



March 29, 2020

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Waiver of Medicare Telehealth Restrictions during COVID-19

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to request that the Secretary of the U.S. Department of Health and Human Services (HHS) use its authority under Section 3703 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act to allow audiologists and speech-language pathologists (SLPs) to provide Medicare Part B services via telehealth during a national emergency, including the current COVID-19 pandemic.

ASHA is the national professional, scientific, and credentialing association for 211,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

Section 3703 of the recently-passed CARES Act states:

“Section 1135 of the Social Security Act (42 U.S.C. 1320b–5) is amended— (1) in subsection (b)(8), by striking “to an individual by a qualified provider (as defined in subsection (g)(3))” and all that follows through the period and inserting “, the requirements of section 1834(m).”; and (2) in subsection (g), by striking paragraph (3).”

This amendment grants the Secretary the authority to waive the requirements within Section 1834(m) of the Social Security Act, which restricts coverage of telehealth services to only those services provided by physicians and practitioners. This authority is broad, which is critical during national emergencies. This gives the Secretary the authority to designate additional categories of clinicians authorized to provide and be reimbursed for services provided to Medicare beneficiaries via telehealth. ASHA recommends that the Secretary use this authority expeditiously to include audiologists and SLPs based on the parameters outlined below.

Medicare flexibility for telehealth is necessary for several reasons:

1. Audiologists and SLPs provide critical health care services to Medicare beneficiaries. For example, SLPs provide swallowing treatment, which can prevent liquids from traveling to the lungs placing a patient at risk for aspiration

pneumonia. In addition, both professions provide medically necessary services that maintain or improve function for patients and assist them in returning to their homes and communities in a quick and safe manner. Many of these services can be safely performed, with the same quality and efficacy, via the use of telehealth.

2. SLPs have been designated as essential health care workers by the Department of Homeland Security (DHS), which may place some providers in a challenging situation without the ability to use telehealth.
3. The use of e-visits, announced March 17, has limited utility to SLPs and their patients.
4. Many states, private payers, and Medicaid agencies have allowed audiologists and SLPs to bill for telehealth services on a permanent basis. Furthermore, the Department of Veterans Affairs also allows audiologists and SLPs to provide services via telehealth. Since the national emergency related to COVID-19 was declared, many more private payers and state Medicaid agencies are allowing audiologists and SLPs to perform services via telehealth during this crisis. In addition, CMS has expanded flexibility to state Medicaid agencies via the use of 1135 waivers. The use of telehealth should be equitable across payers to maintain access to care and stem the spread of COVID-19.

Audiologists and SLPs are Qualified Providers of Telehealth Services

Research demonstrates the efficacy of telehealth and its equivalent quality as compared to in-person service delivery for a wide range of diagnostic and treatment procedures for adults and children.¹ Studies have shown high levels of patient, clinician, and parent satisfaction supporting telehealth as an effective alternative to the in-person model for delivery of care.² Use of telehealth by audiologists and SLPs must be equivalent to the quality of services provided in person in order for such practice to be allowed within ASHA's Code of Ethics.³

Telehealth expands practitioners' availability to those in need—regardless of geographic location or state of quarantine—saving critical time and resources for both patients and providers. According to the Centers for Disease Control and Prevention (CDC) those at greatest risk and vulnerability from COVID-19 include older adults and people with serious chronic medical conditions. The CDC has also indicated that if a COVID-19 outbreak occurs within a community, it could last weeks or months.⁴ Offering telehealth options to audiologists, SLPs, and other allied health professionals could help reduce the spread of COVID-19 because of the vulnerable populations that these professions serve. In addition, extending telehealth coverage could put these critical health care providers back to work at a time when the nation's economy needs it the most.

ASHA recommends coverage when provided via real-time, interactive (synchronous) audio-video telecommunication equipment that is compliant with the HIPAA. Asynchronous store and forward technology paired with synchronous audio communication with the patient may also be appropriate, particularly for audiology services such as clinical analysis and review of an audiogram.

The audiologist or SLP may furnish medically necessary services within their Medicare-recognized scope of practice via telehealth when clinically appropriate for the patient and within the providers' ability to comply with the technical requirements for telehealth service delivery.

ASHA recommends telehealth coverage for select audiology and speech-language pathology Current Procedural Terminology (CPT ® American Medical Association) codes as outlined in Appendix A.

Additional codes within the scope of practice of audiology and speech-language pathology may be appropriate for telehealth coverage but may require specialized implementation requirements that make broad coverage less appropriate. Please see Appendix A for our CPT recommendations.

Audiologists and SLPs Require the Ability to Provide Telehealth Services to Maintain Safety and Slow Transmission of COVID-19

SLPs were designated by the DHS as essential health care workers on March 19.⁵ ASHA concurs that audiology and speech-language pathology services are medically necessary to help a patient maintain or improve function and assist a patient in returning to their home or community quickly and safely. In some situations, these services are also essential, as in the case of a patient with a swallowing disorder that can cause them to choke or develop aspiration pneumonia.

