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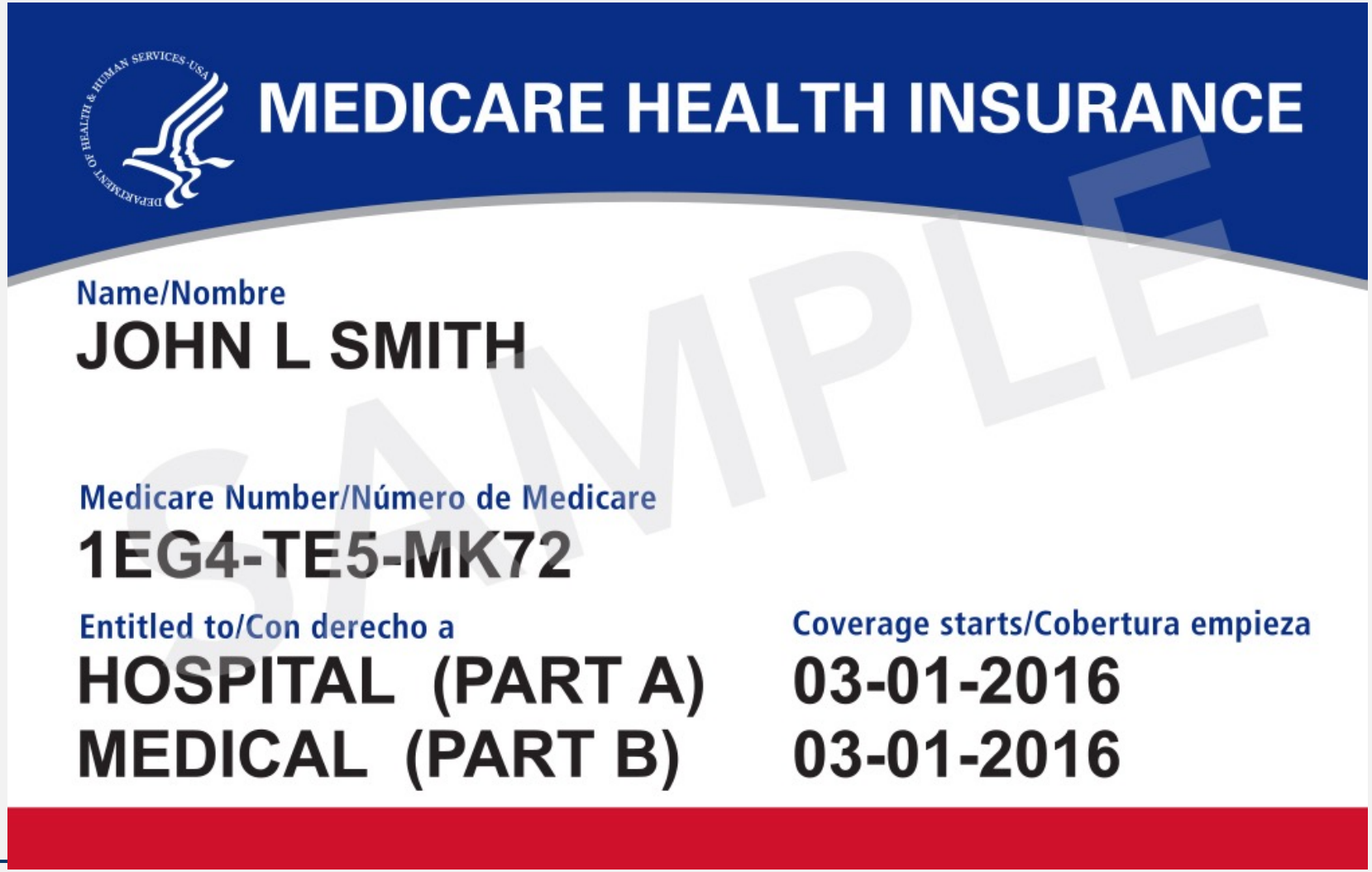

