

Provisions and Problems in Medicare Payments

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Reimbursement for Aural Rehabilitation Services

At the present time, Federal health insurance, or Medicare, does not reimburse for any aural rehabilitative services except under Part A when the hearing impairment was the direct result of the accident or illness that necessitated the client's hospitalization. That service, at the present time, can only be reimbursed when provided by an ASHA certified speech pathologist, or one who is licensed by that state, or is eligible for ASHA certification or under that person's supervision and **only** under the prescription and monitoring of the client's physician. Audiometric evaluations, however, are reimburseable to the audiologist if the audiologist is ASHA certified or licensed by that state or is eligible for ASHA certification, usually on an 80 percent basis (if the audiologist accepts assignment), when the amount charged by the audiologist is reasonable, proper, and customary as compared with other such services provided locally, when it is conducted as a part of an examination of the cause of the hearing impairment and/or to determine whether or not the hearing impairment is medically treatable, and if the audiologist has been awarded a Medicare provider number. If the audiologist has not requested and/or been awarded a provider number through Medicare or a Medicare fiscal intermediary, audiometric assessment will only be reimbursed if it is conducted under the supervision of a physician or an audiologist who possesses a provider number. Hearing aid evaluations for the purpose of prescribing and fitting a hearing aid are not reimburseable at the present time.

The allowable charge for services under the Medicare Program is dependent upon the type and extent of services described on the claim form. The benefit approved in this case is based upon the information reported on the Medicare form and is in accordance with the maximum allowable charge for the type of services described. I cannot stress enough that the description of services provided must be clearly stated. Terms familiar to the audiologist, but not to the claims reviewer at your Fiscal Intermediary's office, can, and usually does, result in reimbursement that is lower than it would have been or listing of the service as a "non-allowable charge". For example, rather than using the term "hearing test", use "hearing evaluation" or "audiometric evaluation". Rather than using terms such as "special test battery" for tests for site of lesion, use precise descriptive terms such as "acoustic impedance testing", or "assessment for site of auditory lesion—short increment sensitive index and assessment for tone decay." Under "Nature of Illness or Injury Requiring Services", use terms such as "Mixed severe to profound sloping sensorineural loss—right ear, and moderate sensorineural hearing loss sloping into the higher frequencies—left ear", rather than "moderate hearing loss—right and left ears", or "sensorineural hearing loss—bilaterally". The more descriptive the terminology, the greater probability for reimbursement (or less difficulty in reimbursement). The terminology should be worked out with personnel from the disbursement and claims review division of your fiscal intermediary. Since there is always the possibility for change-over in staff within the fiscal intermediary office, however, still use as descriptive a terminology as possible so that new personnel will have fewer questions.

In accordance with Health Care Financing Administration regulations, the maximum allowable charge for a specific service is based upon the charge most frequently submitted by the individual supplier or physician for that specific service. This must be taken into consideration when the supplier is contemplating an increase in price for various services. This charge is compared to the charge, for that same service, which has been most frequently submitted by all other suppliers or physicians in the same speciality, in that state. The Medicare Program is authorized to allow benefit equal to the lower of the two charges. In addition, an economic index is applied to all charges which limits the percentage of increase in benefits from year to year. Each fiscal year, the benefits allowed for every service provided are re-evaluated using this comparison. If a supplier of services was not in practice prior to October 1, 1977 (had not provided services under a Medicare Provider Number), allowable charges are based upon that 50 percentile—Area of Speciality.

If a supplier of services is not satisfied with a determination of reimbursement rate, or has asked for a review determination of

his/her reimbursement rate and is still not satisfied, the supplier may request, in writing, within six months of the date of the notice, a hearing before a hearing officer if the amount in controversy (the amount of benefits in question) is \$100.00 or more. To meet the \$100.00 limitation, the supplier may combine other of their claims that have been through the review or reopening process within six months of the date of the hearing request. This request must be sent either to the Office of Professional Relations Division of your fiscal intermediary, or to any Social Security Office.

The American Speech and Hearing Association is working with the Social Security Administration and Congress to encourage passage of legislation to include comprehensive aural rehabilitation treatment by audiologists as a reimbursable service under Medicare. This author is encouraged enough to feel that such legislation will be passed within the near future.

To avoid difficulties in obtaining third-party reimbursement for assessment services and to insure that your procedures are correct, it is stressed that a meeting with the person who is responsible for disbursement and claims review for your Medicare fiscal intermediary be held to discuss the use of forms, terminology, coverage vs non-coverage, billing procedures, and so on. Such a meeting will resolve many potential problems which could, otherwise, occur. Ignorance of the law is not an acceptable excuse in the eyes of any State or Federal court.

The information and procedures for reimbursement through Federal health insurance is such a complex topic that a brief presentation as this could be misunderstood by some. I would be most happy to talk with any of the listeners to help unravel some of those complexities. It is again urged that persons interested in becoming a provider through the Medicare Program should meet with persons in the office of their fiscal intermediary to review procedures and forms.

