Pulling a Rabbit Out of a Hat??

It's More Than Magic That Makes a Facility Successful

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Understanding The Role of the Audiologist, Both Defined and Perceived!

Dr. 'AuD"

- Merriam-Webster definition of doctor: someone who is a "learned or an authoritative teacher, a person who has earned one of the highest academic degrees conferred by a university"
- **Professional success**: the audiologist should be a "mindful practitioner" guided by strong insightful skills, integrates technical skills with core knowledge, listens attentively…

The Audiologist should have a PRESENCE!

The Consummate Professional

- Understands and performs or refers the procedures within the audiologist's scope of practice
- Is able to communicate and interact with the patient and family, as well as educational and medical professionals
- Embraces hearing loss as a ***symptom*** and ***not a disease*** until proven otherwise
  - Rushing to amplification as the "cure" can be a missed opportunity for providing optimum patient care
  - Must know the 18 categories of the body as defined by Evaluation and Management (E&M) and their relationship to hearing and balance disorders

The Approach to Patient Care
Is Transitioning

- Allied healthcare professionals are often the “gate-keepers” – the “go-to” professional for the patient
- This is long overdue, BUT, it comes with responsibility
  - Stay within your scope of practice – this is obvious – but the boundaries of patient care overlap
  - Multi-disciplinary patient care is a key component of newly mandated healthcare
  - To provide quality care, practitioners need to understand the role each professional affords in patient care
  - The responsibility is huge and not necessarily taught while being educated
  - The audiologist has a great deal to learn and integrate especially when identified by a patient as the gatekeeper

Is There a New Frontier? The audiologist must…

- be familiar with the potential side effects of prescribed and over-the-counter meds?
- be able to perform an accurate otoscopic exam
- understand the various radiographic studies and their application
- be knowledgeable of the treatment modalities for identified diagnoses and syndromes

The audiologist of today, regardless of practice setting, must be a respected professional with all members of the medical community. The audiologist's role in providing patient recommendations and securing positive treatment outcomes can not be marginalized!

Opportunity

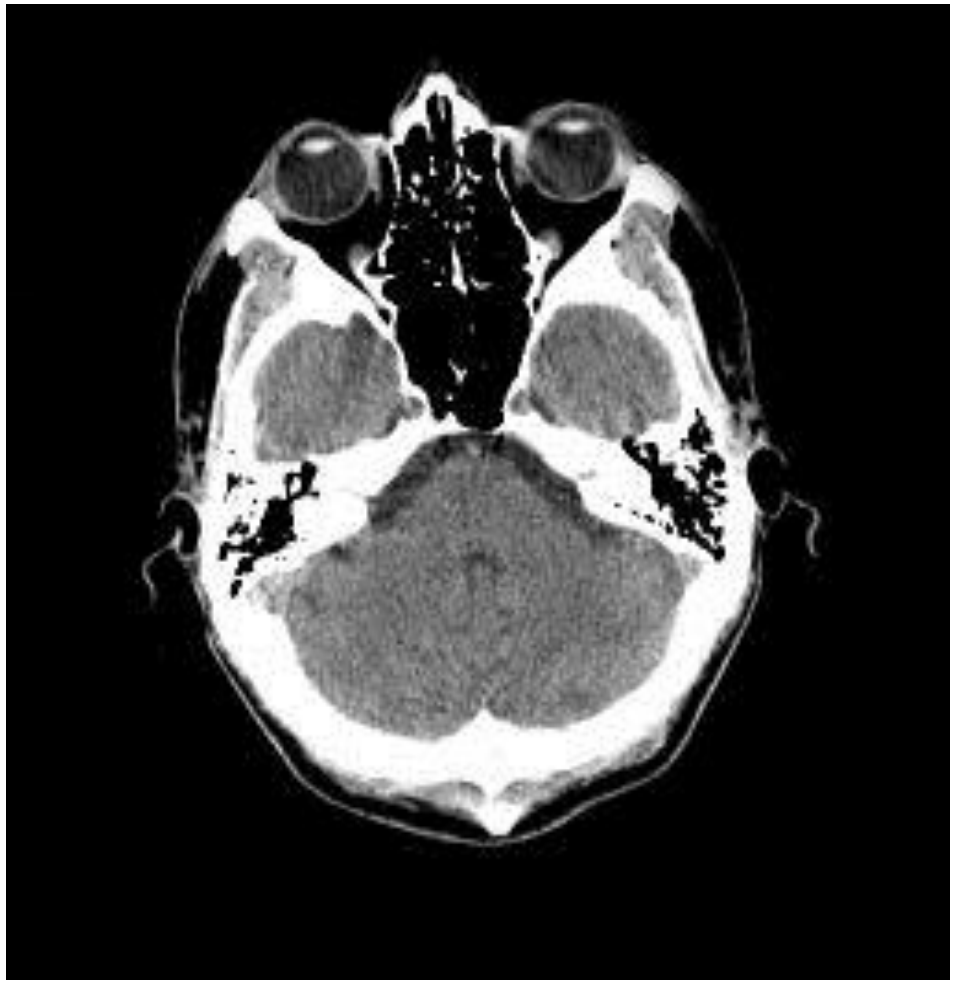
- Time to build relationships with the medical community
  - Internists
  - Gerontologists
  - Family practitioners
  - Pediatricians
  - Concierge physicians
  - Physician assistants and nurse practitioners

- Become a respected and active member of the “medical team”; hearing aid referrals will increase, as well

The Transitioning Medical Model:
Skill Sets to Improve Your Role

CT Scan

- **CT (Computerized Axial Tomography)**
  - Preferentially “looks” at bone
  - Ideal for examining the ossicles, mastoid cavity, and surrounding bones



