

MANAGING MANAGED CARE

Kim Cavitt, AuD

Audiology Resources, Inc.

October 19, 2024

INSURANCE CARD EXAMPLES – TRADITIONAL MEDICARE



MEDICARE HEALTH INSURANCE

Name/Nombre

JOHN L SMITH

Medicare Number/Número de Medicare

1EG4-TE5-MK72

Entitled to/Con derecho a

HOSPITAL (PART A)

MEDICAL (PART B)

Coverage starts/Cobertura empieza

03-01-2016

03-01-2016

INSURANCE CARD EXAMPLES – MEDICARE PART C (ADVANTAGE)

UHC

BCBS HMO



INSURANCE CARD EXAMPLES – MEDICARE PART C (ADVANTAGE)

BCBS STATE HEALTH PLAN MEDICARE PLUS



BCBS MEDICARE



INSURANCE CARD EXAMPLES – MEDICARE SUPPLEMENT (MEDI-GAP)

AARP | Medicare Supplement Plans
insured by UnitedHealthcare
Insurance Company

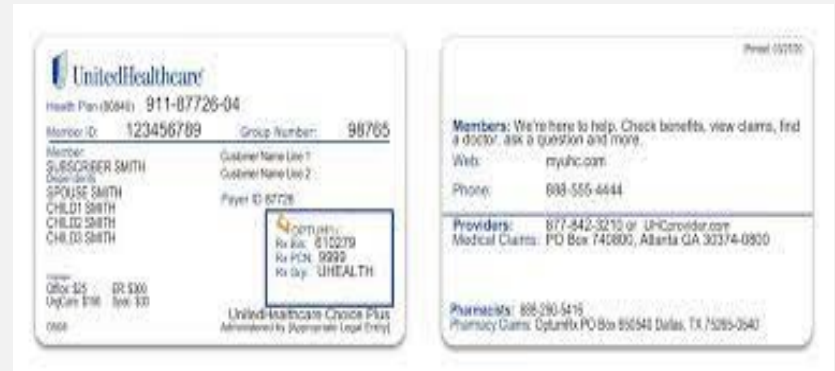
MEMBERSHIP ID 123456789-11
MR JOHN Q SAMPLE
EFFECTIVE DATE: 00-00-000
AARP MEDICARE SUPPLEMENT PLAN F

Insured by UnitedHealthcare Insurance Company (for NY residents, UnitedHealthcare Insurance Company of NY).

INSURANCE CARD EXAMPLES – COMMERCIAL INSURANCE

BSBS

UHC



MICHIGAN MEDICAID EXAMPLES

STATE MEDICAID



BCBS



MEDICAID EXAMPLES

MOLINA




Member Name: <Member Name>
 Member ID: <Member ID>

Beneficiary ID: <Beneficiary ID>
 PCP Name: <PCP Name>
 PCP Phone: <PCP Phone>

MEMBER CANNOT BE CHARGED
 County: MI

Continuum

MedicareRx
 Prescription Drug Coverage

Rx BIN: <Rx BIN>
 Rx PCN: <Rx PCN>
 Rx GTP: <Rx GTP>
 Rx CD: <Rx CD>

In an emergency, call 911 or go to the nearest emergency room. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice Line.

Member Services: (800) 732-5504, TTY: 711
 24-Hour Nurse Advice Line: (800) 489-2544
 Website: www.molinahealthcare.com
 Behavioral Health Services: (800) 344-2009, TTY: (800) 630-1844
 Michigan: (866) 965-2264, TTY: 711
 24-Hr Behavioral Health Crisis Line: (800) 241-4242, Michigan: (588) 337-8180

Submit Claims To: P.O. Box 22068, Long Beach, CA 90801
 EOI Claims: Enrolled Payer ID: 38334

Claims Inquiries: (855) 322-4377

UHC



UnitedHealthcare | Community Plan | Michigan

Health Plan (80840) 911-95467-00

Member ID: 999999999 Group Number: MIPHCP

Member: SUBSCRIBER BROWN Payer ID: 95467

State Assigned ID: 999999999

PCP Name: DR. PROVIDER BROWN

PCP Phone: (999)999-9999


Effective Date: 09/01/2018



Rx Bin: 610494
 Rx Grp: ACUMI
 Rx PCN: 4242

0501 Administered by UnitedHealthcare Community Plan, Inc.

INSURANCE CARD EXAMPLES – DUAL ELIGIBILITY MCO

 **UnitedHealthcare** | Community Plan

Health Plan (80840): **911-87726-04**

Member ID: **999999999-99** Group Number: **MIDSNP**

Member:
SUBSCRIBER BROWN

PCP Name:
PROVIDER BROWN

PCP Phone: (999) 999-9999

Payer ID:
87726

Dental Benefits Included

MedicareRx
Prescription Drug Coverage X

RxBin: **610097**
RxPCN: **9999**
RxGrp: **MPDCSMI**

UnitedHealthcare Dual Complete (HMO SNP)
Medicare limiting charges apply.

