Navigating the Shift: Understanding the New Hearing Device Services Codes
October 14, 2025
Transcript

Denise Garris: Welcome to the American Academy of Audiology and the American Speech-Language-Hearing Association's webinar, Navigating the Shift: Understanding the New Hearing Device Services Codes.

Denise Garris: Today, we'll walk through the 12 new CPT codes that replace legacy 92590 and 92595, and show how they define the audiologist's work involved in the full care continuum, from candidacy and device selection to verification and follow-up.

Denise Garris: While the hearing device service codes will take effect on January 1, 2026, we anticipate a gradual ramp up in recognition and adoption, which is typical for newly implemented codes.

Denise Garris: You'll hear from experts directly involved with the code development on the rationale for these changes, and how to prepare for implementation.

Denise Garris: They received questions submitted with registration for the webinar, and have tried to address many of these in their presentations. Additionally, you may submit questions tonight throughout the process in the Q&A feature.

Denise Garris: If we do not get to your question, we'll incorporate these into future updates on the FAQ lists, which were posted on both the Academy and ASHA's websites.

Denise Garris: Tonight's speakers include Dr. Annette Burton, the Academy CPT HCPAC advisor, Dr. Erin Miller, the Academy RUC HCPAC advisor, Dr. Mike Sharp, ASHA CPT HCPAC advisor, Dr. Leisha Eiten, ASHA's RUC HCPAC advisor.

Denise Garris: Before we begin today's webinar, we would like to share a few housekeeping items.

Denise Garris: First, one-hour professional development will be available to those attending the live event only. Please note that this is not available for the Academy or ASHA CEUs.

Denise Garris: A certificate of attendance link will be provided toward the end of the webinar for those who attend the full live presentation. Please be sure to download the certificate at the end of the webinar.

Denise Garris: And finally, as a reminder, the chat feature has been disabled for the presentation, and the slide deck will not be available. You will, however, be able to submit questions through the Q&A function feature. Now let's begin. Over to you, Erin.

Erin Miller: Thanks, Denise. Just to let everybody know that tonight's webinar will be a very high-level overview, and that there will be more educational opportunities relative to the code set coming out very soon. Some of that will happen either virtually in the same format we're providing this webinar this evening, or through our AAA and ASHA conferences that will be coming up in the next few months.

Erin Miller: As Denise said, we have tried to incorporate many of the questions that you submitted during the registration, and we appreciate that you did so we'll try to answer all those questions tonight, and if we don't get to them, you will see them in some of the other resources that will be made available to you towards the end.

Erin Miller: So, to get… jump right in here, you know, I know that we're all very much aware that the CPT codes are designed to describe medical, surgical, and diagnostic services that are provided, and to be able to communicate that with other care providers, as well as with payers.

Erin Miller: But those codes should also reflect the work or the detail of the services that we are providing.

Erin Miller: And so, you know, that was a main focus of why we wanted to take a look at this code set, and reevaluate where it stands today and what we could do to modernize the code set.

Erin Miller: There also were some members and other audiologists who have had, you know, some concerns relative to the growing number of beneficiaries who have Medicare Part C supplemental coverage for hearing aids

Erin Miller: as well as the increasing number of third-party payers who are providing reimbursement of devices and services. And so it…

Erin Miller: was the impetus for us to take a look at these code. And we really started looking at this, you know, it's been about five years from when our start time to the implementation of these codes.

Erin Miller: The final piece was when we reviewed the Build Back Better legislation back in late 2021, or H.R. 5376, which actually had included language for coverage of hearing aids for Medicare beneficiaries.

Erin Miller: Now, I know if you've been practicing for a while, you've seen many pieces of legislation that would cover hearing aids, but it really was the first time that there was an appropriation, or funding created for hearing instruments

Erin Miller: in the neighborhood of $35 billion, and that actually successfully passed through one chamber of commerce, through the House. It did stall in the Senate, but as it was written, we had some genuine concerns over the services and how we would identify those services, because the current code set we had didn't adequately do so.

Erin Miller: Next slide, please.

Erin Miller: Thank you.

Erin Miller: So, if we take a look at what most of us are probably most familiar with is our diagnostic code set. Those codes are within the audiologic function.

Erin Miller: test subsection of the CPT manual, and they are very prescriptive in nature. When it indicates you need to perform something, you must perform all of those services within the code, and we'll take a little bit deeper dive on this as well. But now, the new hearing aid codes will be included in the Evaluative and Therapeutic Services subsection.

Erin Miller: Which is a little bit more like, an E&M-type service, because it gives the clinician flexibility relative to what is needed for that particular patient.

Erin Miller: So it's very different than what we're used to, utilizing, and I think it's, important for us to take maybe a little bit deeper dive into this. So if we go to the next slide.

Erin Miller: It lays out

Erin Miller: our core code and what we're very familiar with, which is 92557. Again, this is very prescriptive in nature.

Erin Miller: It provides some time for us to review the patient's chart and to get ready to actually perform the testing.

Erin Miller: And then it includes what must be completed, and all of those services must be completed, pure tone airbone, SRT, and discrim. And then it gives us a little bit of time at the end to actually just briefly review those results with the patient, you know, complete whatever medical report we need to, and then send to the referring physician. And I think if we all consider the amount of time we're spending

Erin Miller: patients.

