



April 24, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Attention: CMS-1744-IFC  
P.O. Box 8016  
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to respond to the interim final rule (IFR) and to request expansion of Medicare telehealth coverage for 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).

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 recognizes 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. Considering the broad waiver authority provided by Section 3703 of the CARES Act, ASHA urges CMS to take immediate action to expand telehealth coverage to include additional clinicians, including audiologists and speech-language pathologists (SLPs) as soon as practicable. The Act states:

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

This amendment grants the Secretary authority to waive the requirements within Section 1834(m) of the Social Security Act, which restricts coverage of telehealth services to only those services provided by physicians and practitioners. This broad authority is critical during national emergencies and gives the Secretary the ability to designate additional categories of clinicians authorized to provide and be reimbursed for services provided to Medicare beneficiaries via telehealth. ASHA recommends that the Secretary use this authority to include audiologists and SLPs based on the parameters outlined below. In addition, the attached bipartisan, bicameral letters clarify congressional intent for CMS to “immediately and broadly exercise this waiver authority, including by allowing additional types of health care professionals to furnish telehealth services . . .”.

ASHA's comments address the following areas:

1. Full expansion of telehealth coverage for audiologists and SLPs (Section II.A.16).
2. Clarification on the use of remote evaluation of patient images/videos and virtual check in codes (G2010 and G2012) (Section II.D.).
3. Clarification on the use of telephone assessment codes (CPT codes 98966-98968) (Section II.S).
4. Clarification on the waiver of face-to-face requirements associated with national and local coverage determinations for speech-generating devices (Section II.U.1.).

### **Full Expansion of Telehealth Coverage for Audiologists and SLPs (Section II.A.16)**

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Section 3703 of the CARES Act grants the Secretary broad authority to waive the requirements of 1834(m) of the Social Security Act (SSA)—which restricts Medicare coverage of telehealth services to physicians and practitioners—during a public health emergency (PHE). This authority should be used immediately to allow for coverage of telehealth services provided by audiologists and SLPs.

Coverage of telehealth services provided by these clinicians is necessary to maintain access to medically necessary services during the Coronavirus Disease 2019 (COVID-19) pandemic and slow transmission of the disease. Using the waiver authority Congress has given the Secretary reinforces what states, Medicaid programs, and many private insurers acknowledge; audiologists and SLPs are qualified to provide services via telehealth and are critical members of the interdisciplinary care team. Full expansion of telehealth coverage is necessary as the existing flexibilities granted, such as the use of e-visits, virtual check ins, and telephone assessments—collectively referred to as communication technology-based services (CTBS)—do not allow for the evaluation and treatment of Medicare beneficiaries. In addition, expansion of telehealth services will better align with new policies outlined in the IFR, which has created confusion regarding what types of telehealth services and clinicians are covered.

### ***Audiologists and SLPs are Qualified Providers of Telehealth Services***

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

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

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

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

Audiologists provide audiologic testing under the Medicare diagnostic benefit category, with referral from a physician. Computer-based audiologic diagnostic testing applications are common. Audiologists providing telehealth services use computer peripherals—such as audiometers, auditory brainstem response (ABR), otoacoustic emissions (OAEs), and immittance testing equipment—that can be interfaced to existing telehealth networks. As hearing implant technology evolves, more patients have access to implant devices with synchronous or store-and-forward capabilities. Audiologists use telehealth technologies to provide hearing diagnostic services, including auditory function evaluation for pre-implant candidacy and post-implant status, cochlear implant fitting and programming, pure-tone audiometry, speech-in-noise testing, and video otoscopy.

SLPs provide evaluation and treatment services under a physician-certified plan of care as part of the Medicare therapy benefit category. SLPs providing telehealth services evaluate and treat a wide range of speech, language, cognitive, voice, and swallowing disorders associated with stroke, traumatic brain injury, neurodevelopmental disorders, neurodegenerative disease, and other medical conditions.

ASHA recommends telehealth coverage for select audiology and speech-language pathology Current Procedural Terminology (CPT® American Medical Association) codes as outlined in Appendix A. Additional codes within the scope of practice of audiology and speech-language pathology may be appropriate for telehealth coverage but may require specialized implementation requirements that make broad coverage less appropriate.

