



**ASHA**  
American  
Speech-Language-Hearing  
Association

October 5, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Attention: CMS-1734-P  
P.O. Box 8016  
Baltimore, MD 21244

RE: Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (CMS-1734-P)

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) proposed rule.

The American Speech-Language-Hearing Association (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.

ASHA's comments focus on the following areas:

- Telehealth and Other Services Involving Communications Technology (section II.D.)
  - Payment for Medicare Telehealth Services Under Section 1834(m) of the Act
    - Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List
    - Incident to Billing for Telehealth Services
  - Communication Technology-Based Services (CTBS)
  - Audio-only Visits
  - Virtual Services
- Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic (section II.F.)
  - Overview of Policies Finalized in CY 2020 for CY 2021: Negative Redistributive Impacts Related to Office/Outpatient E/M Services
  - Revaluing Services that are Analogous to Office/Outpatient E/M Visits

- Scopes of Practice and Related Issues (section II.G.)
  - Provision of Maintenance Therapy by Therapy Assistants
- Valuation of Specific Codes (section II.H.)
  - Auditory Evoked Potentials (AEP) Testing
  - Vestibular Evoked Myogenic Potentials (VEMP) Testing
- CY 2021 Updates to the Quality Payment Program (section IV.)
- Regulatory Impact Analysis (section VIII.)
  - CY 2021 PFS Impact Discussion

### **Telehealth and Other Services Involving Communications Technology** (section II.D.)

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#### **Payment for Medicare Telehealth Services Under Section 1834(m) of the Act** (pg. 50095)

Audiologists and speech-language pathologists (SLPs) are trained and qualified to provide telehealth services. However, ASHA recognizes that Section 1834(m) precludes Medicare payment for telehealth services provided by audiologists and SLPs. Through Section 3703 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law 116-136) Congress provided flexibility to allow additional categories of clinicians, including audiologists and SLPs, to be reimbursed for telehealth services during the public health emergency (PHE). To date, CMS has added a short list of services provided by audiologists and SLPs (please see Appendix A). **Therefore, ASHA requests that CMS expand the list of covered audiology and speech-language pathology telehealth services during the public health emergency (please see Appendix B).**

While ASHA recognizes that CMS has worked extremely hard during the PHE to develop flexibilities that meet the needs of Medicare beneficiaries, ASHA notes with concern that no additional audiology and speech-language pathology services have been added in the nine months since the PHE was first declared, especially since many of these services delivered via telehealth have been covered by most other insurers during the PHE. As many as 16 million Medicare beneficiaries are estimated to experience communication changes such as hearing, swallowing, communication, and cognitive problems. As such, robust coverage of audiology and speech-language pathology services would help ensure their safety and quality of life.<sup>1</sup> ASHA also seeks inclusion of our services permanently based on proposals outlined in the rule and discussed in greater detail below.

ASHA's Code of Ethics requires that clinicians use their clinical judgment to determine the most appropriate services for their patients and deliver care via telehealth only if the services are equal in quality to those delivered in person.<sup>2</sup> Delivering care that does not meet the standard for in-person care represents an actionable violation of the ASHA Code of Ethics, which helps ensure patient protection when receiving telehealth services from ASHA certified audiologists and SLPs. A recent ASHA survey of audiologists and SLPs regarding telehealth services during the public health emergency found that 38% of audiology respondents and 43% of speech-language pathology respondents do not provide services via telehealth because they have determined those services are not clinically appropriate for individual patients. This demonstrates that ASHA members maintain a commitment to upholding professional ethical standards and only providing telehealth for clinically appropriate patients when audiology and speech-language pathology services are equivalent in quality to in-person care.

*Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services From the Medicare Telehealth Services List (pg. 50098)*

ASHA requests that both the services currently covered during the PHE and the additional services requested through the sub-regulatory process continue as covered services beyond the PHE through the proposed third approval category which allows for services to be provided via telehealth on a temporary basis. ASHA was disappointed that CMS did not propose to include any audiology or speech-language pathology services currently approved for coverage during the PHE to this list in the proposed rule. On numerous occasions, ASHA has outlined how these services produce a demonstrated clinical benefit to the patient.

This third approval category would allow for the development of the evidence necessary to meet the requirements of one of the two current approval categories. While ASHA recognizes that, absent a change in federal law, audiologists and SLPs would not currently be reimbursed directly for telehealth services after the end of the PHE, a proposed change to incident to requirements outlined in the rule, would allow them to provide these services if CMS included the codes on the authorized telehealth services list. Inclusion would provide the opportunity to develop the evidence necessary to meet CMS coverage criteria for permanent inclusion.

CMS has outlined the specific criteria it requires for addition to the authorized telehealth services list under category three. ASHA undertook an analysis of the Current Procedural Terminology (CPT®) codes most commonly used by audiologists and SLPs to determine if they would meet these criteria. As noted above, ASHA recommends the inclusion of these services because clinicians can perform them safely, and with the same quality, and effectiveness via telehealth, both during the PHE and after. Please see *Appendices A and B* for the code descriptors. Full details of ASHA's telepractice guidance can be found on our website at <https://www.asha.org/Practice-Portal/Professional-Issues/Telepractice/>.

**A. CPT Codes 92507, 92508, 92521, 92522, 92523, 92524, 96105**

1. *By whom and for whom are the services being delivered via telehealth during the PHE?*

SLPs provide these services to patients of all ages with speech, language, voice, communication, and auditory processing disorders.

2. *What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed?*

**Safeguards:** Evaluation of patient's clinical presentation and comfort with technology. Professional standards of practice and ethics dictate mode of service delivery.

**Transition:** Ongoing assessment to determine if transition to in-person services are necessary. A facilitator may also be used to assist with the implementation of a skilled treatment plan established by the SLP by serving as an extender. The facilitator may be able to continue with effective transition to in-person services or a hybrid model with a combination of in-person and telepractice services.

3. *What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit?*

- Patient experience of care
- Outcomes measures to track improvement in life participation and functional communication, including patient related outcome measures

4. *How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person?*

The visual component of the telehealth service allows the clinician to observe the physical appearance of the patient as well as the patient's physical environment to determine how to establish the plan of care, patient compliance, and necessary modifications to the plan to respond to patient needs. In addition, the standardized assessments and evaluative processes used by SLPs are similar, if not the same as, those used when the service is provided in person.

5. *Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care?*

The inclusion of these services under Category 3 will improve patient access and experience of care both for these services themselves as well as other health services the patient receives. Improved functional communication results in a better patient-provider relationship, reduced social isolation and depression, improved health literacy, and greater patient compliance with services due to reduced strain on patient resources spent to access services.

6. *Whether furnishing this service or services via telecommunication technology promotes prudent use of resources?*

Providing these services via telehealth limits use of personal protective equipment (PPE), limits travel costs for the beneficiary (e.g., fuel, time off of work for caregiver, etc.), and improves infection control practices.

7. *Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth?*

By adding these services, CMS would help facilitate seamless access to medically necessary services during emergencies as well as deter the spread of infectious diseases because it will reduce close physical interactions between patient and providers, particularly for patients that are older and have underlying health conditions. Timely access to medically necessary services via telehealth that reduces the risk of infection improves patient outcomes.

8. *What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded)?*

Providing services via telehealth improves the ability of clinicians to access patients when in-person service delivery is not possible. Sufficient capacity exists to meet needs both in person and via telehealth and these services do not require additional specialized equipment.

#### **B. CPT Codes 92526, 92610**

1. *By whom and for whom are the services being delivered via telehealth during the PHE?*

SLPs primarily provide these services to patients of all ages with swallowing and/or feeding disorders. Swallowing disorders (dysphagia) are closely related to the aging process and to diseases and health problems common in the elderly, such as stroke and

dementia.<sup>3</sup> Estimates indicate that the prevalence of dysphagia may be as high as 22% in adults over the age of 50.<sup>4</sup>

2. *What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed?*

**Safeguards:** Evaluation of patient's clinical presentation and comfort with technology. Professional standards of practice and ethics dictate mode of service delivery.

**Transition:** Ongoing assessment to determine the necessity of transition to in-person services. A facilitator may also assist with the implementation of a skilled treatment plan established by the SLP by serving as an extender. The facilitator may continue with effective transition to in-person services or a hybrid model with a combination of in-person and telepractice services.