Erin Miller: And this may be facility dependent, but I certainly know many of us spend considerably more time at the beginning of our session with our patients doing a more focused history, audiologic history, or ear history. And we also spend considerably more time at the end of it reviewing results, counseling our patient. But in the diagnostic codes, those services are not included.

Erin Miller: that it's very specific to the diagnostic codes, it's the service that you're providing. These new codes are different, and they reflect more of that E&M-type service. So, next code, please. Or next slide, please.

Erin Miller: When we look at our… legacy codes,

Erin Miller: there are six codes, but I would really describe these as three services, because there are two codes that describe the hearing aid examination and selection

Erin Miller: for one ear or two, the hearing aid check for one ear or two, or electroacoustic analysis for one ear or two. These legacy codes will be deleted from use starting on January 1st of 2026, but I want to point out here, and I know this will be pointed out throughout the seminar tonight, that there is no change to the V codes.

Erin Miller: And the reality is some payers may continue to favor those V codes, so you should be aware of that, and we're also aware of that.

Erin Miller: Next slide, please.

Erin Miller: So, if we look at why did we really want to develop a new code set, the current hearing aid code set that does exist does not have a description of procedure. So, it's really challenging for us when we go to payers as

Erin Miller: organizations, or either… even as we're describing what we do to other professionals, it's hard for them to appreciate the work involved in actually providing these services. I firmly believe that there are some payers that believe we just hand a patient a hearing aid, and they're not really familiar with all the services associated with really good outcomes for our patients.

Erin Miller: So it's difficult for us to advocate for reimbursement of these services when there's really no description of the procedure.

Erin Miller: And I think if I split up the group, and I put you in two different sections, and you were looking at what do you do during a hearing aid examination and selection, or during a hearing aid check, we would have some very different, descriptions of what we might be doing.

Erin Miller: Probably the only one we would probably agree on is the electroacoustic analysis. There's a pretty set design of what we do when we're performing that service.

Erin Miller: But I think for the others, it would be site-specific to some extent. Now these codes will have a much more definitive definition of what needs to be included during that encounter with a patient.

Erin Miller: So, on the next slide.

Erin Miller: We can look at just some excerpts from the description of procedure for the hearing aid fitting. And this doesn't include all of it. I know there's some details here, but just to give you an idea, when we're going through the CPT process

Erin Miller: to have codes approved, we really need to be very detailed in what happens during that encounter. So, we're describing exactly what the qualified health professional is, and that's the language CPT uses for, any

Erin Miller: Provider of services.

Erin Miller: And so we might be looking at the patient's record, we're going to review some of the results that have already performed, and then there are going to be services that we might report separately. So in this case, you might want to perform an electroacoustic analysis as a quality control measure, and you would report that code separately from the hearing aid fitting code. And that includes some of the other services that doc…

Erin Miller: Dr. Burton will talk about. Obviously, we look in the patient's ear, we assess their ear canal and pinna status, we're going to go ahead and fit the device and make sure it fits appropriately. Then we may need to program the device, we may need to, you know, make certain selections based on that patient's specific need. And then on the next slide, please.

Erin Miller: It will go into a bit more detail on some verifications. So on the hearing aid fitting, we have verification listed, but we're really talking about a very simple verification. How does it sound to the patient? Is it loud enough?

Erin Miller: Because we did recognize that when we look at the data, we don't… not typically our…

Erin Miller: verification with probe mics or other kind of behavioral verification. They're not being performed

Erin Miller: Typically, and that means it needs to be 51% or more of the time, and we did not have data that indicated that was the case.

Erin Miller: Then we might perform probe mic measures. You're going to report that code separately as well. And then we're going to have to show the patient really what we're doing to perform, and take care of the device itself.

Erin Miller: And then, next slide, please. So, when we really looked at creating these code set, I want you to know we went through

Erin Miller: the practice standards that currently exist. Some of those are very recent. We looked at guideline documents. We were able to support some of the code structure based on what our colleagues are doing through evaluation of practice analyses, which helps us establish what's happening in current practice.

Erin Miller: We worked with individuals who are providing this service, clinical experts, across the country in different types of facilities, from private practice to large medical centers, and also across the lifespan, pediatric audiologists,

Erin Miller: individuals working with adult and a geriatric population. And then finally, we had input from some coding professionals and other audiology societies that represent different segments of the profession.

Erin Miller: So I'm going to pass it over to Annette, who's going to review the code structure and the codes that were created that will really describe the patient's journey as they're fit with amplification.

Annette Burton: Thank you, Erin.

Annette Burton: So, the new code set is mainly divided into four areas, which represent the phases of care for the treatment of hearing loss and hearing aids. The purpose of this new modernized code family is really not to dictate how you practice, but it allows us to report the work that we're already doing.

Annette Burton: And, you know, much of that is really not currently recognized, and the provision of hearing aids is viewed as very transactional, you know, that we're giving someone a hearing aid, maybe we do a couple beep-beep-whoop-boops, and then, you know, hand the patient the hearing aid, and that's it. And we all know that there's a lot more that goes into caring for

Annette Burton: the patients. The structure of the codes does allow for clinical flexibility, and your encounters are going to look very different depending on the patient's age, the degree of hearing loss, and their cognitive abilities.

Annette Burton: And so, as mentioned, the codes will, be effective January 1st, but adoption by payers will be varied, because CPT has released 288 new CPT codes, and so it is… will take time for payers to,

go through the clinical

Annette Burton: coverage policies. And when we look at the different clinical coverage policies right now, most of them just have the devices in there, and there's not necessarily the current six CPT codes. And so there may be some services that will not be covered by insurance, but that doesn't really mean that you should have… you should not be able to account for your time.