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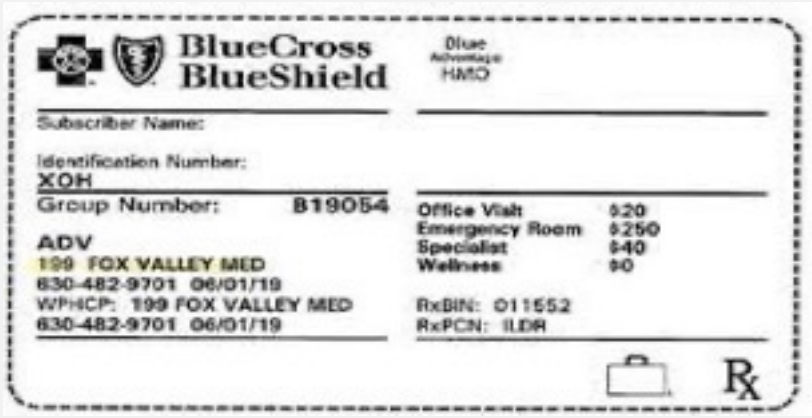

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INSURANCE CARD EXAMPLE MEDICARE SUPPLEMENT (MEDI-GAP)

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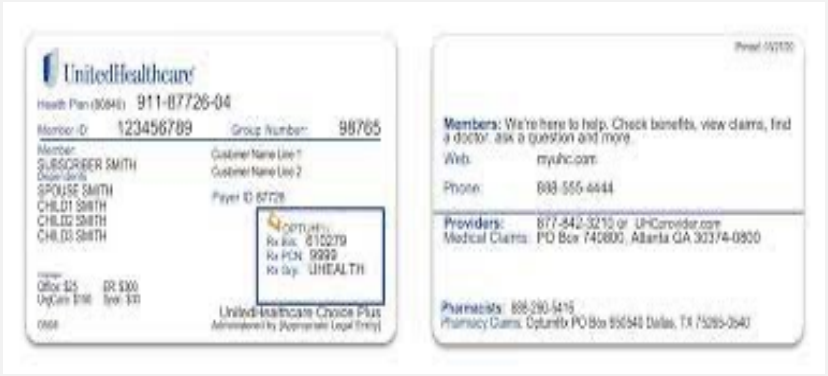

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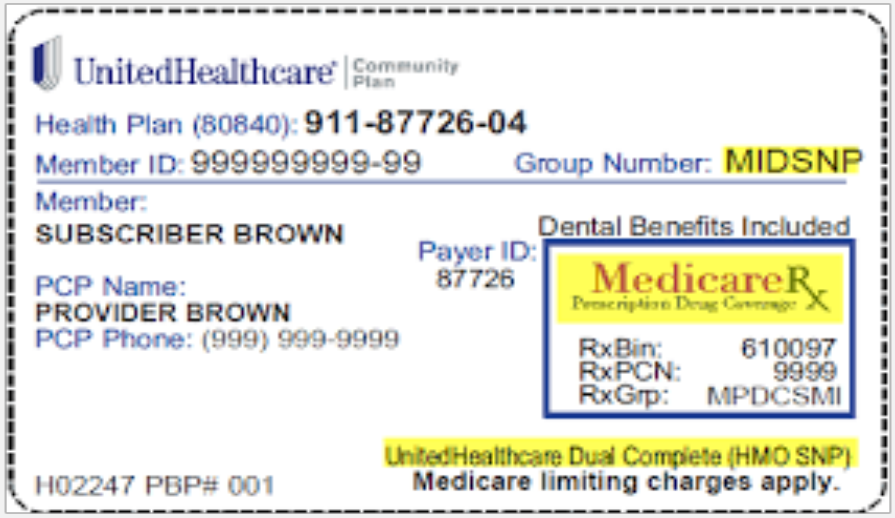

PLAN COVERAGE TIPS

	Traditional Medicare	Medicare Advantage	Medicaid/Medicaid MCO/Dual	Commercial
Routine Services	Not covered	May be covered	May be covered	May be covered
Diagnostic Services	Covered if medically necessary and may need an order	Covered if medically necessary	Covered if medically necessary	Covered if medically necessary
Treatment Services	Not covered	Rarely covered	May be covered	May be covered
Hearing Aid Services	Not covered; discount program may be available through supplemental policy	Typically a discount program through TPN. Unionized plans may have coverage	Covered for children and adolescents 21 and under and coverage is plan dependent for adults 22 and older	Plan dependent
Out of Network/Not Enrolled	Free	Covered services allowed at Medicare Limiting Charge	No coverage	Plan dependent

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MICHIGAN MEDICAID EXPANSION

- Guidance
- Health Information Technology Resources
- Training Opportunities

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- *([illegible]: [illegible] 92559 [illegible] 92561 [illegible] 1/1/22. C[illegible] 92700 [illegible] B[illegible]).