H02247 PBP# 001

PLAN COVERAGE TIPS

	Traditional Medicare	Medicare Advantage	Medicaid/Medicaid MCOs/Dual	Commercial
Routine Services	Non-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	Non-covered	Rarely covered.	May be covered.	May be covered.
Hearing Aid Services	Non-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.

PAYER GUIDANCE AND MEDICAL AND COVERAGE POLICIES

- Many third-party payers do not cover amplification for the treatment of tinnitus in the absence of hearing loss.
- Aetna: <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#>
- Cigna: <https://www.cigna.com/health-care-providers/coverage-and-claims/policies/>
- Humana: http://apps.humana.com/tad/tad_new/home.aspx?type=provider
- UHC
 - <https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html>
 - Also search subsidiaries, such as Optum and Oxford, separately.
- VA Community Care
 - <https://vacommunitycare.com/provider>
 - https://www.va.gov/COMMUNITYCARE/revenue_ops/Fee_Schedule.asp#current

MICHIGAN MEDICAID RESOURCES

- [Guidance](#)
- [Hearing Services](#)
- [Provider Manual](#)

BCBS OF MICHIGAN MEDICAL POLICY

- Hearing Services:
<https://www.bcbsm.com/amslibs/content/dam/public/mpr/mprsearch/pdf/76836.pdf>
- Established codes: 92551 92552 92553 92555 92556 92557
92558 92571 92584 92563 92575 92587 92565 92577 92588
92567 92579 92650 92568 92582 92651 92570 92583 92700*
- *(Note: codes 92559 and 92561 were removed from policy as the codes were deleted on 1/1/22. Code 92700 is only allowed to report group audiometric testing and Bekesy).

BCBS OF MICHIGAN MEDICAL POLICY

- Exclusions (Experimental/Investigational):
 - • Automated audiometry (self-administered or administered by non-audiologists)
 - • 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:
<https://www.bcbsm.com/amslibs/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:
<https://www.bcbsm.com/amslibs/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
 - In all other situations not listed in inclusions
 - All other laboratory-based vestibular function tests not described above.

BCBS OF MICHIGAN MEDICAL POLICIES

- Vestibular:
<https://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

BCBS OF MICHIGAN MEDICAL POLICIES

- Bone Anchored Devices:
<https://www.bcbsm.com/amslibs/content/dam/public/mpr/mprsearch/pdf/77357.pdf>
- Cochlear Implants:
<https://www.bcbsm.com/amslibs/content/dam/public/mpr/mprsearch/pdf/2177862.pdf>
 - Effective November 1, 2023.

THIRD-PARTY MEDICAL POLICIES – UHC COMMERCIAL 2023

- <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/hearing-aids-devices-including-wearable-bone-anchored-semi-implantable.pdf>
- “Standard plans include coverage for wearable Hearing Aids that are purchased as a result of a written recommendation by a Physician.
- Benefits are provided for the Hearing Aid and for charges for the associated fitting and testing. The wearable Hearing Aids benefit does not include batteries, accessories, or dispensing fees.
- If more than one type of Hearing Aid can meet the member’s functional needs, benefits are available only for the Hearing Aid that meets the minimum specifications for the member’s needs. If the member purchases a Hearing Aid that exceeds these minimum specifications, UnitedHealthcare will pay only the amount that it would have paid for the Hearing Aid that meets the minimum specifications, and the member will be responsible for paying any difference in cost”.
 - I would recommend a waiver that clearly reflects this fact.

THIRD-PARTY MEDICAL POLICIES 2023 – AETNA

http://www.aetna.com/cpb/medical/data/600_699/0612.html

“Air conduction hearing aids are considered medically necessary when the following criteria are met:

- hearing thresholds 40 decibels (dB) HL or greater at 500, 1000, 2000, 3000, or 4000 hertz (Hz); *or*
- hearing thresholds 26 dB HL or greater at three of these frequencies; *or*
- speech recognition less than 94 percent”.

THIRD-PARTY MEDICAL POLICIES 2023 – AETNA

”Aetna considers the Bose Hearing Aid and other FDA-cleared hearing aids available over the counter without a prescription as medically necessary equally effective alternatives to hearing aids available only by prescription for persons whose hearing has been evaluated and meet medical necessity criteria for air conduction hearing aids, and the member has a prescription for the hearing aid from a physician or provider licensed to prescribe hearing aids.

