Non-Audiologists and Cochlear Implant MAPping

By John A. Coverstone, AuD

Audiologists across the United States, and particularly those involved in the State Leaders Network, have worked for years to develop and write into law a comprehensive, accurate, and exclusive scope of practice. Since moving to state licensure as a minimum credential to practice audiology, this has been an important endeavor to define the boundaries of audiology training and to ensure that non-audiologists do not provide services for which audiologists are uniquely qualified.

Approximately one year ago, as the chair of the State Network Committee, I was approached by then Academy President Kris English to investigate the need for an informal statement regarding non-audiologists fitting and MAPping cochlear implants. Following a survey of two manufacturers and pertinent clinicians, I reported that this was not a significant concern at that time, although the possibility of a non-audiologist labor pool expanding into this area was definitely looming. Both manufacturers with whom I spoke were only aware of one clinic that used hearing instrument dispensers (HIDs) under the supervision of the resident ENT physician to map cochlear implants. Neither manufacturer expressed support for this practice.

It is feasible that physicians may look increasingly to non-audiologists to provide fitting and MAPping services, as it can significantly decrease salary costs for post-surgical services. I believe this to be due to a number of factors, some of which audiologists are able to address:

1. Insurance reimbursement is going down in many areas and follow-up services are not cost-effective to provide. A non-audiologist provider, working at a reduced salary, may look attractive to administration and physician-owners.

2. Many ENT physicians dramatically undervalue the expertise and unique qualifications of audiologists, believing that anyone can be trained to do what we do.

3. In some cases, physicians (particularly physician owners in private facilities) may desire to cut costs by minimizing patient follow-up visits, a practice not supported by audiologists.

Fast forward to 2010: The Academy Government Relations Committee was recently made aware of action in North Carolina (NC) in which the state’s Hearing Aid Dealers and Fitters Board discussed whether to accept cochlear implants as falling under the regulation of that board. This discussion was reportedly centered on whether audiologists working only with cochlear implants (and not hearing instruments) would need to be licensed by this board (NC is a dual license state). If this occurs, it is feasible that this action may open the door for HIDs to fit and MAP cochlear implants. (See the Academy’s Cochlear Implant Public Policy Resolution 2010 on the next page).

It is unlikely that this will be an isolated issue. There have been numerous instances over the years of HIDs attempting to expand their scope of practice to include audiological services. While these attempts have typically not found traction in state legislatures, they underscore an apparent perception on the part of HIDs that they are capable (or at least desire) to perform the duties of an audiologist. It would seem probable that this perception arises from two incorrect assumptions: (1) Dispensers perceive audiologists as providing the same services (hearing instrument dispensing) and in the same way. This is a perception that, unfortunately, has merit some of the time. My own observations are that many of our colleagues do not utilize verification tools or outcome measures, and do not perform audiological evaluations that are truly diagnostic in nature, and (2) that HIDs are qualified to perform procedures currently protected by the audiologist scope of practice.

If these threats to audiologists’ scope of practice are to be neutralized, audiologists must prepare in the short-term to defend individual threats, and in the long term, to create a more accurate perception of
ACADEMY PUBLIC POLICY RESOLUTION: COCHLEAR IMPLANTS (September 2010)

Whereas, audiologists, by virtue of academic degree, license to practice, and clinical training are uniquely qualified to identify audiologic candidacy requirements for adult and pediatric patients considering cochlear implantation, and

Whereas, audiologists possess comprehensive knowledge of the peripheral auditory system, as well as the neuroanatomy and physiology of the auditory nerve, allowing them to administer and interpret evoked physiological responses of the auditory nerve, and within the cochlea, to establish cochlear implant device parameters, and

Whereas, audiologists are specially trained to provide programming (MAPping) of the speech processor utilizing objective and behavioral methods, and

Whereas, “audiology professionals” are specified on the manufacturer’s FDA-approved package inserts for the cochlear implant as trained members of the cochlear implant team working in conjunction with the cochlear implant surgeon, and