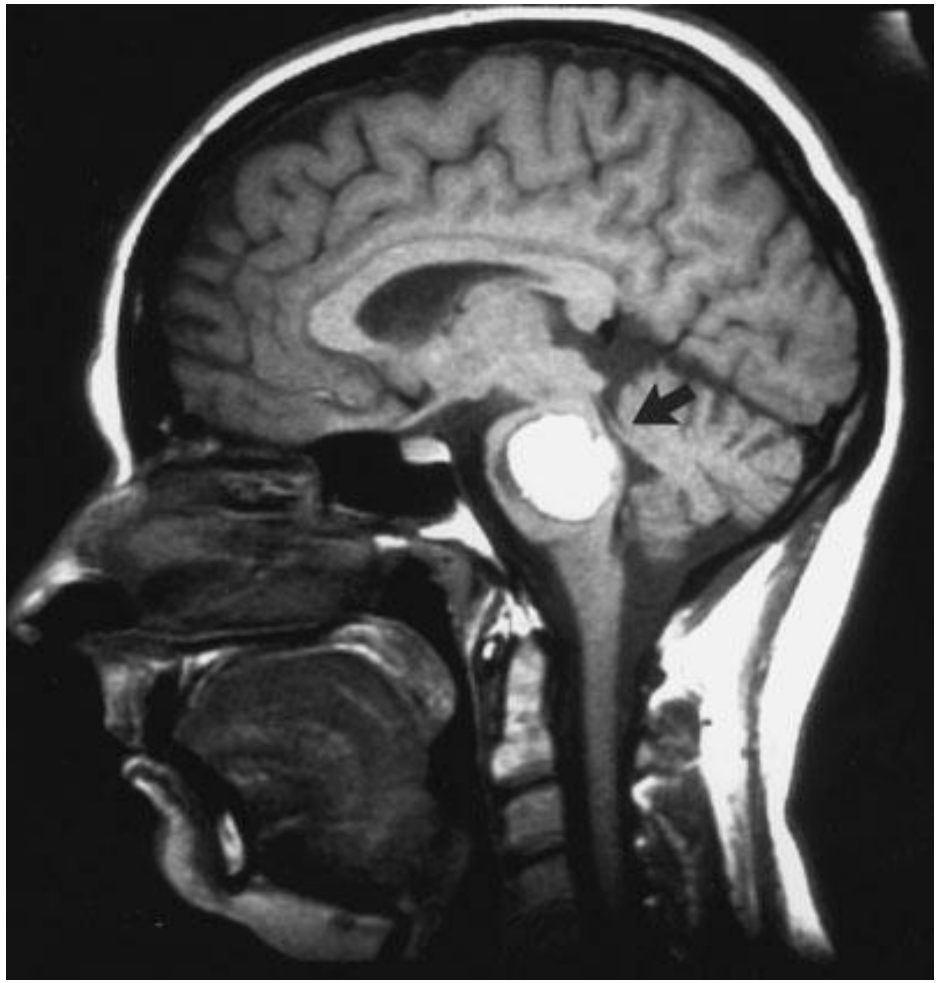
Audiological Indication for a CT

- Confirmation of otosclerosis
- Investigation of potential temporal bone fracture
- Suspicion of cochlear malformation such as

  Mondini’s Aplasia, etc.

MRI Scan

- **MRI (Magnetic Resonance Imaging)**
  - Preferentially “looks” at soft tissues such as brain, spinal cord, nerves, muscle, etc.
  - Better contrast between different tissues

