AMERICAN ACADEMY OF AUDIOLOGY

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September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1676-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018

Dear Administrator Verma,

The American Academy of Audiology (the "Academy") is the world's largest professional organization of, by, and for audiologists, representing over 12,000 members. The Academy promotes quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness, and support of research. The Academy appreciates the opportunity to offer comments in response to the Centers for Medicare and Medicaid Services (CMS) Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for the CY 2018 proposed rule (CMS-1676-P) as published in the Federal Register on July 21, 2017. Those comments are below.

Methodology for Determining Indirect Practice Expense (PE) for Low-Volume Services

The Academy is pleased that CMS has accepted the longstanding recommendation of the American Medical Association's Relative Value Scale Update (RUC) to utilize the anticipated or "expected" specialty for low-volume services (fewer than 100 allowed services in the Medicare claims data). We agree that the use of service-level overrides for low and no volume services will help mitigate annual fluctuations and provide greater stability in the valuation of these services. We support CMS' proposal to use the expected specialty as identified on a list rather than basing the specialty mix on utilization data for codes that fall under this category. The Academy supports CMS' proposal to use the list that was developed based on the Agency's medical review of the list most recently recommended by the RUC. The Academy provided input to the RUC regarding audiology-related services that appear on the list. Those specific recommendations will be brought forth by the RUC in their proposed rule comments. We also agree with CMS' proposal to review and/or change this list on an annual basis.

Methodology for Determining Malpractice Relative Value Units (MRVUs): Premium Crosswalks

The Academy supports CMS' proposal to crosswalk non-physician specialties, including audiologists, to the lowest MD risk factor specialty for which their contractor collects premium rates-Allergy/Immunology. The Academy believes that a direct crosswalk to Allergy/Immunology is a reasonable proposal.

Proposed Valuation of Specific Codes

In recent years, CMS has proposed many refinements to the values for individual services recommended by the RUC. For example, for CY 2016 CMS proposed a lower value for the caloric vestibular codes (CPT codes 92537, 92538) than what was recommended by the RUC, despite the fact that RUC's valuation recommendations were based on a rigorous, detailed, and systematic review process. CMS instead used a direct crosswalk to assign value, citing a rationale that the Academy believes was inherently flawed.

The Academy is encouraged to see that for CY 2018, CMS has proposed valuation for individual services based almost entirely on recommendations of the RUC. Instead of proposing alternative values, CMS has published questions and/or observations related to their review of the RUC recommendations that allow specialty societies to provide feedback directly to CMS to address these questions. The Academy strongly supports this approach as it appears to foster a more transparent and collaborative approach to valuation that recognizes the rigorous process utilized by the RUC in the valuation of services. This approach also provides specialty societies with an opportunity to provide clarification on the rationale and evidence-based decision-making behind the valuation for specific services.

MACRA Patient Relationship Categories and Codes

The Academy has reviewed CMS' proposed policy with regard to the voluntary reporting of projected MACRA patient relationship codes/HCPCS modifiers for eligible clinicians in CY 2018. The Academy supports CMS' attempt to ease provider burdens related to the adoption of new policies and allow providers the opportunity to gain familiarity with the system without penalty. We would also appreciate efforts by CMS to educate providers on the proper use of such codes/modifiers.

Audiologists will not be considered eligible clinicians in the Quality Payment Program (QPP) until CY 2019 at the earliest. Those considered eligible clinicians since CY 2017 will have had the benefit of two years of flexible onboarding to adapt to the QPP. The Academy urges CMS to consider the position of providers ineligible to participate in the QPP until CY 2019. We ask the Agency to consider extending the same opportunities for flexibility, education, and voluntarily applying the modifiers without penalty to those providers. We also look to CMS to provide clarification in order to ensure that providers, including audiologists, apply the modifiers accurately and consistently.

Request for Information on CMS Flexibilities and Efficiencies

The Academy appreciates CMS' efforts to solicit feedback on how to reduce burdens for providers and patients, while also seeking ways to improve quality of care and decrease costs within the health-care

system. The Academy looks forward to working with the Agency to enhance flexibility for both patients and providers within the Medicare program. In response to CMS' RFI, the Academy has identified potential opportunities to increase flexibility, reduce burdens, and improve quality and cost-effectiveness of care. Those opportunities are outlined below.

Improving Efficiency and Decreasing Cost Related to Dizzy Patients

As CMS seeks to identify areas of quality improvement and cost savings, the Academy urges the Agency to consider the current trends for the diagnosis and management of dizzy patients. Vestibular testing is an objective and sensitive battery of tests using voluntary and involuntary eye movements (known as nystagmus) to assess the peripheral and central vestibular systems. Most information obtained through vestibular testing cannot be obtained by other means. Additionally, diagnosing a benign vestibular disorder often safely rules out a worrisome stroke or brain lesion. Due to highly problematic changes in payment policies related to vestibular testing (e.g. reductions in payment for important vestibular services) we have seen a marked decrease in patient access to and utilization of vestibular testing since 2008. At the same time, we have seen an increased use of neuro-imaging in the assessment of dizzy patients. For example, cranial CT scans were ordered on 39 percent of dizzy patients in 2011.