Annette Burton: Because, you know, sometimes we need to, obtain reimbursement for insurance, but other times they'll be used to just report for the work that we're doing, account for our productivity, and bill the patient if they're responsible. Next slide, please.

Annette Burton: So, the first two codes for candidacy reflect the work that goes beyond the diagnosis of a hearing loss. And so this encounter allows you to review with the patient and their family the findings of diagnostic hearing testing,

Annette Burton: to perform any additional tests that better identify the patient's areas of difficulty and need. And this work is work that you're already doing, such as speech and noise, LDL, ANL, needs assessment, questionnaires. And it also captures the time spent discussing the proposed treatment plan for the patient.

Annette Burton: At the end of this encounter, the patient may not want to proceed with your recommendations, or for some reason, they're unable to move into selection, at this visit. And so that would be where the, this encounter ends. Next slide.

Annette Burton: So, for the next two codes, the selection reflects the work that you would… that would need to be done when the patient has decided to move ahead with the devices, and you now need to determine what type of hearing aid would be best for the patient. In this encounter, you're making specific recommendations. When selecting devices, we provide both formal and informal assessments

Annette Burton: of the patient's hearing goals, ability to manipulate the devices. So, for example, in your history, if you find out that someone has visual problems, and also maybe has some dexterity issues, neuropathy, maybe they can't handle certain devices, that's also going to go into your

Annette Burton: selection decisions.

Annette Burton: And you're also able to complete additional testing and assessments necessary to determine the patient's needs. So…

Annette Burton: candidacy and selection cannot be billed on the same date of service, but the selection encounter does allow for flexibility for you to choose additional assessments that weren't already performed that you may need for selection during this encounter.

Annette Burton: So we're gonna go to the next slide, please.

Annette Burton: So, for hearing aid fitting, these codes reflect the work that you're doing. So, to determine that the patient has the proper fit for their devices, and that the settings are optimized for the

patient's needs. You're also providing instruction to the patient, family, or caregiver on expectations, device operation and care.

Annette Burton: And you may be connecting the hearing aids to their phone, remote mics, or other

Annette Burton: types of devices. Next slide, please.

Annette Burton: So, the post-fitting follow-up codes account for the time spent with the patient after they've received the hearing aids.

Annette Burton: And so, when you use or report these codes will probably depend on a number of factors. So, in the surgical world, there's something called a global period, and that basically is, is that you're getting paid for a certain activity, and there's a certain number of days that

Annette Burton: is expected to be included in that price. And we might see that with, you know, trial periods that are,

Annette Burton: mandated by state regulations or payer policy. So, but most certainly when, that global period might be over, that's when the patient can come back to you, and you can use the post-fitting

Annette Burton: follow-up codes more appropriately.

Annette Burton: And this can also be used for someone who already has hearing aids and maybe is transferring care and, you know, is seeking help.

Annette Burton: So, this encounter can be used for a number of reasons, monitoring the patient's progress, making programming adjustments in different settings for the hearing aids, troubleshooting patients' concerns, continued counseling and education on expectations, device operation and care, and once again, connecting the phone

Annette Burton: Or, you know, remote mics, etc.

Annette Burton: Next slide, please.

Annette Burton: So during the fitting and post-fitting, we instinctively make informal verification judgments on the patient's performance with their hearing devices as we inquire about the sound of their voice, audibility, comfort, or loudness. But there are also objective measures that

Annette Burton: utilize measurable techniques, which involve equipment that's beyond our computer and the manufacturer's software. So there's three procedures that have their own CPT codes, which also may be reported during the fitting or post-follow-up encounters, but it's not included in the overall time.

Annette Burton: Electro-acoustic analysis can also be reported independently outside of the fitting or post-fitting visits.

Annette Burton: The last code, is 92642,

Annette Burton: which is a code that is specifically designed for some situations when someone is obtaining hearing assistive technology outside of the fitting or post-fitting session. So, examples would be FMDM device, you know, setting that up. Or someone's purchased a television device and you're just hooking it up.

Annette Burton: But this code can also be reported in conjunction with candidacy, because, there was not a decision to move forward with

Annette Burton: selection of a hearing aid.

Annette Burton: So, you're… so we're gonna go to the next slide, please.

Annette Burton: So, many of us are probably not used to, working with time-based codes unless you're doing, APD evals, or 9262627 for cochlear implant candidacy and follow-up, or the, AOD codes that are for fitting. So…

Annette Burton: I just want to show you this table, and you will find the language that's in this table, although we think this one's prettier, in the CPT manual, and it'll also be available in the resource sections of, you know, the ASHA and Academy websites. And so I'm not going to spend a lot of time on this, but I just want to show you how the table works.

Annette Burton: And for each code, it tells you the minimum time that needs to be reported in minutes.

Annette Burton: And so, for 92628, for example, for candidacy, you must spend at least 16 minutes in order to report this code. And if you spend 38 minutes, then you can also report the 92629. But if you need to report another unit of 92629, you'll have to have completed

Annette Burton: the entire 15 minutes of, you know, the first one.

Annette Burton: So, I know there were some questions regarding, you know, "how many units can we report?" and that's really going to be payer decisions, and so that's not something that, we really have input on. And so,

Annette Burton: that's it for this one, and if we can go to the next slide, please.