- State dispensing laws will matter here.

For plans that do not exclude hearing aids, either OTC and prescription hearing aids are eligible for coverage if they are cleared by the FDA and prescribed by a qualified healthcare provider and medical necessity criteria for hearing aids above are met”.

THIRD-PARTY MEDICAL POLICIES 2023/4 – FEHP

<https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/>

- In 2024, this program will require prior authorization .
- FEHP hearing aid benefits are not “one size fits all”.
 - Allowable rates are payer dependent.
- BCBS FEHP plan:
 - Deductible does not apply to standard plan but does apply to basic plan.
 - “Hearing aids for children up to age 22, limited to \$2,500 per calendar year.
 - Here is a rationale for an unbundled delivery.
 - Hearing aids for adults age 22 and over, limited to \$2,500 every 5 calendar years. Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.”
 - The patient is responsible for all costs which exceed \$2500.

MEDICARE PHYSICIAN ORDER CHANGES

- Effective January 1, 2023
 - Technically, audiologists can provide non-acute hearing assessment unrelated to disequilibrium or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids once every 12 months without a physician order.
 - This applies to traditional Medicare beneficiaries. Medicare Advantage plans, generally, do not require a physician order (unless specified in your agreement).
 - Vestibular services (92517-92519 and 92537-92549) and 92700 will always require a physician order for traditional Medicare coverage.
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THE LIST OF
 AUDIOLOGIC
 PROCEDURES THAT
 CAN BE PROVIDED FOR
 NON-ACUTE
 CONDITIONS
 WITHOUT A PHYSICIAN
 ORDER ONCE EVERY 12
 MONTHS

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 imittance 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 thrshld est mlt freq i&r

MEDICARE PHYSICIAN ORDER CHANGES

- When a physician order is not required and not obtained, no ordering physician will be listed on the claim. Instead, the AB modifier (Audiology service furnished personally by an audiologist without a physician/NPP order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary) must be added to every procedure code performed on that date of service.
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MEDICARE PHYSICIAN ORDER CHANGES

- **92700 ALWAYS** requires a physician order.
 - Generally, the services billed on a traditional Medicare claim, will all either be physician ordered (where the name and national provider identifier of the ordering physician or non-physician practitioner is listed on the claim) or not ordered (non-acute hearing assessment and unrelated to disequilibrium or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids where the AB modifier is added to every item and service listed on the claim).
 - One exception may be when billing for some services to obtain the required Medicare denial. In this case, the GY modifier (item or service statutorily excluded or does not meet the definition of a Medicare benefit) would be added to those items and services which are non-covered by Medicare. Failure to document an ordering physician AND failure to add an AB modifier to every service on a claim (that was provided without an order) will result in a claims denial.
 - It is recommended that practices either utilize an Advanced Beneficiary Notice, prior to assessment, or secure a physician referral. If their practice has 1) no record of the use of the AB code (and associated testing), by their or another practice within the past 12 months, 2) does not have a physician order AND 3) are planning, as a result of the lack of a physician order, to utilize the AB modifier. Again, this is another example where triage at scheduling can be invaluable. We also encourage audiologists to reach out to their Electronic Health Record/Electronic Medical Record (EHR/EMR) vendors to determine what internal verification processes might exist.
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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 (<https://www.asha.org/practice/reimbursement/medicare/audiology-medicare-prohibitions-faqs/>). The ONLY exceptions are indigence or if your practice were to ONLY bill insured patients (<https://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 (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf>; <https://www.bcbs.com/healthcare-fraud>; <https://www.uhc.com/fraud/faqs>). 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 following 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 anti-kickback legislation (https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf) and has been well documented in healthcare (<https://www.justice.gov/opa/pr/united-states-settles-false-claims-act-allegations-cochlear-americas-880000>; <https://www.justice.gov/usao-edmo/pr/united-states-reaches-291288-civil-settlement-dr-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/physicians-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_c185384.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 (<https://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 (<https://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 lesions, middle ear infections) 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 non-covered 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 <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html>, <https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html>, and <https://www.tricare.mil/CoveredServices/IsItCovered/HearingAids#:~:text=TRICARE%20doesn't%20cover%20hearing,aids%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 (<https://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/physicians-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, AAPC, Zupko, etc..) and health plan education and guidance when you have questions.**

THANK YOU

Email:

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Phone or text:

(773) 960-6625

Calendly:

<https://calendly.com/audiologyresources>

Website:

www.audiologyresources.com