ASHA also provides clinical scenarios illustrating how telehealth services provided by audiologists and SLPs can play a key role in the provision of medically necessary care during the COVID-19 pandemic, as outlined in Appendix A.

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

SLPs were designated by the Department of Homeland Security (DHS) as essential health care workers on March 19.<sup>5</sup> ASHA concurs that audiology and speech-language pathology services are medically necessary to help a patient maintain or improve function and assist a patient in returning to their home or community quickly and safely. In some situations, these services are also essential, as in the case of a patient with a swallowing disorder that can cause them to choke or develop aspiration pneumonia.

The need to provide medically necessary or essential health care services must be balanced against the risk of transmission of COVID-19 to clinicians and patients given the reports of limited availability of personal protective equipment (PPE). **One way to accomplish these**

**important goals is to provide these services via telehealth.** This consideration is acknowledged in the HHS guidance, as it states:

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

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

### ***Health Care Consumers and Medicare Beneficiaries Deserve Equitable Application of Telehealth Policies Across Payers***

In January 2020, CMS issued a request for feedback on scope of practice restrictions under Medicare regulations that contradict state law and prevent clinicians from practicing at the top of their license. In response to this request, ASHA highlighted how the exclusion of audiologists and SLPs from the Medicare telehealth benefit conflicts with numerous state laws. The disconnect between Medicare coverage of telehealth and coverage provided by private payers and Medicaid programs, as well as state licensing and scope of practice laws, has only worsened during the response to COVID-19. For example, 33 states have in place permanent laws allowing audiologists and SLPs to perform services via telehealth. In addition, 26 states have put into place emergency temporary laws for the provision of telehealth as a specific response to COVID-19.<sup>6</sup> A recent ASHA analysis shows that at least 30 commercial health plans and 47 Medicaid programs either have permanent or temporary provisions authorizing audiologists and/or SLPs to provide services via telehealth. **ASHA recommends that CMS acknowledge the significant work states and private insurers have done to ensure appropriate access to medically necessary services and use its authority to waive restrictions on the reimbursement for telehealth services provided by audiologists and SLPs.**

In addition, as part of its response to the pandemic, CMS has granted 44 section 1135 waivers to state Medicaid programs, many of which include telehealth flexibility. ASHA is concerned that CMS has elected to exercise its waiver authority to allow telehealth services only under Medicaid despite the fact that both Medicare and Medicaid provide coverage for health care services required by the most vulnerable populations including children, seniors, and people with disabilities. **Again, ASHA strongly urges CMS to use its authority to waive telehealth restrictions across Medicare and Medicaid.**

### ***Audiologists and SLPs Cannot Use Existing Regulatory Flexibilities to Evaluate or Treat Patients***

Although expansion of the use of e-visits, virtual check-ins, and other CTBS codes help facilitate some interactions between patients and SLPs, these services do not facilitate comprehensive evaluation and treatment, have limited practical utility, and do not extend access to services otherwise covered when provided in person.

CMS also determined that audiologists may not report CTBS codes under the audiology diagnostic benefit, meaning that audiologists have no way to serve Medicare beneficiaries at a

time when individuals with hearing disorders are at an even higher risk for isolation and depression. **Absent the ability to provide telehealth services, ASHA urges CMS to provide Medicare beneficiaries with a means to access limited audiology services by allowing audiologists to report CTBS codes.** Although the audiology benefit is diagnostic-only, ASHA maintains that audiologists can appropriately report CTBS codes when working with beneficiaries to troubleshoot implant equipment issues or assess whether additional hearing diagnostic or other medical services are warranted, potentially mitigating the need for an in-person office visit during the COVID-19 pandemic.

Outpatient hospital settings do not have a means to report CTBS or telehealth services, though there are many scenarios in which audiologists and SLPs could provide remote or virtual services to patients to minimize the need for in-person visits and reduce the risk of exposure to COVID-19 for our most vulnerable populations. **Although ASHA recognizes the claims processing challenges associated with facility-based billing, we urge CMS to explore options to ensure equitable access to medically necessary CTBS and telehealth services across outpatient settings.**

It is unclear if CTBS codes can be used effectively, particularly with new patients, given other regulatory requirements. For example, CTBS codes cannot represent an evaluation service, which is used to develop the plan of care. A plan of care is a required part of the documentation in the medical record for speech-language pathology services. Without access to full evaluation services via telehealth, use of CTBS codes for new patients could potentially violate both regulatory and clinical guidelines.