Annette Burton: So, the documentation for time codes, in a way, is not very different than any of our documentation, because what's in the medical record needs to provide clear picture of the encounter, and must align with procedures and the codes that are being reported. And tests that are performed that have their own procedure

Annette Burton: codes are not included in the overall time for timed codes, because they're reported separately. You know, there are some facilities and maybe a few payers that want

Annette Burton: exact times of start and stop, but we've found that that's starting to not be as common, especially with the implementation of the new physician E&M codes that have time, as well as

Annette Burton: procedures with their own codes. It's really kind of hard to just mark stop and stop time… start and stop times.

Annette Burton: So, using just vague references of only start and stop times should be avoided, because if you say you're starting your stopwatch or your E&M, maybe you had to leave the room for a little bit, maybe you forgot to turn it off. So, you know, that's not necessarily going to be the be-all and end-all to really

Annette Burton: detail what it is that happened during that encounter. Next slide, please.

Annette Burton: So, when you are documenting encounters, verifications, assessments, and, evaluations, it really just needs to reflect what did you do in the visit. So, activities of the encounter.

Annette Burton: And in terms of objective measurements, like probe mic verification, or results in the medical record.

Annette Burton: Any scores, graphs, if you're doing electroacoustic analysis, you know, that printout, those things should be in the medical record, and there should be some mention of what those results mean in terms of your assessment. So, next slide, please.

Annette Burton: So, here's an example of a narrative that you can use for…

Annette Burton: at the end of your note, not for your note. So, total time spent for the patient's evaluation for hearing aid candidacy today was X minutes. This includes time spent before the visit reviewing the chart, time spent during the visit, and time spent after the visit on documentation. So, time spent after the visit really needs to be

Annette Burton: related to the documentation in the medical record, and wouldn't necessarily include when you're ordering the hearing aid and filling out paperwork and that kind of thing.

Annette Burton: Next slide, please.

Annette Burton: So, if you… here's an example of if you are also reporting codes that have their own CPT code in addition to the timed code. So, there should be another sentence talking about that.

Annette Burton: So after you use the first paragraph, which is talking about the actual timed encounter, you should also add something that says, total time excludes the time spent for performing, for example, probe mic verification.

Annette Burton: Next slide, please.

Annette Burton: So,

Annette Burton: kind of in closing, I wanted to just remind once again that the HCPC codes are not being changed, that's the V codes, and the CPT codes pertain to professional services. You know, there may be a co-mingling of those, or there may be, have to be used instead based on different payer information.

Annette Burton: And the codes do go live in January, but it doesn't mean that

Annette Burton: the whole transition will be January, it only means that those 60 PT codes have been discontinued. And I wrote a little note to myself to also say that as we modernized this set, we realized that,

Annette Burton: you know, there's a lot more bimodal fittings, right, and hearing aids do,

Annette Burton: sometimes come into play when the patient has a hearing aid in the other side, so we've made language in the CPT introductory language that helps explain and, support the use of some of these codes on the same date of service on the opposite ear.

Annette Burton: And I believe that's it for me, so I am going to turn this over to Dr. Eiten, who will be talking about preparing for the 2026 changes.

Leisha Eiten: Thanks, Annette.

Leisha Eiten: Mike wanted… Mike's gonna jump in here because he wanted to address kind of a common question that's been coming up in the chat, so Mike, I'm going to turn it over to you first, and then we'll get started with our slides.

Mike Sharp: Yep, so just a couple quick things. There's, and anyone on the panel wants to join in. Couple things. One is, defining the difference between candidacy and selection, and why they're not billable on the same day.

Mike Sharp: It was kind of a common one that we're seeing a lot come through a lot, so I don't know who wanted to jump in on that.

Leisha Eiten: Well, I feel like you have to decide in that case, if you cannot bill them both, and you do sort of a combined, candidacy and selection evaluation, how much, you know, you could count

Leisha Eiten: the thing that you're spending the most amount of time on. And if that most amount of time is actually beyond the minimum time requirements.

Leisha Eiten: I actually, you know, have looked at the practice where I'm working and feel like we do a lot of that sort of candidacy counseling very quickly following the hearing testing, but don't necessarily… or… and spend the primary amount of time really about device selection.

Leisha Eiten: So…

Erin Miller: As I… this is Erin. I was gonna say, as I see it, and I've been answering some of these codes.

Leisha Eiten: mmhmm

Erin Miller: questions as quickly as I can. But for… I see candidacy as you're doing some additional tests, you're reviewing the results with the patient, and you start talking about, you know, are they ready to

move forward with amplification? And they say no. Now you have a code to report all that time you spent performing that.

Erin Miller: But if in my practice they were to say yes, and now I go through, like, the device selection, I can include those additional tests, because there are additional tests allowed for in the selection, and then I would just bill that time that I spent with the patient, because it's a 30 minutes, and then the add-on codes.

Erin Miller: And I don't anticipate, if I move forward with the selection, at least in our practice, that it would be more than about 45 minutes if I did both candidacy and selection on that same date.

Erin Miller: I don't know if… Annette, if you wanna…

Leisha Eiten: Well, I mean, so clearly, there… it does provide us a fair amount of flexibility, which I think is where people start to fear. We are all wanting to do things correctly. Many of us are super Type A, and we want to make sure we're not making any errors and we're not billing improperly.