3. *What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit?*

- Patient experience of care
- Outcomes measures to track improvement in life participation and functional communication, including patient related outcome measures
- There are inherent risks to providing oral trials of different food and diet consistencies to individuals with dysphagia. These risks related to aspiration and choking have not been found to be any higher when managing dysphagia via telepractice compared to in-person service delivery. Absent a feeding tube or alternate nutrition, the patients will be eating to avoid malnutrition and clinical evaluation will enhance, not reduce, safety for the patient over time.

4. *How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person?*

The visual component of the telehealth service allows the clinician to observe the physical appearance of the patient as well as the patient's physical environment to determine how to establish the plan of care, patient compliance, and necessary modifications to the plan to respond to patient needs. In addition, the standardized assessments and evaluative processes used by SLPs are similar, if not the same as, those used when the service is provided in person.

5. *Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care?*

The inclusion of these services under Category 3 will improve patient access and experience of care. Improved functional communication results in a better patient-provider relationship, reduced social isolation and depression, improved health literacy, and greater patient compliance with services due to reduced strain on patient resources spent to access services. In addition, through the management of a swallowing disorder, patients who have problems eating can avoid weight loss, malnutrition, choking, aspiration, and dehydration thereby reducing hospital readmissions.

6. *Whether furnishing this service or services via telecommunication technology promotes prudent use of resources?*

Providing these services via telehealth limits use of PPE and limits travel costs for the beneficiary (e.g., fuel, time off of work for caregiver, etc.) and improves infection control practices.

7. *Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth?*

By adding these services, CMS would help facilitate seamless access to medically necessary services during emergencies as well as deter the spread of infectious diseases because it will reduce close physical interactions between patient and providers, particularly for patients that are older and have underlying health conditions. Timely access to medically necessary services via telehealth that reduces the risk of infection improves patient outcomes.

8. *What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded)?*

Providing services via telehealth improves the ability of clinicians to access patients when in-person service delivery is not possible. Sufficient capacity exists to meet needs both in person and via telehealth and these services do not require additional specialized equipment.

**C. CPT Codes 92550, 92552, 92553, 92555, 92556, 92557, 92563, 92565, 92567, 92568, 92570, 92585, 92586, 92587, 92588, 92625**

1. *By whom and for whom are the services being delivered via telehealth during the PHE?*

Audiologists primarily provide these services to patients of all ages who experience hearing loss and/or tinnitus. Ear, nose and throat (ENT) physicians may also provide these services. Approximately 25% of adults between the ages of 65 and 74 and 50% who are 75 and older suffer from hearing loss.<sup>5</sup>

2. *What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed?*

**Safeguards:** Evaluation of patient's clinical presentation and comfort with technology. Professional standards of practice and ethics dictate mode of service delivery.

**Transition:** Ongoing assessment to determine the necessity of transition to in-person services. The facilitator may continue with effective transition to in-person services or a hybrid model with a combination of in-person and telepractice services.

3. *What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit?*

- Patient experience of care
- Outcomes measures to track improvement in life participation and functional communication, including patient related outcome measures

4. *How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person?*

Audiologists can observe and engage the patient through the use of cameras and computer platforms which would essentially replicate the in-person experience between the provider and patient. Computer-based software with remote access capability allows the audiologists to control the diagnostic testing equipment.

5. *Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care?*

Providing these services via telehealth improves patient access and experience of care as well as overall quality of care, as it maintains the continuity of the clinician-patient relationship. This continuity can lead to greater patient compliance with the treatment plan established by the physician. Access to services helps to reduce or eliminate social isolation that can lead to depression and other medical disorders.

6. *Whether furnishing this service or services via telecommunication technology promotes prudent use of resources?*

Providing these services via telehealth limits person-to-person exposure and aids in the sustainable use of PPE. It also ensures access to diagnostic services that would likely be more limited in their availability due to social distancing and infection control protocols.

7. *Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth?*

By adding these services, CMS would help facilitate seamless access to medically necessary services during emergencies. Providing this service in a timely fashion through telehealth assists patients with communication disorders in understanding the clinical guidance provided by health care providers and can greatly reduce hospital readmissions and patient compliance with recommended discharge or follow up instructions.

8. *What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded)?*

Providing services via telehealth improves the ability of patients to access audiologists, especially in audiology shortage areas.

#### **D. CPT Codes 92601, 92602, 92603, 92604**

1. *By whom and for whom are the services being delivered via telehealth during the PHE?*

Audiologists provide these services to patients with a cochlear implant (CI).

2. *What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed?*

**Safeguards:** Evaluation of patient's clinical presentation and comfort with technology. Professional standards of practice and ethics dictate mode of service delivery.

**Transition:** Ongoing assessment to determine the necessity of transition to in-person services. The facilitator may continue with effective transition to in person services or a hybrid model with a combination of in-person and telepractice services.

3. *What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit?*

- Patient experience of care
- Outcomes measures to track improvement in life participation and functional communication, including patient related outcome measures

4. *How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person?*

Audiologists can observe and engage the client through the use of cameras and computer platforms which would essentially replicate the in-person experience between the provider and patient. Audiologists can provide secure, synchronous programming/reprogramming of the CI with computer-based software provided to the patient before the appointment.

5. *Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care?*

Providing these services via telehealth improves patient access and experience of care as well as overall quality of care, as it maintains the continuity of the clinician-patient relationship. This continuity can lead to greater patient compliance with the treatment plan established by the physician. Access to services helps to reduce or eliminate social isolation that can lead to depression and other medical disorders.

6. *Whether furnishing this service or services via telecommunication technology promotes prudent use of resources?*

Providing these services via telehealth limits person-to-person exposure and aids in the sustainable use of PPE. It also ensures access to diagnostic services that would likely be more limited in their availability due to social distancing and infection control protocols. It also limits travel costs for the beneficiary (e.g., fuel, time off of work for caregiver, etc.).

7. *Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth?*

By adding this service, CMS would help facilitate seamless access to medically necessary services during emergencies as well as deter the spread of infectious diseases because it will reduce close physical interactions between patient and providers, particularly for patients that are older and have underlying health conditions. Timely access to medically necessary services via telehealth that reduces the risk of infection improves patient outcomes.

8. *What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded)?*

Providing services via telehealth improves the ability of clinicians to access CI patients when in-person service delivery is not possible. There is sufficient capacity to meet needs both in-person and via telehealth.

#### **E. CPT Codes 92607, 92608, 92609**

1. *By whom and for whom are the services being delivered via telehealth during the PHE?*

SLPs provide these services to patients of all ages who need a speech-generating device (SGD), including patients with neurodegenerative diseases, such as amyotrophic lateral sclerosis (ALS) or Parkinson's disease.

2. *What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed?*

**Safeguards:** Evaluation of patient's clinical presentation and comfort with technology. Professional standards of practice and ethics dictate mode of service delivery.

**Transition:** Ongoing assessment to determine the necessity of transition to in-person services. A facilitator may assist with the implementation of a skilled treatment plan established by the SLP by serving as an extender. The facilitator may continue with effective transition to in person services or a hybrid model with a combination of in-person and telepractice services.

3. *What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit?*

- Patient experience of care
- Outcomes measures to track improvement in life participation and functional communication, including patient related outcome measures

4. *How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person?*

The visual component of the telehealth service allows the clinician to observe the physical appearance of the patient as well as the patient's physical environment to determine how to establish the plan of care, patient compliance, and necessary modifications to the plan to respond to patient needs. A remote access platform allows SLPs to control the SGD screen, access communication software, and adjust settings. In addition, the standardized assessments and evaluative processes used by SLPs are similar, if not the same as, those used when the service is provided in person.

5. *Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care?*

The inclusion of these services under Category 3 will improve patient access and experience of care. Improved functional communication results in a better patient-provider relationship, reduced social isolation and depression, improved health literacy, and greater patient compliance with services due to reduced strain on patient resources spent to access services.

In addition, patients with neurodegenerative diseases, such as ALS, may quickly lose the ability to communicate if they are not evaluated by an SLP for suitability for an SGD early enough.

6. *Whether furnishing this service or services via telecommunication technology promotes prudent use of resources?*

Providing these services via telehealth limits use of PPE, limits travel costs for beneficiary (e.g., fuel, time off of work for caregiver, etc.), and improves infection control practices.