Congressional Action

Further, recommendations by the United States House of Representatives Select Committee on Aging, Sub-Committee on Health and Long-Term Care have been made concerning Medicare coverage for hearing aids which could eventually impact on the audiologist who dispenses hearing aids. Even though the Report was published in 1976, the Sub-Committee is still actively working toward Congressional acceptance of its recommendations for inclusion in the laws governing provisions under Medicare.

As Representative Claude Pepper has stated, "The elderly of this nation are entitled to the best health care that is available in the United States." As this report demonstrates, in the area of Medical appliances, they are not getting it.

The Sub-Committee states, "Over one-half of all persons over

65 years of age and over suffer from impaired hearing...”, so they do have a good estimate of the incidence at hand. The disturbing aspect of their report, however, relates, “For millions of elderly Americans, the solution to these problems...” e.g. the seriousness of the hearing impairment, “...is the use of a suitable hearing aid.” The use of a suitable hearing aid as a part of a total aural rehabilitation program for those who require amplification to cope with their communication deficit is not mentioned in their report, and must be stressed in future reports which may include implementation of services for the aging. The Staff Director of this House Sub-Committee asked me to comment on the statements in the Report, and I did stress the need for statements to include aural rehabilitation as a part of a total service to the hearing impaired elderly which may or may not include the use of a hearing aid—that a hearing aid is not always the solution.

The Sub-Committee Report stresses abuses in the dispensing of hearing aids, particularly the selling of unnecessary hearing aids to the elderly for inflated prices. They do, further, include co-statements by the American Speech and Hearing Association, such as the need for rejection of the waiver of medical examination prior to purchase of a hearing aid, particularly for those persons over age 65 years, and the inadequacy of most “hearing aid dealer” study courses in preparing the salesperson to make objective judgements and recommendations necessary for viable and ethical rehabilitation of hearing impaired persons.

In regard to their recommended provision of reimbursement for hearing aids, the House Sub-Committee’s suggested restrictions and safeguards appear to be well founded. These include the “freedom of choice” concept, the necessity for examination by a hearing specialist for the elderly client prior to being fit with a hearing aid, the barring of certain “dispensing” practices such as door-to-door sales and the encouragement of continuing education and training programs for audiologists and physicians in order to improve the quality of services to the hearing impaired elderly. The major weakness in the recommendations in the Report is that no specification as to who would be allowed to dispense hearing aids was made. The major emphasis in regard to safeguards appeared to be in the area of the costs of hearing aids, which is of course important, but certainly not the only consideration. They, further, state that the audiologist or a hearing aid dealer can teach the hearing impaired to best use the hearing aid, perhaps inadvertently suggesting that the typical hearing aid dealer is equally qualified to work with the hearing impaired person. They do state, however, that the hearing impaired elderly can “receive further training in lipreading and other skills that will improve hearing comprehension at a hearing clinic.” They fail to specify what a “hearing clinic” is, or who should provide the service.

In conclusion, relative to the United States House of

Representative's recommendations for reimbursement for hearing aids through Medicare provisions, they appear to be cognizant of the necessity for stringent safeguards, but the audiologist in the provision of a total aural rehabilitation service, of which the hearing aid may be a part, is not stressed. That appears to be a major weakness in their recommendations. If Congressman Abner Mikua's (HR-9413) Bill which was submitted last year could be eventually passed as written, the provision of aural rehabilitation services by the audiologist would be greatly enhanced. The Bill would add aural rehabilitation to the services now covered by Medicare and, according to Dick Dowling, Public Affairs Department Director of ASHA, would substitute a written referral requirement for the present written specifications requirement that speech pathologists are still faced with the present time. The American Council of Otolaryngologists has criticized the Bill, stating that the Bill would remove physician control over audiologic and speech pathology services stipulated under Medicare.

Let us all applaud Congressman Mikua and the ASHA personnel who are encouraging expansion of our services as independent providers of services.

Concluding Statement

Taking a little farm philosophy and applying it to Medicare reimbursement, here are three important ingredients for acquiring the reimbursement harvest that is due you:

1. Water represents your degree and certification as an audiologist, the element that makes your services possible.
2. Fertilizer represents the beneficial professional services you provide which stimulates your practice to grow and flourish.
3. The water and fertilizer are very important ingredients, but in terms of reaping the Medicare reimbursement that is due to you, no matter how much water and fertilizer are used, as in any other endeavor, it is how you prepare the soil that counts. Lay the groundwork with your fiscal intermediary first before submitting reimbursement claims. Acquaint them with you. Talk with them about your services. Apply for your Provider number. Discuss with them the professional terms you will use on reimbursement claim forms, what services you will be requesting reimbursement for and their reasonable cost. Discuss the Medicare laws and which services are reimbursable and under what circumstances.

By preparing the soil well initially, you will be reimbursed for your services with more consistency and less time will be spent correcting needless errors.

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