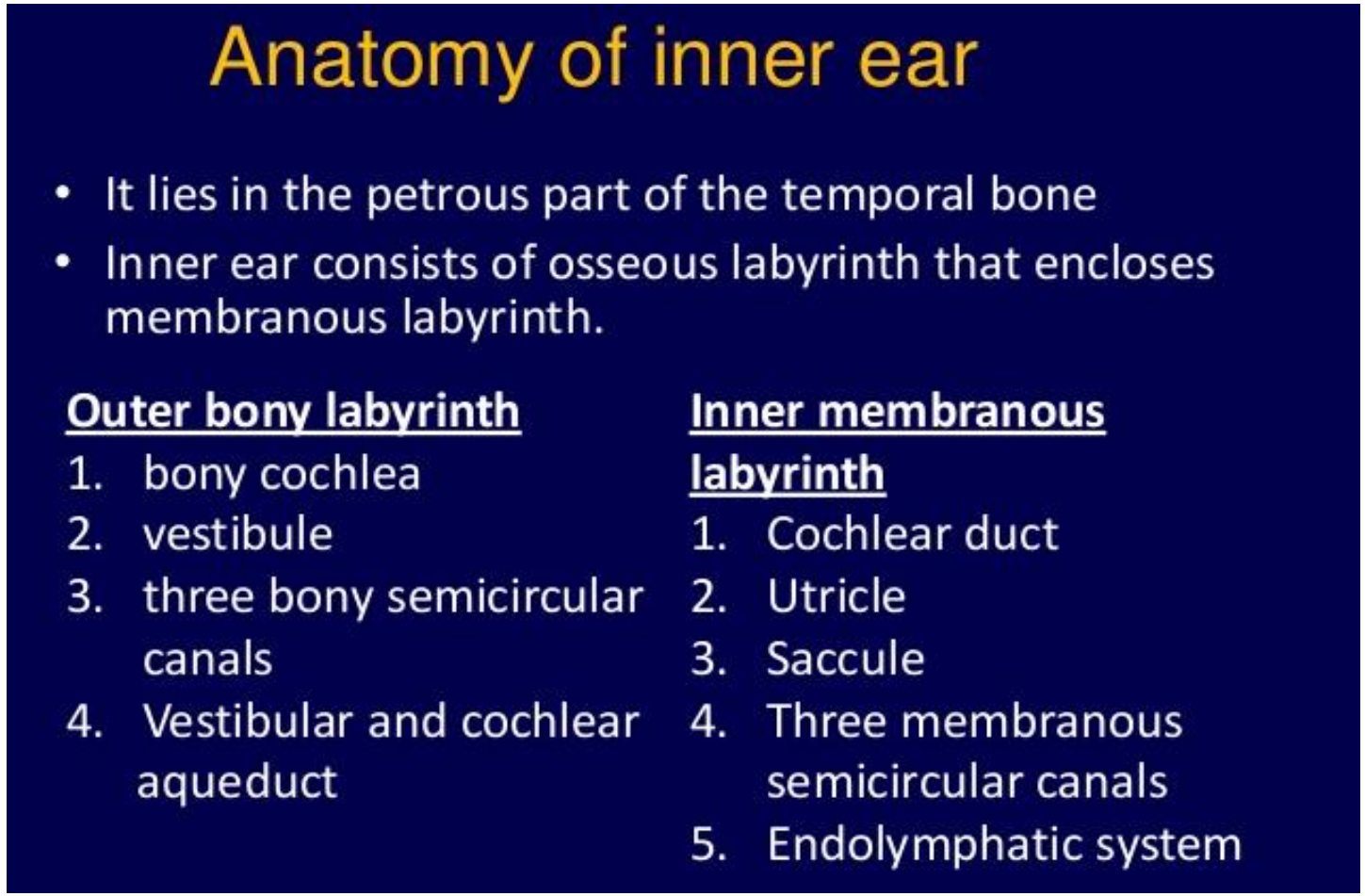


Indication for an MRI

- Identifying a space occupying lesion (ex., acoustic neuroma)
- Confirming a demyelinating disease such as multiple sclerosis

Indication for an MRI and CT

- **Vestibular Aqueduct Syndrome**



MRA Scan

- **MRA (Magnetic Resonance Angiogram)**
  - Specialized MRI to evaluate blood vessels
  - **Indications:**
    - Aneurysms
    - Stenosis or occlusion
    - Dissection of an arterial wall
    - Arteriovenous Malformations (AVMs)
  - Utilizes gadolinium (not iodine contrast)

Audiological Application

- Identifying a possible cause for pulsatile Tinnitus
- Identifying a possible cause for “whooshing” in the ear(s)

Otoscopy Made Easy

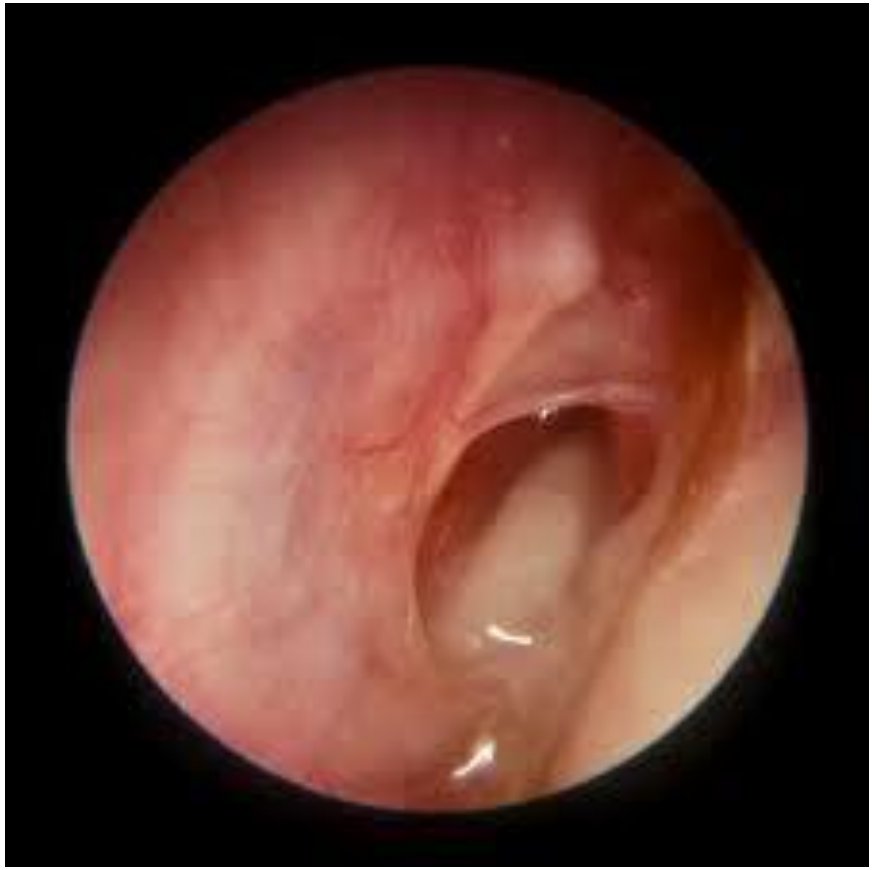
Otoscopy

- Optimally, visualization occurs when the acoustic meatus is in line with the canal
- For adults, pull the auricle upward and backward
- In children, the auricle should be pulled downward and backward
- Hold the otoscope like a pen/pencil and use the little finger area as a fulcrum. This prevents injury should the patient turn suddenly