7. *Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth?*

By adding this service, CMS would help facilitate seamless access to medically necessary services during emergencies as well as deter the spread of infectious diseases because it will reduce close physical interactions between patient and providers, particularly for patients that are older and have underlying health conditions. Timely access to medically necessary services via telehealth that reduces the risk of infection improves patient outcomes.

8. *What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded)?*

Providing services via telehealth improves the ability of clinicians to access patients when in-person service delivery is not possible. Sufficient capacity exists to meet needs both in-person and via telehealth and this service does not require additional specialized equipment.

#### **F. CPT Codes 92626, 92627**

1. *By whom and for whom are the services being delivered via telehealth during the PHE?*  
Audiologists provide these services to patients of all ages with hearing loss who may be candidates for or already have a surgically implanted hearing device, such as a cochlear implant (CI).

2. *What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed?*

**Safeguards:** Evaluation of patient's clinical presentation and comfort with technology. Professional standards of practice and ethics dictate mode of service delivery.

**Transition:** Ongoing assessment to determine the necessity of transition to in-person services. The facilitator may continue with effective transition to in-person services or a hybrid model with a combination of in-person and telepractice services.

3. *What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit?*

- Patient experience of care
- Outcomes measures to track improvement in life participation and functional communication, including patient related outcome measures

4. *How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person?*

Audiologists can observe and engage the client through the use of cameras and computer platforms which would essentially replicate the in-person experience between the provider and patient. Computer-based software with remote access capability allows the audiologists to control the diagnostic testing equipment.

5. *Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care?*

Providing these services via telehealth improves patient access and experience of care as well as overall quality of care, as it maintains the continuity of the clinician-patient relationship. This continuity can lead to greater patient compliance with the treatment plan established by the physician. Access to services helps to reduce or eliminate social isolation that can lead to depression and other medical disorders.

6. *Whether furnishing this service or services via telecommunication technology promotes prudent use of resources?*

Providing these services via telehealth limits person-to-person exposure and aids in the sustainable use of PPE. It also ensures access to diagnostic services that would likely be more limited in their availability due to social distancing and infection control protocols.

7. *Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth?*

By adding this service, CMS would help facilitate seamless access to medically necessary services during emergencies as well as deter the spread of infectious diseases because it will reduce close physical interactions between patient and providers, particularly for patients that are older and have underlying health conditions. Timely access to medically necessary services via telehealth that reduces the risk of infection improves patient outcomes.

8. *What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded)?*

Providing services via telehealth improves the ability of clinicians to access patients when in-person service delivery is not possible. There is sufficient capacity to meet needs both in person and via telehealth.

#### **G. CPT Codes 96125, 97129, 97130**

1. *By whom and for whom are the services being delivered via telehealth during the PHE?*  
SLPs provide these services to patients of all ages with cognitive impairments.

2. *What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed?*

**Safeguards:** Evaluation of patient's clinical presentation and comfort with technology. Professional standards of practice and ethics dictate mode of service delivery.

**Transition:** Ongoing assessment to determine the necessity of transition to in-person services. A facilitator may also assist with the implementation of a skilled treatment plan established by the SLP by serving as an extender. The facilitator may continue with effective transition to in-person services or a hybrid model with a combination of in-person and telepractice services.

3. *What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit?*

- Patient experience of care
- Outcomes measures to track improvement in life participation and functional communication, including patient related outcome measures

4. *How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person?*

The visual component of the telehealth service allows the clinician to observe the physical appearance of the patient as well as the patient's physical environment to determine how to establish the plan of care, patient compliance, and necessary modifications to the plan to respond to patient needs. In addition, the standardized assessments and evaluative processes used by SLPs are similar, if not the same as, those used when the service is provided in person.

5. *Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care?*

The inclusion of these services under Category 3 will improve patient access and experience of care. Improved functional communication results in a better patient-provider relationship, reduced social isolation and depression, improved health literacy, and greater patient compliance with services due to reduced strain on patient resources spent to access services.

6. *Whether furnishing this service or services via telecommunication technology promotes prudent use of resources?*

Providing these services via telehealth limits use of PPE, limits travel costs for beneficiary (e.g., fuel, time off of work for caregiver, etc.), and improves infection control practices.

7. *Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth?*

By adding this service, CMS would help facilitate seamless access to medically necessary services during emergencies as well as deter the spread of infectious diseases because it will reduce close physical interactions between patient and providers, particularly for patients that are older and have underlying health conditions.

Timely access to medically necessary services via telehealth that reduces the risk of infection improves patient outcomes.

8. *What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded)?*

Providing services via telehealth improves the ability of clinicians to access patients when in-person service delivery is not possible. There is sufficient capacity to meet needs both in person and via telehealth and this service does not require additional specialized equipment.

Even after the end of the PHE, the impact of the virus on the ability of patients to access medically necessary services safely will likely remain a critical concern. Furthermore, establishing a path to telehealth coverage through the inclusion of these codes on the authorized telehealth services list will help ensure an effective and efficient transition once Section 1834(m) is changed to include audiologists and SLPs. For these reasons and the justifications provided above, ASHA requests CMS add audiology and speech-language pathology services as authorized telehealth services both during and after the PHE.

*Proposed Clarification of Existing PFS Policies for Telehealth Services* (pg. 50114)

Medicare regulations allow SLPs to provide their services incident to a physician when complying with all requirements, such as the direct supervision of the physician (Federal law specifically prohibited audiologists from providing their services incident to a physician). In the proposed rule, CMS would modify the definition of direct supervision to allow for virtual supervision until the latter of the end of the PHE or December 31, 2021. ASHA supports this flexibility. ASHA continues to assess whether such flexibility is warranted and appropriate on a permanent basis and could recommend a permanent extension of this definition in future comments.

**Communication Technology-Based Services (CTBS)** (pg. 50112)

ASHA appreciates CMS's efforts to give providers who cannot bill evaluation and management (E/M) codes to Medicare a reporting mechanism for virtual assessments during the PHE. **ASHA supports the proposal to adopt this policy permanently to allow SLPs and other qualified health care professionals to bill Medicare for e-visits (G2061-G2063/98970-98972), virtual check-ins (G20X2), and remote assessments of patient recorded videos/images (G20X0) beyond the PHE.** ASHA also agrees that CMS should designate these virtual assessment codes as "sometimes therapy" services and to value G20X0 and G20X2 identically to G2010 and G2012.

ASHA notes a discrepancy in the descriptor for G20X2, which describes a virtual check-in by "a qualified health care professional who cannot report evaluation and management services". However, the descriptor later details a service "not originating from a related e/m service...". **ASHA recommends the descriptor for G20X2 read "not originating from a related service," as is also described in similar language for G20X0.**

*Audiologists and CTB Services*

CMS seeks comment regarding other benefit categories into which CTB services might fall. **ASHA maintains that CTB Services codes fall within the scope of the audiology**

**diagnostic benefit category and urges CMS to allow audiologists to bill Medicare for these services.**

Audiologists provide audiologic testing under the Medicare diagnostic benefit category. They may provide virtual assessments as diagnostic services for patients when a physician or nonphysician practitioner orders an assessment of hearing and/or balance that requires a battery of tests. We understand that the statutorily established Medicare benefit classifies audiology services as diagnostic tests. However, ASHA asserts that the examples outlined below describe services that appropriately involve the referring physician and stay within the Medicare diagnostic benefit, allowing Medicare beneficiaries timely access to care and avoiding potential overutilization of in-person visits. **Should CMS determine that such services do not fall under the scope of the audiology diagnostic benefit category, ASHA respectfully requests the Agency provide detail regarding its rationale in order to provide more information about the parameters of their benefit category.**

**Patient with a cochlear implant:** A Medicare beneficiary recently received a cochlear implant (CI)—a surgically implanted device to help with severe hearing loss. The physician refers the patient to an audiologist for CI analysis and programming (CPT codes 92601-92604). The audiologist sees the patient to activate the external sound processor post-surgery, and to perform the diagnostic analysis and programming of the implant. Initial programming typically occurs over a series of visits and is individualized to each patient based on the results of the diagnostic analysis of auditory perception. The patient may need additional programming to adjust the sound processor to accommodate improvements or decline in the patient's ability to hear and understand speech.