The Academy believes decreased access to vestibular testing has led to an increased use of neuro-imaging with more patients visiting the emergency room (ER) for complaints of dizziness. With the increased use of neuro-imaging, the estimated costs for ER services are estimated at $4 billion per year as of 2011. A 2013 research report released by the Johns Hopkins University School of Medicine examined two large, national public databases to gain a better understanding of emergency room visits for extreme dizziness. In the Johns Hopkins report, researchers found that a large percentage of patients who visit the emergency department with dizziness are suffering from a benign inner-ear disorder, while just 5 percent of those whose major complaint is dizziness are having a stroke. Despite this, nearly half of the patients that come to the emergency department still receive CT scans.[1] For Benign Paroxysmal Positional Vertigo (BPPV), the most common cause of vertigo, studies show that 85 percent of patients saw symptoms resolved in the same day they receive the correct diagnosis by a trained specialist. Unnecessary testing can delay identifying the proper diagnosis and increase health-care costs.

It is estimated that with policy changes and education, these services could be reduced by $1 billion per year. The Academy strongly encourages CMS to consider the diagnostic testing of dizzy patients as they look to improve efficiency within the Medicare program. Improving access to vestibular services helps to save on the use of expensive neuro-imaging and plays an important role in preventing falls among the Medicare population. The Academy would be happy to provide in depth resources and supporting data to assist CMS in these efforts.

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1 http://www.hopkinsmedicine.org/news/media/releases/johns_hopkins_study_cost_of_treating_dizziness_in_the_emergency_room_soars

Role of Audiologists in Care Coordination

The Academy recognizes CMS' continued efforts to focus on collaboration with primary care, specialists, and other providers for patients with multiple chronic conditions, mental and behavioral health issues, cognitive impairment, and mobility-related disabilities. As referenced in the section above, care coordination among audiologists and other types of providers including primary care providers, otolaryngologists, cardiologists, and emergency departments can help to improve the quality and efficiency of care currently received by patients reporting dizziness and other hearing and balance disorders. The Academy also believes that improved coordination of care will also result in a reduction in overall costs to the health-care system. We believe this approach reflects the high-quality, cost-effective health-care goals set forth by the Agency.

As we see the continued development and increased focus on care management, the Academy urges CMS to consider the important role and involvement of non-physician providers, including audiologists, in providing care for Medicare patients. Audiologists regularly collaborate with primary care providers and other specialties to provide efficient, high-quality care to Medicare beneficiaries, yet there are a number of barriers that exist for both patients and providers in accessing this important care. Audiologists and other non-physician providers are engaging in care coordination and providing comprehensive patient care and are unable to be paid for such services, especially as they do not have access to Evaluation and Management (E/M) codes. We believe that audiologists play a critical role in providing high-quality, cost-effective care for patients and look to CMS to appropriately recognize audiologists for this care. We believe that reimbursement algorithms should be on a level playing field for all credentialed providers and that audiologists should be paid for the intensity and complexity of their services (global patient care including engaging with the patient, other health-care providers, and family members), not just for administering and interpreting the diagnostic exam. Again, we encourage CMS to consider the inclusion of other health specialties as the Agency expands coding and payment changes related to care coordination and management, especially with regard to expanding access to E/M codes.

Expanding Medicare Telehealth Services

The Academy requests that CMS consider opportunities to expand the list of eligible providers and related covered services. There a number of legislative proposals before Congress to make statutory changes to expand the list of eligible providers of Medicare telehealth services. These proposals specifically include audiologists among the list of eligible providers. The Academy believes audiologists are appropriate providers of telehealth services and urges Congress and CMS to work together to make the statutory and regulatory changes required to expand reimbursement to improve patient access to care. Broadening the list of eligible providers of telehealth services to include audiologists will allow for audiology services to be available in rural and shortage areas. Allowing greater access to telehealth services also benefits patients who are not able to travel to a professional, which includes many elderly Medicare beneficiaries seeking the services of an audiologist. The U.S. Department of Veterans Affairs (VA) has already implemented a number of successful programs related to the provision of audiology services via telehealth. These programs can serve as a model in expanding telehealth services under the Medicare program.

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The Academy appreciates the opportunity to comment on this proposed rule. Please contact Kate Thomas, senior director of advocacy and reimbursement, by phone 703-226-1029 or via email at kthomas@audiology.org should you have any questions regarding the Academy's comment letter.

Sincerely,

Ian Windmill, PhD
President, American Academy of Audiology