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National Center for Hearing Assessment and Management
PRACTICAL CONSIDERATIONS IN
EHDI PROGRAM DELIVERY DURING COVID-19
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>> WILLIAM EISERMAN: In are some others that are upcoming. I have them on the screen right there and will show them at the end of today's presentation, so we invite you to come back and enjoy some of these other presentations that we'll be having.

So without any further delay, I'll turn it over to Kim.

>> KIM CAVITT: Hi. Nice to meet you. Today I'm going to talk about really from a licensure and a compliance and a coding and reimbursement process from my perspective how Early Intervention works. So I'm really going to start with some opening facts.

No question that we can ask or no situation has a singular National answer when it comes to an EHDI process. The scope of practice of all types of health care providers whether it's nurses, physicians -- well, not physicians -- audiologists, speech-language pathologists, that's going to really differ completely in every state and territory and that's actually going to influence how this process can and should work. Every state Medicaid program is unique again to the state or territory. While some states or territories do not cover newborn hearing screening procedures separately of the birth process, some states do. It's just very much dependent on the state.

So again, you cannot paint it with one big brush.

Insurance is regulated and administered in each state and territory independently, as well. We don't really have any insurance industry that's like interstate commerce kind of capacity. Each one is essentially administered independently and how each of those private payers are going to handle newborn hearing screening is going to differ state by state and payer by payer and again finally telehealth is regulated differently in each state and territory. Some states, even in the COVID world, do not allow audiologists to provide telepractice, or telehealth.

Some states do not allow anyone who's not licensed in their state to treat their citizens via telehealth. In any state you have to be a licensed provider in the state in which the patient presides in order to treat them even via telehealth and even in a COVID world, and again, many payers do not cover telehealth provided by an

audiologist. It's not -- that coverage is not guaranteed. Again, even in the COVID world.

So I'm going to go over a few terms so that people can kind of understand a little bit of the basics about how insurance works. So the first thing is something called an allowable rate schedule. This is something that every payer has. All state Medicaid programs, their allowable rate schedules are published, typically easily accessed just by Googling them online. But it is for every code, is it a covered procedure, and at what dollar amount rate is it covered.

So that's what an allowable rate schedule is. A payer's fee schedule for every product they have, and that they offer, what codes they recognize and at what rate. Now, just give a little general information, let's use the UnitedHealthcare as an example. UnitedHealthcare, one insurer can offer many insurance products. They might have an HMO, they might have a PPO, they might have a managed Medicaid, they might have a managed Medicare, they might have a lot of products. For each one of those products even though you're under the UnitedHealthcare umbrella you can have different allowable rate schedules and different rules of allowable benefits. An allowable charge is on that allowable rate schedule for a given item or service, what do they cover, so at what rate. The allowable charge is when you add up what the insurance company is paying, a co-payment, a co-insurance, an unmet deductible, if you add all of those up together, they will equal that allowable charge. That allowable charge is the maximum amount that you can collect for that given item or service if you are an in-network provider.

Asynchronous telemedicine is that you have -- it's not done in real time. That maybe that patient visit has been recorded, and then it's being reviewed by someone at a later date. Let's go to direct supervision.

That means the supervisor, the supervising provider, must be present in the office suite, not in the room with someone but must be in the greater office suite. They can't be in the OR, they can't be off that day because they have to be immediately available throughout the performance of the procedure to participate in that procedure, if needed.

Supervision, there's three types of supervision, I'll talk about all three. Supervision is typically required for payment when a technician is performing a procedure. A technician is someone who is unlicensed, so if that unlicensed or that individual who needs -- they're an audiologist assistant, some sort of assistant role -- there's typically -- payers typically require some level of supervision of the provider it's billed out under. Direct means that a supervising provider is available to be involved in the care, and is in the office suite. Distant site in telehealth represents the location of the provider during the telehealth visit. That's what distant site means. That's where is the provider sitting.

General supervision is a procedure that's furnished under the overall control and direction of the supervising provider but their presence isn't required so that means essentially they're signing off on the item or service. They're not actually again have to be available. They can be off, they can be on vacation. They're just signing off on the given item or service.

Incident to, is that you are -- this is a technician, an assistant -- is performing the procedure and is being billed out under the National provider identifier and under the supervision of a physician. Audiologists cannot have things be billed incident to them unless they were provided by a student that they have personally supervised so incident

to is when, let's say, a technician performs an OAE, and they're being directly supervised by a physician, and it's billed out to the payer underneath the National provider identifier of the physician, those OAEs were performed incident to that physician. That means that physician needed that in order for the -- to direct their overall care. That's when something is billed out under someone else that's incident-to billing.