The patient contacts the audiologist through the secure patient portal after the initial programming session to report that she is not hearing well with the CI. After finishing clinical care for the day, the audiologist reviews the message received through the portal and responds with a series of questions to assess whether there is a malfunction with the CI equipment, a change in health status that may require medical attention, or a need for the audiologist to adjust the CI programming. The patient answers the initial questions and a few follow-up questions through the portal. Based on the patient's description of the problem and examples of specific situations in which hearing is most challenging and any precipitating events, the audiologist determines that the hearing difficulties are likely due to equipment malfunction and recommends the patient contact the CI manufacturer's consumer line directly to troubleshoot the CI processor for possible repair or replacement.

The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the portal. **This scenario illustrates a shorter interaction that could be reported with G2061/98970 (5-10 minutes cumulative).**

However, if the initial exchange points to issues unrelated to equipment malfunction, the audiologist will proceed to ask additional questions to assess whether a potential change in health status has occurred or a need for further analysis and programming of the CI exists. This involves reviewing relevant medical history such as recent head trauma or injury to the site over the implant, illness, hormonal changes, and/or medications. This may lead to a consult with the referring physician that results in the patient's follow-up office visit with the physician, a recommendation for additional CI programming with the audiologist, or a discussion of strategies the patient can implement before returning for a regularly scheduled

follow-up appointment for diagnostic analysis and programming. The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the portal. **This scenario illustrates a lengthier interaction that could be reported with G2062/98971 (11-20 minutes, cumulative) or G2063/98972 (21 minutes or more, cumulative),** depending on the patient's ability to describe symptoms and the level of follow-up probing required, and if the assessment does not lead to a related service within the next 7 days.

**Patient with tinnitus:** A Medicare beneficiary was previously evaluated by the physician and audiologist with a diagnosis of tinnitus. This includes the audiologist's diagnostic testing of tinnitus severity, current level of tinnitus handicap, and impact on daily function (CPT code 92625). The testing may also include a brief depression screening, as required by Measure #134 of the Medicare Merit-Based Incentive Program (MIPS).<sup>6</sup> The physician has reviewed the results of the audiologic testing and discussed treatment options with the patient.

The established patient contacts the audiologist through the secure patient portal four months later, reporting a sudden increase in tinnitus loudness, severity, and impact on concentration and sleep. The audiologist responds with a series of questions about health and medication changes and administers standardized questionnaires such as a tinnitus handicap inventory (THI) and/or tinnitus function inventory (TFI) via the portal to assess the current amount of tinnitus the patient is experiencing. The patient answers the initial questions and completes and returns the questionnaires. The audiologist compares current results to initial measures. Based on the patient's description of the problem and amount of tinnitus change and medical history, the audiologist determines the need to refer the patient back to the referring physician. The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the secure patient portal. **This scenario illustrates a shorter interaction that could be reported with G2061/98970 (5-10 minutes cumulative).**

However, if the initial exchange points to potential emotional, behavioral, or mental health issues, the audiologist will proceed to ask additional questions to assess the patient's depression level and risk of harm to self and others. If the patient reports severe—but not emergent—changes the audiologist will consult with the referring physician, which may lead to referring the patient to an appropriate physician or behavioral health professional for intervention. If the audiologist identifies emergent needs, they must proceed with additional referrals (such as psychiatry, psychology, and/or primary care) and recommendations to ensure the safety of the patient because of their status as a mandated reporter. The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the secure patient portal. **This scenario illustrates a lengthier interaction that could be reported with G2062/98971 (11-20 minutes, cumulative) or G2063/98972 (21 minutes or more, cumulative),** depending on the patient's ability to describe symptoms and the reported severity level.

#### **Comment Solicitation on Continuation of Payment for Audio-only Visits (pg. 50113)**

ASHA agrees with CMS that the need for audio-only interaction could extend beyond the PHE, as Medicare beneficiaries continue to practice social distancing measures to avoid the potential resurgence of the virus. ASHA **supports the development of coding and payment for a service similar to the virtual check-in, but for a longer unit of time and with a higher value**

**commensurate with the added time and work.** For consistency, ASHA recommends using a similar structure to the current e-visit codes, which include increasing increments of time at each code level. CMS should include detailed guidance regarding circumstances under which audio-only services may or may not be appropriate. ASHA also urges CMS to make separate payment for audio-only services a permanent policy under the MPFS. These services can help promote efficiency and cost savings, as they can mitigate the need for unnecessary office visits.

#### **Comment Solicitation on Coding and Payment for Virtual Services** (pg. 50114)

ASHA appreciates CMS's ongoing work to identify inherently non-face to-face virtual services that Medicare does not classify as telehealth services. Virtual services, such as e-visits and virtual check-ins, play an important role in improving health care access and promoting efficiency both during and outside of a PHE. However, ASHA has received feedback from audiologists and speech-language pathologists that payment is not commensurate to the level of work and time required to provide and document these services, or to ensure patients have access to and can effectively use the required technology. For example, the amount of time to obtain informed consent, review patient records, establish medical necessity, and document cumulative time and clinical decision-making often outweighs the payment for a 5 to 10-minute e-visit. As such, **ASHA recommends CMS closely consider additional pre- and post-service time and direct practice expense costs associated with these services.**

ASHA also firmly maintains that virtual services are within the scope of more Medicare benefit categories than CMS has identified to date, including the audiology diagnostic benefit category. **Therefore, ASHA reiterates that CMS should allow audiologists to bill Medicare for these services, as they already provide medically necessary services that could be reported as virtual services.** Please refer to our comments related to CTB services on page 13 for a detailed rationale and clinical scenarios.

#### **Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability During the COVID-19 Pandemic** (section II.F.)

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##### **Overview of Policies Finalized in CY 2020 for CY 2021: Negative Redistributive Impacts Related to Office/Outpatient E/M Services** (pg. 50122)

ASHA supports the coding and payment changes to office/outpatient E/M services. ASHA also recognizes that, under normal circumstances, CMS must meet the statutory requirement to maintain budget neutrality by offsetting the E/M payment increases. **However, ASHA remains extremely concerned by the significant negative financial impact the budget neutrality requirement will have on many specialties—including audiology and speech-language pathology—that cannot report E/M services as part of their Medicare benefit category.** ASHA urges CMS to consider the far-reaching implications of this policy, especially given the unprecedented circumstances facing the health care system at this time.

CMS' actions cannot be considered in a vacuum. Other payers tie their fee schedules directly or indirectly to the Medicare Physician Fee Schedule (MPFS). The majority of private contracts, as well as the Department of Veterans Affairs' Community Care, the Department of Defense's TRICARE, workers compensation programs, and state Medicaid agencies reference the MPFS in their payment rates. As such, this policy will not only negatively affect Medicare providers and beneficiaries, but also non-Medicare providers and the patients they serve, including veterans, TRICARE enrollees, and commercially insured and self-pay patients.

Other Medicare payment reductions, such as sequestration and the multiple procedure payment reduction (MPPR) applied to therapy services will compound the proposed reductions. Although some have pointed to the Quality Payment Program (QPP) as a means to offset the cuts, there is little potential for meaningful relief under this program which must also remain budget neutral, providing a net-zero increase for participating providers. Audiologists, SLPs, and other nonphysician providers have limited opportunities for payment adjustments under the Merit-Based Incentive Payment System (MIPS) and few pathways for participation in Alternative Payment Models.

Furthermore, the unanticipated public health emergency (PHE) has resulted in significant economic challenges, causing increased concern regarding the sustainability of provider practices, especially those in rural or underserved areas. We also now know that the recovery and return to full patient utilization of health care services will continue longer than initially expected. The cumulative impact of the E/M changes and the PHE will leave many providers unable to sustain their practices, further hampering economic recovery and restricting Medicare and non-Medicare patient access to medically necessary services, including the essential hearing, balance, speech, language, swallowing, and cognitive services audiologists and SLPs provide.

Absent consistent access to medically necessary evaluation and treatment, patients with hearing, balance, cognitive, communication, and swallowing disorders may see a decline in their ability to complete activities of daily living or to communicate their physical or emotional needs, leaving them susceptible to further medical complications and adding additional pressures and cost to the health care system. For example, without timely diagnosis by an audiologist, Medicare beneficiaries may not receive treatment for balance conditions that could lead to falls, the leading cause of fatal injury for people age 65 and older.<sup>7</sup> Patients with neurodegenerative diseases, such as amyotrophic lateral sclerosis (ALS), could experience a rapid decline in their ability to communicate if not evaluated by an SLP for a speech-generating device soon enough.