Leisha Eiten: I think this helps us

Leisha Eiten: just take a little breath and think about, our practices and how we want to fit these in. And that's that change management. When we add new codes that are for a service, we haven't been able to bill before.

Leisha Eiten: When it's diagnostics, we're all like, yay, we can do it, but we still all… also encounter some hitches when it comes to implementation with payers. This is no different, but we're really kind of in a sea change of how we're thinking about the service that we provide and showing that we provide valuable services.

Leisha Eiten: Can we move to the next slide? Because I just want to do a quick

Leisha Eiten: Look at some of the things we're gonna, zip through here before the end of the hour, which is really about prep.

Leisha Eiten: And thinking about what your potential pain points could be.

Leisha Eiten: So I'm gonna just try to, pull these out, and…

Leisha Eiten: get through it so it stimulates some of your thinking. We go to the next slide.

Leisha Eiten: So, change management is all about preparation, but preparation from your practice's perspective. So, this is the opportunity to really talk about

Leisha Eiten: Amongst your… the providers you work with, and within your clinic to determine what

Leisha Eiten: how this fits onto the practices that you… the services you already provide. So, we'll let you talk amongst yourselves later, but let's move on to the next slide.

Leisha Eiten: This is…

Leisha Eiten: I just wanted to lay it out here in terms of where do the preps… we have, sort of

Leisha Eiten: pockets of preparation that need to be handled.

Leisha Eiten: Some of this would be handled more at the director level or a supervisor level, but know that even if that's not your responsibility, there is a lot of other prep that does go into it to make sure that from your service to getting paid for your service.

Leisha Eiten: things are…

Leisha Eiten: sort of moving through the system well. So I'm going to pull these out one at a time. So let's just take a look at clinic prep first. And, if you didn't take a shot of this, that you can come back to this later, but let's move on to the next slide.

Leisha Eiten: It's all about getting your timing going, because we are moving into primarily time codes for these, longer services. So,

Leisha Eiten: what I've been thinking about, and what I'm encouraging you to think about, is what are your clinic's processes? What are your, kind of, standard patterns to determine how that's going to link onto the service codes that we are introducing?

Leisha Eiten: And it's a lot of education, but also an agreement with staff within a clinic of, alright, I understand how this works, this fits into my practice and our processes in this way, and that's how we're going to make that work. It may mean that

Leisha Eiten: Different appointment types and times, descriptions could be added in that can be helpful.

Leisha Eiten: We're… I'm going to stress this again: hearing aid services codes are not prescriptive. They are descriptive of what you are doing with the patient and devices at that particular time.

Leisha Eiten: We did talk a little bit that there are some things that can be billed together and things that can't be billed together.

Leisha Eiten: We're going to be providing ongoing education here, so I'm not going to get into the weeds on parentheticals, but I know there's been some questions already. This is where we want to continue to provide good member education. So let's go on to billing preparation.

Leisha Eiten: Because again, we're talking about time and timed codes. How does your medical record system handle coding timed codes?

Leisha Eiten: So they may be set up to do things like an evaluation and management or office visit code, where a start and a stop time might be recorded. I think you need to understand your medical record system, check in with the people who

Leisha Eiten: do a lot of the medical record programming and updates, and ask them, how can I … how can I use the medical record system to help me record when I started the service and when I stopped the service? We feel like this is your opportunity to really start asking some business questions.

Leisha Eiten: Does my practice… do I have the ability to bundle or unbundle, and how would I fit the hearing device services into that?

Leisha Eiten: We're actually looking at how we can unbundle a little bit more, and feel like with these service codes, it makes it easier to track what we're doing. I know there have been some questions that already came up about, "well, what about our walk-ins, and what about our repairs?"

Leisha Eiten: And that isn't going to be necessarily a CPT code in this family.

Leisha Eiten: It may actually be a V code that's already existing, that you might be already using for things like walk-in repairs and appointments. And you would determine, are you really going to spend 16 minutes or more with somebody on a walk-in repair? If so, it might

Leisha Eiten: be appropriate for your practice to say," yes, that is going to be a follow-up code." And other practices would say, "no, that's more appropriately one of the V codes that's in the system." I think we all need to know what are we worth per hour, and that's a bigger calculation

Leisha Eiten: than just what you're paid. And in a bigger system, it'd be an average of salaries, but it's also benefits, it's rental, it's electricity, it's the equipment you have in there. That is not a simple calculation, but if you don't know what your service is worth, your per hour service, time to study it a little bit.

Leisha Eiten: I also feel like it's so critical to know who your billing staff is, because you need to start making friends and connections within your billing system, and get to know who's the person who's going to give me the correct information and is knowledgeable about coding, and I can share with you the fact that I'm knowledgeable about my codes

Leisha Eiten: codes I handle and the codes I'm billing. And those kinds of relationships really are helpful.

Mike Sharp: And also from a private practice perspective, too, if you don't know how to use inside your EMR system, or whatever it is you're using, to contact your vendors, and then those are the people that can guide you through, "okay, if I use system A,

Mike Sharp: what are the things that I need to set up in place to make sure that I have these available for me?" Or, you know, versus cycle, tims, whatever that happens to be.

Mike Sharp: If you're not aware, it'd be the time… now is the time to contact to do that.

Leisha Eiten: Yeah. So the billing preparation, if you are working with a business manager that's directly responsible for, you know, how things are coded and billed out to insurances,

Leisha Eiten: this is their… this is where they live, right? So, it's time to maybe get a little insight into how they calculate things. Be helpful.

