

## **A Guide to Itemizing Professional Services**

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Due to a widespread change in the delivery of hearing health services and related devices by both private and public payers, many audiologists are considering a change in their office billing practices by separately itemizing hearing instruments and professional services associated with the fitting and follow-up care for these devices and the ongoing care for patients as they adjust to amplification (a practice typically referred to by the profession as “unbundling” services).

This informational document was developed by the American Academy of Audiology (the “Academy”) as a guide to itemizing professional services.<sup>1</sup> There are many ways to incorporate itemization into a practice. When dealing with a private-pay patient, a practitioner may choose to offer one or more options:

1. Present a fee for the device(s) and present a separate fee for each associated professional service.
2. Present a combined fee for the device(s) and pre-defined set of service options over a specified time period with an itemized listing of the associated professional services included.
3. Some other variation of the above.

While some payers reimburse from a bundled model, other commercial payers require itemization. In cases where itemization is required, it will be advisable to identify and itemize professional fees separately from the hearing device(s) if this is their standard practice for reimbursement of other types of medical devices. The dollar amount for hearing aid(s) and services should equal the same total fee, whether a bundled or itemized model is used.

This guidance is separated into three sections.

- I. Developing a Business Plan**
- II. Itemizing for Insurance**
- III. Hearing Aid Services Claim Submission Examples**

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<sup>1</sup> Disclaimer: The purpose of the information provided above by the American Academy of Audiology Coding and Reimbursement Committee is to provide general information and educational guidance to audiologists. Action taken with respect to the information provided is an individual choice. The American Academy of Audiology hereby disclaims any responsibility for the consequences of any action(s) taken by any individual(s) as a result of using the information provided herein.

## I. Developing a Business Plan

1. To begin, download the editable superbill template from the Academy website, as it contains many of the procedure codes used for the devices/services outlined below.

[Academy Superbill Template \(2022\)—American Academy of Audiology](#)

2. Itemize the delivery model.

Practices may vary in their approach, but there are common elements to setting fees that all practices should follow.

First, identify all services and products including hearing aids that are offered in the practice. The itemization may include the following:

- a. hearing aid assessment to determine need for and the type of device(s)
- b. device(s)
- c. dispensing fee
- d. fitting/orientation/check fee
- e. conformity evaluation
- f. batteries
- g. earmolds (if indicated)
- h. earmold impressions (if indicated)
- i. accessories
- j. follow-up visits
- k. aural rehabilitation

Second, based on the practice's individual business model, offer a post-warranty service package for office visits and services. These packages could be structured for the provision of basic or more advanced services as defined by the practice. For example, a basic package could offer a one-year warranty on the device(s), a pre-determined number of office visits, and a pre-determined number of minor in-house repairs (the practice will need to define exactly which repairs are considered basic or more advanced and will likely depend on the amount of time and resources used).

A premium service package could include a longer warranty period, more office visits, and in-house repairs, for example. The practice will also have to determine whether (and if so, how) service packages will be offered to patients who obtained their devices from another practitioner or through another delivery model.

3. Develop a fee schedule for the identified services. Professional service fees typically include costs incurred to provide services, such as overhead expenses [rent, staff (salaries, benefits), utilities, equipment, and supply costs, etc.] and time providing the service (to include charting, calls on behalf of the patient to other healthcare providers and other follow-up care).

To establish fees, calculate the cost of doing business on an hourly basis and apply that rate to services. The following are suggested key steps:<sup>2</sup>

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<sup>2</sup> The key steps have been adapted from the following two references: Foltner, K., (2009) What's my time worth? Part 3: Breakeven analysis. *Advance for Audiologists*, 11(3), 44; and Sjoblad, S. Warren, B. (2011) Mythbusters: Can one unbundle and stay in business? *Audiology Today* 23(5):36-45.

- Establish Annual Contact Hours:
  - Determine how many hours per week are spent in providing direct patient care. Although the practice may operate 40 hours per week, consider the non-billable time as well (this is time that is spent that cannot be billed to patients or insurers).
  - Calculate the number of weeks/hours per year that patient care services are actually provided (factor in holidays, vacation, sick and professional leave).
  - Determine the number of providers in the practice.
  - Multiply the hours per week by weeks per year by the number of providers.
- Calculate the operating costs for the practice. Ideally this would be broken down into several different expense categories, such as:
  - *clinical and support personnel* (salary/benefits),
  - *clinic expenses* (rent, utilities, communications technology, marketing, etc.)
  - *cost of goods* (all things you buy for resale).
- Determine the break-even hourly rate.
  - Subtract the cost of goods from total annual clinic expenses, and divide the remaining amount by the ‘annual contact hours’ established in step one.
  - This is the break-even hourly rate in an unbundled model.
- Add-in desired profit margin
  - Take annual expenses less cost of goods, add desired profit and divide this number by the annual contact hours.
  - This is the hourly rate including the desired profit margin.

