ASHA
American
Speech-Language-Hearing
Association

August 31, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1849-P
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities to Apply for Available Slots

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), we write in response to the calendar year (CY) 2027 outpatient hospital prospective payment system (OPPS) proposed rule.

ASHA is the national professional, scientific, and credentialing association for 247,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Many ASHA members work in outpatient hospital settings and serve as integral members of multidisciplinary care teams dedicated to improving patient access, quality, safety, and outcomes.

Given the important role audiologists and SLPs play in hospital outpatient care, ASHA appreciates the opportunity to comment on several provisions of the proposed rule that affect payment, access to services, quality measurement, communication access, and administrative requirements. Our comments and recommendations are provided below.

Section II.A. Recalibration of APC Relative Payment Weights

Several services audiologists provide to patients in outpatient hospital departments are assigned to ambulatory payment classifications (APCs) 5012, 5721, 5722, 5723, 5724, 5732, 5733, 5734, and 5741. ASHA appreciates CMS' proposed increases to the CY 2027 payment rates for these APCs. Appropriate payment is essential to 1) recognize the resources required to provide audiology services and 2) support continued Medicare beneficiary access to necessary diagnostic services. ASHA encourages CMS to finalize the proposed payment rates for these APCs.

Section III.A. Proposed OPPS Treatment of New and Revised HCPCS Codes

ASHA appreciates CMS' ongoing efforts to ensure that new and revised Current Procedural Terminology (CPT®) codes are appropriately recognized under the OPPS. We support CMS' proposed assignment of three new vestibular assessment codes—92X10, 92X11, and 92XX5—to APC 5721 for CY 2027. These new codes reflect advances in vestibular testing and provide greater specificity for reporting services used by audiologists to evaluate vestibular function. These new codes include:

- **92X10**, Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral semicircular canal function;
- **92X11**, Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral and vertical semicircular canal function;
- **92XX5**, Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report; and
- **92XX6**, Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report; with velocity step testing (VST).

However, ASHA is concerned with CMS' proposed assignment of status indicator "N" to CPT code 92XX6, which would package payment for VST into payment for the base rotational vestibular assessment service (92XX5). ASHA recognizes CMS' longstanding policy of packaging most procedures described by add-on codes. However, we believe the distinct resource requirements associated with 92XX6 warrant reconsideration.

The additional velocity step testing represented by 92XX6 requires clinical work and resources beyond those necessary to perform the base SHA testing service represented by 92XX5. This includes additional provider time and greater work intensity associated with 92XX6. The new CPT code family distinguishes the base SHA assessment from the additional VST service.

Applying a packaging policy that results in the same OPPS payment regardless of whether the additional testing is furnished risks obscuring the meaningful difference in resources between these services. ASHA has consistently opposed OPPS packaging policies when they fail to adequately recognize the resources associated with audiology services and may harm hospital outpatient departments' ability to provide medically necessary diagnostic services.

Therefore, ASHA urges CMS to reconsider the proposed status indicator "N" for 92XX6 and establish a payment approach that appropriately recognizes the incremental resources associated with VST.

Section XXIII. Request for Information (RFI) on Strengthening the Standardization and Comparability of Hospital Price Transparency Data

ASHA appreciates CMS' ongoing efforts to ensure price transparency for patients. We have commented on federal price transparency policies since 2018, including CMS RFIs and proposed regulations addressing hospital price transparency and transparency in coverage. ASHA has consistently supported policies that provide patients with meaningful, understandable information about the cost of their care and that protect them from financial exposure.

While these reporting requirements do not directly apply to audiologists, many of these clinicians work in hospital settings and recognize that price transparency can influence patients' health care decisions and access to needed services. It is also important for clinicians practicing

within hospital systems to have a clear understanding of the costs and payment arrangements associated with services they provide. Therefore, ASHA offers the following recommendations in response to the RFI:

1. In introducing the questions posed in the RFI, CMS notes that interested parties have recommended greater standardization of payer and plan information, including development of a standardized list of commonly reported payers; use of unique payer or plan identifiers, such as tax or employer identification numbers; and inclusion of additional clarifying information like product and plan type. Given the number and variety of health plans that clinicians—including audiologists—must navigate, ASHA supports greater standardization that makes payer and plan information easier to identify and understand. Greater consistency in how this information is reported could improve the usability and comparability of data for clinicians, patients, and other stakeholders.

