement (in or out-of-network) unless you understand EXACTLY how you will be reimbursed.
Being an Insurance Player Means:

- Knowing the rules especially for Medicare
- Federal funds are different than private payers
- Rules are different for Third Party Administrators (TPA)
- Is the facility being paid the contracted amount?
- It is okay to bill the patient...
- Contracts: “Know when to hold’em and when to fold’em!”

Bundle or Unbundle

- Hearing aids are typically sold as a “bundled” package
  - The cost of goods is not differentiated from the cost for performing professional services
- Bundling is relatively unique to the profession of audiology
  - Most insurance companies don’t prohibit the audiologist from billing for professional services in addition to the negotiated amount

The “Convention” For Pricing

Typically, the purchase price for hearing aids are quoted with no additional charge for:
1. Diagnostic testing securing a differential diagnosis
2. Cerumen management
3. Speech-in-Noise testing
4. Hearing aid evaluation
5. Earmold impression taking
6. Verification of hearing aid performance
7. Electroacoustic evaluation

Non-Charged Services (cont’d)

8. Batteries
9. Cleaning of the hearing aids
10. Tubing replacement
11. Replacement of battery doors, earhooks, microphone covers, etc
12. Earmolds especially for the initial fit
13. Hearing aid supplies (cleaners, sanitizers, moisture prevention kits, etc)
14. Office visit
15. Aural rehabilitation

What Are Some of the Options?

- Bundle without exception
- Unbundle without exception
- Bundle services for two years or while under warranty, and then bill for all remaining services
- Give the patient the option of a bundled plan or an unbundled plan

The options are endless, but unbundling provides value. This is data is necessary as third party payers try to determine appropriate compensation for services and/or products

V-Codes

- To describe technology (examples):
  - V5242 – Hearing Aid, analog, monaural, CIC
  - V5252 – Hearing Aid, programmable analog, binaural, ITE
  - V5261 – Hearing Aid, digital, binaural, BTE
V-Codes

• To describe dispensing fees (examples):
  − V5240 Dispensing fee BICROS
  − V5200 Dispensing fee, CROS
  − V5110 Dispensing fee, bilateral
  − V5241 Dispensing fee, monaural
  − V5090 Dispensing fee, unspecified hearing aid

• To describe assistive technology (examples):
  − V5274 Assistive listening device, not specific
  − V5268 Telephone amplifier
  − V5270 Telephone amplifier

• Miscellaneous Codes (examples):
  − V5275 Ear impressions, each
  − V5020 Real ear measures
  − V5090 Hearing service, miscellaneous

Sample Invoice

Bundled

Services and Product:
Hearing Aids $6000.00
Tax $110.00
Amount owed $6110.00

Disclaimer: Prices listed are for demonstration only and are not suggested pricing.

Sample Invoice

Bundled With Additional Information

Services and Product:
V5261 Binaural Digital BTE’s $6000.00
Tax 110.00
Amount owed $6110.00

Disclaimer: Prices listed are for demonstration only and are not suggested pricing.

Sample Invoice

Hybrid

Services and Product:
V5261 Binaural Digital BTE’s $4000.00
Tax $80.00
Professional services $2020.00
Amount Owed $6100.00

Disclaimer: Prices listed are for demonstration only and are not suggested pricing.

Sample Invoice - Unbundling

Purchase Total
V5261 Binaural Digital BTE’s $4000.00
Dry and Store $100.00
Batteries $50.00
Earmolds (binaural and non-refundable) $200.00
Tax $190.00
Total Services Total: $1000.00

92557 (Diagnostic test) $110.00
92591 (Hearing Aid Evaluation) $150.00
92567 (Diagnostic test) $30.00
V5110 (Dispensing fee) $250.00
V5275 (Ear Impressions) $100.00
V5020 (Real Ear) $100.00

AMOUNT OWED: $5540.00

Disclaimer: Prices listed are for demonstration only and are not suggested pricing. "Savings": $560.00
If Unbundling...
• Are professional fees non-refundable even if the patient returns the hearing aids?
• Are the visits during the trial period free, or are they billable?
Question: Do practices track how many times a patient visits during the warranty period when the visits are free compared to when there is a charge?

