

# The Changing Hearing Healthcare Landscape

Robert Burkard, Ph.D. CCC-A  
Professor and Chair  
Rehabilitation Science  
University at Buffalo

## **Disclaimers:**

Robert Burkard is a member of The American Speech-Language Hearing Association (ASHA) Health Care Economics Committee, was an organizer and participant in ASHA's 2012 Healthcare Summit, a member of the Audiology Quality Consortium, and was the Chair of ASHA's ad hoc Committee on Interprofessional Education.

# Cost Containment for Health Care

- Multiple organizations are recommending going away from a “Fee for Service” model and replacing it with ***Value Based Purchasing***
- “Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services...” M. Porter, What is Value in Health Care? NEJM, 2010, 363: 2477-2481
- Fee for service:
  - Encourages increased utilization
  - More services results in more payment, but raises the issue of the true medical necessity for these increased services

# Audiology & Value Based Purchasing

- The potential biggest impact will be working to identify procedure groups to bundle – such as the changes in audiometric, immittance and vestibular testing bundled CPT codes:
  - 92557: Comprehensive Audiometry Threshold evaluation and Speech Recognition
  - 92570: Acoustic Immittance Testing (tympanometry, acoustic reflex threshold, acoustic reflex decay)
  - 92540: Basic Vestibular Evaluation (spontaneous nystagmus, positional nystagmus, optokinetic nystagmus, foveal and peripheral stimulation)
- One could envision further efforts along these lines. So in effect paying for a group of diagnostic procedures with a single payment – the group of procedures is to result in diagnostic AND functional information.

# **Unbundling (This is a contentious issue):**

Hearing Aids are not covered by Medicare or most private insurance companies. Audiologists frequently sell a hearing aid bundled with their services:

- The device
- Earmold
- Assessment (unaided, real ear measure, behavioral gain)
- Batteries
- Repair/earwax removal
- Counseling
- Aural rehabilitation

Online and other (similar) hearing aid sales typically provide the device, but not the above-listed services, and are substantially cheaper than when the hearing aid is 'bundled' with the above-listed services. Practices need to have a plan on how to work with these patients.

Unless one unbundles, any service you give away (or appear to give away) which might be billable to Medicare (including threshold estimation) must be done for free for all patients. Thus, if a patient buys a hearing aid online, then asks you to provide the other services for free, you might be obligated to do so.

# How Does One Code for Outcome?

Another phase of the overall change in the hearing healthcare landscape is the change to ICD 10 coding:

- October 1, 2014: International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification ICD-10-CM
- ICD-9-CM approximately 18,000 codes, while ICD-10-CM approximately 160,000 available codes provides more specificity than ICD-9-CM:

Noise-induced hearing loss due to dolphin encounter (initial encounter):

H83.3X3- Noise effects on inner ear, bilateral

W56.09Xa- Other contact with dolphin

- ICD-10-CM could be used with the International Classification of Functioning, Disability & Health (ICF) for coding level of severity (i.e., 0 is 'no problem' while 4 is 'complete problem')

# Brief ICF Core Set for Hearing Loss:

## **Body Functions (7):**

Temperament and Personality Functions  
Attention Functions  
Memory Functions  
Emotional Functions  
Seeing Functions  
Hearing Functions  
Sensations Associated with Hearing  
and Vestibular functions

## **Environmental Factors (7):**

Products and Technology for  
Communication  
Sound  
Immediate Family  
Health Professionals  
Individual Attitudes of Immediate  
Family Members  
Societal Attitudes  
Health Services, Systems and Policies

## **Body Structures (4):**

Structure of the Brain  
Structure of the External Ear  
Structure of the Middle Ear  
Structure of the Inner Ear

## **Activities and Participation (9):**

Listening  
Handling Stress and other Psychological  
Demands  
Communicating with- receiving- Spoken  
Messages  
Conversation  
Using Communication Devices and  
Techniques  
Family Relationships  
School Education  
Remunerative Employment  
Community Life

# Physician Quality Reporting System (PQRS)

- CMS designed PQRS to improve quality of care for Medicare beneficiaries
- Since 2007, quality reporting has been voluntary for services to Medicare Part B Fee for Service beneficiaries
- The Patient Protection and Affordable Care Act (PPACA) includes transition from incentive for participation in PQRS to penalty for non-participation
- There are currently few measures specific to audiology

# Why Should Providers Participate in PQRS?:

*It is all about reimbursement*

To avoid 2% penalty, in 2014 must report on 50% of qualifying patients for three measures (or as many as are available)

To receive 0.5% incentive, must report on 50% of qualifying patients for 9 measures including 3 quality domains\* (or as many as are available)

\*Quality domains: Patient Safety; Person and Caregiver-Centered Experience and Outcomes; Communication and Care Coordination; Effective Clinical Care; Community/Population Health; Efficiency and Cost Reduction

[http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/July\\_25\\_2013\\_National\\_Provider\\_Call\\_Presentation.pdf](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/July_25_2013_National_Provider_Call_Presentation.pdf)



# Measure Development: Audiology Quality Consortium (AQC): 10 Audiology organizations\*

- Inclusion in current PQRS measures:
  - Referral for dizziness
  - Smoking cessation counseling
  - Blood pressure measurement
  - Pain assessment
  - Falls prevention
- Currently drafting 6 measures for future use (and considering more):
  - Speech-in-noise testing for CI referral
  - Functional communication ability
  - Tinnitus screening/evaluation (2)
  - Ototoxic baseline measurement/monitoring
  - Vestibular testing