However, this need to provide medically necessary or essential health care services must be balanced against the risk of transmission of COVID-19 to clinicians and patients, particularly given the reports of limited availability of PPE. **One way to accomplish these equally important goals is to provide these services via telehealth.** This consideration is acknowledged in the DHS guidance as it states:

“Workers should be encouraged to work remotely when possible and focus on core business activities. In-person, non-mandatory activities should be delayed until the resumption of normal operations.”

Given this designation, ASHA has received reports from SLPs working in health care settings—such as hospitals or skilled nursing facilities—that they are being forced to provide services in ways that may facilitate the transmission of COVID-19. **CMS can mitigate this risk by expanding access to SLPs via telehealth.** ASHA is receiving emails and calls each day from our members expressing concerns about forced provision of therapy services. Examples of the concerns include:

“I’m an SLP in a SNF setting... We have just been deemed as “essential” staff by the federal government. With the high contagion of the virus, why would they want us adding to the traffic in and out of the buildings, which could potentially further infect our vulnerable patients? Will they want us

using the already sparse PPE equipment that should be reserved for truly critical interactions? We only have the flimsy masks and gloves! We do not have N95 masks.

Our facility has been out of masks and we don't know if/when we will get some. When we do, they will not be the N95 grade. Patients are starting to show symptoms (temperatures, coughing) and though at least two of them were sent to the hospital last night, they were not tested but simply returned to our facility. We are not sure if it's because of a lack of testing supplies, their age or what?

I witnessed staff not wanting to deliver them their breakfast trays and making statements about being fearful for going in and caring for these patients (because we don't have masks). I couldn't blame them for feeling this way but now the patients are at risk because staff is at risk. I asked them to report their concerns to administration.

We've also been told that if we have our own masks, we are not to wear them in the building because they will 'induce panic'. We are only to wear them with appropriate respiratory viruses and/or if a patient is suspected as positive for Covid 19."

Another SLP reached out with the following concerns:

"I am currently a speech-language pathologist working in a skilled nursing facility in New York City and am still required to come into work regularly. I have seen the recent guidance issued by the U.S. Department of Homeland Security, where "caregivers (e.g., physical and occupational therapists and assistants, social workers, speech pathologists)" are considered essential staff and are required to continue to go into work. While this may be necessary in the hospital setting, I firmly do not believe that it is essential for those of us to continue coming into work in a subacute setting such as a skilled nursing facility, and believe that it causes more harm to our patients than good. The repeated exposure that our elder patients are experiencing in a subacute setting is not necessary with therapists (i.e. physical, occupational, and/or speech) as they are transferred from the hospital to us in a stable condition and greatly increases their risk of developing COVID-19 as we already have confirmed cases at our facility.

We also do not have the equipment needed to continue seeing these patients yet they are telling us to continue treating as usual using the same surgical mask for 3 days straight and not enough goggles, disposable gowns, or N95 masks available for all staff members. This brings our patients at higher risk when they continue to receive therapy services.

I am asking ASHA to reach out to Medicare, Medicaid and other insurance companies to reconsider reimbursing therapy costs during this epidemic for

those facilities/companies refusing to use teletherapy in order to save clinicians and patients' lives.”

Audiologists and SLPs Cannot Use Existing Regulatory Flexibilities to Treat Patients

CMS recently expanded the use of e-visits by SLPs to report and receive payment for non-face-to-face digital communications that require a clinical decision. It is important to note that the use of e-visits is not the same as full telepractice, which would enable audiologists and SLPs to provide certain diagnostic and treatment services in compliance with scope of practice and state law. We do not anticipate that these codes will allow appropriate access to ASHA members' services and will have limited utility. **Therefore, we reiterate the importance of CMS using its waiver authority to expand telehealth to audiologists and SLPs.**

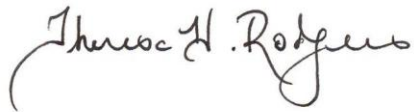
Health Care Consumers and Medicare Beneficiaries Deserve Equitable Application of Telehealth Policies across Payers

In January 2020, CMS issued a request for feedback on scope of practice restrictions under Medicare regulations that contradict state law and prevent clinicians from practicing at the top of their license. In response to this request, ASHA highlighted how the exclusion of audiologists and SLPs from the Medicare telehealth benefit conflicts with numerous state laws. This disconnect between Medicare coverage of telehealth and coverage provided by private payers and Medicaid programs as well as state licensing and scope of practice laws has only worsened during the response to COVID-19. For example, 33 states have in place permanent laws allowing audiologists and SLPs to perform services via telehealth. In addition, 26 states have put into place emergency temporary laws for the provision of telehealth as a specific response to COVID-19.⁶ A recent ASHA analysis shows that 11 health plans and 30 Medicaid programs either have permanent or temporary provisions authorizing audiologists and SLPs to provide services via telehealth. **ASHA recommends that CMS acknowledge the significant work states and private insurers have done to ensure appropriate access to medically necessary services and use its authority to waive restrictions on the reimbursement for telehealth services provided by audiologists and SLPs.**