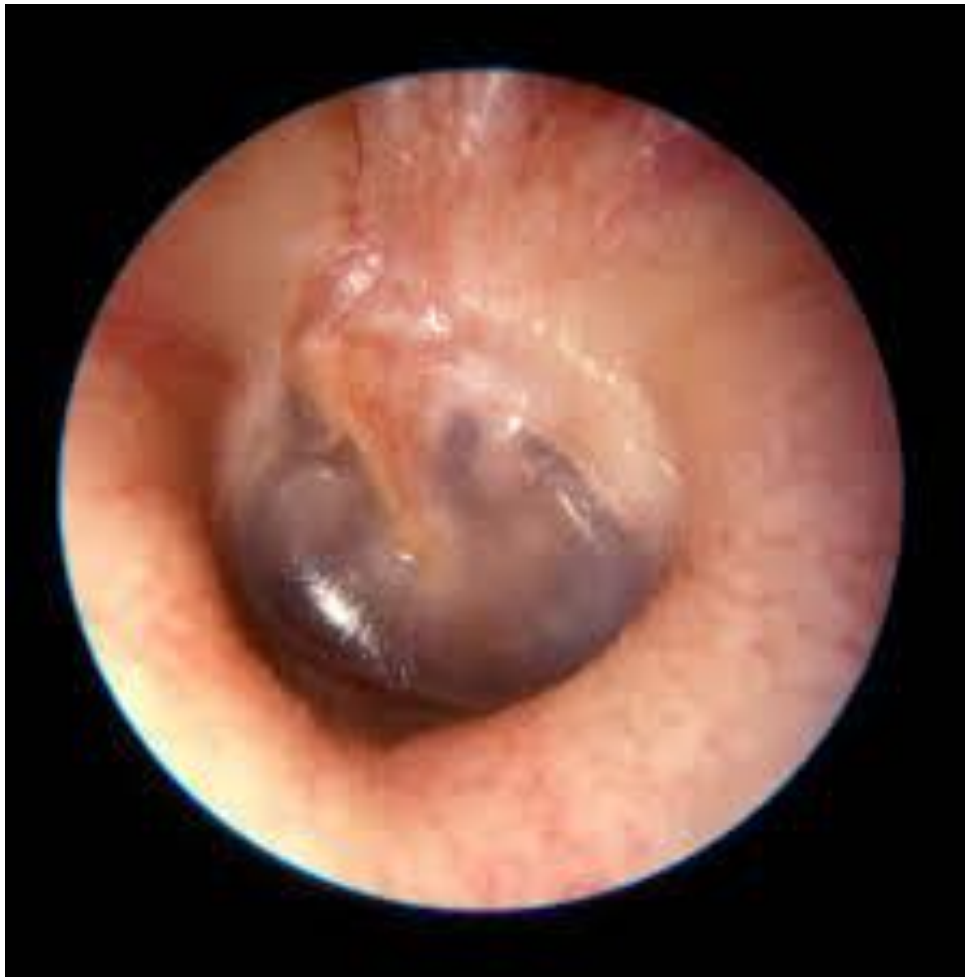
Suggestions

- Select an otoscope with a good light source
- Use largest speculum that can be tolerated
- External auditory canal can be sensitive, so “explore” with a gentle touch
- Evaluation under a microscope is optimal

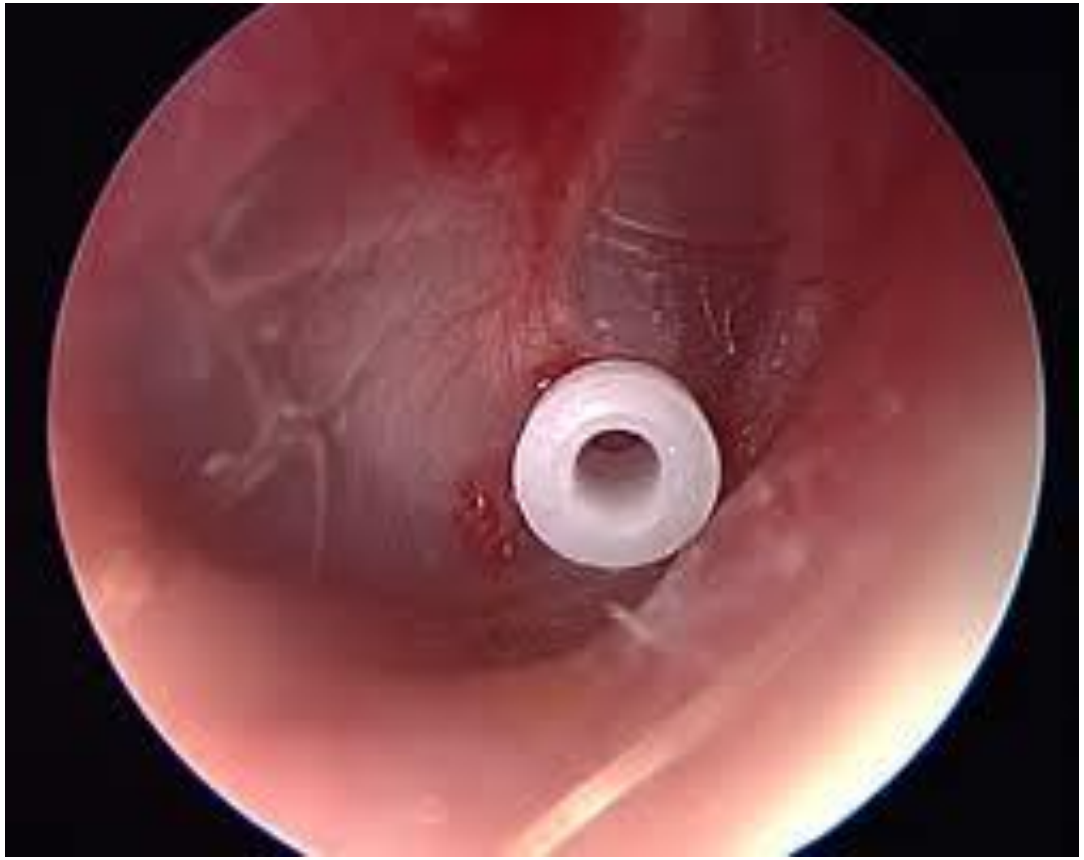
And the Diagnosis is?