BCBS OF MICHIGAN MEDICAL POLICY

- Exclusions (Experimental/Investigational)
  - Automated audiometry (self-administered or administered by non-audiologist)
  - Speech in noise (SIN)
  - Hearing in noise test (HINT)
  - Tests solely used to determine the appropriate type of hearing aid (e.g., SIN, HINT)
- Exclusions (tests considered obsolete and thus not medically necessary):
  - Lombard test (replaced by the Stenger test and auditory evoked potential) (92700)
  - Alternate binaural loudness balance test (92562)
  - Short increment sensitivity test (replaced by pure tone audiometry/auditory evoked potential) (92700)
  - Bekesy audiometry/screening (92700)
  - Staggered spondaic word test (92572)
  - Synthetic sentence identification test (92576)

BCBS OF MICHIGAN MEDICAL POLICIES

- Vestibular
  http://www.bcbsm.com/amslib/content/dam/public/mpr/mprsearch/pdf/77357.pdf
- Inclusions: Vestibular function testing using an electronystagmography and videonystagmography testing batteries, caloric testing, or rotational chair testing may be considered medically necessary when the following conditions have been met:
  - • The patient has symptoms of vestibular disorder (e.g., dizziness, vertigo, imbalance); AND
  - • A clinical evaluation, including maneuvers such as the Dix-Hallpike test if indicated, has failed to identify the cause of the symptoms. The ENG/VNG testing batteries may include caloric testing, positional tests, and oculomotor evaluation (i.e., spontaneous nystagmus including gaze-evoked nystagmus, positional nystagmus, optokinetic nystagmus, smooth pursuit tracking, saccade test).

The ENG/VNG testing batteries may include caloric testing, positional tests, and oculomotor evaluation (i.e., spontaneous nystagmus including gaze-evoked nystagmus, positional nystagmus, optokinetic nystagmus, smooth pursuit tracking, saccade test).

BCBS OF MICHIGAN MEDICAL POLICIES

- Vestibular
  http://www.bcbsm.com/amslib/content/dam/public/mpr/mprsearch/pdf/77357.pdf
- Exclusions Vestibular function testing for
  - Vestibular evoked myogenic potential tests
  - Assessment of typical benign paroxysmal positional vertigo that can be diagnosed clinically
  - Repeat testing when treatment resolves symptoms
  - all other situations not listed in inclusions
  - All other laboratory-based vestibular function tests not described above

BCBS OF MICHIGAN MEDICAL POLICIES

- Vestibular
  http://www.bcbsm.com/amslibs/content/dam/public/mpr/mprsearch/pdf/77357.pdf
- Established codes: 92537 92538 92540 92541 92542 92544 92545 92546 92547
- Other codes (investigational, not medically necessary, etc.): 92517 92518 92519 92700

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  - E[illegible]l, 2023.

CHILD-ADULT MEDICAL POLICIES
HC CODE CIA 2023

- https://www.cms.gov/Medicare/Coding/MedicalCodingEducation/Downloads/HCPCS-Publication-Ordering-Information.pdf
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CHILD-ADULT MEDICAL CONCEPT 2023 ADDENDUM

https://www.federalregister.gov/documents/2022/06/29/2022-13699/0612.pdf

A number of commenters requested clarification regarding the following:

- Whether the 40 percent (B) H[illegible] 500, 1000, 2000, 3000, 4000 [illegible] (H); and
- Whether the 26 B H[illegible];
- [illegible] 94 [illegible]

CHILD-AGE MEDICAL DEVICE 2023 UPDATE

A BRIEF OVERVIEW OF THE FDA-REGULATED MEDICAL DEVICE INDUSTRY, INCLUDING THE PROCESS FOR OBTAINING MARKET AUTHORIZATION FOR A MEDICAL DEVICE, THE DIFFERENT TYPES OF MEDICAL DEVICES, AND THE REGULATORY REQUIREMENTS FOR MEDICAL DEVICES.