Originating site is the telehealth, the site where the patient is located. So that's what originating site. Distant site is where the provider is. Originating site is where the patient is.

Patient responsibility is amount the patient owes for a given item or service once the payer has processed the claim. This is the patient's out of pocket. Patients typically have to pay out of pocket for co-payments, co-insurance, that's that percentage of dollars they're responsible for, like if you have an 80/20 insurance plan, the 20% is the co-insurance. Patients can be responsible for that. Patients can be responsible for unmet deductibles and they can be responsible for non-covered services.

The payable amount is the amount that the payer is paying out on a given date of service. So again, the payable amount is what the payer paid. The allowed amount may be more than the payable amount because the patient may have co-insurance, co-payment, or unmet deductible.

Personal supervision, this is actually required by many Medicaid programs, if a student is providing the procedure. That means the supervising audiologist needs to be in the room with the student. Personal supervision means they must be in attendance in the room for the entire performance of the procedure, and must be actively engaged in that visit. They can't be in another room seeing another patient. They have to be in that room, with that student. That's what personal supervision is.

Place of service is the location where the patient is seen for care on the date of service.

There's some codes, not every code, but some codes have what's called a TC/PC split. This professional component is the PC, it's often known as the 26 modifier. This represents the supervision, the interpretation, the medical decision-making, the reporting of the procedure, that was provided by a physician or other health care professional, or technician, working under the supervision of a physician. This is that interpretation.

So some codes, 92587, 92588, the diagnostic OAE codes, 92585, 92586, they have that TC/PC split to them, so a technician can perform the procedure and it can then be interpreted by a physician. So that's how -- what a professional component means.

Prior authorization, which is a very common component of State Medicaid programs, is a written authorization for a managing/treating physician to proceed with the provision of a specific item or service. So again, many Medicaid or HMO-type plans require a prior authorization before they will pay for certain items or services.

Synchronous telemedicine is -- in health, this means the service was delivered in real-time via interactive audio or video. You have your technical component. That means that a technician or an audiologist or some form of personnel performed the procedure. They're actually -- they performed it and that would be the TC modifier, and then another provider, a physician, interpreted and supervised it. That would be the TC or 26 modifier so technical component was the performance. Professional component

was the interpretation and reporting.

Telehealth is the use of electronic telecommunications systems to support long-distance clinical health care. This is the remote care and treatment of an individual. Unfortunately, in telehealth, there's very limited coverage for telehealth provided by audiologists, and in this EHDI process, there's very few things that can actually be provided via telepractice, based upon the type of procedures that we're talking about. But we'll talk about those individually in a minute.

So let's start by talking about what happens at birth. So there's always two major considerations. First is licensure. Who is legally allowed to provide the screenings in your state? That is typically going to be indicated either in the guidelines, the regulations, of your State EHDI Program, but it's also regulated by the licensure laws of medicine, nursing, of audiology, of speech-language pathology, as to who can provide these services. Otherwise, if you have someone providing services that they're not licensed or allowed to provide, they would be either practicing medicine or practicing audiology without a license so again, does your state have license exemption for people providing telehealth that are not licensed as an audiologist or a physician? And if they have these provisions, what type and level supervision might be required?

Then there are the coverage requirements, so you can meet the licensure requirements but that doesn't mean that it meets the coverage requirements of a payer. Payer can make their own rules that are independent of licensure. That they can say, we're only going to cover this if it's provided by an audiologist. Or we're only going to cover this if this is provided X. They can make those rules.

So you need to know, for coverage, what are the coverage requirements around a payer. It can depend on who's providing the screening, and was it inclusive to the obstetric global care package and again if not, if it's not part of that payer's global obstetric care package it can be billed separately. You can't make the assumption it's always included under the global care package. UnitedHealthcare, for example, doesn't include it in their obstetric local care package. Just not part of that package so it can be billed separately so it's really just going to depend kind of on the payer.

So who can physically provide -- and physically means they actually push the buttons -- who can physically provide the initial screening? And this will vary greatly state by state, from options, though. A physician can provide -- a great rule of thumb, a physician can provide anything, really anything in the health care space, they can do anything. They can do speech-language pathology if they want. They can literally do anything.