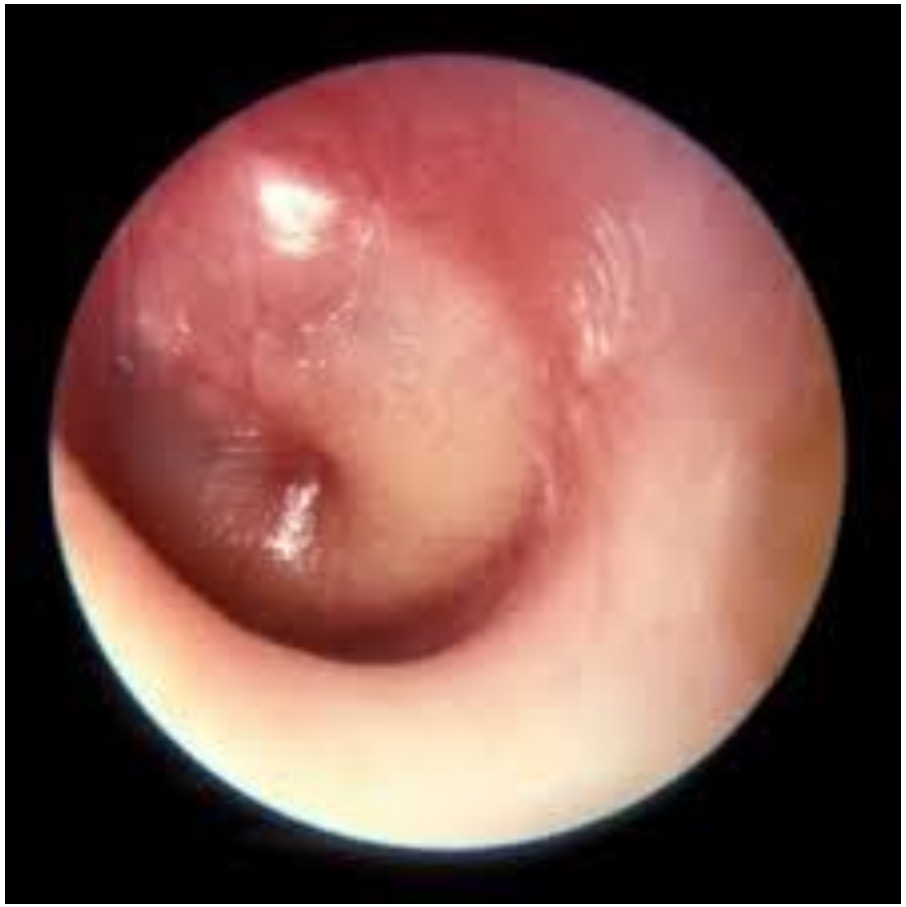
Diagnosis?



Diagnosis?



Diagnosis? What Kind?



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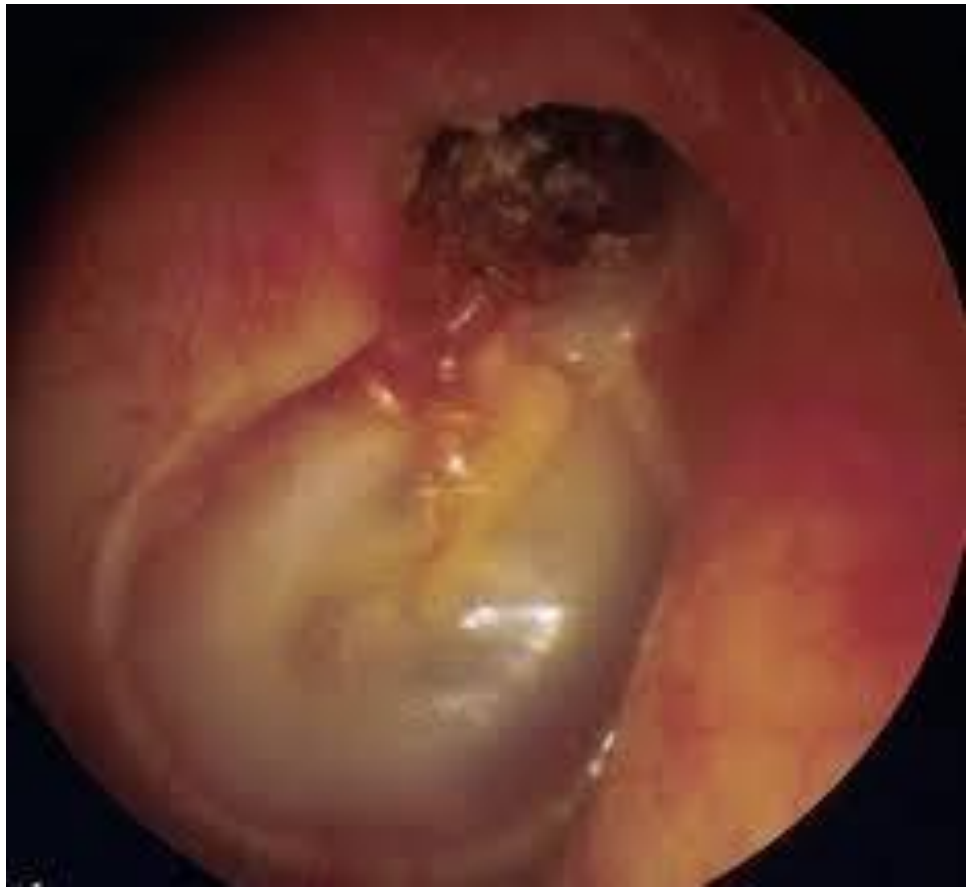