- THE FDA'S ROLE IN REGULATING MEDICAL DEVICES.

FOR MEDICAL DEVICE MANUFACTURERS, THIS PRESENTATION CAN HELP THEM UNDERSTAND THE FDA REGULATORY PROCESS AND THE REQUIREMENTS FOR MARKETING A MEDICAL DEVICE.

CHIP-A MEDICAID POLICIES 2023/4 – FEH

https://www.dhs.wisconsin.gov/publications/p-nwnet/p-nwnet-2023-04.pdf

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  - [illegible] $2500.

MEDICARE PHYSICIAN FEE SCHEDULE CHANGES

- Effective January 1, 2023
- Office/outpatient evaluation and management (E/M) visits (99202-99215) and prolonged services (99354-99357, 99415-99416) will be reported using either medical decision making or total time on the date of the encounter, regardless of the place of service. Total time is the sum of the time spent by the physician and/or qualified health care professional and clinical staff providing services to the patient on the date of the encounter. Total time includes, but is not limited to, the following activities: preparing to see the patient (e.g., review of tests); obtaining and/or reviewing separately obtained history; performing a medically appropriate examination and/or evaluation; counseling and educating the patient/family/caregiver; ordering medications, tests, or procedures; referring and communicating with other health care professionals (when not separately reported); documenting clinical information in the electronic or other health record; independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver; and care coordination (not separately reported).
- Critical care services (92517-92519 and 92537-92549) and 92700 (Somatosensory testing) will be reported using only total time on the date of the encounter.

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

MEDICARE PHYSICIAN FEE SCHEDULE CHANGES

- The Medicare Physician Fee Schedule (MPFS) is updated annually. In 2015, the AMA Relative Value Scale Update Committee (RUC) reviewed 291 codes and made recommendations to CMS on the appropriate work relative value units (RVUs), practice expense RVUs, and malpractice RVUs for these services. In addition, CMS identified 42 potentially misvalued codes for review in 2015. CMS accepted 12 of the RUC recommendations for the 2015 MPFS. CMS also made changes to the payment rules for certain services.

MEDICARE PHYSICIAN FEE CHANGES

- **92700 ADD A MODIFIER**

- Given the complexity of the procedure and the variation in the amount of time it takes to perform the procedure, the physician work relative value unit (RVU) for the procedure is based on the 25th percentile of survey times (that is, the survey time at which 25 percent of the survey respondents reported shorter survey times and 75 percent reported longer survey times). The practice expense RVUs, however, are based on the 50th percentile (median) survey time, consistent with the methodology we use for most services. We believe that the 25th percentile survey time for the physician work RVU is appropriate because it takes into account efficiencies that clinical staff have with the procedure, as clinical staff are responsible for the majority of the work in the practice expense RVUs.
- We received many comments on the proposed rule regarding the proposed deletion of CPT code 92700 (Unlisted otorhinolaryngological service or procedure). Commenters stated that CPT code 92700 is frequently used to report the application of a hearing aid and that deletion of the code would result in inappropriate reporting of the service. Commenters requested that we maintain CPT code 92700 for the application of a hearing aid.
- In response to these comments, we agree with the commenters that CPT code 92700 is frequently used to report the application of a hearing aid, and we will maintain CPT code 92700 for this purpose. We will add modifier 52 (Reduced services), modifier 53 (Discontinued procedure), modifier 73 (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure prior to the administration of anesthesia), and modifier 74 (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure after administration of anesthesia) to CPT code 92700.

THINGS NOT TO DO

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

THINGS NOT TO DO

- **Do** not fit stock hearing aids on a patient and bill the hearing aids to a health plan
  - Medical necessity for the item being dispensed must be documented in the medical record Many payers in their coverage and benefits language medical policies or contract language require a manufacturer's invoice be submitted when requested Also some health plan's allowable is based upon a percentage of the manufacturer's invoice cost and as a result the invoice must be submitted as part of the claims process This invoice must reflect the actual invoice cost (and not single unit or MSRP), be dated after the date of the hearing aid evaluation and should contain the name of the patient
  - The solution Select and order hearing aids for each specific patient from the manufacturer folowing the communication needs assessment hearing aid evaluation when a health plan is paying in whole or in part of the item
- **Do** not bill a health plan for an item you received at no charge
  - This is a potential violation of false claims and antkickback legislation (https /oig hhs go /documents physicians resource /947/roadmap_web_version pdf) and has been well documented in healthcare (https /www justice gov op /p /united states settles false claims act allegations cochlear americas 380000; https /www justice go /usao edmo p /united states reaches 291288- civil settlement d -sherry ma and aima neurology llc,
  - The solution If the item was free provide it to the patient for free