An audiologist can provide newborn hearing screening, speech-language pathologists in many states are allowed by scope and practice and regulations to pride a newborn hearing screening. Physician's assistant depends again on their scope of practice in their state licensure and the same with the nurse. Is this something that falls underneath their scope within licensure?

Technicians, this is what I have to bring up, and I'll bring this up in a second when I talk about a code. The code 92558 for an OAE screening does not have a TC/PC split, so what that means is, it can't be provided by a technician, because it doesn't have the ability to break that code up into a technical and professional component. And when codes cannot be broken up, then they are not supposed to be provided by a technician for coverage, again, unless there are licensure rules and exceptions kind of around that

that you might be able to work an appeal around. So again that's why technician is not here, or volunteer, because the code for that OAE screening requires technical and professional skills within the code. It can't again be broken into pieces.

So the Otoacoustic Emissions screening is 92558. This is again a pass/fail automated analysis. Again, who can provide the testing for third party coverage? It requires, for coverage, a physician, an audiologist, or another qualified health professional who's allowed by licensure to provide this screening.

So again, it's really going to depend on what your regulations say and what the licensure laws say and what the payers say but I can tell you that if it's provided by a physician or audiologist, it will be covered as long as it's not in that global care package.

There's also the ABR. This is the limited ABR that is really -- that code was really created for the ABR screening that could be part of a Newborn Hearing Screening Program, because again, this has that TC/PC split. It could be provided by a physician, an audiologist, somebody else in their licensure that's allowed, or by a qualified technician under the supervision of a physician. So the ABR could be provided in the supervision of a physician by a tech. The OAE cannot.

For coverage. We're talking about coverage.

So when it comes to diagnoses, to diagnosis, you have to -- you have to look at what needs to go out in the claim. You want to consider pre- and post-natal conditions or symptoms, any co-morbidities that may exist, especially if that maybe is in the NICU. Anything else you see or measure, so if they failed the screening you code the type of hearing loss that hasn't been ruled out. Because you really want to always avoid using unspecified codes. Any code that comes up as "unspecified" will oftentimes immediately result in a denial.

Some other codes that can be useful are these Z codes. Z codes again can result in denial if they're the only procedure code -- diagnosis code used, or the first one listed, because you can have up to 12 diagnoses but Z05.8 is a great one for a baby that was maybe born at home and this is your first newborn hearing screening that you're doing after birth but it wasn't done as part of the Newborn Hearing Screening Program in a hospital because they had to be row brought in for this because they were born at home or again there is a Z01.01. This is the exam of ear and hearing without abnormal findings. I cannot stress enough you do not want to code a hearing loss if they pass the newborn hearing screening. We don't know what's going to happen with preexisting type conditions and remember coding is part of someone's medical record and so you don't want to code -- ever code anything that you've already ruled out so if they fail the hearing screening you can't code a hearing loss but if they pass that screening you never want to code a hearing loss because they don't have one. You're going to have to think -- to code something different and again I've given you a few alternatives to consider. When you're considering the co-morbidities or pre- and post-natal conditions if you can't diagnose them but you can pull them from the medical records, so you might see those diagnoses listed in the medical records. You also might need to reach out to the attending or ordering physician, again once you have that diagnosis documented you can put that in your records to show where you got this diagnosis of whatever, especially that co-morbidity is, you can put that in and where you got it so that you could use it in your diagnosis coding.

It's really important that for every procedure in the newborn hearing screening

world, from date of birth to date of identification, final identification as normal hearing, or hard of hearing, that every single procedure in that continuum have a 33 modifier added to it. That modifier was allowed to be used as the preventive service modifier. It's only utility and audiology, it's only one is around this newborn hearing screening process so you want to add that 33 modifier from every single procedure again from birth to identification, and I will also say that this is important, that modifier will oftentimes override any issues you have with diagnosis coding.

We also have to have in our claim place of service codes. These are two-digit codes placed on claims to indicate the setting in which the service was provided. If you change your setting, you change your place of service code.

I've given you Medicare has the best descriptions of place of service codes. Here are the ones that we're going to see the most commonly. The ones with the asterisks, those are facilities, and that typically means if you're coming in from the outside, that means you're not an employee of that facility, then that facility is going to -- you can't bill that from your outpatient. You're going to have to have the facility pay you an hourly rate to be there, and then the facility is going to have to be the one who bills these items or service when you're talking about hospitals and birthing centers and ambulatory surgery centers.

