



June 3, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Attention: CMS-5531-IFC
P.O. Box 8016
Baltimore, MD 21244

RE: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program (CMS-5531-IFC)

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to thank you for extending telehealth coverage to audiologists and speech-language pathologists in the most recent interim final rule with comment period (CMS-5531-IFC). The expansion will ensure continuity of care for individuals with communication disorders while reducing the risk of transmitting COVID-19 to clinicians and patients alike. In order to further enhance those outcomes, I also write to request expansion of additional Current Procedural Terminology (CPT) codes for telehealth services provided by audiologists and speech-language pathologists using the waiver authority provided to the Secretary of the U.S. Department of Health and Human Services (HHS) under Section 3703 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136). Further expansion of available telehealth services aligns with the congressional waiver authority provided in the CARES Act. As you know, Congress intended the flexibility be utilized in the broadest and most robust manner possible as outlined in the attached letters to the Secretary.

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 appreciates that the Centers for Medicare & Medicaid Services (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)

The IFC also authorized the following CPT codes, which are typically provided by speech-language pathologists (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 will improve safety for thousands of Medicare beneficiaries and Medicare-enrolled health care providers. However, adding the following CPT codes through the CMS subregulatory process will further improve access to medically necessary care 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.**

Recommended Audiology Telehealth Services and Clinical Scenarios

- **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)
- **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.

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.¹ **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 what is 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 Telehealth Services and Clinical Scenarios

- **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.² 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: A Medicare beneficiary is six months post-stroke. He was discharged from inpatient rehabilitation to home where he lives with his spouse, who is his primary caregiver. His wife contacts the physician, noting that he is struggling 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 that has been approved for administration via telehealth and identifies a moderate impairment of cognitive function. She establishes a plan of care, which is certified by the referring physician.

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 is able to retain 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 HIPPA-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.

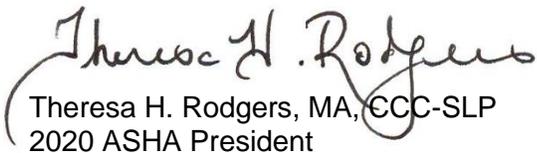
When the selected device arrives, the vendor representative again assists with the physical set-up and the SLP provides four appointments—which can be effectively conducted via telehealth—to train the patient and caregivers on how to set up and customize the communication software to minimize effort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

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.³ 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. During the COVID-19 pandemic, ASHA urges CMS to meet the congressional intent of the telehealth waiver authority by allowing health care providers and Medicare beneficiaries the flexibility to obtain the broadest possible range of clinically appropriate services in the interest of saving lives as well as putting our health care workforce back to work in the safest manner possible.

Thank you for the opportunity to provide these comments on the IFC. If you or your staff have any questions, please contact Neela Swanson, ASHA's director of health care policy, coding and reimbursement, at nswanson@asha.org.

Sincerely,



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

Attachments

¹ 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>.

² 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/.

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