U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Report to Congress
Direct Access to Licensed Audiologist
Under the Fee for Service Medicare Program Medicare Funding of Second Year

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Introduction


“The conferees request from CMS a determination as to the current legal authority to permit direct access to licensed audiologists under similar terms and conditions used by the Department of Veterans Affairs and the Office of Personnel Management. A report shall be submitted to the House and Senate Appropriations Committees by April 2006.”

BACKGROUND

Current Medicare Policy

Current Medicare policy regarding access to audiologists is based on the treatment of diagnostic tests in the Social Security Act (the Act), regulations and instructions to Medicare contractors. The statutory authority to pay for diagnostic tests for Medicare beneficiaries is found in section 1861(s)(3) of the Act. The statute specifies a benefit for diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests. Audiology tests are considered as other diagnostic tests. The regulations governing these diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests, at 42 CFR 410.32, specify that all diagnostic tests must be ordered by a treating physician, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and uses the results in the management of the beneficiary’s specific medical problem. The regulation specifies further that tests not ordered by the physician who is treating the beneficiary are not considered reasonable and necessary under 42 CFR 411.15(k)(1). These regulatory requirements are based on the statutory prohibition in section 1862(a)(1)(A) against payment for items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The Medicare statute authorizes coverage of services furnished by certain nonphysician practitioners (such as physician assistants, nurse practitioners, and clinical nurse specialists) that would be physicians’ services if furnished by a physician when the nonphysician practitioner is operating within the scope of authority under State law. Thus, diagnostic audiology tests ordered by these nonphysician practitioners are covered under the same conditions as they would be if ordered by a physician treating a beneficiary.

Diagnostic testing (including hearing and balance assessment services) furnished by a qualified audiologist is covered when a physician or nonphysician practitioner orders such testing for the purpose of obtaining additional information necessary for his/her diagnosis and evaluation of the need for or the appropriate type of medical or surgical treatment of a hearing deficit or other medical problem.
Medicare manuals\(^1\) state that if a physician or nonphysician practitioner refers a beneficiary to an audiologist for evaluation of signs or symptoms associated with hearing loss or ear injury, the audiologist’s diagnostic services are covered even if the only outcome is the prescription of a hearing aid. Audiology services are not covered when the diagnostic services are furnished only to determine the need for or the appropriate type of hearing aid because section 1862(a)(7) of the Act specifically excludes coverage of hearing aids and associated examinations.

If a beneficiary undergoes diagnostic testing furnished by an audiologist without a physician or nonphysician practitioner order, the tests are not covered even if the audiologist discovers a pathologic condition.

**Current Department of Veterans Affairs Policy**

The Veterans Health Administration (VHA) has allowed direct access to audiologists without a referral from a physician since 1992. This policy was adopted by means of Veterans Health Administration Directive 10-92-009 dated January 17, 1992. Under this policy, an ear, nose, and throat examination is not routinely required before an audiological assessment but, instead, only when medical management is necessary. Veterans who are experiencing hearing problems can make appointments directly with an audiologist, who is generally a staff member of the VHA. Patients who see an audiologist without a physician’s order are referred by the audiologist to a physician for medical management when referral is clinically indicated. Unlike the Medicare program, hearing aids are covered for certain veterans under the benefit structure for the VHA. This is a distinct difference between benefits available to hearing aids through the VHA and benefits under the Medicare program, which is prohibited by law from providing payment for hearing aids or related examinations.

**Office of Personnel Management (OPM) Policy**

We reviewed all of the 2005 Federal Employees Health Benefit (FEHB) plans approved by the OPM and offered by carriers. Plans can choose to allow direct access to audiologists and include this as a part of their benefit package. OPM would review this choice as part of its usual review of the entire package a plan is proposing to offer.

Approximately 60 percent or 96 of the 161 plans allowed direct access to licensed, certified, or registered audiologists. Direct access was permitted in three circumstances:

- for the diagnosis of a hearing problem,
- for services related to an accident/injury/surgery, or
- for limited screenings of adults.

