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ACADEMY OF AUDIOLOGY

A Guide to Itemizing Professional Services

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Due to a widespread change in the delivery of hearing health services and related devices by both private and public payers, many audiologists have changed their office billing practices by separately itemizing charges for hearing instruments and the professional services associated with them. This practice is referred to by the profession as “unbundling.” Whether a bundled or itemized model is used, the dollar amount for the hearing aid(s) and services should yield the same total. This informational document was developed by the American Academy of Audiology (the “Academy”) as a guide to itemization.¹

There are many ways to incorporate itemization into practice. For example, a practitioner may present a private-pay patient one or more of the following options:

1. Present a fee for the device(s) and a separate fee for each associated professional service.
2. Present a combined fee for the device(s) and a predefined set of professional and/or device service options over a specified time period. The included services would be itemized for the patient.
3. Some variation of the above.

In cases where itemization is required (i.e. billing insurance), it is advisable to identify and itemize professional fees separately from the hearing device(s). This practice accomplishes 2 goals: 1. It demonstrates to the insurance company that the practitioner is providing professional services and not simply a product, and 2. It will maximize insurance reimbursement for the device AND the professional services delivered.

Develop a Fee Schedule

1. In order to begin itemizing professional services, a fee schedule is critical. When determining the value of the fees to bill patients/insurance, it is helpful to begin with

¹ Disclaimer: The purpose of the information provided above by the American Academy of Audiology Coding and Reimbursement Committee is to provide general information and educational guidance to audiologists. Action taken with respect to the information provided is an individual choice. The American Academy of Audiology hereby disclaims any responsibility for the consequences of any action(s) taken by any individual(s) as a result of using the information provided herein.

the fee schedule(s) of insurance payers with whom the practice is contracted. This information may have been supplied to the practice when the contract was finalized. In many cases, it can also be obtained from a provider portal for the insurance company or through Availity. The Academy's Superbill Resource can be accessed with the following link, and may be helpful in identifying procedure codes to include for hearing devices and associated services.

[Academy Superbill Resource \(2025\)—American Academy of Audiology](#)

2. Itemize the delivery model.

Practices will vary in their approach to unbundling, but there are common elements to setting fees that all practices should follow. First, identify all services and products, including hearing aids, that will be offered in the practice. Some examples include:

- a. hearing aid evaluation/assessment
- b. hearing device(s)
- c. dispensing fee
- d. fitting/orientation/check
- e. conformity evaluation
- f. batteries/chargers
- g. domes
- h. cerumen guards
- i. earmolds
- j. earmold impressions
- k. accessories
- l. follow-up visits
- m. aural rehabilitation/counseling services
- n. Other services without a procedure code but require professional time, ie letter writing

Second, consider whether the practice will offer a post-warranty service package for office visits and services. These packages could be structured for the provision of basic or advanced services as defined by the practice. For example, a basic package could offer a one-year warranty on the device(s), a predetermined number of office visits, and a predetermined number of minor in-house repairs. A premium service package could include a longer warranty period, more office visits, and in-house repairs. The practice may also want to extend service packages to patients who obtained their devices from another practitioner or through another delivery model.

3. Determine the break even hourly rate for the practice. Professional service fees typically include costs incurred to provide services, such as overhead expenses [rent, staff (salaries, benefits), utilities, equipment, and supply costs, etc.] and time providing the service (to include charting, calls on behalf of the patient to other healthcare providers, other follow-up care, etc.). Knowing the break even hourly rate is necessary in order to appropriately value the professional services (Step5).

The link below can be easily used to calculate the hourly rate for a practice:

[Download Worksheet](#)

Key steps for determining hourly rate are listed in the table below:²

- Establish Annual Contact Hours:
 - Determine how many hours per week are spent in providing direct patient care. Although the practice may operate 40 hours per week, consider the non-billable time as well (this is time that is spent that cannot be billed to patients or insurers).
 - Calculate the number of weeks/hours per year that patient care services are actually provided (factor in holidays, vacation, sick and professional leave).
 - Determine the number of providers in the practice (include audiology assistants).
 - Multiply the hours per week by weeks per year by the number of providers.
- Calculate the operating costs for the practice. Ideally this would be broken down into several expense categories, such as:
 - *clinical and support personnel* (salary/benefits),
 - *clinic expenses* (rent, utilities, communications technology, marketing, etc.)
 - *cost of goods* (all things you buy for resale).
- Determine the break-even hourly rate.
 - Subtract the cost of goods from total annual clinic expenses, and divide the remaining amount by the 'annual contact hours' established in step one.
 - This is the break-even hourly rate in an unbundled model.
- Add-in desired profit margin
 - Take annual expenses less cost of goods, add desired profit and divide this number by the annual contact hours.
 - This is the hourly rate including the desired profit margin.