\*Academy of Doctors of Audiology, Academy of Rehabilitative Audiology, American Academy of Audiology, American Academy of Private Practice in Speech Pathology and Audiology, American Speech-Language-Hearing Association, Association of VA Audiologists, Directors of Speech and Hearing Programs in State Health and Welfare Agencies, Educational Audiology Association, Military Audiology Association, National Hearing Conservation Association

# PPACA – Essential Health Benefits to be covered by Exchanges and Medicaid programs

## 10 categories of covered service areas:

Ambulatory patient Services

Emergency Services

Hospitalization

Maternity and newborn care

Mental Health and substance use disorder services

Prescription drugs

*Rehabilitative and habilitative services and devices*

Laboratory services

*Preventative and wellness services and chronic disease management*

Pediatric services, including oral and vision care

# Essential Health Benefits

- If hearing services are not specifically listed as an essential health benefit, it seems highly unlikely they will be included individually in an ACO structure
- What is needed to make Hearing services “essential”?

Evidence must show that diagnostic and therapeutic hearing services make a significant difference in the outcomes of the patients, and does so in a cost effective manner (i.e., we must be able to demonstrate our “Value”).

## **Hearing healthcare providers do not play well with one another:**

Despite evidence (e.g., Zapala et al. 2010) that audiologists are able to diagnose hearing conditions associated with significant morbidity and mortality (and thus make appropriate medical referrals), AAO-HNS quite strongly opposes Direct Access for Audiology. In light of this opposition, it is unlikely that a bill about direct access for audiology (proposed by the American Academy of Audiology) will be supported:

Representative Mike Ross (D-AR) has introduced the Medicare Hearing Health Care Enhancement Act of 2011 (H.R. 2140), along with 11 original co-sponsors. H.R. 2140 eliminates the need for Medicare patients to obtain a physician referral prior to visiting an audiologist for an evaluation. Federal employees and members of Congress also have direct access to an audiologist. This bill would afford Medicare patients the same direct access to an audiologist.

# **Audiology: Internecine Battles:**

## AAA: Direct Access

## ASHA: Comprehensive Medicare Coverage for Audiology Services:

### **Overview of H.R. 2330 - The Medicare Audiology Services Enhancement Act of 2013**

#### **More Information**

H.R. 2330 moves audiology forward in the current health care system by recognizing audiologists as diagnostic and treatment providers, able to receive Medicare reimbursement for professional services provided; increases access to care by allowing Medicare beneficiaries to receive diagnostic **and treatment** services from audiologists

<http://www.asha.org/Advocacy/Overview-of-HR-2330/>

## ADA (Academy of Doctors of Audiology): Audiology's 18 by 18

### **Campaign Aims to Achieve *Limited License Physician Status, Direct Access and Expanded Audiology Benefits under Medicare:***

- Allow for Medicare coverage of medically necessary, covered treatment services such as vestibular rehabilitation, cerumen removal, and aural rehabilitation provided by an audiologist practicing within their state defined scope of practice.
- Eliminate the need for the physician order required for a Medicare beneficiary to receive coverage of medically necessary, covered audiology and vestibular services
- Allow audiologists the autonomy to make clinical recommendations and practice the full scope of audiology and vestibular care as allowed by their state license and as dictated by their educational requirements and competencies.

<http://www.audiologist.org/publications20/advocacy15/18x18-initiative>

## **My Personal Opinion:**

If we want to make it possible for more elders to live independently longer, to reduce medical non-compliance because those elders with hearing loss do not understand what their physician is telling them, and to improve their quality of life, we must support legislation that mandates that Medicare cover the costs of hearing aids, and allow audiologists to be reimbursed for their (re)habilitative services.

# Interprofessional Education (IPE)

“When students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (World Health Organization, 2010)

2013 Cochrane Review (Reeves, Perrier, Golsman, Freeth and Zwarenstein, 2013):

- 15 studies that met inclusion criteria
- “..due to small number of studies and heterogeneity of interventions and outcome measures, it is not possible to draw generalizable inferences about the key elements of IPE and its effectiveness.”
- Need to compare effectiveness of IPE interventions to discipline-specific Interventions

The Bottom Line: *We need more evidence that IPE leads to better value in healthcare delivery.*

## Research Areas:

1. The audiogram is not an optimal functional measure of hearing. Studies investigating hearing-related disability should use hearing handicap scales and/or speech-in-noise measures.
2. We must move away from a disease-based scale of hearing loss (e.g., ICD-10) to a functional-based scale (e.g., ICF). The ICF core set and brief core set of hearing loss should be considered as measures of severity of hearing loss, quality of life, as well as quality of care metrics.
3. We have no good site-of-lesion tests to separate out the many causes of sensorineural hearing loss (e.g., strial, inner hair cell, synaptic, neural).
4. There are both strengths and limitations to correlational research: A correlation between hearing loss and dementia does not mean that treating the hearing loss will reduce the incidence of dementia. We need data that suggests that there is VALUE in adult hearing loss screening.
5. Medicare is broken, and needs to be fixed. Specifically, our valuation system for CPT codes (by the RUC and RUC HCPAC) is at best flawed and at worse biased (in part due to AMA involvement in the process).
6. Funded pilot studies should investigate the value of direct access for audiologists, and what happens to quality of care when audiologists are reimbursed by Medicare to provide (re)habilitative services.





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