Whereas, audiologists are singularly qualified to validate the cochlear implant MAPing and measure maximization of device function, and accurately fine tune the processor to best meet the patients rehabilitative needs, and

Whereas, audiologists have extensive academic training in the psychosocial aspects of prelingual and post-lingual deafness, cultural, and ethical issues surrounding cochlear implantation, and

Whereas, audiologists provide support and counseling for patients and their families considering cochlear implantation by offering unbiased information about the device, alternative amplification devices, and expected outcomes with all available options, and

Whereas audiologists possess academic and clinical expertise in evaluating speech perception and auditory skill development in pediatric and adult populations with severe to profound hearing loss, and

Whereas, audiologists can provide the necessary audiologic rehabilitation and auditory training for individuals who have received cochlear implants to maximize their success with the device, and

Whereas, audiologists understand the potential impact of classroom acoustics on the ability of children with cochlear implants to function in the educational environment, and can provide assessment and recommendations to improve use of the cochlear implant in this setting, and

Whereas, audiologists in all practice settings recognize that cochlear implant MAPping should take place only after consultation with a member of the cochlear implant team, principally the “implant audiologist” to make certain that appropriate continuity of care is attained, and

Whereas, all audiologists providing cochlear implant services work collaboratively with other members of the cochlear implant team including the cochlear implant surgeon, speech language pathologists, psychologists, counselors, and educators to ensure optimal use of the cochlear implant.

RESOLVED, that the American Academy of Audiology maintains audiologists are the only licensed professionals who should be permitted to evaluate, recommend, program, verify, and validate cochlear implants in patients of all ages, and

RESOLVED, that the American Academy of Audiology will work with other interested partners who serve the needs of patients seeking cochlear implant services to ensure they receive the appropriate assessment and treatment required to ensure their success with this device.

References:


may serve as a starting point for state leaders to review, edit, expand, and ultimately develop a sound strategy that audiologists in any state may use.

1. Hearing instruments and cochlear implants are simply not similar devices. Cochlear implants are surgically implanted, produce electrical stimulation, use completely different processing strategies, and fit together completely differently. These differences create a situation in which dozens or hundreds of HIDs would be inadequately prepared to work with these devices should state regulations be updated to include cochlear implants under their scope of practice.

2. The FDA classifies cochlear implants differently. They are surgically implanted devices, requiring that the practitioner providing follow-up care (fitting, MAPping) have sufficient training and education to recognize problems that may arise. This is also an issue where existing HIDs would be ill-prepared.

3. FDA candidacy requirements are different for each device with specific guidelines. The patient populations have little overlap, and there are many medical considerations involved with assessing candidacy for a cochlear implant. Again, HIDs are not prepared to make the necessary assessments.

4. The argument in NC was that audiologists working with cochlear implants should be regulated by the board. No direct link was made to HIDs performing this duty (although it may be implied). Assuming (as is usually the case) that the board regulating hearing instrument dispensing in your state is primarily comprised of hearing instrument dispensers, those who would be overseeing clinical activities relating to cochlear implants do not have the background (as stated earlier) to understand these practices.

5. Keeping this activity under existing audiologist regulation actually increases consumer protection.

There is also the reality of the issue. Elected officials and government employees associated with state board are not ignorant of the issue that hearing instruments and cochlear implants are very different devices. A simple statement of this fact may be sufficient to ground any discussion to the contrary. As always, the most important thing is to remain diligent, use common sense, and be proactive in communication with involved parties.

The opinions in this article are those of the author, and do not necessarily reflect those of the American Academy of Audiology.

As of January 1, 2010, Arkansas audiologists started a new chapter in hearing aid funding for their patients. It all began in 2009 when Arkansas Representative Pam Adcock (D) proposed a bill to mandate coverage of hearing aids in Arkansas. It is now known as Act 1179 since its acceptance in November 18, 2009.