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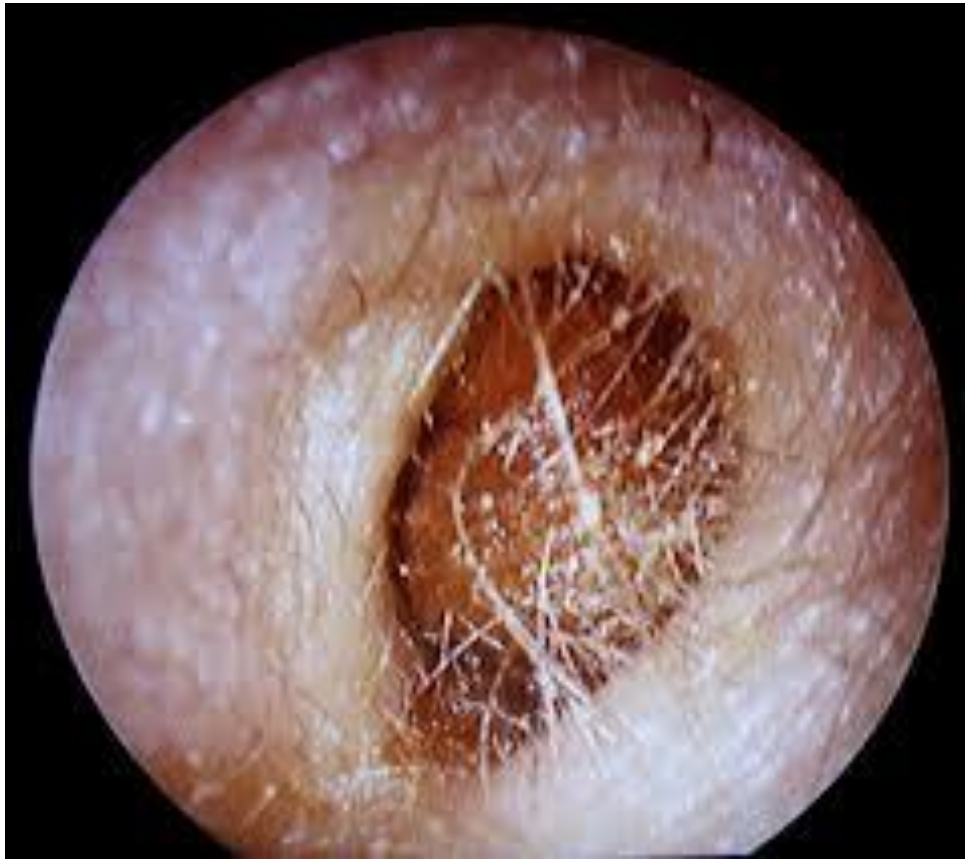

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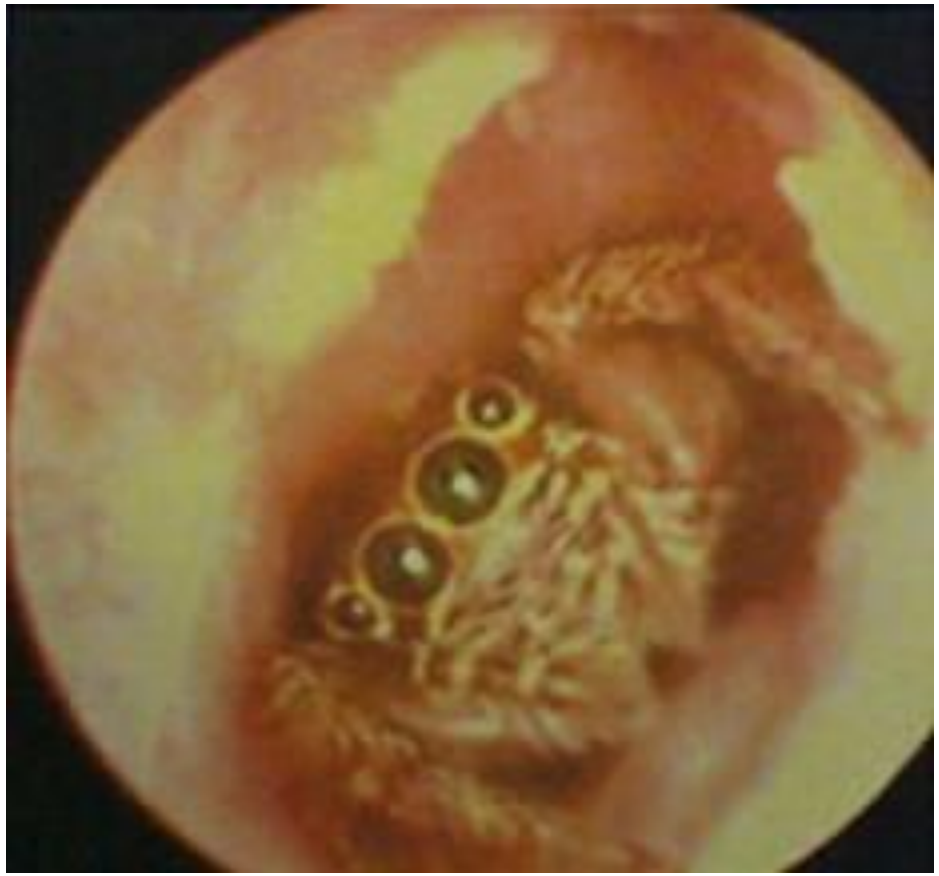

Diagnosis?

Diagnosis

Hint: When you hear the sounds of hooves, think horses, not zebras

Key Performance Indicator

The Medical Perspective

Key Performance Indicators
Medical Model Perspective

- How often do you measure them?
- Do you measure them as a group or individually?
- Commission? Bonus? Individual? Group?
- **Do you measure discounts/free and the fiscal impact?**
- **Physician referrals – Who? How often? Stopped?**
- **Return on investment for electronic marketing (ex. MailChimp) versus traditional options**


Out with the
OLD
and in with the
NEW

Pay-For-Performance

The Current Way of "Doing Business"

- A reimbursement model which compensates professionals for reducing costs without compromising care
- What happened to FEE-FOR-SERVICE?
  - A provider sets his/her own fee schedule, insurance pays what is "customary and usual" and the patient is billed for what the insurance company doesn't pay

HMMMM

- Federal mandates are reinventing reimbursement
  - Affordable Care Act (ACA)
- Quality of care at reduced cost – what does that really mean?