Leisha Eiten: How about payer prep? Let's go on to the next slide.

Leisha Eiten: And, just a reminder, the payers also get those hundreds of new codes every year and have to figure out what they're going to do with all of those in payment. So, it's good to know who your payers are and who your payer reps are. Now, I am in a bigger facility.

Leisha Eiten: not a huge facility, so we're kind of a small hospital, but my contracts don't necessarily get decided by me. But in a smaller practice, or a private practice that's audiology more exclusively, you should… if you are not responsible for the contracts

Leisha Eiten: maybe start asking questions about what do our contracts actually cover? You might have third-party contracts. Sometimes there's Medicare Advantage contracts, where you're signing, things beside a TPA. So every payer may have a different philosophy on how they want to see these codes work.

Leisha Eiten: Again, these address services, and that is what CPT actually is supposed to be doing. Common procedural

Leisha Eiten: right? That's a common procedural language that we use. The HCPCs are devices, and our device codes are completely untouched. None of those have changed. So…

Leisha Eiten: That is where we're trying to say, we have valuable services, and we would like you to cover those services plus the devices that are being dispensed.

Leisha Eiten: I feel like it gives us a lot more power to say we are… this is where our value is. Look at the things that we do. It is not just the widget, it's not just the device.

Leisha Eiten: Our service gets that person a successful hearing aid fitting.

Leisha Eiten: So we have had some questions about how… well, where would you set it? How would you set your per hour fee? And we can't do that. The societies can't do that. That's considered antitrust. Fees are going to be unique to each practice. What a private practice is going to be setting it shouldn't be too far off, maybe, from what

Leisha Eiten: not-for-profit hospital might do, but still, those are going to be unique to that practice and how the hearing aid whole service provision is handled.

Leisha Eiten: Alright, let's move on to the next slide.

Leisha Eiten: So, we tried to think about, kind of, where you would expect and not be surprised that you're going to have some pain, so I'd rather it would be, I have the pain of gamer's thumb.

Leisha Eiten: because I was prepared, versus the pain of, I stepped on a Lego, and I can't walk now. So, I'm hoping we keep it to the lower levels of pain, if we can predict maybe where the main ones are that we're seeing. So, let's take a look at some of those.

Leisha Eiten: Let's go on to the next slide. So, first of all, we're making some big changes, and none of us

are comfortable.

Leisha Eiten: It takes a lot of talk and a lot of thinking about how you're going to make that work for you. This is not a cookbook.

Leisha Eiten: These give you much more flexibility, and… but it's a big shift in how we think about it, and how we practice it. So, it's going to take time, and it's going to take training. However, it helps you to think about it. Just keep studying the crosswalks

Leisha Eiten: and ongoing information, maybe that have more clinical scenarios. The things to remember is we're moving away from monaural and binaural. We feel like the most common fittings are actually binaural.

Leisha Eiten: The next one would be maybe a monoral or a contralateral fit. So they're really based on what's the most common service we provide, and when you think about the time that it takes to do a monoral versus a binaural new fit.

Leisha Eiten: maybe the times are not that different, because the training and the orientation and the counseling might be the majority of the time that you're working there, and so it accounts for that service. Those very specific verification codes are assumed to be binaural.

Leisha Eiten: So you would only indicate a reduced service modifier for those times when you're only testing one device instead of two.

Leisha Eiten: If you're going to bill…

Mike Sharp: Sorry.

Leisha Eiten: Sorry, go ahead, Mike.

Mike Sharp: Well, I just kind of want to jump in, too, because we're talking about this paradigm shift, and a few of the questions that have come in

Mike Sharp: have been things around the requirements mentioned in the codes, to remember that these descriptions of these codes are not requirements of all the services that you have to provide.

Mike Sharp: There are examples of services provided during candidacy and things like that, but it's not… it's not a cookbook, it's not a checklist of all the things that need to be done. So, when you look at these codes, and again, this is part of that paradigm shift.

Mike Sharp: It's not meant to be a, you have to do ABCD before you can then say, "okay, now I'm able to bill this code."

Leisha Eiten: I agree. So, again, it takes some thought, and it takes some reading, but we are trying not to make it more difficult, we're trying to provide more flexibility instead. Can we move to the next slide?

Leisha Eiten: So…

Leisha Eiten: therapeutic time codes are not a bundle. I've been seeing a lot of questions about, "well, isn't this just a bundled service?" In a sense

Leisha Eiten: it is not a traditional bundle of service, it's a collection of activities that are sort of grouped into, is this a candidacy activity? Is this a device selection activity, fitting or follow-up? And, a variety of things could be employed in a therapeutic service

Leisha Eiten: within a period of time. And it will depend on, do I have a pediatric patient, or a very elderly patient, or someone who has had some cognitive, effects from aging, and we're having to spend a lot more time on practice, those kinds of things. So, they're not

Leisha Eiten: another thing to keep in mind, paradigm shift, is time codes are not eligible for reduced service modifier. You have to hit the minimum time requirement

Leisha Eiten: in order to bill the service, and you must kind of calculate your time

Leisha Eiten: with the patient in that activity to know what is my total time. This is going to take some study.

Leisha Eiten: And maybe start practicing now. Like, should I be practicing writing down the times

Leisha Eiten: when I started my service and when I ended my service. Now, if we get good at it now, that practice is going to help later.