Therefore, ASHA offers the following comments and recommendations and urges CMS to consider these and other regulatory options to mitigate the impact of the E/M coding and payment changes.

ASHA also notes that we, along with many other provider groups and coalitions, have provided similar comments in response to this policy during 2020 rulemaking and subsequent meetings, yet CMS has not responded substantively to the majority of our recommendations or questions. By declining to respond fully, CMS may have contravened federal law.

For example, the Regulatory Flexibility Act (P.L. 96-354) requires CMS to analyze regulatory options for small businesses and other entities. The analysis must include a justification concerning the reason for action, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities. In the Regulatory Impact Analysis section of the 2021 PFS proposed rule, CMS estimates approximately 95% of practitioners, other providers, and suppliers meet the definition of small entities, based upon the SBA standards. CMS further states, "*The analysis explains the rationale for and purposes of this proposed rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we would use to minimize the burden on small entities.*" **Given the overwhelming majority of the impact will fall on small businesses, a full examination of the impact and mitigation strategies is**

**not only required under the law, it is critical to maintain beneficiary access to health care services.**

Again, ASHA offers the following regulatory options to mitigate the impact of the office/outpatient E/M policy. ASHA believes these options, *when implemented together*, represent the best means to resolve or, at a minimum, mitigate the cuts while maintaining the increases to the office visit E/M services.

#### *Use CMS's Authority Under the PHE to Waive Budget Neutrality*

ASHA appreciates CMS's ongoing efforts to use its waiver authority to give providers the flexibility to care for Medicare beneficiaries during the PHE. However, ASHA worries that the negative adjustment to the conversion factor (CF) required to maintain budget neutrality of the E/M payment changes will compound the economic instability and lack of access to timely care created by the COVID-19 pandemic. This contradicts Executive Order 13924 (Regulatory Relief to Support Economic Recovery) issued in May, which directs agency heads to rescind, modify, or waive unnecessary regulations that impede economic recovery following the COVID-19 pandemic.<sup>8</sup> **As such, ASHA strongly urges CMS to use its authority under the PHE to waive the budget neutrality requirement for the new office/outpatient E/M services policy as a means to support economic recovery and increase patient access to medically necessary care during the COVID-19 pandemic, as directed by the Executive Order.**

#### *Apply Savings from Past Overestimates of Spending*

Medicare statute allows CMS to account for past overestimates of spending when applying the budget neutrality adjustment to the fee schedule<sup>9</sup>. For example, CMS based the 2013 budget neutrality offset for transitional care management (TCM) on a significant overestimation of the initial utilization of the service than actual utilization following implementation of the TCM policy. **ASHA urges CMS to consider restoring the overestimated budget neutrality adjustment from past overestimates in spending, including from the initial years of the TCM policy.** This would allow CMS to apply those savings to the budget neutrality calculation and soften the negative impact to affected providers. **Furthermore, ASHA urges CMS to implement this option to correct under-valuation of the fee schedule—even if the Agency waives budget neutrality—to foster economic growth during the PHE.**

#### *Delay or Cancel Implementation of Add-On Code GPC1X*

ASHA urges CMS to reconsider implementation of the Healthcare Common Procedure Coding System (HCPCS) add-on code GPC1X, *visit complexity inherent to evaluation and management associated with medical care services*. ASHA believes that CMS must cancel or, at a minimum, delay this policy, given that CMS continues to seek comment regarding the definition of GPC1X and strategies to refine its utilization assumptions. Cancellation of the policy would allow CMS to apply those savings to the budget neutrality calculation and lessen the negative impact to affected providers. Should CMS elect to proceed with GPC1X, ASHA recommends the Agency delay implementation and work with the CPT Editorial Panel and specialty societies to better define the code and adopt clear guidelines for appropriate use. **As such, ASHA requests that CMS cancel implementation of HCPCS add-on code GPC1X or, at a minimum, delay implementation for further reevaluation and refinement.** If CMS proceeds with finalization of the code, ASHA requests that it be implemented on a “no-pay” basis in 2021 to allow the agency to collect reliable utilization data to inform future budget neutrality calculations. In addition, ASHA recommends CMS reexamine utilization assumptions for add-on CPT code

99XXX, *prolonged office or other outpatient evaluation and management services; each 15 minutes*, given its potential overlap with services described by GPC1X.

*Phase-In Payment Changes to Reduce the Immediate Impact to Providers*

Although ASHA does not support the dramatic nature of the reductions for many providers, ASHA recommends CMS implement a “phase-in” of the cuts, should the agency decline to use its authority under the PHE to waive budget neutrality. ASHA notes that precedent exists when a proposal will result in significant changes to Medicare payment and policies. For example, in CY 2019, CMS implemented a 4-year phase-in of practice expense pricing updates “to minimize any potential disruptive effects during the proposed transition period that could be caused by other sudden shifts in RVUs...”<sup>10</sup> **ASHA strongly urges CMS to implement a phase-in of any payment changes for E/M services to mitigate the immediate negative financial impact on affected providers. Furthermore, ASHA reiterates that CMS should implement the phase-in in addition to other options to reduce the cuts, as outlined above.** Implementing any of these options in isolation will not provide meaningful relief to audiologists, SLPs, and other affected specialty providers.

**Revaluing Services that are Analogous to Office/Outpatient E/M Visits** (pg. 50124)

ASHA applauds CMS for recognizing certain evaluation services as analogous to office visits and supports the Agency’s efforts to adjust work values to ensure their relativity to the increased values for the office/outpatient E/M codes. However, ASHA notes that CMS applied the adjustments to select services and specialties, which jeopardizes the relativity of the resource-based relative value scale that is the foundation of the MPFS. **ASHA urges CMS to apply the adjustments uniformly across analogous services and specialties to maintain relativity within the MPFS and to carefully consider ASHA and other specialty society comments related to the overall impact of the office/outpatient E/M policy.**

*Therapy Evaluations*

ASHA supports CMS’s proposal to adjust the work RVUs for therapy codes 92521, 92522, 92523, and 92524, representing evaluations of speech, language, voice, and other communication disorders typically furnished by SLPs. However, ASHA requests that CMS review the family of CPT codes beyond 92521-92524 that also describe speech-language pathology work assessing and managing patients with a range of speech, language, cognitive, communication, and swallowing disorders. It is vital to maintain the relativity of services across the family of therapy evaluations. **As such, ASHA requests that CMS apply the same approach used to adjust the values of CPT codes 92521-92524 to other evaluation codes primarily reported by SLPs.** ASHA offers the following examples of speech-language pathology evaluations that include work analogous to office/outpatient E/M services.

CPT	Descriptor	ASHA Description
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Assesses suitability for a speech-generating device (SGD) and informs a speech-language pathology plan of care to ensure appropriate patient and caregiver training on the use of the SGD for functional communication.

CPT	Descriptor	ASHA Description
92610	Evaluation of oral and pharyngeal swallowing function	Assesses oral-motor, laryngeal, and swallowing function to determine the need for further instrumental assessment. Informs a speech-language pathology plan of care to address swallowing function, compensatory strategies, safety, nutrition, and caregiver training.
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	Assesses the patient's ability to complete specific functional tasks, identifies cognitive deficits. Informs a speech-language pathology plan of care for cognitive function intervention, including therapeutic activities to address memory, attention, pragmatics, and to develop compensatory strategies.

### *Audiology Evaluations*

ASHA reiterates that CMS should apply adjustments uniformly across analogous services and specialties, including for assessments furnished by audiologists. Audiologists specialize in preventing, assessing, and treating hearing and balance (vestibular) disorders using quantitative and qualitative measures, including standardized testing, observations, and procedures with appropriately calibrated instrumentation. Audiologic and vestibular testing leads to the diagnosis of hearing and/or balance disorders. The audiologist's assessment includes interpretation of test results identifying the probable cause of impairment and functional ability within hearing, balance, and other related systems. Audiologists also serve on care teams and the results of audiologic and vestibular assessments play a critical role in physician and other qualified health care professional management of Medicare beneficiaries with hearing and vestibular disorders. **As such, ASHA urges CMS to review audiology services and adjust work RVUs for analogous evaluation codes primarily reported by audiologists to ensure relativity within the MPFS.** ASHA offers the following examples of audiology evaluations that include work analogous to office/outpatient E/M services.