The Acronym Game

- ACA: Affordable Care Act
- MACRA: Medicare Access and CHIPS Reauthorization Act of 2015
- MIPS: Merit-Based Incentive Payment System
- MPFS: Medicare Physician Fee Structure
- PQRS: Physician Quality Reporting System
- RUC: Relative Value Scale Update Committee

Physician Quality Reporting System PQRS

- Recognized as the first Pay-For-Performance initiative
- Sunset effective 2017 reporting period
- Applied to Medicare Part B (outpatient services)
- Goal of PQRS:
    - Was to improve the quality of patient care

Medicare Access and Chips Reauthorization Act of 2015 (MACRA)

- April 14, 2015, the Senate passed MACRA with a vote of 92-8
- Established a new payment structure for Medicare
  - Merit-Based Incentive Program **(MIPS)**
- Abolished the 21% annual threat of reduced payments
- Implemented a 0.5% increase for 2016-2019
- 2019 – 2025 rates will remain constant, but there will be a chance to incur a bonus, or a penalty
- After 2025, rates will increase annually by 0.5% (????)
- Established Alternate Payment Models **(APMs)** - multidisciplinary approach to improving quality and cutting costs with provider incentives

MIPS

- New payment mechanism that will provide annual updates to providers effective 2019 (Still 2-year lag for bonus; reporting began Jan 1, 2017)
- Performance based in 4 categories: **Total** - (100 pts)
  - **Quality**: Value-Based Modifier (30 pts)
  - **Resource use**: Value-Based Modifier (30 pts)
  - **Clinical Practice Improvement Activities** (15 pts)
  - **Meaningful Use of an EHR** (25 pts)

Clinical Improvement Category

- Data will be generated from beneficiaries
  - Same-day appointments
  - Care coordination (telehealth)
  - Beneficiary engagement
  - Patient safety
  - Population management (monitoring population health)

Eligibility for MIPS

- First two years (2019-2020), the following Part B providers are eligible (data collected 2017 & 2018):
  - Physicians, physician assistants, nurse practitioners, and nurse anesthetists
- As of the third year, audiologists are expected to be part of the initiative

Understanding the 2-Year Lag

- **PQRS** reporting ended in 2016
  - Last data collected will be reflected in 2018 payments
- **MIPS** program “begins” in 2019
  - **Performance** data collected beginning 2017, reflected in 2019 payments
  - Continuing in 2018 to be reflected in 2020
- **MIPS** for Audiologists begins in 2021
  - Will use performance data collected in 2019
  - What happens for 2017 and 2018 for audiologists???

Alternate Payment Models APMS

- Details are not finalized; 6 different types are being devised
- Team of providers – some may remain fee-for-service
- Degree of bonus is based on cost savings – to all?
- If a provider meets the APM, then don't typically participate in MIPS
- ***Members of the APM knowingly take financial risk should the APM not perform at a profit significant enough to provide a financial bonus***

Voluntary Reporting?
…and More

- Though audiologists are not considered MIPS eligible until at least 2019, there is an option to voluntarily report
- It is hoped that CMS will provide audiologists with detailed feedback as if they were participants, making the eventual transition easier and more effective
- Current Medicare regulatory definition places audiologists in the “Other Diagnostic Procedures” classification which is limiting. Audiology organizations are requesting participation in interdisciplinary measures

MIPS Composite Score

- Due to our limited number of quality measures, quality reporting is challenging
- We are statutorily excluded from Meaningful Use of the EHR
- Currently, there are no scored measures in the resource use performance category. Current trends for the diagnosis and management of dizzy patients by the audiologist would provide invaluable input (ex., less imaging)
  - **This may be a strong opportunity to be part of an APM team, but would this indirectly limit the scope of practice performed if solely performing vestibular specific diagnostic services "monitored" by a gatekeeper?**

ACA

- Doesn’t create insurance: it regulates private insurance to ensure rights and protection allowing tens of millions to get access to “high quality” insurance
  - State exchanges might be an option
  - Premiums are not cheap; subsidies may occur based on wage

So…

- Getting insurance is one thing, paying monthly premiums is another!!!!
- Insurance is sometimes a deductible expense from an employee's paycheck
- For the ~11.7 million Americans enrolled in health insurance in 2015 (Dep't of Health and Human Services data), by **MARCH 31**, **~13%** had not paid their first premium. Loss of payment results in loss of coverage (given a 90-day grace period)

90-day Grace Period

- First 30 days, the insurer must pay the claim to the provider
- 31 – 90 days, the **insurer** can withhold payment on claims. Provider is not paid!
- After 30 days of premium delinquency, the insurers are required to inform the medical provider (Are you tracking this????)
- Patients are **exempt** from paying premiums if evicted, filed for bankruptcy over the past 6 months, deemed ineligible for Medicaid

Is the New Administration Going to Abolish Obamacare (ACA)?

- House Speaker Ryan:
  - “It will take time…clearly there will be a transition and a bridge so that no one is left out in the cold, so that no one is worse off.”
  - “Obama care is failing and failing quickly, and there is nowhere to go but up with respect to Obamacare”
- “Experts” believe a full legislative repeal, requiring 60 Senate votes, is unlikely to occur within the first 100 days of Trump’s Presidency
- Options: Beneficiaries will be given government subsidies to help them buy private insurance

Medicare
Premiums for 2017

- Most Medicare retiree beneficiaries will pay $109 per month or thereabouts in 2017, up from $104.90 in 2016
- About 70% of them have their premiums deducted automatically from their Social Security benefits (significant for those on fixed incomes)
- Medicare beneficiaries who enroll in Part B for the first time in 2017, don't receive Social Security benefits or are billed directly for their Part B premiums will pay $134 per month in 2017 (up from $121.80 per month in 2016: **~10% increase**)

Earn More, Pay More…
(Data from Kiplinger)

Single Filer Income	Joint Filer Income	Part B Premium	Part D Surcharge
Up to $85,000	Up to $170,000	$134	--
$85,001 - $107,000	$170,001 - $214,000	$187.50	$13.30
$107,001 - $160,000	$214,001 - $320,000	$267.90	$34.20
$160,001 - $214,000	$320,001 - $428,000	$348.30	$55.20
More than $214,000	More than $428,000	$428.60	$76.20