Telehealth, about what capacities you can use telehealth for. It's really first about the technical capacities. What capacities does your facility have in order to do remote testing? Some facilities do have the capability to do ABRs remote, and the reasons why they have that ability is for intraoperative monitoring so there are some facilities that do have setups to be able to do an ABR remotely. There's not a lot of people, I don't know of anybody, who can do Otoacoustic Emissions remotely. You're also going to have to see about State regulations, can an audiologist or can this provider provide telepractice? And again if they can provide it, is there coverage?

Again, there's a lot of payers. In COVID, many states right now have waivers that if Medicaid covers it in face-to-face interactions, they will cover it in remote interactions, but again, that's not every state. It just depends on each particular state's -- if they've had executive orders written to again extend that coverage.

Now we're going to talk about follow-up/identification. So let's say our baby failed newborn hearing screening. So who can physically provide that testing? So that can be a physician, an audiologist, a technician, and that would be -- the technician would have to be working under the supervision of a physician. Technicians in coding in the insurance world cannot bill things incident to an audiologist in most cases. Not in every case. There's some exceptions. But in most cases audiologists can't have anything billed to them except things that were provided by a student.

So the otoacoustic emissions, the diagnostic ones, I'm actually going to term them a little bit different, so 92587 would be distortion product otoacoustic emissions that confirms the presence or absence of hearing loss, it would be 3-6 frequencies per ear. You can't repeat test the same ones or transient evoked otoacoustic emissions, and you have to have interpretation and a report.

There's also comprehensive OAEs. This is 92588. You first have to make sure that the equipment that the audiologist has, the pediatrician or whoever, that that can do comprehensive OAEs. A lot of equipment cannot so this is the qualitative analysis of outer hair cell function and you have to have 12 or more distinct frequencies per ear

with an interpretation and report.

So I want to go back to really talk about follow-up could be done in a pediatrician's office. All they would really need to do is, because the physician can have a technician do it, or nurse or an assistant, they would just need to be all appropriately trained and have the equipment at their disposal but if a physician billed OAEs or audiologist billed OAEs the coverage amount would be the same. There's no coverage different. If it's non-covered to an audiologist it's non-covered to a physician but again that could be billed in a pediatrician or in a medical office as well. These two codes can.

Who can bill this testing again to a third party payer? A physician, an audiologist, a qualified health provider. Again in some rural areas some nurse practitioners and some physician's assistants are allowed to bill these types of codes underneath themselves as well, or a technician who is being supervised by a physician, so these codes again have that split so they can be performed by a technician.

We have our ABR codes. There is your limited ABR, we talked about that a little bit before. But we also have the comprehensive ABR and this is typically a threshold search ABR. There is one code for an ABR for a comprehensive one, if it takes you 15 minutes or 3 hours. There is a singular code for this procedure and that's 92585.

So again, this testing can be performed by a physician, an audiologist, a qualified health professional or by a technician because again it has that ability to bill the technical component separately from the professional component.

You might have some other considerations in follow-up. You might have tympanometry, you might have tympanometry and acoustic reflex threshold testing. I will tell you tymps and reflexes both have to be performed by an audiologist or physician or someone allowed to perform them in their own practice. They cannot be performed by a technician because they don't have that separate technical component. You also might have things around costs and charges and fees around sedation, nursing, or physician supervision of sedation, Operating Room or facility fees and again that's everything surrounding the fees surrounding a sedated ABR. That will very much depend what those fees are and how it's coded will very much depend on where the procedure is performed, whether it's in a hospital, an outpatient hospital, an ambulatory surgery center is where that's performed we're talking about follow-up testing hear so for 110 you have ICD10, it could drive a denial, but it generally doesn't as long as you have 33 modifiers. You want to make sure that follow-up for failures that this was an encounter for a hearing exam following a failed screening. Again you can code the pre- and post-natal conditions, co-morbidities, anything you see and measure and avoid the use of unspecified codes. For the hearing loss codes there are many, many, options for what you can code for what you see or measure. There are probably about 30 different hearing loss codes whether it's conductive mixed, sensorineural, depending on what your outcomes are.

And again, those are easily accessible from National associations if you'd like to see a list of what those code options are.

There's some modifiers -- a 22 modifier is something -- a 22 modifier means increased procedural service. This can be really valuable to hospital systems who they want to reflect productivity so the additional time around the sedated ABR, can it lead to additional coverage? Sometimes, but generally it's really more about reflecting time than it is producing additional coverage.