Representative Adcock introduced this bill not only as an Arkansas State Representative of District 35, but also as a parent of a child with hearing loss. From the committee meeting to the finalization of the bill, professionals, parents, and individuals affected by hearing loss joined the efforts to support Rep. Adcock. It was a tremendous undertaking, as this bill proposed not only hearing aid coverage for children, but also for adults. Arkansas Medicaid, Tefra, and ARKids already supported children with hearing loss by providing hearing aids and FM systems to those enrolled in those plans. However, adults and children with private insurance in need of the same services had no options other than to pay out of pocket for hearing aids and/or FM systems.

Act 1179 provides a “mandatory offering,” this act has created extra procedural steps for the audiologist and/or office staff to ensure each patient’s insurance coverage will indeed pay for his or her hearing aids.

Act 1179 provides a “minimum amount of coverage that must be offered that cannot be less than $1,400 per ear for each three-year period.” The benefit cannot be subject to any deductibles or co-payment requirements, but the benefit may be subject to co-insurance provisions. The hearing aid must be dispensed by an individual properly licensed by the State of Arkansas, which allows for audiologists and hearing instrument specialists to dispense under Act 1179.

As Act 1179’s inaugural year comes to an end, it will be interesting to see how it has benefited the State of Arkansas. It is hoped that audiologists and consumers of Act 1179 will give feedback to better utilize this resource in years to come.
Wyoming Uses Different Approach to Obtain Single Licensure

By Carole Martin, AuD

Although it has been awhile, it may be of interest to state leaders that audiologists in Wyoming used a different approach to eliminate dual licensure that might still be useful. Effective 2002, the Wyoming Board of Speech Pathology and Audiology ended years of dual licensure for audiologists through the written opinion of the Wyoming Attorney General’s (AG) office. In the AG opinion, the conclusion was that “Wyoming licensed audiologists possess skills and abilities that surpass those required to obtain a license under the hearing aid dispensing license found in the hearing aid practice act.”

In Wyoming, each professional licensing board has two attorneys from the AG’s staff assigned to each board. One attorney serves in an advisory capacity in order to ensure compliance with Wyoming laws and regulations, and regularly meets with the board. The second attorney, if needed, would serve as the board representative if action were taken against a licensee.

The board had attempted other strategies to eliminate dual licensing, but without success. The first attempt had been to actually change the law through the legislative process and then through a possible merger with the Wyoming Board of Hearing Aid Specialists. Both of these strategies were unsuccessful, primarily due to opposition from within the professions.

Later, board members raised the issue of dual licensure with their advisory AG attorney representative. The board was asked to put together information regarding the licensure issue, as well as what issues the board wanted the AG’s office to review. The board gathered information regarding licensure status for individual states, especially those in the Rocky Mountain region from the American Academy of Audiology. They also obtained copies of graduate curricula for audiologists at universities in the region, along with a brief written history of audiology licensure and hearing aid dispensing licensure status. This was submitted to the AG’s office along with a written request to determine if Wyoming Speech Pathologists’ and Audiologists’ Practice Act, Wyo. Stat. 33-33-101 et seq, authorizes an audiologist, licensed in Wyoming, to “dispense hearing aids without first obtaining a separate dispensing license from the Wyoming Board of Hearing Aid Specialists.”

On November 28, 2001, the AG’s office issued its opinion that eliminated the need for dual licensure. They recognized that there were conflicts between the laws empowering both boards, but that did not negate the extensive training and experience of audiologists. The Wyoming Board of Speech Pathology and Audiology then notified Wyoming audiologists that single licensure was now the law.

How’s Your Hearing? Ask an Audiologist! Use this Slogan in Ad Campaigns

Planning an advertising campaign for your state audiology organization and wondering what will catch the attention of consumers in your state? The Academy’s service mark “How’s Your Hearing? Ask an Audiologist!” is available to state audiology organizations for use in advertising campaigns.