2. CMS also asks whether additional contract methodologies between hospitals and payers should be reflected as valid values in the machine-readable file (MRF), beyond the current valid values of fee schedule, capitation, per diem, and case rate. ASHA recommends that CMS consider including additional methodologies that reflect the growing use of quality and value-based care payment arrangements. These include (but are not limited to) risk sharing, per-member-per-month payments, bundled or episode-based payments, care management or infrastructure payments, and quality-based payment incentives or reductions. Including these arrangements would more accurately reflect the range of payment methodologies currently used between hospitals and payers and improve the completeness and usefulness of MRF data.

Section XV. Hospital Outpatient Quality Reporting (OQR) Program

ASHA supports CMS' interest in meaningful outpatient quality measurement. However, we remain concerned that existing quality measures in the OQR fail to capture many functional outcomes that are central to patients' health, safety, independence and ability to participate in their own care. Expansion of functional outcomes measures can achieve our mutual goals of improving the quality and outcomes of care as well as lead to longitudinal decreases in cost of care. These include outcomes related to communication, hearing, cognition, swallowing, nutrition and hydration, and caregiver training, all of which are important core components of patient-centered outpatient care and may help reduce avoidable downstream utilization and costs.

Meaningful functional outcome measurement is especially important in the outpatient setting, where maintaining or improving function can help patients remain safely in the community and avoid preventable complications or higher-acuity care. Caregiver training and education can also support sustained function and successful carryover of treatment strategies at home.

Therefore, ASHA urges CMS to consider a more comprehensive approach to outpatient quality measurement that recognizes communication, hearing, cognition, swallowing, nutrition and hydration, caregiver training, and other functional outcomes as core components of patient-centered care. Failing to capture holistic functional outcomes creates an incomplete picture of care quality, may leave beneficiaries vulnerable to significant health risks, and can lead to avoidable costs to Medicare.

Section XV.C. RFI on the Advance Care Planning Electronic Clinical Quality Measure (eCQM)

When considering the addition of the Advance Care Planning eCQM in the OQR, ASHA recommends that CMS recognize communication access as essential to valid patient participation in such planning. Audiologists and SLPs serve as valuable members of interprofessional collaborative care teams by ensuring patients have communication access.

Communication access means that people with communication disabilities can fully engage in various services, particularly in health care settings, by utilizing necessary communication supports. This concept is crucial for promoting effective communication, which is a fundamental human right. When communication barriers are present, individuals may face significant challenges in accessing information and services, leading to poorer health outcomes.

Health care professionals outside of audiology and speech-language pathology—who likely receive limited training in communication disorders—may not recognize or be familiar with how to accommodate hearing loss, mild cognitive impairment, aphasia from a past stroke, residual effects of cardiac events, use of augmentative and alternative communication (AAC), stuttering, articulation disorders, and other communication difficulties. Audiologists and SLPs are uniquely qualified to identify and address these barriers through supported communication strategies, AAC, accessible verbal and written materials, and care partner involvement.

Without appropriate communication supports, nurses, physicians, and other health care professionals may not be able to communicate effectively with patients. This potentially compromises the integrity of advance care planning discussions and the patient's ability to participate meaningfully in shared decision making and informed consent. Providing care and planning without first establishing communication access can result in higher rates of hospital readmissions, higher total cost of care, reduced patient safety, reduced compliance, and low patient satisfaction.[1,2,3,4,5]

Incorporating audiologists and SLPs effectively into advance care planning, when appropriate, will help ensure that patients understand their options, communicate their preferences, and participate fully in decisions about their care.

Section XIX. Expansion of Botulinum Toxin Injection Codes for Hospital Outpatient Department Prior Authorization Process

CMS proposes adding botulinum toxin injection codes to the existing category of services subject to the hospital outpatient department prior authorization process for dates of service on or after July 1, 2027.

While SLPs do not order or administer botulinum toxin injections, they provide services to patients who receive these injections for conditions that affect voice, speech, and swallowing, including spasmodic dysphonia, sialorrhea, neurological disorders, spasticity, and dysphagia. Delays in prior authorization requests, document submission, decision making, and communication can delay patient care and worsen patient outcomes. In some cases, lengthy prior authorization processes can lead patients to abandon recommended care.[6]

To avoid such outcomes, ASHA recommends that CMS establish safeguards to improve the transparency, consistency, and accountability of the prior authorization process, including:

- clear information for providers and patients regarding prior authorization requirements, documentation expectations, and review criteria;
- specific explanations of denials, including identification of insufficient or missing information or documentation;
- public reporting of prior authorization metrics, including utilization of prior authorization rates, denial rates, reasons for denials, and appeal outcomes; and
- monitoring and reporting of denials, delays, appeals, and patient outcomes for individuals with communication and swallowing-related diagnoses.

Thank you for your consideration of our comments. If you have any questions, please contact:

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Submitted on behalf of the American Speech-Language-Hearing Association

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