While we appreciate CMS's efforts to provide flexibility in the provision of services in a PHE, these efforts have been insufficient to meet the needs of certain nonphysician clinicians and their patients. **Applying the full waiver authority vested to CMS by Congress will help small or solo audiology and speech-language pathology practices survive by providing them an opportunity to continue providing care to the Medicare beneficiaries they are committed to serving, while adhering to state and federal mandates for social distancing.**

### ***The Expansion of Telehealth Services without Expansion of Covered Providers Prevents Meaningful Access to Care for Medicare Beneficiaries***

The IFR expands the types of covered telehealth services, as represented by CPT codes, to include speech-language pathology services. The codes include 92507, 92521, 92522, 92523, and 92524. However, it restricts telehealth coverage for these services to physicians and practitioners and does not cover these services when provided by an SLP. This is despite the fact that, 90% of the time these services are provided by SLPs, not physicians or practitioners, as CMS acknowledged in the rule. Although CMS wrote the IFR when it still lacked the statutory authority to provide coverage for telehealth services provided by SLPs, the passage of the CARES Act granted that authority. As a result, ASHA urges CMS to use its waiver authority to ensure Medicare beneficiaries have access to these services delivered by qualified SLPs.

As noted in Appendix A, SLPs can appropriately provide additional covered services beyond those included as part of the IFR. At a minimum, ASHA requests that CMS add select codes associated with dysphagia evaluation (CPT code 92610) and treatment (CPT code 92526) to ensure the safety of Medicare beneficiaries who might otherwise be at risk of choking, dehydration, malnutrition, and/or aspiration pneumonia.

The IFR does not include audiologists as eligible providers of the CTBS codes nor are audiology services included for coverage by physicians and practitioners. Audiologists are qualified and able to provide diagnostic services via telehealth. CMS should use its waiver authority to include audiologists as covered telehealth providers based on ASHA's recommended code list and supported by the clinical scenarios outlined in Appendix A.

**Clarification on the Use of Remote Evaluation of Patient Images/Videos (G2010), Virtual Check-In (G2012), and Telephone Assessment Codes (98966-98968) (Sections II.D. & II.S.)**

ASHA thanks CMS for allowing SLPs to use these CTBS codes during the PHE, but we reiterate that these codes have limited utility. We also seek clarification on appropriate reporting of these codes, which may not be reported when a related evaluation and management (E/M) service is provided within the previous seven days or within the following 24 hours or soonest available appointment. SLPs may not report E/M services under their benefit category. It is unclear to ASHA, if an SLP provides a related evaluation or treatment service within the same timeframe outlined in the code requirements for E/M services, if the CTBS code would be bundled into the evaluation or treatment service or reported separately.

**Clarification on the Waiver of Face-to-Face Requirements Associated with National and Local Coverage Determinations for Speech-Generating Devices (Section II.U.1.)**

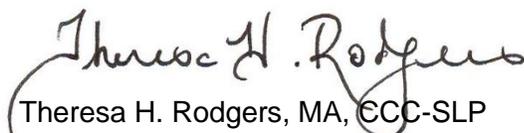
The IFR states:

“Therefore, on an interim basis, we are finalizing that to the extent an NCD or LCD (including articles) would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements would not apply during the PHE for the COVID-19 pandemic.”

ASHA requests CMS to clarify whether this would apply to national and local coverage determinations for speech-generating devices (SGDs), which require a face-to-face visit by the physician prior to the prescription of the SGD.

Thank you for the opportunity to provide these comments on the IFR. If you or your staff have any questions, please contact Sarah Warren, MA, ASHA's director of health care policy, Medicare, at [swarren@asha.org](mailto:swarren@asha.org).

Sincerely,

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

**Attachments**

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

<sup>2</sup> Ibid.