Permission for use of the service mark for a period of one year will be granted for a fee of $100, and all materials to be used in the advertising campaign must be reviewed and approved prior to use. Contact Joyanna Wilson, senior publications manager, at jwilson@audiology.org or 703-226-1031, to request permission or for more information.

11th Annual State Leaders Workshop and Luncheon

Plan to attend this event on April 6, in Chicago, IL, at AudiologyNOW! 2011. For reservations, contact Ed Sullivan at esullivan@audiology.org.

Science Fair Recruitment Opportunity for State Audiology Organizations

Looking for a way to find the audiologists of tomorrow? Attend your state science fair! State audiology organizations can now apply for a stipend to fund science fair awards for local secondary school students. Applications will be accepted on a rolling basis through March 15, 2011. Visit www.audiology.org and search key words “science fairs.”
State Audiology Organizations Listing

Alabama
Alabama Academy of Audiology
http://alabamaaudiology.org

Arkansas
Arkansas Academy of Audiology
www.araudiology.org

California
California Academy of Audiology
www.caaud.org

Colorado
Colorado Academy of Audiology
www.coloradoaudiology.org

Connecticut
Connecticut Academy of Audiology
www.ctaud.org

Florida
Florida Academy of Audiology
www.floridaaudiology.org

Georgia
Georgia Academy of Audiology
www.georgiaaudiology.org

Illinois
Illinois Academy of Audiology
www.ilaudiology.org

Kentucky
Kentucky Academy of Audiology
www.kyaudiology.org

Maine
Maine Academy of Audiology
www.maineaudiology.org

Maryland
Maryland Academy of Audiology
www.maaudiology.org

Massachusetts
Massachusetts Academy of Audiology
www.audiology-mass.org

Michigan
Michigan Academy of Audiology
www.mi-hearing.org

Minnesota
Minnesota Academy of Audiology
www.minnesotaudiology.org

Missouri
Missouri Academy of Audiology
www.maaudiology.org

Nevada
Audiology Association of Nevada

New Hampshire
New Hampshire Academy of Audiology
www.newhampshireaudiology.org

New Jersey
New Jersey Academy of Audiology

New York
New York Association of Audiology

North Carolina
North Carolina Academy of Audiology

North Dakota
North Dakota Academy of Audiology

Ohio
Ohio Academy of Audiology
www.ohio-academy-of-audiology.org

Oregon
Oregon Academy of Audiology
www.oregonaudiology.org

Pennsylvania
Pennsylvania Academy of Audiology
www.paaudiology.org

Puerto Rico
Puerto Rico Academy of Audiology

Rhode Island
Rhode Island Academy of Audiology

South Carolina
South Carolina Academy of Audiology
www.scaa.net

South Dakota
South Dakota Academy of Audiology

Tennessee
Tennessee Academy of Audiology
www.taaslp.org/taa

Texas
Texas Academy of Audiology
www.texasaudiology.org

Virginia
SHAV (an independent professional organization representing audiology in Virginia)
www.shav.org

Washington
Washington State Academy of Audiology
www.washingtonaudiology.org

Lending a Helping Hand

Recognizing the value of the State Leader Network and the opportunity to take advantage of a “ready resource,” the board of the American Academy of Audiology has assigned an additional charge to the State Network Committee as follows:

Be a resource for Academy committees to coordinate and disseminate information to the State Leader Network in support of Academy initiatives such as advocacy, audiology awareness, etc.

Using the State Leaders Network to promote audiology is not exactly new. Adding the charge makes it official and informs other committees of the availability of this resource.

Seeking State Leader Updates!

The State Leaders Network is always seeking updates to the network. If your state association(s) has changed leadership, please be sure to notify us.

Please forward any updates to Ed Sullivan, at esullivan@audiology.org, Kevin Willmann, at kwillmann@audiology.org, or new chair Marcia Raggio, at mraggio@ohns.ucsf.edu.