4. Assign procedure codes for all identified services. Note: there are currently no nationally agreed-upon definitions for many of the hearing aid procedure codes. Having actual codes assigned to procedures is not necessary unless insurance claims are submitted, however assigning codes for all services provided is good business practice for compliance and for using this information for internal reporting or tracking purposes.

Some third-party payers may have different interpretations of which specific codes can be used to identify certain procedures for payment. Be sure to know these specific interpretations by insurers and adhere to the guidelines when submitting claims.

## II. Itemizing for Insurance

Because many commercial payers and state Medicaid programs consider hearing aids durable medical equipment (DME), be sure to itemize all fees, or risk non-payment for professional services. As long as it is not contractually excluded, patients should expect to pay for professional services rendered. You will need to check with your state Medicaid program to verify if hearing aids are considered DME in your state.

It is important to note that some commercial payers may not intend or desire to fund convenience accessories, such as life-long follow-up care or extended warranties, etc. This is not the typical model for reimbursement for medical devices. Some items, fees and services that are considered good patient care may not be considered medically necessary by the payer and will not be covered. These services can still be provided but payment will be the patient's financial responsibility and the patient needs to be informed of this, preferably in writing.

1. Check the fee schedules of each of the commercial payers with whom there is a contract for services to determine whether the codes that will be billed are covered. If the desired codes are not on the fee schedule for the commercial payer, the insurance company will not reimburse for the codes. You can contact the commercial payer to request the addition of frequently used codes that are not on the current fee schedule and you can take this time to educate the commercial payers on all the services that will be provided by the practice. (Several examples provided below should assist in this process).
2. In some states, the patient is provided with an "allowance" (e.g., \$1,000.00) toward the hearing aids and services, and the patient is expected to pay the balance, which is often called "balance billing." In other plans, balance billing is not allowed but a payer may allow patients to upgrade to a higher level of technology that is beyond their intended (commercial payer) benefit. This option, as well as required protocols and forms, must be verified with the payer in advance. Ask the commercial payer how the patient can share in the cost of an upgrade and how that cost-share will be reflected on the explanation of benefits (EOB) so that the patient is informed of their financial responsibility. This process will ensure that services provided are covered either by the commercial payer or the patient.

Commercial payers may offer a *financial waiver* for use with the patient to inform them of who is responsible for payment of which services. If a waiver is not provided, it would be best to develop one for the practice. It is important to understand any state rules and payor rules in terms of whether any type of balance billing or "upgrade" is allowed. This varies across the country and across insurers.

The services/devices claim examples provided in the next section do not include services that may be billed for after the adjustment period or after the expiration of the manufacturer's hearing aid warranty.

Additional service categories and charges for follow-up services, such as re-checks, programming, and extended warranty packages may be created by the practice.

\*Any additional service categories should be discussed with the patient prior to completing the contract. The Academy recommends the additional categories be documented in writing and a copy provided to the patient. Each item should be reviewed with the patient to ensure they understand the details.

\*State regulations and/or licensure laws may have additional requirements regarding documentation and the practitioner is responsible for ensuring compliance with state and federal regulations regarding the practice of hearing aid dispensing.

### III. Hearing Aid Services Claim Submission Examples

The Healthcare Common Procedure Coding System (HCPCS) service codes listed below are provided by way of example **ONLY** and represent the full range of code possibilities available to audiologists for hearing aid services.

**Note: The examples below do not include the audiometric examination, which would be reflected using appropriate codes, such as 92557 or S0618. However, some plans, such as Medicare, do not cover audiometric testing if testing is completed for hearing aid purposes.**

Audiologists should use their clinical judgment and expertise to administer and bill for services only when said services are deemed medically necessary and are supported by accurate documentation for use of the procedure code(s). The Academy is **NOT** suggesting that audiologists seek reimbursement for the full listing of procedure codes in each example.

Because of the variability within each practice setting and the variability of commercial payer contracts, the Academy does not and cannot recommend or endorse the use of specific codes or groups of codes, but rather offers these hearing aid services claim examples to demonstrate different approaches a practice can take for itemizing services.