CPT	Descriptor	ASHA Description
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	Assesses vestibular function using a comprehensive battery of tests to diagnose balance disorders and distinguish between peripheral and central pathologies. Informs a plan of care to manage and/or treat a balance disorder and prevent falls.

CPT	Descriptor	ASHA Description
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	Assesses behavioral responses from the patient using pure tone air and bone conduction, and speech threshold and recognition to diagnose a hearing loss and determine the need for additional testing. Informs a plan of care to manage and/or treat a hearing disorder.
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	Assesses auditory function through behavioral and audiologic testing for suitability for a surgically implanted hearing device, as well as post-surgical implant performance. Informs the final surgical decision and post-surgical plan of care to improve functional hearing abilities.

**Scopes of Practice and Related Issues: Provision of Maintenance Therapy by Therapy Assistants** (Section II.G., pg. 50147)

While Medicare currently does not recognize speech-language pathology assistants (SLPAs) as qualified providers, ASHA has begun certifying SLPAs and has a future interest in the Medicare regulation of assistants providing therapy services. CMS has maintained different maintenance therapy policies for therapy assistants based on practice setting. For example, assistants may provide maintenance therapy in skilled nursing facilities and, more recently, home health under Part A but not for clinicians or facilities that bill Part B, such as private practices. A lack of a clear, consistent policy can create confusion and may jeopardize access to care.

During the PHE, CMS has waived the restrictions on the provision of maintenance therapy provided by assistants under Part B. In the proposed rule, CMS would allow, on a permanent basis, therapy assistants to provide maintenance therapy under the supervision of the therapist. **ASHA supports this proposal and recommends CMS finalize it.**

**Valuation of Specific Codes** (section II.H.)

**(36) Auditory Evoked Potentials (CPT codes 92584, 92X51, 92X52, 92X53, and 92X54)** (pg. 50164)

ASHA appreciates CMS’s proposal to accept the RUC’s recommended work relative value units (RVUs) and direct practice expense (PE) inputs for CPT codes 92584, 92X52, 92X53, and 92X54. ASHA also thanks CMS for displaying the recommended work RVU of 0.25 for 92X51, *auditory evoked potentials; screening*. However, CMS did not publish proposed PE and malpractice (MP) RVUs for 92X51, although the RUC recommendations included direct PE inputs and a crosswalk code for professional liability insurance. ASHA understands CMS did not propose valuation for CPT code 92X51 because it is not a covered Medicare service. However, CPT code 92X51 is a key component of universal newborn hearing screening programs that are widely furnished across the country. As such, it is critical for CMS to display the total RVUs—to include the RUC’s recommended work, PE, and MP RVUs—to allow state Medicaid agencies, newborn hearing programs, and commercial insurers to appropriately value 92X51. There is

precedent from other hearing screenings, such as CPT code 92558, *evoked otoacoustic emissions, screening*, which is marked as a non-payable code but for which CMS displays work, PE, and malpractice RVUs.

ASHA also notes a discrepancy between Addendum B—which indicates 92X51 is an active code (status indicator “A”)—and the narrative in the proposed rule, which states that 92X51 is a screening and not payable by Medicare.

In addition, ASHA requests CMS create a professional and technical component (PC/TC) split for CPT codes 92X51, 92X52, 92X53, and 92X54. Creating the split will allow audiologists who have a contractual relationship with—but are not employees of—a facility to accurately report the professional component of these procedures. ASHA notes that CPT codes 92585 and 92586, which are being replaced by 92X51-92X52, also included the PC/TC split. Furthermore, there is precedent from other audiologic testing services, such as 92588, *distortion product otoacoustic emissions, comprehensive*.

**ASHA urges CMS to finalize the proposed values for 92584, 92X52, 92X53, and 92X54, and to display the total RVUs for 92X51. ASHA also requests CMS create the PC/TC split for the new auditory evoked potential testing codes (92X51-92X54).**

**(37) Vestibular Evoked Myogenic Potential Testing (CPT codes 925X1, 925X2, and 925X3)**  
(pg. 50164)

ASHA appreciates and supports CMS’s proposal to accept the RUC’s recommended work RVUs and direct PE inputs for CPT codes 925X1, 925X2, and 925X3. In addition, we request that CMS create a professional and technical component (PC/TC) split for the new codes. As noted above, audiologists who perform services in a facility setting require a mechanism to accurately report the professional component for their services. There is precedent from other vestibular testing codes, such as 92548 and 92549, *computerized dynamic posturography*, which have both PC/TC split.

**ASHA urges CMS to finalize the proposed values and publish the PC/TC split for CPT codes 925X1, 925X2, and 925X3.**

**CY 2021 Updates to the Quality Payment Program** (section IV., pg. 50275)

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Audiologists and SLPs first became eligible for MIPS in the 2019 performance year and related 2021 payment year. CMS does not propose changes to the MIPS audiology and speech-language pathology specialty measure sets for the 2021 performance year. However, ASHA is seeking clarification regarding the application of the cost performance category to audiologists and SLPs and CMS’s current position regarding any potential changes to the low-volume threshold.

*Modifications to the Audiology and Speech-Language Pathology Specialty Measure Sets*

The audiology and speech-language pathology measure sets were significantly modified for the 2020 performance year to add a significant number of new measures. ASHA appreciated CMS’s efforts to develop more robust measure sets. However, ASHA also appreciated that CMS did not propose additional modifications to these measure sets for the 2021 performance year. ASHA believes audiologists and speech-language pathologists need additional time, as relatively new entrants into the MIPS program, to gain experience with these existing measures

and to demonstrate improvement and achievement with a consistent measure set. ASHA looks forward to an opportunity to engage with CMS and measure stewards to identify measures more relevant to our members' clinical expertise in the future.

#### *MIPS Performance Categories*

In the proposed rule, CMS clarifies that the promoting interoperability (PI) category will not apply to audiologists and SLPs in the 2021 performance year. ASHA supports redistributing this category's score to other performance categories because the PI performance category remains difficult for ASHA's members to participate in effectively. Many of the current measures for the PI category do not apply to our members; particularly because audiologists and SLPs do not prescribe medications.

However, CMS does not explicitly propose to redistribute the cost category of MIPS to other performance categories for audiologists and SLPs. While the episode-based cost measures proposed in the rule do not appear to include the coding (procedural or diagnostic) associated with audiology and speech-language pathology services, ASHA requests that CMS explicitly clarify that they will redistribute the cost category's score to other performance categories for audiologists and SLPs in the 2021 performance year. **Given that audiologists and SLPs do not have the authority—under Medicare policy—to control the trajectory and total cost of care for patients, ASHA opposes application of the cost performance category to our members.** ASHA welcomes the opportunity to work with CMS to identify mechanisms that might appropriately address cost performance for ASHA members in the coming years.

#### *Low-Volume Thresholds*

CMS does not propose to modify the low-volume thresholds for the 2021 performance year. ASHA recommends that CMS proactively announce any potential plans for modifying the low-volume threshold over time so that clinicians can prepare appropriately for their inclusion in MIPS.

#### **Regulatory Impact Analysis: CY 2021 PFS Impact Discussion** (section VIII., pg. 50376)

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CMS published specialty-level impacts for CY 2021 in Table 90. Of note, this table does not include specific impact data for certain specialties, such as speech-language pathology, which is currently included in calculations for physical/occupational therapy. ASHA does not believe it is appropriate to include SLPs in this category, as speech-language pathology billing and utilization patterns are not analogous to physical or occupational therapy services. Medicare providers must have access to the estimated impact data specific to their specialty, given the potential for significant payment reductions due to the E/M coding and payment changes. Without this data, SLPs and other providers face a distinct disadvantage as they attempt to prepare for the impact of the CY 2021 coding and policy changes. **As such, ASHA urges CMS to separate speech-language pathology from the physical/occupational therapy category and to eliminate the "other" category to include specific specialty-level impacts of finalized E/M payment and other policies for all specialties that provide services paid under the MPFS. In addition, ASHA requests that CMS continue to include specific specialty-level impact data for all specialties, including SLPs, in all future rulemaking.** This practice will ensure equitable access to information for all Medicare providers and aligns with CMS's ongoing commitment to transparency.