4. Assign procedure codes for all services the practice will provide. Note: there are currently no nationally agreed-upon definitions for many of the hearing aid procedure codes. Having CPT or HCPCS codes assigned to procedures is not necessary unless insurance claims are submitted, however assigning codes for all services is good business practice for compliance and for internal reporting/tracking

² From Foltner, K., (2009) What's my time worth? Part 3:Breakeven analysis. Advance for Audiologists, 11(3), 44; and Sjoblad, S. Warren, B. (2011) Mythbusters: Can one unbundle and stay in business? Audiology Today, 23(5), 36-45.

purposes.

*** It is important to also recognize that there will not be an associated procedure code for all professional services or accessories. When a code does not exist, that does not imply that the service(s) should be provided at no charge. Patients should be billed directly for such services/devices. Some practice management systems will allow for the creation of non-billable 'codes' for self-pay services. Practices should work with their practice management vendor to determine if development of such codes is an option.

When choosing procedure codes to represent hearing devices and professional services, it is helpful to understand the contracted rate paid by insurance payers for those devices and services. It may be in the best interests of the practice, and lower out-of-pocket expenses for patients, to use HCPCS codes instead of CPT codes for some services.

Third-party payers (TPAs) may have different interpretations of which specific codes can be used to identify certain procedures for payment. If a practice is in-network for TPA plans, be sure to know specific coding requirements of insurers and adhere to those guidelines when submitting claims.

5. Based on the hourly rate for the practice, determine fees for the services that will be provided. Professional fees should not only take into consideration the amount of time it takes to perform the service, but also the knowledge and expertise required for that service. i.e. It is ok for a service to cost more than the practice's hourly rate.

Considerations for Itemizing for Insurance

1. Get fee schedules for all insurances you are contracted with. See page 1.
2. In order to optimize insurance reimbursement, be sure to itemize the hearing devices and all professional services. As long as a procedure is not contractually excluded, patients should expect to pay for professional services for which insurance does not reimburse. When billing for Medicaid, check with the state Medicaid program to verify if hearing aids are considered durable medical equipment (DME).
3. States differ in the regulations that dictate reimbursement for hearing devices and related services. Generally speaking, when patients have insurance coverage for hearing devices, the assumption is that coverage is for entry-level technology. Practices should be cognizant of state policies that govern reimbursement. Such policies would allow or restrict billing patients for the portion of hearing devices/services that are not paid by the plan (i.e. balance billing). When insurance reimbursement for hearing devices is not commensurate with the level of technology dispensed, payers may also allow patients to sign a waiver and pay out-of-pocket for upgraded technology beyond the benefit. Verify with payers the required protocols and forms that must be used for upgrade fees in

advance.. Commercial payers sometimes offer a *financial waiver* for use with the patient to inform them of who is responsible for payment of specific services. If a waiver is not provided, it would be best to develop one for the practice.

4. Be sure to verify the benefit coverage period, which should be communicated clearly to patients. Once a benefit for hearing devices has been used in its entirety, patients would be responsible for reimbursement of the charges for professional services.
5. All fees, whether reimbursable by insurance or the patient, should be clearly outlined and reviewed with the patient. The patient should be provided a copy of the contract that specifies the fees at the hearing aid evaluation.

Hearing Aid Services Claim Submission Examples

The Healthcare Common Procedure Coding System (HCPCS) service codes listed below are provided by way of example for billing hearing aids and related services ONLY and do not represent the full range of code possibilities available to audiologists for hearing aid services.

New service delivery codes will be available to bill for professional services beginning in January, 2026. Check the Academy website later this year as more information becomes available.

Binaural behind-the-ear hearing aid, with earmold

- 92590 (Hearing aid examination and selection, monaural), or V5010 (Assessment for hearing aid). Your choice of the code may be payer dependent and/or how the codes are reimbursed.
- V5011 Fitting/orientation/checking of hearing aid
- V5020 Conformity Evaluation
- V5261 or V5140 Hearing aid, binaural, BTE
- V5160 Dispensing fee, binaural hearing aid, any type
- V5266 Battery for use In hearing device
- V5264 x 2 units Earmold/insert, not disposable, any type
- V5275 x 2 units Earmold impression, each
- V5299 Hearing service, miscellaneous (extended warranty packages, for example)

Additional Academy Resources on Coding and Reimbursement

1. American Academy of Audiology Practice Resources for Reimbursement.
<https://www.audiology.org/practice-resources/reimbursement/>
2. American Academy of Audiology Practice Resources for Coding.
<https://www.audiology.org/practice-resources/coding/>