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

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

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

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

## Appendix A

### Audiology Codes and Clinical Scenarios

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- **92550** (tympanometry and reflex threshold measurements)
- **92551** (screening test, pure tone, air only)
- **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)
- **92584** (electrocochleography)
- **92585** (auditory evoked potentials, comprehensive)
- **92586** (auditory evoked potentials, limited)
- **92587** (distortion product evoked otoacoustic emissions, limited, with interpretation and report)
- **92601** (diagnostic analysis of cochlear implant, patient younger than 7 years, with programming)
- **92602** (diagnostic analysis of cochlear implant, younger than 7, subsequent reprogramming)
- **92603** (diagnostic analysis of cochlear implant, age 7 years or older, with programming)
- **92604** (diagnostic analysis of cochlear implant, age 7 years or older, subsequent reprogramming)
- **92625** (assessment of tinnitus)
- **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)

**Cochlear implant programming or reprogramming scenario:** A Medicare beneficiary with a cochlear implant (CI)—a surgically implanted device to help with severe hearing loss—is working exclusively from home during the COVID-19 pandemic. The new work circumstances require him to function in a different listening environment that has changed from primarily in-person conversation to audio and audio-visual based communication. He contacts his physician because he is having trouble hearing and understanding his coworkers and is unable to function effectively in the new work environment. The physician refers him to the CI audiologist. Before initiating device diagnostics and reprogramming, the audiologist uses a videoconferencing platform to discuss the patient’s listening environment and hearing challenges to evaluate his functional communication needs and determine the reason for decline in performance. The patient’s spouse also participates to facilitate communication and use of the software. Based on the functional assessment, the audiologist determines that the CI requires reprogramming. The audiologist can provide secure, synchronous reprogramming of the CI with computer-based software provided to the patient before the appointment. This software is the same as what is used in the office for an in-person visit. The patient initiates the software with remote access capability on his computer, allowing the audiologist to assess internal device function, connectivity of the external device to the internal device, and begin reprogramming of the external device. The reprogramming process includes accessing the patient’s implant record and map from the prior programming session, measuring impedance levels, and setting CI

mapping parameters (such as volume, pulse, and width) according to the patient's individual needs. The patient provides feedback as the audiologist measures hearing threshold levels on a minimum of five electrodes and balances hearing across all electrodes, ensuring optimal sound quality and patient comfort. The audiologist saves the new map and loads it onto the patient's sound processor. The audiologist disconnects the remote access to the CI and discusses additional troubleshooting and compensatory strategies the patient and his spouse can use to optimize his hearing function with the CI before ending the session. The audiologist saves the clinical documentation and forwards a copy to the referring physician.

**This scenario represents CI reprogramming reported with CPT code 92604 (Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming). Audiologists may also provide initial programming of a CI using the same remote technology (CPT code 92603).**

***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 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. The facilitator positions the patient in the soundproof testing booth and places headphones on the patient. Before initiating testing, the audiologist reviews case history with the patient and discusses her complaints of hearing loss and tinnitus. The audiologist then 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, 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 audiometric testing reported with CPT code 92557 (Comprehensive audiometry threshold evaluation and speech recognition).**

## Speech-Language Pathology Codes and Clinical Scenarios

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- **92507** (treatment of speech, language, voice, and/or other communication disorder; individual)
- **92508** (treatment of speech, language, voice, and/or other communication disorder; group)
- **92521** (evaluation of fluency)
- **92522** (evaluation of speech)
- **92523** (evaluation of speech and language)
- **92524** (qualitative evaluation of voice)
- **92526** (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 mods)
- **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)

**Cognitive 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. He requires a walker and gait belt for mobility. 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. His medical condition and mobility issues require him to remain at home during the COVID-19 pandemic.

The SLP evaluates the patient using a videoconferencing platform and identifies a moderate impairment of cognitive function. She establishes a plan of care, which is certified by the referring physician. Goals of therapy include increased independence with problem solving and sustained attention. Each week, the patient logs into the videoconferencing platform with minimal help from his spouse. He works with his SLP on his goals within 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 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 has been seeing an SLP for treatment of swallowing difficulties due to moderate dementia. The swallowing plan of care has been certified by the physician, 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 require her to remain at 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 speech-language pathologist 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 (dysphagia) may include training on how to use muscles for chewing and swallowing, identifying ways to position the head and body when eating, teaching 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).**