This would be again for the audiologist to perform the procedure and again is limited impact over coverage. The 33 modifier again should be on all these procedures and this should be added from birth to identification to every procedure in this process.

Your place of service codes, we're going to be in the same scenario kind of as we were before about where is the patient at that window of time.

And telehealth is again around the technical capacities. Do you have the equipment capacities to be able to screen someone remotely? Again, I've seen people be able to do it for ABR. I've never seen it done for tympanometry or otoacoustic emissions, be able to do that kind of a remote, where the audiologist is driving the equipment remotely.

State regulations are also still going to dictate telehealth even in COVID. Again, right now every state does not allow the telepractice, and coverage allowances, does the payer cover telehealth if provided by an audiologist or physician or that procedure, for that matter.

And now we're to treatment and amplification, so the child has been identified as hard of hearing. What happens in those next steps?

So again, we're back to the two major considerations. When it comes to providing treatment, hearing aids, cochlear implants, anything of that nature, who is legally allowed to provide a hearing aid service to children in a given state? An audiologist and physicians can provide hearing aids or treatment services in most states to children. I don't know if any states -- well, audiologists can in every state. There's one or two states that physicians can't.

Dispensers cannot always in every state provide hearing aids to children. It very much depends on the state.

Are there test requirements? That means to fit a hearing aid in a given state, you have to have air conduction testing, bone conduction testing, speech perception, threshold testing, most comfortable loudness, most uncomfortable loudness. Some states you have to have inventories, what are those requirements? Because that will be important as we talk about telehealth because some of these things are very difficult to provide remotely. You have to actually have someone either because of again equipment capacities or because the equipment that exists was never designed to be used for a child.

Are there test environment requirements? In some states you have to, it says they have to be tested in a booth, for example. They can't be tested remotely. Again medical clearance. Right now today, and we suggest moving forward, children, anyone 0-17 years of age will still have to have a medical clearance prior to getting every new set of hearing aids. It's how the FDA program works. It's a medical clearance for every new set of hearing aids. Not just the first set. Every time the hearing aid is dispensed, new sets of hearing aids, and again you're going to need a medical clearance.

Coverage, coverage is again, is another consideration. Is there a pediatric coverage mandate in your given state? Some states have coverage mandates that will dictate that an insurance company has to offer a benefit for pediatric hearing aid coverage so that's important to know.

Do you have specific Early Intervention Program or children's assistance program coverage in your state for when you don't have a mandate or when the mandate leaves money that's still patient responsibility behind. Are there requirements for coverage for

specific third-party payer? Again I'm going to tell you, insurance is my gig, UnitedHealthcare has coverage requirements. Blue Cross Blue Shield plans have coverage requirements. Aetna, for example, has coverage requirements but you have to have at least -- you can't have a minimal -- like, you can't be at 20 and 25. Aetna doesn't cover hearing aids until you get to, like, 30 decibels so just depends on the plan.

What is the benefit? So what do they cover? How much do they cover? And can the family upgrade? And what that means is, some plans, I'll use Aetna as an example, they have X number of dollar amount allowance, and it is not for the most highest price advanced hearing aid available, and Aetna doesn't let a family pay the difference. They don't let someone upgrade. The allowable rate is paid in full and there can't be an upgrade. That's when some folks have to appreciate that what insurers are responsible for is what's medically reasonable and necessary. They are not responsible for deluxe or premium or anything for patient comfort. It's all about what you can prove to be medically necessary.

Again, Blue Cross Blue Shield and UnitedHealthcare do allow for the upgrade as long as the patient is offered something within the benefit. I've never found a Medicaid program that does allow anyone to pay any differences.

The coverage considerations, you may have limitations on coverage and coverage amounts. Limits on the amount of covered services, is very common with Medicaid. They only will cover so many ear molds in a time, so many repair or follow-up visits in a certain time. They'll only cover hearing aids so often, they have coverage limitations. They may cover only what can be documented again as medically necessary and again they might not allow for any technology upgrade.

Some insurers may not cover auditory prosthetic devices, cochlear implants, auditory brain stem implants, auditory osseointegrated devices especially for single-sided deafness, we're seeing a lot of denials for cochlear implants for single sided deafness. Auditory rehabilitation especially if provided by an audiologist does not have good third party coverage. Counseling, assistive dissing devices, FM systems, accessories, I think it's important, I'm big -- everything isn't covered by a third party. Not how insurance works for any of us.