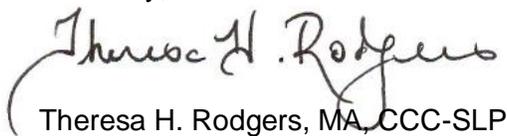
ASHA also notes a discrepancy in Table 90 and in the subsequent impact discussion regarding the specialty level impact for the physical/occupational therapy category, which also includes speech-language pathology. The table lists the combined impact for physical/occupational therapy at **-9%**, but the narrative states “*for the physical/occupational therapy specialty, estimated impacts of -8 percent reflect proposed increased valuations for therapy evaluation services that are analogous to office/outpatient E/M visits*”. **ASHA requests CMS clarify whether the estimated specialty-level impact for the physical/occupational therapy specialty category, including speech-language pathology is -8%, as referenced in the narrative, or -9%, as listed in Table 90.**

## Conclusion

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The 2021 MPFS proposed rule contains several provisions of significant importance to audiologists and SLPs in the areas of telehealth, coding and payment policy as well as quality reporting. ASHA appreciates the opportunity to submit our comments for your consideration. If you or your staff have additional questions, please contact Tim Nanof, ASHA’s director of health care and education policy, at [tnanof@asha.org](mailto:tnanof@asha.org).

Sincerely,



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

## Attachments

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<sup>8</sup> Executive Office of the President. (May 19, 2020). *Executive Order 13924, Federal Register*, 85, 31353. Retrieved from <https://www.federalregister.gov/documents/2020/05/22/2020-11301/regulatory-relief-to-support-economic-recovery>

<sup>9</sup> Social Security Act §1848(c)(2)(B)(ii)(I). Retrieved from [https://www.ssa.gov/OP\\_Home/ssact/title18/1848.htm](https://www.ssa.gov/OP_Home/ssact/title18/1848.htm)

<sup>10</sup> U.S. Department of Health and Human Services. (2018). *Rules and regulations. Federal Register*, 83(226). 59475. Retrieved from <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>

## Appendix A

### Authorized Telehealth Services under the Public Health Emergency

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ASHA appreciates that CMS has taken extensive action to remove barriers to providing care in the safest and most efficient manner possible.

CMS has authorized the following CPT codes to be billed by audiologists as telehealth services:

- **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)

CMS has also authorized the following CPT codes, which are typically provided by SLPs as telehealth services:

- **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)

Thank you for including these codes on the telehealth list. Access to these telehealth services improves safety and enhances functional outcomes for thousands of Medicare beneficiaries and Medicare-enrolled health care providers.

## Appendix B

### Recommended Telehealth Services and Clinical Scenarios

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Adding the following CPT codes through the CMS subregulatory process will further improve access to medically necessary care while reducing the risk of transmission of COVID-19 for more Medicare beneficiaries with hearing, communication, cognitive, and swallowing disorders. As the national association setting standards of clinical practice, ASHA affirms that these recommended services are clinically appropriate for telehealth and urges CMS to use the subregulatory process to add the following CPT codes to the Medicare telehealth list for the duration of the public health emergency.

#### **Audiology Services**

- **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)
- **92563** (tone decay test)
- **92565** (stenger test, pure tone)
- **92567** (tympanometry)
- **92568** (acoustic reflex testing; threshold)
- **92570** (acoustic immittance testing, including tympanometry, acoustic reflex threshold and decay testing)
- **92585** (auditory evoked potentials, comprehensive)
- **92586** (auditory evoked potentials, limited)
- **92587** (distortion product evoked otoacoustic emissions, limited, with interpretation and report)
- **92588** (distortion product evoked otoacoustic emissions, comprehensive, with interpretation and report)
- **92625** (assessment of tinnitus)
- **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 minutes)

The audiology CPT codes ASHA recommends adding to the telehealth list represent core diagnostic tests for identifying the type, severity, and etiology of hearing loss or the need for further vestibular testing. Audiologists can conduct testing for any of the listed services using remote access software to connect with a computer-based audiometer or auditory brainstem response (ABR) testing system at the originating site. In addition, an audiologist can use a video otoscope connected to the same computer to examine the ear before testing to ensure cerumen will not impede testing. A trained facilitator at the originating site acts as an extension of the audiologist and performs very specific tasks at the audiologist's direction, such as positioning the video-otoscope or placing headphones on the patient.

Although these services require the patient to leave the home to access audiologic testing equipment, telehealth provides a safe and effective means for the audiologist to conduct testing from a secondary location, such as a satellite office, without personal protective equipment (PPE) obscuring their face during the public health emergency. Visual cues, such as facial expressions and lip movement, are critical components of communication for patients with hearing loss. If the audiologist provides in-person testing with the necessary PPE, the quality and efficiency of testing may be significantly hampered by the need to write instructions or use a speech to text application to ensure the patient understands and complies with testing instructions. Telehealth services also limit the exposure of both the beneficiary and audiologist by reducing the number of face-to-face contacts needed to deliver the service.

Absent any means to receive core audiologic testing services via telehealth, Medicare beneficiaries with undiagnosed hearing or balance disorders face an even higher risk for isolation and depression. ASHA urges CMS to allow Medicare beneficiaries access to practices that are already fully equipped and providing telehealth services to non-Medicare patient populations. Audiology telehealth services are well-established and diagnostic video-otoscopy, audiometry, otoacoustic emissions, and ABR conducted remotely yield equivalent results when compared to in-person testing.<sup>11</sup> ASHA strongly recommends that CMS add the above-listed CPT codes to the telehealth list and provides the following clinical scenario illustrating how diagnostic audiologic testing is safely and effectively provided via telehealth during the COVID-19 pandemic.

***Audiometric testing scenario:*** A Medicare beneficiary contacts her physician with complaints of decreased hearing and pronounced ringing in her ears (tinnitus). The physician refers her to the audiologist for diagnostic testing.

Due to COVID-19 concerns, the clinic has limited staff working onsite to reduce risk of exposure and conserve their limited supply of PPE. The audiologist provides remote testing from a satellite office while working with a trained facilitator who is onsite and dressed in PPE. The audiologist uses a videoconferencing platform to communicate with the patient and facilitator and controls the diagnostic testing equipment (audiometer) through computer-based software with remote access capability. This software is the same as that used in the office for an in-person visit. Before initiating testing, the audiologist reviews case history with the patient, discusses her complaints of hearing loss and tinnitus, and provides a description of how testing will work. The audiologist then directs the facilitator to position the video otoscope to allow the audiologist to view the live video of the ear canal and ensure there are no obstructions in each ear. After the facilitator positions and places headphones on the patient, the audiologist initiates audiometric testing for each ear, including pure-tone air and bone conduction testing at multiple frequencies and speech reception threshold (SRT) and speech recognition testing. During air conduction testing, the audiologist instructs the patient to respond to sounds sent to the headphones by raising her hand. For bone conduction testing, the facilitator places a small device behind the patient's ear. The audiologist sends sounds through the device to gently vibrate her skull, allowing testing of the inner ear. During SRT and speech recognition testing, the audiologist speaks words through the headphones and asks the patient to repeat what she hears. The audiologist completes testing, reviews the audiogram on the computer screen, and discusses the results with the patient before ending the session. The audiologist saves the audiogram and clinical documentation and forwards a copy to the referring physician. **This scenario represents hearing testing reported with CPT code 92557 (Comprehensive audiometry threshold evaluation and speech recognition).**

## Speech-Language Pathology Services

- **92526** (treatment of swallowing dysfunction and/or oral function for feeding)
- **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 modification)
- **92610** (evaluation of oral and pharyngeal swallowing function)
- **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)
- **96125** (standardized cognitive performance testing, with time in interpretation and report, per hour)
- **97129** (cognitive function intervention, initial 15 min)
- **97130** (cognitive function intervention, each additional 15 min)

The speech-language pathology CPT codes ASHA recommends adding to the telehealth list represent evaluation and treatment of a range of communication and swallowing disorders that SLPs are already providing via telehealth to non-Medicare beneficiaries. These services do not require additional specialized equipment and may be provided safely with the patient at home, when clinically appropriate. Access to these services via telehealth is essential during the public health emergency, as in-person speech-language pathology services often require close contact with the patient. For example, swallowing evaluation and treatment requires examination of the patient's oral structure and function, and speech-generating device (SGD) services require the clinician to position the patient's assistive equipment and reach over and around the patient to program and modify the device. Providing these services via telehealth with the assistance of a caregiver to position the patient and the video camera allows the clinician an equivalent level of access to examine the patient and perform clinical functions required during evaluation and treatment.