Leisha Eiten: We can see if our medical records help us… help us with, like, start and stop.

Leisha Eiten: But again, start and stop is not the be-all, end-all here. We've got a combination of add-on services and standalone services, so high-level view is, I really need to understand what I can put together and how to put that together within the time. That's why we want to keep providing more

Leisha Eiten: detailed instruction on some of these specifics, and we are hoping you can help us point out where we need to keep working.

Leisha Eiten: So let's go to the next slide, and be mindful of time here.

Leisha Eiten: This is a transition from diagnostic, which is prescriptive,

Leisha Eiten: is all the listed elements of a diagnostic code typically should be provided for me to be able to bill that code. Therapeutic coding, however, is descriptive of

Leisha Eiten: these are the elements that I felt were important to be evaluated as part of this service that I provided.

Leisha Eiten: Did I take a look at, what's their body orientation?

Leisha Eiten: Can they find their ears if they're not looking at their hands? Asking questions about vision. These are all things that we already do, but we don't really think about it as the important service that we provide. We're saying, yeah, that's an evaluative and therapeutic service.

Leisha Eiten: So, let's move on, so we have time for questions. They…

Leisha Eiten: People have asked, "well, why didn't you just leave the electroacoustic codes, at least leave the electroacoustic evaluation codes as is?" First of all, these are now moved into

Leisha Eiten: where they should be within the CPT codebook. They now are linked with CI programming and verification services. This is a much more important place, and I know people don't necessarily

Leisha Eiten: think about how important the groupings are in CPT, but from a Medicare point of view, it is critical that this move went into this therapeutic service. It just helps us continue to make the case that we provide intervention and therapeutic

Leisha Eiten: services within our scope of practice.

Leisha Eiten: They are not technically what's called an "evaluation and management," or what many people call E&M codes, but they have the similar spirit, which is, first of all, that time that you're using is based on the complexity of the patient

Leisha Eiten: and the complexity of the data you're trying to put together. Like, you're trying to make lots of decisions all the way through here.

Leisha Eiten: I should go this direction, I should go that direction. I'm getting some information from the patient, and now I'm going a different direction. That's all the complexity of things we use to make decisions. I have questionnaire information. Oh, I didn't realize that we have to now consider this very important thing that the patient likes to do, which is…

Leisha Eiten: bridge. I don't know, they really want to hear bridge. I don't play bridge, but whatever.

Leisha Eiten: And then E&M also takes into account the total time with the patient, rather than saying, "I have to check off, I did this element, this element, this element, this element, and now I can call it this service."

Leisha Eiten: We're talking about time and complexity here, not necessarily, I hit each one of these requirements that are listed as the possible things I can do in this time.

Leisha Eiten: Mike, go ahead. You had some answers to some questions that you thought might clarify?

Mike Sharp: Yep, just a couple things. One is, there's been a lot of questions coming through about, kind of, the difference between V codes and when to use that. I know we kind of mentioned a little bit, but, for example, for, like, a repair or dispensing fee versus using the new codes. And a lot of it, and we, especially the repairs, I know Leisha had kind of mentioned, it comes down to timing.

Mike Sharp: When we're thinking about, if someone comes in, and you're just gonna do a quick clean, you know, like, maybe you've even only taken a couple steps towards the lab, and you've already figured out, oh, it's the dome, pop it off, pop a new one on, everything's good. Then, if it's really short, quick

Mike Sharp: that's the time where we're thinking a repair code, V-code. If it's something where you're going to sit down with a patient, spend at least 16 minutes with them working on something, then we're going to be thinking about the new code system for that sort of thing.

Leisha Eiten: Yeah.

Leisha Eiten: I think, we're still going to be very much dependent on our payers, and that's okay. I mean, I work with Medicaid. Medicaid moves at a snail's pace to make changes in their fee schedules, and we're…

Leisha Eiten: introducing new codes right in the middle of what my state considers its year.

Leisha Eiten: So, I can still… capture some of the V-code things.

Leisha Eiten: If you feel like over time, it actually makes more sense to keep making the case that a payer should move over to these evaluative and therapeutic types of services, then you could make that transition. We're not saying you can't use the V codes, because there are V codes, they're also not very specific.

Leisha Eiten: But they may be continued to be used on, on…

Leisha Eiten: insurance fee schedules. I guess, kind of got a little tied up there, but… Anything else, Mike?

Mike Sharp: Another one that was a little bit interesting that came up for a couple places, too, is for anyone who's doing CI codes and CI services and billing these at the same time should not, to the best of my knowledge, run into any conflicts, but please correct me if I'm wrong...I'm wrong there, but that question's come up a few times.

Leisha Eiten: hm

Leisha Eiten: You just need to be really careful about your time, and if you're kind of going… again, it's like, that's a in-the-weeds sort of specificity, is you just have to keep track of your time properly. You just have to be scrupulous about recording your times of this activity, that activity.

Leisha Eiten: Okay, let's move on.

Annette Burton: And you would also need to differentiate the time for each activity, and you would still have to use the, you know, 59 modifier for that.

Leisha Eiten: So, another part that we have to have more discussion on, and I think we… this is clear where we need to provide some very specific information for people.

Leisha Eiten: There are some very special payer considerations, and we know these are pain points. If you're working with Medicaid, like I do in my state, this is state-specific coverage, and like I said, it can move very slowly.