#### **EXAMPLE 1: Monaural in-the-canal hearing aid**

- **92590** (Hearing aid examination and selection, monaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5255** Hearing aid, digital, monaural, ITC
- **V5241** Dispensing fee, monaural hearing aid, any type
- **V5266** Battery for use In hearing device
- **V5275** Earmold impression, each
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

#### **EXAMPLE 2: Monaural behind-the-ear hearing aid, with earmold**

- **92590** (Hearing aid examination and selection, monaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5257** Hearing aid, digital, monaural, BTE
- **V5241** Dispensing fee, monaural hearing aid, any type
- **V5266** Battery for use In hearing device
- **V5264** Earmold/insert, not disposable, any type
- **V5275** Earmold impression, each
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

### **EXAMPLE 3: Binaural open-fit behind-the-ear hearing aids\***

- **92591** (Hearing aid examination and selection, binaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5261** Hearing aid, digital, binaural, BTE
- **V5160** Dispensing fee, binaural hearing aid
- **V5266** Battery for use In hearing device
- **V5265** Earmold/insert, disposable, any type (This will need to be filed with 2 units)
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

**\*For receiver in the canal (RIC) technology, the receiver could be billed as V5267, hearing aidsupplies/accessories.**

### **EXAMPLE 4: Binaural behind-the-ear hearing aids, with binaural earmolds**

- **92591** (Hearing aid examination and selection, binaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5261** Hearing aid, digital, binaural, BTE
- **V5160** Dispensing fee, binaural
- **V5266** Battery for use In hearing device
- **V5264** Earmold/insert, not disposable, any type (This will need to be filed with 2 units for 2 earmolds)
- **V5275** Earmold impression, each (This will need to be filed with 2 units for 2 earmold impressions)
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

### **EXAMPLE 5: CROS behind-the-ear hearing aid**

- **92590** (Hearing aid examination and selection, monaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5171** Hearing aid, contralateral routing device, monaural, in the ear
- **V5200** Dispensing fee, contralateral, monaural
- **V5266** Battery for use In hearing device
- **V5264** Earmold/insert, not disposable, any type (This would be filed with the number of earmoldsutilized)
- **V5275** Earmold impression, each (This will need to be filed with the number of EMIs taken)
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

### **EXAMPLE 6: BICROS behind-the-ear hearing aid**

- **92590** (Hearing aid examination and selection, monaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid

- **V5020** Conformity Evaluation
- **V5221** Hearing aid, contralateral routing system, binaural, BTE/BTE
- **V5240** Dispensing fee, contralateral routing system, binaural
- **V5266** Battery for use In hearing device
- **V5264** Earmold/insert, not disposable, any type (This would be filed with the number of earmoldsutilized)
- **V5275** Earmold impression, each (This will need to be filed with the number of EMIs taken)
- **V5299** Hearing service, miscellaneous (extended warranty packages, for example)

**EXAMPLE 7: Binaural hearing aids [when required by payer to file with a right (RT) and left (LT)modifier]**

- **92591** (Hearing aid examination and selection, binaural), or **V5010** (Assessment for hearing aid). Yourchoice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5257-RT** Hearing aid, digital, monaural, BTE
- **V5257-LT** Hearing aid, digital, monaural, BTE
- **V5241-RT** Dispensing fee, monaural hearing aid, any type
- **V5241-LT** Dispensing fee, monaural hearing aid, any type
- **V5264-RT** Earmold/insert, not disposable, any type
- **V5264-LT** Earmold/insert, not disposable, any type
- **V5275-RT** Earmold impression, each
- **V5275-LT** Earmold impression, each
- **V5020-RT** Conformity evaluation
- **V5020-LT** Conformity evaluation
- **V5267-RT** Hearing aid supplies/accessories, if indicated
- **V5267-LT** Hearing aid supplies/accessories, if indicated
- **V5011-RT** Fitting/orientation/checking of hearing aid
- **V5011-LT** Fitting/orientation/checking of hearing aid
- **V5266-RT** Battery for use In hearing device
- **V5266-LT** Battery for use In hearing device

**EXAMPLE 8: Fitting PSAP device**

- **92591** (Hearing aid examination and selection, binaural), or **V5010** (Assessment for hearing aid). Your choice of the code may be payer dependent.
- **V5011** Fitting/orientation/checking of hearing aid
- **V5020** Conformity Evaluation
- **V5274** Assistive listening device, not otherwise specified
- **V5298** Hearing aid, not otherwise classified
- **V5299** Hearing service, miscellaneous

**IV. Additional Academy Resources on Coding and Reimbursement**

1. American Academy of Audiology Practice Resources for Reimbursement.  
[www.audiology.org/practice-resources/reimbursement](http://www.audiology.org/practice-resources/reimbursement)
2. American Academy of Audiology Practice Resources for Coding.  
[www.audiology.org/practice-resources/coding](http://www.audiology.org/practice-resources/coding)