\(^1\) Chapter 15, Section 80.3 (Otologic Evaluations) of Publication 100-02 (Medicare Benefit Policy Manual) of the Internet Only Manual.
The remaining FEHB plans require a physician to make a referral to an audiologist. The audiology services covered under the FEHB plans are typically the same regardless of whether the service is furnished via direct access or via physician referral. Generally, hearing aids and the testing and examinations for them are not covered by the plans. However, some plans cover these items and services when they are medically necessary as a result of an accident, injury, or surgery.

Discussion

Medicare requires a referral from a physician or certain nonphysician practitioners (e.g., physician assistants, nurse practitioners, and clinical nurse specialists) in order for a beneficiary to see a licensed audiologist for covered Medicare services. The VHA does not require a referral for veterans, and FEHB plans each establish their own policies regarding the need for a physician referral. Medicare’s referral requirements are set forth in regulation, not in statute, and are the same for all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests including those commonly furnished by audiologists.

Except for screening tests that are explicitly covered under Title XVIII, Medicare does not cover screening tests. Diagnostic tests are not considered reasonable and necessary unless they are ordered by the patient’s physician or nonphysician practitioner who will employ the tests to diagnose and treat the patient’s symptoms and conditions, in which case they are not considered screening tests. Denials of claims are based on the exclusion in section 1862(a)(1)(A) of the Act, contained in regulations at section 411.15(k)(1) -- that is, the services are not “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” The physician (or authorized nonphysician practitioner) referral requirement is a condition of coverage and payment for diagnostic tests under the Medicare program. The physician or nonphysician practitioner ordering diagnostic tests uses the results of such tests to treat and manage the beneficiary’s specific medical problem(s). The physician or practitioner referral policy is a key means by which the Medicare program assures that beneficiaries are receiving medically necessary services, and avoids potential payment for asymptomatic screening tests that are not covered by Medicare (as opposed to necessary services for the diagnosis of the individual’s medical symptoms and conditions).

Conclusion

It is difficult to draw conclusions about the legal authority for Medicare to permit direct access to licensed audiologists under similar terms and conditions used by the Department of Veterans Affairs and the Office of Personnel Management. The three programs are distinctly different. The VA employs its own licensed audiologists, and does not make payments for individual items and services furnished by those audiologists. The OPM oversees federal employee health benefits. Under that program, individual health plans have certain flexibility in designing the benefit package which leads to varying premiums among the plans. In contrast, the fee-for-service Medicare benefit package is set and health care providers are paid on a per service basis.
Assessing the scope of CMS’s legal authority, if any, to permit direct access to licensed audiologists in the fee-for-service Medicare program involves considering the interaction between several aspects of the statute and regulations, and Medicare program construction. Not only must one consider the statutory language itself, including the exclusion of coverage of hearing aids and associated examinations contained in section 1862(a)(7), but also whether a particular policy could impact the ability to implement other statutory requirements or require broad, or undesirable changes in long-standing policies. Finally, one must also consider budget implications of particular policies.

For example, if one were to take the view that sufficient legal authority exists under the Medicare program to permit direct access to licensed audiologists, any exercise of authority pursuant to this statutory interpretation could be at odds with the statutory requirement prohibiting Medicare payment for screening tests (except for those that are authorized by statute). Indeed, Medicare has used the ordering requirement for diagnostic tests as the principal means to ensure that Medicare does not pay for medically unnecessary screening tests in contravention of the statute and regulations.

We are not aware of a reasonable alternative mechanism to assure that Medicare avoids payment for screening tests not allowed by the statute. Moreover, even if such an alternative mechanism were feasible with respect to services furnished by audiologists, we are not aware of any adequate rationale for distinguishing audiology services from other diagnostic tests. Clearly, broad removal of the ordering requirement for diagnostic tests as a whole would make it even more difficult to adhere to the statutory command not to pay for medically unnecessary tests and screening tests not authorized by statute. In addition, there would be significant budgetary consequences flowing from revision of the requirement.

In short, the assertion by CMS of any potential legal authority to permit direct access to licensed audiologists could have significant adverse legal, regulatory, and budgetary consequences. Therefore, under the governing statutes, we cannot say that CMS has clear and unqualified legal authority to allow Medicare beneficiaries direct access to audiologists.