So when it comes to cochlear implants, insurers cover the programming of devices. They don't cover all of the time which is a lot of time around fitting and orienting the processor and really all the instruction around the device. That's something that's not covered by a payer. That's something that would be the financial responsibility then of the family.

They don't cover home visits, they don't cover IEP visits. That's not something that's covered within a health insurance plan. Typically health insurers don't cover anything that is related to anything educational. That is typically the financial responsibility of a school system.

Again when it comes to treat, telehealth is not typically advised by most pediatric audiologists. Most pediatric audiologists are not comfortable fitting or programming or modifying an implant or a hearing aid on anyone probably under the age of 12 remotely. Just not something people are -- the technology they're not really comfortable with from a safety standpoint.

Also, telehealth though is dictated by technical capacities. What kind of equipment? There's a lot on the cochlear implant side, there's some adjustments that can be made

via an app. There's a lot of adjustments that can be made to hearing aids via app, but again, how much of that are people comfortable with, with a little one? And that's something that again I talked to in preparing for this I talked to some pediatric audiologists, and everyone uniformly is not really that comfortable. It's not about letting go, that they're uncomfortable with technology or letting go. Some of them are doing it while -- they're very comfortable with teens and adolescents, comfortable on that end. They're just not comfortable on the little guys making some of those changes because a lot of what you need to be able to see and experience and have them to see what their reactions are, and that's always not possible necessarily via telepractice.

Now, auditory rehabilitation, those types of their business for some of those kids is completely possible. We're talking right now about those treatments, if we're talking about AR, can completely be provided by telehealth. We're talking about adjusting or modifying the technology. State regulations again are going to dictate telehealth and any coverage allowances or coverage regulations.

Okay. I got done in the exact time, we're going to have questions.

I also want to put you're free to reach out to me after this event. If you're not comfortable asking questions now or you want to talk to me one on one specifically about your state and your situation so we can look through your licensure laws, your rules, what your payers look like, again, because it's all very unique, you can all reach out to me at no charge by phone, by text, by email and again that is completely no charge until July 1.

After that, you can reach out to associations you're a member of for any guidance or support.

So --

>> WILLIAM EISERMAN: Great.

>> KIM CAVITT: How you can reach me, that's my email, that's my phone number. Thank you so much for letting me present to you today and if anybody has any questions, I will sit and wait for them.

>> WILLIAM EISERMAN: Great. So thank you, Dr. Cavitt. Q&A is open on the left side so if you could type in any questions or comments you'd like to engage our presenter in. The first question that came in, reads: I'm just curious, who or what would be a third-party insurance.

>> KIM CAVITT: That's a very good question. So a third-party insurance is anybody that's not the patient. So that would be Medicaid, Medicare -- Medicare doesn't apply to children. Medicaid, Blue Cross Blue Shield, United Health care, Aetna, Humana, Kaiser Permanente, any of the managed Medicaid plans that may come under a million different names in your given state. It's any one that is paying for the item or service that's not the family themselves.

>> WILLIAM EISERMAN: Great. Thank you.

The next question is: What CPT code can audiologists use for aural habilitation prelingual?

>> KIM CAVITT: 92630.

But I want to give you a "but" about that code. That code is generally, as a general -- let me give you a little just tidbit of information.

Private insurers tend to be fairly lazy, and so they tend to follow Medicare, so oftentimes if Medicare doesn't cover something, they don't cover something. It's not an

uncommon, so you will see very limited coverage for aural habilitation provided -- it's 92630.

>> WILLIAM EISERMAN: Great, thank you.

>> KIM CAVITT: So you will see very limited coverage for that. That doesn't mean you don't provide it. There's just not always third-party coverage.

Do I anticipate changes to telehealth regulations after COVID?

Yes and no. So I think that a lot -- so states that did not have telehealth coverage in their -- telehealth capacity in their licensure law will have probably -- I can't guarantee it will remain but I bet a lot of states will take that up in creating bills in their Legislature to enable people to provide telehealth. That's the first step.

The second step is coverage. I think coverage will honestly depend on how much fraud and abuse they potentially see. So if they see a lot of things billed and then they start auditing those things and it's not legit, I think we might not see coverage increase, but if we see a lot of people get a lot of member -- insurance company are called members or beneficiaries, if we see a lot of insurance companies, members or beneficiaries get befits we might get continued coverage. Medicaid is a little roll of the dice because it's going to be about money. It's remember, do they have the funds in order to maintain this type of access to care?