Practices don’t steer themselves
• Set goals and stick to them
• Measure and monitor them consistently

Financial Policy is Critical

Create a Business Mindset
• Should the practice accept insurance?
• In-Network or Out-of-Network?
• Financial policy needs to be signed and enforced
  • Confirm appointments?
  • Charge for rescheduled appointments?
  • Charge interest for overdue accounts?
    • Who codes and how is it processed?
  • Paper
  • Clearinghouse

More Questions...
• Hearing Aid Supplies: What is the profit margin?
  – Batteries, Dry and Store, etc.
• What is the hourly billable rate?
  – For the owner?
  – Employees?
• Can you afford “free”?
  – What is the cost of “free”?

Remember...
• Insurance is a third party contract
  between the insurance company and
  the patient
  IT IS NOT A Healthcare Provider
  CONTRACT!
• It is okay to bill the patient
Examples/EOBs

EOB

Front office etiquette/protocols

Perception is REALITY

- Website
  - Online history submission
  - Patient access to appointment making
- Receptionist
  - Speaks in friendly voice
  - Welcomes and greets patient
  - Personalizes your services
  - Not to be combative, audiologists must handle difficult patients
- Professional credentials identifies professional responsibilities
- Delivery Model
  - Retail
  - Wholesale
- What diagnostic tests will be offered?
- Are you reimburse, clients, or customers?
- Different counseling for the patient versus a loved one (child, spouse)
- Remember to speak to the patient when family members or caregivers are present.
Patient Journey

• Appearance of the office/equipment/staff
  – Do you need to wear a white coat?
  – “Wear” professionalism
  – Provide a larger room for families who want to participate
  – Furniture and counter surfaces must be clean
  – Garbage cans emptied throughout the day

• Professional demeanor
  – Good listener
  – Good eye contact
  – Provide a call-to-action
  – How many choices do you give the patient?
    ▶ Dictator vs director of need

GOAL: Patient Retention

• Job Description: Must encourage the “team” to provide the patient with a memorable experience (differentiates “you” from the competition)

• Communicate: Introduce yourself, smile, listen, educate...
  – Poor communication is the #1 reason patients have complaints; 18 sec rule – be a good listener

• Satisfied patient – 3 friends; Unsatisfied – 9

What are the Rules of Engagement?

• Certain patient protocols can be templated
  – What time to arrive for the visit – 15 minutes before the scheduled appointment
  – History including medications
  – Insurance card; demographic updates
  – Cell #, home #, work #, email
  – Appointment reminder calls
  – Birthday cards, referral thank you
  – Letter to referring professional
  – Collect at the time of service
    ▶ Strict protocols for past due accounts
    ▶ Non-Service pets

• Receptionist provides brief description of first visit:
  insurance, patient info, check for cerumen…

Case Study

• DS is an 82 long-term hearing aid user and client of your practice. He purchased his first set of high end binaural hearing aids approximately 5 years ago. He never missed a payment. 3 months ago, he purchased a new set of binaural aids. Per his payment plan, he paid what was asked that day, but he has missed payments the last two months. Your secretary has called him, but he is still delinquent in his payments. You suspect this is a memory and cognitive issue. What would you do?

• If patients have one poor experience: 92% will simply leave

• If you provide patients with an average experience: they are open to being attracted by someone else

• If you provide patients with an extraordinary experience: they will never leave
Case Study

- The patient has secondary insurance that will cover hearing aids, but the secondary insurance refuses to process the claim until the primary insurance company (Medicare) denies the claim. What does the receptionist do? She doesn’t want to be audited for submitting a fraudulent claim.

Case Study

A patient is very rude to the receptionist because he feels you have too many forms for him to fill-out. He is also complaining to other patients in your waiting room about how “this place is a racket.” You are running ten minutes behind and when you call him in for his visit, he greets you with “My time is as valuable as yours…I should bill you for keeping me waiting.”

How do you handle this situation?

QUESTIONS???