Without access to a clinical evaluation of swallowing, Medicare beneficiaries may not be identified for risk of aspiration or recommended for further instrumental assessment and intervention. Patients with neurodegenerative diseases, such as amyotrophic lateral sclerosis (ALS), may quickly lose the ability to communicate if they are not evaluated by an SLP for suitability for an SGD early enough. Local coverage determinations require an SGD evaluation by an SLP before delivery of the SGD.<sup>12</sup> Without consistent access to therapy, patients with cognitive, communication, and swallowing disorders may see a decline in functional ability to complete activities of daily living or communicate their physical or emotional needs, leaving them susceptible to further medical complications. ASHA strongly recommends that CMS add the above-listed CPT codes to the telehealth list and provides the following clinical scenarios illustrating how speech-language pathology services are safely and effectively provided via telehealth during the COVID-19 pandemic.

**Cognitive evaluation and therapy scenario:** Following a stroke, a Medicare beneficiary was discharged from inpatient rehabilitation to home where he lives with his spouse as his primary

caregiver. Six months post-stroke, his wife contacts the physician, noting that he struggles with memory and attention, impacting his ability to complete activities of daily living. The physician refers the patient to an SLP for evaluation and treatment of cognitive function.

The SLP evaluates the patient using standardized testing approved for administration via telehealth and identifies a moderate impairment of cognitive function. She establishes a plan of care, which the referring physician certifies.

Each week, the patient logs into the videoconferencing platform with minimal help from his spouse. Goals of therapy include increased independence with problem solving and safety/judgment in activities of daily living. He works with his SLP on his goals using functional activities via screen share, document viewing, and joint typing activities. His spouse also participates to learn strategies to assist the patient to promote carryover and functional improvements. Because the SLP can use real-world, in-home activities during therapy, the patient retains more information and has seen significant improvement.

**This scenario represents cognitive evaluation reported with CPT code 96125 (standardized cognitive assessment), and cognitive therapy reported with CPT codes 97129 (Cognitive function intervention, initial 15 minutes) and 97130 (Cognitive function intervention, each additional 15 minutes).**

**Swallowing therapy:** A Medicare beneficiary sees an SLP for treatment of swallowing difficulties due to moderate dementia. The physician has certified the swallowing plan of care, as required by Medicare. The patient lives at home with her spouse but has recently been in and-out of the hospital and skilled nursing facilities due to complications resulting from a fall. Her advanced age and mobility issues make it difficult for her to leave the home during the COVID-19 pandemic. As her dementia progresses, one of the most difficult issues to manage is her decreasing independence with swallowing, primarily with chewing and moving food or liquid into the throat (oral phase). She ruminates and holds food in her mouth for several minutes and is having increasing difficulty sequencing to self-feed and initiate a swallow. The SLP uses a videoconferencing platform to continue therapy to address the patient's swallowing difficulties. Because the telehealth session occurs at the patient's home, the SLP can see her in her own environment and even work with her during mealtimes, with her spouse and other family members present. Due to her dementia, the patient does not do well with changes in her routine and is more likely to successfully participate in her own home with only family present.

Treatment of swallowing dysfunction may include training on how to use muscles for chewing and swallowing, identifying ways to position the head and body when eating, teaching cognitive sequencing strategies to help swallow better and safer, and making recommendations regarding food texture and consistency to make swallowing easier for the patient. The SLP also provides the family with education and strategies to promote carryover from treatment. Families and caregivers are often actively engaged in strategies to ensure the patient is swallowing safely and effectively at home by helping with exercises, making food and drinks the patient can swallow safely, and keeping track of how much the patient is eating and drinking.

**This scenario represents swallowing therapy reported with CPT code 92526 (Treatment of swallowing dysfunction and/or oral function for feeding).**

**SGD evaluation and therapy scenario:** A physician refers a Medicare beneficiary with ALS to an SLP for an SGD. The patient is wheelchair bound. The SLP conducts a speech evaluation via telehealth and determines he is in urgent need of an SGD because his intelligibility has

dropped from 100% to 80% within the last 3 months. Decline with ALS typically continues to progress along the same trajectory and the process of obtaining an SGD, from evaluation to delivery, will be at least 3 months.

During the initial portion of the SGD evaluation, the SLP uses a videoconferencing platform to conduct a visual inventory of possible methods the patient may use to input messages into his SGD, since his fingers are paralyzed and he can no longer write or type. This includes observation of his head and arm movement, based on her direction to imitate various functional tasks. The SLP then asks the patient's spouse to pull the family laptop back and focus the video camera on his lower extremities. The SLP determines the patient may be able to activate a foot pedal. The SLP also performs standardized ALS cognitive and behavioral screenings to assess changes in the patient's language, cognition, or behavior that could impact his language, spelling, concentration, set-shifting, and other executive functions important to using an SGD. The clinician can screen share images of test items and the patient can name and spell the items as well as perform other tasks that are presented verbally and through images. The SLP also emails the spouse a standardized questionnaire about behavioral changes which she fills out, takes a picture of, and emails back by replying to the clinician's encrypted email. The patient's screens all return normal results. The SLP also informally screens his vision and hearing. Finally, she explores the patient's specific functional communication needs, such as continuing to work, assisting his son with homework, and communicating with family by phone. The SLP discusses the results of the initial evaluation, next steps for trialing SGD systems, and then forwards a report to the referring physician.

After the evaluation, the SLP contacts three SGD vendors in her patient's county and sets up separate dates for delivering the requested equipment to the patient's home. She asks the vendors to bring a variety of access methods, including different mouse options, various switches and buttons, a foot pedal, and SGDs with eye tracking access. Patients with ALS may ultimately require eye tracking access when all other movement is gone so the SLP will trial eye tracking in anticipation of future needs.

After the disinfected SGD equipment is delivered to the patient's home, the vendor works with the spouse to set up and calibrate the equipment. The SLP then initiates the HIPAA-compliant videoconference platform connected to both a front facing camera on the SGD and side facing camera on the laptop. This allows the clinician to visualize all aspects of the patient necessary for the evaluation. She can also see and remotely control the SGD screen, allowing her to access different communication software and adjust settings. The SLP works with the patient to observe his ability to use various accessibility options to interact with the device.

The SLP, patient, and his spouse go through a similar process with each of the devices being trialed. By the end of the trials, they select an SGD with a camera that easily tracked his eyes at the screen corners, and offers software he can independently customize, simple phone access, as well as a loud call chime to alert his spouse, when needed. They also select the ergonomic mouse and foot pedal, but the family understands that if it becomes difficult to use, they can set up another telehealth visit with the SLP to reassess his access needs and order the appropriate accessories, including eye tracking, to maintain his ability to communicate as the condition progresses. They also discuss the treatment plan. The SLP forwards the trialing results to the referring physician.

When the selected device arrives, the vendor representative again assists with the physical setup and the SLP provides four appointments—which can be effectively conducted via telehealth—to train the patient and caregivers on how to set up and customize the

communication software to minimize effort and facilitate communication with his SGD. Telehealth appointments for therapeutic services related to the SGD also use videoconferencing technology connected to the laptop and SGD, allowing the SLP to remotely access the communication software and see the patient from both the front and the side during the clinical interaction.

**This scenario represents an SGD evaluation reported with CPT codes 92607 (evaluation for speech generating device; first hour) and 92608 (each additional 30 minutes of evaluation time), and therapy reported with CPT code 92609 (therapeutic services using speech generating device, includes programming and modification).**

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<sup>11</sup> Swanepoel, D. W., & Hall, J. W. (2010). A systematic review of telehealth applications in audiology. *Telemedicine and e-Health*. 16(2).181-200. Retrieved from <http://dx.doi.org/10.1089/tmj.2009.0111>.

<sup>12</sup> American Speech-Language-Hearing Association. (n.d.). *Medicare Coverage Policy on Speech-Generating Devices*. Retrieved from [https://www.asha.org/practice/reimbursement/medicare/sgd\\_policy/](https://www.asha.org/practice/reimbursement/medicare/sgd_policy/).