And then finally, it's about the technology, because right now we've been enabled -- we've been able -- they have reduced the HIPAA requirements for COVID that you don't have to have a HIPAA-secured system so you can use Zoom or Skype or Webex or whatever it is. Before COVID, you couldn't. You had to use a HIPAA-secured system.

Again, we're going to have to see was anyone harmed in this process. And we still have in audiology limits on the technology capacity to be able to do certain things remotely. So that we're still limited that OAEs and ABR need to be hooked up to a baby, so those technology limitations are still going to be there.

>> WILLIAM EISERMAN: So our next question, we have so many good questions coming in, our next question reads: Our Regional Children's Hospital closed the Audiology Department during COVID. They are the only provider for failed screenings, and also see 98% of all kids in our area. There are no services for the foreseeable future.

Do you have any advice to families, any solutions?

>> KIM CAVITT: Have they reached out to other practices in the community? So, like, I teach in an ABE program. I was on a call today and the only people would be -- the only people doing this follow-up is a private practice, so sometimes it might be -- an ENT practice in your community might be open, might be able to see -- you have to try to divert -- to not just refer everything back to the hospital. You have to maybe find other solutions in your community that can do -- because again, most ENT practices and a large portion of audiology private practices have OAEs so if they see children, they might be very capable and very willing, and maybe more likely to be open to be able to see these follow-ups. Again, it's going to depend on your community.

I also want to add that I know Regional -- this is a decision that that Regional Hospital made. I know Audiology Departments across the country that have stayed open just to do these follow-ups to newborn hearing screening so you're just going to have to widen the net to find people just outside the hospital system. There's a lot of people capable to do this that just aren't the hospital alone.

>> WILLIAM EISERMAN: So the next question is, we're all over the board here in their questions. The next one has to do with your coding again, I believe. Do individual state Medicaids recognize different modifiers?

>> KIM CAVITT: Yes, but I want to give a "but" to that. The primary exception recognizing different modifiers is the California Medicaid system. HIPAA requires what are called standard transaction and code sets. That means everyone is using the same coding and the same modifiers. There are some states that have some exceptions to that and one of them is California, and the Medical system. Generally everyone uses -- that 33 modifier comes from the U.S. preventive health service. That's used by everyone. TC/PC is used by everyone. A 22 modifier used by everyone. Medical does have their own codes and modifiers that are used by them.

>> WILLIAM EISERMAN: Thank you for that clarification. The next question has to do with conditions under which a child might be denied. And it reads: When you said single-side as a possible reason for denying medical coverage, do you mean that if the patient has a unilateral hearing loss or the decision to put an amplification on either the right ear or the left ear?

>> KIM CAVITT: Well, I generally do not see a denial for single-sided. Single sided does mean that they have normal hearing in one ear and they're significantly hearing-impaired in the other. You are right, that is what that means. I've seen, I've rarely seen coverage denials for across hearing system for that but I have seen denials for an osseointegrated device or a cochlear implant for that, many times.

>> WILLIAM EISERMAN: The next question is in our state Medicaid covers aural rehabilitation at 62% of usual and customary.

>> KIM CAVITT: Okay, that's great. But again, a question I always have to ask about aural rehabilitation: Is that provided by an audiologist or speech pathologist? Because speech pathology uses a different code for aural rehabilitation, 92507 or 92508, they may see coverage. 92630 and 92633 tend to have very limited coverage across Medicaid and across health insurers but if 92630 and 92633 are covered, that's great.

>> WILLIAM EISERMAN: Excellent, thank you. The next question is: Is there an easy go-to place to find things like testing requirements prior to dispensing?

>> KIM CAVITT: Easy? Is there a go-to place, yes. Is it easy? No. So the best place for you to jump off from, ASHA, or the American Speech-Language Hearing Association has something called a state by state guide. You literally Google ASHA state by state and it will show all the states and it will link you -- it's not going to tell you what those requirements are but it's going to help you link to the dispensing law in that state.

So you're going to need to look into the hearing aid dispensing law in that specific state. If you can't find it, let me know. I know a lot of this sadly because I've been digging because of telehealth over the last 8 weeks, I've been digging extensively into this so I have most of them at my disposal if you have any issues finding them.