In addition, as part of its response to the pandemic, CMS has granted 13 1135 waivers to state Medicaid programs, many of which include telehealth flexibility. It seems odd that despite the fact that Medicare and Medicaid provide coverage for health care services required by some of the most vulnerable populations, including children, seniors, and people with disabilities, it has only seen fit to exercise its waiver authority to allow telehealth services under Medicaid. **ASHA recommends that CMS use its waiver authority to waive telehealth restrictions across Medicare and Medicaid.**

In conclusion, ASHA recommends that the Secretary exercise his authority under Section 3703 of the CARES Act to allow audiologists and SLPs to provide telehealth services to Medicare beneficiaries. Thank you for your attention to this request. If you or your staff have questions, please contact Sarah Warren, MA, ASHA's director of health care policy for Medicare, at swarren@asha.org.

Sincerely,

A handwritten signature in cursive script that reads "Theresa H. Rodgers". The signature is written in black ink and is positioned below the word "Sincerely,".

Theresa H. Rodgers, MA, CCC-SLP
2020 ASHA President

¹ Grogan-Johnson, S., Alvares, R., Rowan, L., & Craghead, N. (2010). A pilot study comparing the effectiveness of speech language therapy provided by telemedicine with conventional on-site therapy. *Journal of Telemedicine and Telecare*, 16, 134–139.

² Ibid.

³ American Speech-Language-Hearing Association. (2016). *Code of Ethics*. Retrieved from <https://www.asha.org/Code-of-Ethics/>.

⁴ Centers for Disease Control and Prevention. (2020). *Coronavirus Disease 2019 (COVID-19)*. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>.

⁵ U.S. Department of Homeland Security Cybersecurity & Infrastructure Security Agency. (2020). *Memorandum on the Identification of Essential Critical Infrastructure Workers during COVID-19 Response*. Retrieved from <https://www.cisa.gov/sites/default/files/publications/CISA-Guidance-on-Essential-Critical-Infrastructure-Workers-1-20-508c.pdf>.

⁶ American Speech-Language-Hearing Association. (2020). *COVID-19: Tracking of State Laws and Regulations for Telepractice and Temporary Practice*. Retrieved from <https://www.asha.org/uploadedFiles/State-Telepractice-Policy-COVID-Tracking.pdf>.



Appendix A

Speech-Language Pathology Codes

- **92507** (treatment of speech, language, voice, and/or other communication disorder; individual)
- **92508** (treatment of speech, language, voice, and/or other communication disorder; group)
- **92521** (evaluation of fluency)
- **92522** (evaluation of speech)
- **92523** (evaluation of speech and language)
- **92524** (qualitative evaluation of voice)
- **92526** (clinical evaluation of swallowing)
- **92607** (evaluation for speech generating device; first hour)
- **92608** (evaluation for speech generating device; each additional 30 minutes of evaluation time)
- **92609** (therapeutic services using speech generating device, includes programming and mods)
- **92626** (evaluation for pre-implant candidacy or post-implant status of auditory function; first hour)
- **92627** (evaluation for pre-implant candidacy or post-implant status of auditory function; each additional 30 min)
- **96105** (assessment of aphasia, per hour)
- **96112** (developmental test administration, with interpretation and report; first hour)
- **96113** (developmental test administration, with interpretation and report; each additional 30 min)
- **96125** (standardized cognitive performance testing, with time in interpretation and report, per hr.)
- **97129** (cognitive function intervention, initial 15 min)
- **97130** (cognitive function intervention, each additional 15 min)
- **97533** (sensory integrative techniques, each 15 min)

Audiology Codes

- **92550** (tympanometry and reflex threshold measurements)
- **92552** (pure tone audiometry, air only)
- **92553** (pure tone audiometry, air and bone)
- **92555** (speech audiometry threshold)
- **92556** (speech audiometry threshold; with speech recognition)
- **92557** (comprehensive audiometry)
- **92561** (Bekesy, audiometry; diagnostic)
- **92563** (tone decay test)
- **92565** (stenger test, pure tone)
- **92567** (tympanometry)
- **92568** (acoustic reflex testing; threshold)
- **92584** (electrocochleography)
- **92585** (auditory evoked potentials, comprehensive)
- **92586** (auditory evoked potentials, limited)
- **92587** (distortion product evoked otoacoustic emissions, limited, with interpretation and report)

- **92601** (diagnostic analysis of cochlear implant, patient younger than 7 years, with programming)
- **92602** (diagnostic analysis of cochlear implant, younger than 7, subsequent reprogramming)
- **92603** (diagnostic analysis of cochlear implant, age 7 years or older, with programming)
- **92604** (diagnostic analysis of cochlear implant, age 7 years or older, subsequent reprogramming)
- **92625** (assessment of tinnitus)