THINGS NOT TO DO

- **Do** not bill services provided by unlicensed or non-credentialed provider to a health plan under another provider's national provider identifier
  - Recent graduates are unlicensed providers. They cannot see any patient, regardless of payer, until they are licensed (unless their state has clear provisional or temporary licensure or privileges, which is not common). The newly licensed and new employees cannot see patients and bill the items and services to a health plan until the audiologists are credentialed providers for the health plan (with few exceptions). Otherwise, this is a false claim (https://www.fbi.gov/scams-and-safety/common-scams-and-crimes/health-care-fraud, https://oig.hhs.gov/documents/physician-resources/947/roadmap_web_version.pdf).
  - The solution: *Do* not begin employment as an audiologist until licensure is conferred and do not allow audiologists to see patients where insurance claims are being submitted for covered services until the provider has been credentialed with the health plan.
- **Do** not market to existing patients that they are "due" or "eligible" for new hearing aids
  - This can be seen as a solicitation or as potential fraud, abuse or waste when medical necessity for the replacement device has not been clearly documented (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf). Some health plans, including most state Medicaid programs, have medical policies that clearly require documentation of medical necessity (not just that the eligibility date has arrived) for replacement devices (https://www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_a085384.html).
  - The solution: Recommend, fit and bill health plans for replacement hearing aids when it is medically reasonable and necessary to replace existing hearing aids.

THINGS NOT TO DO

- **Do** not assume an item or service is non-covered just because the treatment plan includes hearing aids and, as a result, charge the beneficiary privately for the service
  - While Medicare does not cover "examination for the purpose of prescribing, fitting, or changing hearing aids" or "routine" services (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf), coverage of audiometric testing is not automatically precluded JUST because the patient is a hearing aid user or because the treatment plan includes hearing aids. The Update to Audiology Policy (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R84BP.pdf) indicated "It is appropriate to pay for audiological services for patients who have sensorineural hearing loss and who wear hearing aids if the reason for the test is anything other than evaluation of the hearing aid. For example, there may be a perceived change in hearing or tinnitus that makes testing appropriate and covered. Such testing might rule out other reasons for the symptoms (auditory nerve lesion, middle ear infection) and result in subsequent evaluation of the hearing aid (not covered) or aural rehabilitation by a speech-language pathologist (covered)." So, in other words, if the testing is physician ordered and medical necessity has been documented, Medicare will cover the testing. The patient should not be held financially responsible.
  - The solution: Allow the patient to access their health plan benefits by reviewing the patient's case history, documenting medical necessity for the services provided, and billing the health plan for medical necessary services

THINGS NOT TO DO

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

THINGS NOT TO DO

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

THINGS NOT TO DO

- If you are fitting a patient with a CROS/BICROS system (two devices), do not bill the devices as a hearing aid plus a “contralateral routing device, monaural”, either on a single date of service or separate dates of service
  - This constitutes a false claim (https://oig.hhs.gov/documents/physician-resources/947/roadmap_web_version.pdf), unless the health plan, in specific medical policy or payment guidance, allows for this coding scenario.
  - Just because it processed and paid does not mean that the health plan could not come back, at a later date, and legitimately request these monies.
  - The solutions
    - Bill CROS/BICROS systems on the same date of service using the ”contralateral routing system, binaural” codes
    - Attempt to renegotiate your allowable rates for the CROS/BICROS code set
    - Appeal payment decisions by sharing invoice information, illustrating how the devices are invoiced to your practice
    - Itemize your claim to the health plan
- Do not get your advice on billing, coding, or managed care solely from social media.
  - All of the scenarios from this “what not to do” section were created because someone, on social media, recommended this to their colleagues.
  - The solution: Reach out to state and national audiology associations, industry experts (myself, AA□C, Zupko, etc.) and health plan education and guidance when you have questions.

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