CAN OTC HEARING AIDS ACT AS A CATALYST FOR AUDIOLOGY REIMBURSEMENT UPDATES?

By Kim Cavitt, Au.D., and Nicholas S. Reed, Au.D.

HEARING LOSS IMPACTS

two-thirds of Americans over the age of 70 years. Traditionally ignored as a benign chronic condition, "hearing loss" has begun to cement its status as a public health concern. Recent literature suggests hearing loss is independently linked to important health markers and outcomes, such as cognitive decline, dementia, falls, and depression, and increases health resource utilization.

Hearing loss may be a modifiable risk factor such that appropriate hearing care could help overcome the mechanistic pathways that relate these outcomes. For example, although research is ongoing, hearing aid use could help improve the signal presented from the peripheral auditory system to the brain to improve cognitive load or reduce the impact of hearing loss on working memory (i.e., cognitive decline).

In the U.S., the uptake of hearing aids by persons with hearing loss remains low at less than 20 to 30 percent. This statistic, when taken in the context of the strain that many of the comorbidities associated with hearing loss place on the healthcare system and quality of life, has played a central role in calls to improve access and affordability of hearing care. The current model of hearing care, which has remained relatively stagnant for decades and premised on the medical model, diminishes the importance of audiologists' services from the public view when bundled with the sale of the hearing aid.

From an audiologic perspective, we believe the OTC Hearing Aid Act of 2017 is an opportunity. Decoupling the sale of devices from the audiologist or dispenser will highlight the importance of services provided by the professional. Moreover, whereas hearing care was a single point of entry model system, it now becomes a pyramid of multiple care offerings and entry points for the healthcare consumer.

OTC Hearing Aid Market Provides Optimism

The passage of the OTC Hearing Aid Act of 2017 enables the FDA—by the year 2020—to create a regulatory system for self-fitting hearing aids. These devices are aimed at those with mild to moderate hearing loss that will be available OTC.

The law aims to increase accessibility by providing direct access to devices for those unwilling or unable to see an audiologist. Likewise, affordability, technologic innovation, and public awareness of hearing loss may increase as new companies become involved with the hearing aid sector and target the healthcare consumer.

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Warranted Changes Needed to Cover Services

Despite the optimistic outlook, changes to the current system are still warranted. A lack of access to support services could limit...
Persons surveyed who said they had help paying for their hearing aids, according to a 2018 Hearing Tracker/Hearing Loss Association of America survey of roughly 2,000 hearing aid consumers. The impact of OTC devices, while proper coverage of these services by Medicare could go a long way in improving hearing care in the U.S. We have previously written about the need for Medicare to consider coverage of these services to improve access to necessary care.

Presently, a great number of diagnostic, treatment, and rehabilitative services are either not covered by Medicare or are covered only under specific circumstances. Hearing aids and related services are considered a statutory exclusion. For example, Medicare currently does not cover audiometric testing for the sole purpose of fitting or modifying a hearing aid. Medicare only covers audiologic and vestibular testing that is physician-ordered and medically reasonable and necessary, by their definition. As a result, many procedures and services become the financial responsibility of the patient.

Treatment and rehabilitation currently have even more limited coverage, especially when provided by an audiologist, even when the audiologist is the most trained and appropriate provider to provide the services. Unfortunately, there is currently no code or mechanism to capture third-party coverage for most audiologic treatment. The codes 92626 and 92627 (evaluation or aural rehabilitation status) are only appropriate, for third-party coverage, for pre- and post-operative services in and around an auditory prosthetic device, such as a cochlear implant.

Also, the code 92626 requires at least 31 minutes of patient engagement. These codes currently lack legitimate coverage related solely to a hearing aid or assistive listening device. The codes an audiologist can use to represent a communication needs assessment/hearing aid examination and selection are 92530/1 or 95010.

Medicare never covers these codes and their associated procedures because of the hearing aid coverage exclusion. These codes typically only yield third-party coverage when payers cover the resulting amplification. Also, the code 92507 (treatment of speech, language, voice, communication, and/or auditory processing disorder; individual) is currently used—by speech-language pathologists—to receive coverage for medically necessary aural rehabilitation. Audiologists cannot utilize this code, within the Medicare system and many other payers, to represent the same service. Instead they must use the codes 92830 and 92833 (aural rehabilitation, pre- and post-lingual), which carry little to no third-party coverage, regardless of the payer.

Lack of coverage of these codes, when the service is provided by an audiologist, is especially problematic because it is often the audiologist who is the most appropriate and best trained provider to treat the communication and listening difficulties surrounding the hearing loss. Instead, these services are not provided or are bundled into the cost of the amplification, making the device more expensive to obtain.

Essentially there are no items or services surrounding the evaluation, fitting, or modification of a hearing aid that have consistent third-party coverage. The vast majority of the treatment or rehabilitation of hearing loss and its associated communication difficulties also has limited coverage, except if provided by a physician or speech-language pathologist. This greatly restricts affordable access to valuable audiologic care and limits the impact of over-the-counter hearing aids.
Next Steps

The overriding goal of the delivery of all audiologic and vestibular care is to provide patients with access to patient-centered and evidence-based diagnostic, treatment, and rehabilitative services. Audiologists can succeed and thrive, both professionally and financially, in this paradigm. Monetization and patient care are not mutually exclusive. In the context of the importance of hearing loss as a public health concern and changes in hearing aid regulations and classifications, a call for Medicare to realign coding coverage and reimbursement for these services should be made.

GRACE’S LAW AND HEARING AID COVERAGE FOR CHILDREN

By Jeanine and Grace Gleba

IN DECEMBER 2008, A SMALL (Christmas) miracle happened in the state of New Jersey and personally for our family. It’s hard for us to believe that it has been a decade since Governor Richard Codey said these words:

“...I want to personally thank Grace and the entire Gleba family for their years of advocacy on behalf of children with hearing loss. Grace’s tenacity, and her own example of what children can achieve with the proper treatment for hearing loss, are a major reason why kids in New Jersey will be able to receive the gift of hearing for years and years to come. Grace and her family have taken personal adversity and turned it into something positive for the people of New Jersey. We all owe her a debt of gratitude.”

The governor spoke as we witnessed the passage of Grace’s Law S467/A1571. These bill numbers are emblazoned forever for our family. Grace’s Law is known as Hearing Aid Insurance Legislation (HAIL) and mandates hearing aid coverage for New Jersey children 15 years old and younger. For our family and all of the families who advocated in the state capital of Trenton with us, it was a monumental accomplishment. In fact, it took nine years to raise awareness and fight for this law to become a reality. The statistics validate this being quite a feat as only 3 percent of all bills introduced ever become a law.

Now, in 2018, we are happy that as a result of the Affordable Care Act, the state has made hearing aid coverage an essential health benefit, and since 2014 there is no longer a maximum benefit limit of $1,000 per hearing aid (after deductibles, copays, etc.). Now that’s something to celebrate—even better coverage for children.

The Gleba family lives in New Jersey.