>> WILLIAM EISERMAN: The next question is: Telehealth has been in our service plan for several years now, but this situation has simply exploded our remote work. We need the guidance for the best reimbursement. So thank you, that was just giving you kudos, I believe.

>> KIM CAVITT: Oh, thank you. And again you can always reach out, all of y'all

can reach out to me individually if you want to learn something. In a presentation like this, I can't talk about -- every state is different and every payer is different, so I can't really tell you what those all mean for your area but you're always welcome to reach out to me.

>> WILLIAM EISERMAN: Yeah, and you see Dr. Cavitt's email address is in the lower right-hand corner of her PowerPoint slide there.

The next question reads: How does the FDA label and age for cochlear implants impact reimbursements? And how will this improve with new indications down to 9 months instead of 12?

>> KIM CAVITT: That's a beautiful question, but this is one thing that y'all have to understand about insurance: Insurance doesn't have to cover anything that they don't want to cover. So as families, families can select insurances based upon their coverage.

So sometimes when someone's employed or even when we're talking about Medicaid, some Medicaids have the public/private option. You can see what those coverages are as you select them but just because the FDA allows for it to be performed, but you're not working off-label, doesn't mean an insurance plan has to actually cover the procedure.

So that's something for people to understand about insurance. They don't have to cover everything. Hearing aids are not covered by every insurer. Cochlear implants are not covered by every insurer. Osseointegrated devices are not covered by every insurer. Medicaid, most cover hearing aids for children. They have a lot of limitations on that coverage. Things don't have to be covered, sometimes again it's hard when we're talking about an implant, but sometimes you again have to pay for things when it comes to hearing aids and things yourself.

And again I'll tell you a little story: My daughter, my daughter is 17 but she had her nanny, son, single sided deafness, perfect candidate for a cochlear implant. His insurance company will not cover it, so again that is not an uncommon thing.

>> WILLIAM EISERMAN: Our last question, you can take a big deep breath, is --

>> KIM CAVITT: Oh, yeah. I don't know the answer to this next question. I would actually defer to Karl.

>> WILLIAM EISERMAN: So what percentage of newborn hearing screening programs in the U.S. perform OAEs versus ABRs?

>> KIM CAVITT: I don't know the answer to that and then my follow-up to that is when we were talking about newborn hearing screening programs are you talking about at birth? Are you talking about at follow-up? When you're talking about the program, I think you also have to break that down to: Is this the initial screen versus the follow-up? I can just tell you from experience, most of the people I know, or when I myself did follow-up newborn hearing screenings, I actually did OAEs and ABR in follow-up. It just was a great kind of double check to let you kind of look a little bit at that neuropathy kind of option we did both. What happens at birth I would actually defer to the folks at EHDI. They're going to know way more than I'm going to know.

>> WILLIAM EISERMAN: I think maybe Dr. Karl White is submitting a response to that question, so let's see if that comes in.

While we wait for that, I want to thank Dr. Cavitt for your excellent presentation today. I'm Will Eiserman from NCHAM and know that today's webinar is going to be

posted as a recorded webinar on infanthearing.org in the next couple of days so if you need to review this again or share it with somebody who wasn't able to attend live, you can do it that way. And Dr. White responded and said it's about 40% OAEs, about 40% AABR and about 20% both.

Thank you, Karl.

>> KIM CAVITT: I thought he would know. I knew I could probably turn that direction and he would know the answer to that. Mine was just going to be subjective.

>> WILLIAM EISERMAN: Yep. So thank you, and thank you also to our captioner today for your time and talents, and helping to make our webinar more accessible.

Those are the upcoming webinars, if you haven't heard about them. You can register for them on infanthearing.org through the same way that you registered for today's webinar. We have many coming up in the next week and a half. So we hope you'll return to us, and expand your understanding, and engage in these kinds of dialogues.

Before you all go away, as you go away, please click on this link right here, and give us some feedback on today's webinar. Once again, thank you, Dr. Cavitt, and --

>> KIM CAVITT: Thank you for having me and please don't hesitate to reach out if you have questions. The only dumb question is the one you didn't ask.

>> WILLIAM EISERMAN: Thank you. I put Dr. Cavitt's email address over on the left underneath her name there, so you can see that one last time. And please, click on where it says "please click here to give us feedback." Thank you, everybody, and we will see you in the days ahead.

>> KIM CAVITT: Thank you. Thank you very much. Thanks for having me.

[End of webinar]

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