Leisha Eiten: However, that may mean at your state level of your society that you're involved with, are you going to be the one to step up and say, "hey, I really just want to start advocating with Medicaid to make these changes?"

Leisha Eiten: ASHA, AAA, none of our national societies actually are going to do that at the state level. They can assist and provide you materials, but that is on us as providers to advocate for what we think is appropriate for coding.

Leisha Eiten: I know with third-party payers

Leisha Eiten: the arrangements are very different, but I think you may have actually more power than you know to go back and say, I'm not… I'm renegotiating my contract, and these need to be reflecting the new codes, and my value, the value of my time.

Leisha Eiten: TRICARE is always tricky, because it's a little bit like Medicaid. The VA community care plans are going to be very much depending on… we're looking to the VA to see how quickly the uptake is. We know that our audiologists that work in the VA and the DOD

Leisha Eiten: feel like this is really… these codes are very important for them, because it's helping them actually show their productivity of the service and time that they're putting in. But again, how that moves into a community plan.

Leisha Eiten: We're gonna keep working on it. All right, let's move on to the next slide.

Leisha Eiten: So…

Leisha Eiten: First of all, again, we're at a very high-level view. We know we have to be providing more practical and specific resources, and we're going to keep doing that from both ASHA and AAA's perspective.

Leisha Eiten: The resources are listed here down below. They should be fairly similar from what you see, but we have some things in common between AAA and ASHA, and some things that are different that we have geared more to our specific memberships. But, you know, if you're a member of both, you have access to both.

Leisha Eiten: We would like to know, and if you can pop it into the Q&A, what additional resources you would like to see? Then we really can take those and build even better practical resources for you as we continue to work on this rollout.

Leisha Eiten: Mike, any other questions that have come up that you want to jump in here?

Mike Sharp: Yeah, and as far as… to kind of piggyback off that a little bit, too, you can also feel free to,

even after this, contact your organizations, and, you know, ask your AAA, respectively, depending on the other thing… the things that you want to see, too. It just doesn't have to be tonight.

Mike Sharp: So some of the other questions that have come up, some of the… there have been some scenarios, and I wanted to stress that as we go forward, we're going to create more and specific training, so this is not the end of the training that you'll be receiving from both

Mike Sharp: ASHA and AAA as we move forward to learn more about these codes and clinical scenarios and things like that. But some of the simple questions that have come up are things like, "will these be Medicare billable?"

Leisha Eiten: Well, they're not… none of the hearing aid codes are currently Medicare billable now, so we are not experiencing any change when it comes to Medicare. That is the primary

Leisha Eiten: push for us to not go through a survey of value to try to get a RUC value for these codes, because the current electroacoustic and hearing aid evaluation codes, they have no RUC value either, because they are not a covered service under Medicare. Now, if things change at the national law level, where Congress says

Leisha Eiten: Medicare must now cover hearing aid devices

Leisha Eiten: then we have codes that we could move forward, and at that point, ask for value, for RUC value to help us. But at this point, it was,

Leisha Eiten: so unclear what things were gonna… how things were gonna progress in the national…

Leisha Eiten: politics arena that we feel like we just needed to move forward and have the codes.

Erin Miller: And I would say at least the codes now are ready for the RUC if we did have to survey them.

Leisha Eiten: Absolutely.

Erin Miller: It would be much easier for us to move forward with that survey.

Leisha Eiten: Yeah.

Mike Sharp: And someone in the Q&A brought up a good point, and they were conveying a point of view that they understand it's not a checklist, but they want to make sure that, on the flip side, how can we assure that patients receive a certain minimum standard of care? And one of the things to really stress about CPT codes is CPT codes are not…

Mike Sharp: what we would create as a standard of care. That's not where the standard of care lies, as far as is their purpose, and that's true for all of medicine. So what we have to bear in mind is CPT codes are meant to show, kind of, what's the most typical clinical scenario, and so that obviously comes down to people's

Mike Sharp: Training, best practices, all those kinds of things, and obviously we still want to follow the standards.

Leisha Eiten: Correct. Absolutely.

Leisha Eiten: The other thing that sort of came to mind as I'm looking through some of the questions, oh, is…

Leisha Eiten: well, "where… where should I … where should I really, like, focus and make sure I'm getting paid?" If you're most concerned about

Leisha Eiten: the fact that the current electroacoustic monoral and binaural code is being… codes are being deleted, that code pair, then maybe you want to spend a little bit of extra effort right now to make sure that the new electroacoustic evaluation code

Leisha Eiten: number will be paid.

Leisha Eiten: That can be a very simple thing. You don't have to get into all the weeds of all the others, but if that's one of your primary concerns, work with your payers to make sure they understand it's switched.

Leisha Eiten: It's not that it's gone. It used to be this number, now it's going to be this number. And instead of monaural or binaural, it's going to be assume a binaural code unless

Leisha Eiten: you do a reduced service modifier. So, those kinds of things, it's like, let's work on the little things so we can sort of knock these things through and feel more comfortable as we address all the codes.

Leisha Eiten: So, some things that, you know, the fear is, I'm losing something, right? We're deleting codes. Well, we're not losing. They're transferred, and they're different numbers, but now we have actually more choices that we can pick from in order to reflect the true service we provide.

Denise Garris: Great, thank you all. Thank you to the presenters, and thank you to everyone who attended today's webinar. Please remember to click on the link to download your certificate of attendance, and if you'd like to review this session, or know someone who couldn't join live, a recording will be available soon.