New ICD-10 Options for 2017

- **H90.A11 Conductive** hearing loss, unilateral, **right** ear with restricted hearing on the contralateral side
- **H90.A12 Conductive** hearing loss, unilateral, **left** ear with restricted hearing on the contralateral side
- **H90.A21 Sensorineural** hearing loss, unilateral, **right** ear, with restricted hearing on the contralateral side
- **H90.A22 Sensorineural** hearing loss, unilateral, **left** ear, with restricted hearing on the contralateral side
- **H90.A31 Mixed** conductive and sensorineural hearing loss, unilateral, **right** ear with restricted hearing on the contralateral side
- **H90.A32 Mixed** conductive and sensorineural hearing, unilateral, **left** ear with restricted hearing on the contralateral side
- **H93.A** Pulsatile tinnitus
- **H93.A1** Pulsatile tinnitus, right ear
- **H93.A2** Pulsatile tinnitus, left ear
- **H93.A3** Pulsatile tinnitus, bilateral
- **H93.A9** Pulsatile tinnitus, unspecified ear

Bundle or Unbundle
That Is the Question!

- Combining professional services with product challenges the "value" of the diagnostic investigation
- Also referred to as itemizing…OR, is it both?
- Most insurance plans don't prohibit the audiologist from billing for professional services in addition to the negotiated amount – many expect it and some prohibit it!
- There are many reasons for itemizing
  - Transparency of costs for patients and/or third party payers
  - Delineates covered services, warranties, repairs (in-house and manufacturer), and product, etc.
  - Internal tracking of the above
- It really isn't that hard to unbundle/itemize

Must Identify What Needs Value

Examples Include

Product:

- The hearing aid(s)
- Earmolds
- Assistive devices
- Batteries

Diagnostic and office services:

- Diagnostic services to secure a definitive diagnosis
- Cerumen management
- Hearing aid assessment
- Fitting/dispensing
- Real Ear testing
- Speech-In-Noise
- Follow-up visits/reprogramming/cleaning
- Taking earmold impressions
- Evaluation and Management (E&M “99” codes)

Don’t Forget to Value “Follow-Up” Services/Products

Examples include:

- Electro-acoustic evaluation
- Cleaning of the hearing aid
- Tubing replacement
- Replacement of battery doors, earhooks, microphone covers, waxguards, etc
- Replacement earmolds
- Supplies (cleaners, sanitizers, moisture prevention kits, etc.)
- Aural rehabilitation
- Evaluation and Management services codes

Establishing Value

Products:

- Cost-of-goods plus professional time
  - Must know desired billable hourly rate (salary plus operating expenses)
  - Know what the insurance company is paying and if the patient can be balance-billed

Procedures:

- Are codes listed in the Medicare Physician Fee Schedule MPFS)? – may charge Medicare prices plus a percentage
- Codes listed in the HCPCS code set (V-codes)?
- It is appropriate to bill patients for services not covered by third party payers (including Medicare)
- Know if in or out-of-network

Coding “Assistance”

- 92557 (basic audiometry)
- 92567, 68, 69 (bundled options when indicated)
- 92579 (VRA)
- 92582 (Play Audiometry)
- 92583 (Picture Audiometry)
- 92587/8 (OAE’s)
- 92590 (HAE) monaural
- 92591 (HAE) binaural
- 92592 Hearing Aid Check (monaural)
- 92593 (binaural)
- 92594 Electroacoustic eval (monaural)
- 92595 (binaural)
- 69210 (cerumen)
- 99203 (Initial Office Consult)

HCPCS: V-Codes

Procedures and products not part of the CPT code set

- Describe technology (examples):
  - V5242 – Hearing Aid, analog, monaural, CIC
  - V5261 – Hearing Aid, digital, binaural, BTE
- V5266 – Battery for use in hearing device
- V5299 - Hearing service, miscellaneous (ex. Warranty)
- V5020 – Real Ear
- V5275 – Earmold impression(s), each (by unit)
- V5264 – Earmold, not disposable (filled with by unit(s)
- V5011 Fitting/orientation/checking of hearing aid
- V5241 – Dispensing fee, monaural
- V5160 – Dispensing fee, binaural
- V5200 - Dispensing fee, CROS
- V5240 – Dispensing fee, BiCROS

V-Codes: Assistive Devices
Examples

- V5274 Assistive listening device, not specific
- V5268 Telephone amplifier
- V5270 Television amplifier

Bundled Service Plans
Additional Patient Cost

- May offer “leveled” options such as:
  - Silver Package – 1 year warranty, 3 office visits, 1 cleaning
  - Gold Package – 2 year warranty, 6 office visits, 2 cleanings
  - Platinum Elite - 3 year warranty, unlimited office visits, 2 cleanings per year while under warranty
- Some practices add batteries, an assistive device, etc., as “perks” for top level option packages
- Be creative, but make sure the term office visit (or any perk) is defined in writing
  - Ex. Performance review, programming
- **NEVER include 92557 as a free service**
- Make it clear that some services may be provided by an audiology assistant

Random Thoughts

- Document that patient was given options and what was selected
- Is it cost-effective for an audiologist to perform free services?
- For insurance plans, must know before selecting options if professional services are allowable charges to the insurance company and/or to the patient (if insurance, what is the fee structure)
- For insurance plans, must know if the patient can upgrade and pay the difference (how is it to be V-coded?). Don't assume
- Must know how the EOB will address covered services, non-covered services, and what is patient responsibility
  - Create a signed statement of patient responsibility and always have a signed financial waiver stating that insurance is a contract between the patient and the insurance payer and although "ABC" facility will do everything possible to process a claim, the patient is responsible for all uncovered costs
- Professional fees should be non-refundable should the hearing aid(s) be returned


DON'T WORRY
BE HAPPY
PROZAC
1,000,000 mg


Q
&
A