AMERICAN ACADEMY OF AUDIOLOGY

September 14, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via www.regulations.gov (Docket No. CMS-2026-2377)

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1848-P)

Dear Dr. Oz:

The American Academy of Audiology (the Academy), the largest professional organization of audiologists dedicated to providing quality hearing and balance care, respectfully submits the following comments on the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule. Our members deliver essential diagnostic and rehabilitative services, often in small, independent, or hospital-based clinics that depend on Medicare Part B payment for diagnostic hearing and vestibular services.

The Academy is deeply concerned with the cumulative impact of the conversion factor reduction, the proposed practice expense (PE) methodology overhaul, the continued efficiency adjustment, and CMS's downward revision of a key new vestibular testing code. Taken together, they would produce an estimated 3 percent overall reduction in Medicare reimbursement for audiology services in CY 2027.[1] This cut falls hardest on the small and independent practices that make up a significant portion of the audiology delivery system.

There are several provisions in the proposed rule impacting practicing audiologists and Medicare beneficiaries. In this letter, we offer comments on the following provisions:

Medicare Physician Fee Schedule
- CY 2027 Proposed Medicare Physician Conversion Factor
- Efficiency Adjustment
- Proposed Valuation of select Vestibular Services
  - vHIT - 92XX5, 92XX6; and
  - Rotational Chair - 92X10 and 92X11

[1] American Academy of Audiology, "CMS Releases Calendar Year 2027 Proposed Medicare Physician Fee Schedule (MPFS) and Hospital Outpatient Prospective Payment System (OPPS)," https://www.audiology.org/cms-releases-calendar-year-2027-proposed-medicare-physician-fee-schedule-mpfs-and-hospital-outpatient-prospective-payment-system-opps/

- Practice Expense (PE) Methodology Reform
- Requests for Information
    - Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability
    - Redesigning Primary Care to Make America Healthy Again
    - Current Procedural Terminology (CPT) and the RUC
    - Software as a Medical Service (SaMS)

Quality Payment Program
- Merit-based Incentive Payment System (MIPS)
- MIPS Promoting Interoperability Category
- Transition from traditional MIPS to an MVP

As set forth in detail below, the Academy respectfully urges CMS to correct a practice expense methodology that structurally disadvantages audiology's largely non-clinical-labor diagnostic services, to restore the RUC-recommended work RVU for the new velocity-step-testing add-on code, and to give due weight to the Academy's perspective on the rule's broad Request for Information (RFI) on the CPT and RUC processes. The Academy's specific comments and recommendations follow.

Conversion Factor

CMS proposes two CY 2027 conversion factors (CFs): $33.1693 for clinicians who are Qualifying Participants (QPs) in an Advanced Alternative Payment Model, representing a decrease of 1.19 percent from the CY 2026 CF of $33.5675; and $32.8409 for non-QP clinicians, representing a decrease of 1.68 percent from $33.4009[2]. The audiology workforce is overwhelmingly non-QP, meaning nearly all Academy members would absorb the larger, 1.68 percent cut. This decline is driven not by the modest positive MACRA statutory updates (+0.75 percent QP / +0.25 percent non-QP) or the +0.53 percent budget-neutrality adjustment, but by the scheduled expiration of the one-year, +2.50 percent “Working Families Tax Cut” payment bump enacted for CY 2026 only[3]. As a direct result, audiology practices now confront a real-dollar cliff in CY 2027.

The Academy respectfully urges CMS to work with Congress to secure a permanent, adequate, and inflation-indexed physician fee schedule update rather than continuing to rely on episodic legislative patches. In the absence of any statutory relief, the Academy respectfully requests that CMS exercise all available administrative discretion to mitigate the year-over-year swing and to explicitly acknowledge, in the final rule, the disproportionate effect that conversion factor volatility has on small, diagnostic-testing-dependent practices with thin margins and no facility-fee cushion.

Efficiency Adjustment

The Academy strongly opposes CMS’s continued application of the 2.5 percent efficiency adjustment to non-time-based services. Audiology services are inherently resource intensive, relying on specialized diagnostic equipment, precisely calibrated testing environments, sophisticated and evolving software, and significant hands-on professional expertise to perform, analyze, interpret, and document complex physiologic assessments. There is no reasonable basis to presume that these services become less time- or resource-intensive simply because they are classified as non-time-based. Applying a uniform efficiency adjustment therefore substitutes a generalized assumption for the actual resources required to furnish care and risks systematically undervaluing audiology services.

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[2]CMS, "Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule" Fact Sheet, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-proposed-rule

[3]CMS, "Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule" Fact Sheet, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-proposed-rule

The Academy urges CMS to eliminate the efficiency adjustment for non-time-based services unless, and until, the agency can demonstrate, through specialty- and service-specific data, that measurable efficiencies have actually occurred. Any adjustment should be grounded in empirical evidence reflecting real-world changes in the time, technology, staffing, and resources required to furnish audiology services, rather than applied uniformly across disparate services and specialties.

Work RVUs for Video Head Impulse Testing (vHIT) and Rotational Chair

The Academy supports CMS's proposal to delete CPT code 92546 (sinusoidal vertical axis rotational/rotary chair testing) and replace it with a more precise coding structure consisting of a base sinusoidal harmonic acceleration (SHA) rotational chair service (92XX5) and a velocity-step-testing (VST) add-on service (92XX6). The Academy also strongly supports establishment of the first dedicated CPT codes for video head impulse testing (vHIT): 92X10 for assessment of lateral canal function and 92X11 for assessment of lateral and vertical canal function. These codes represent the culmination of a multi-year clinical, coding, and valuation effort led by the Academy in collaboration with ASHA, AAN, and other participating specialty societies and their CPT and RUC advisors. Together, these changes modernize the vestibular coding framework, replace reliance on less precise or unlisted-service reporting, and provide code-specific mechanisms that more accurately reflect contemporary vestibular diagnostic practice.

CMS proposes to accept the AMA/Specialty Society RVS Update Committee (RUC) recommended work RVUs for three of the four new codes: 0.92 for the SHA base service, 0.53 for vHIT assessing lateral canal function, and 0.84 for vHIT assessing lateral and vertical canal function. The Academy strongly supports CMS's acceptance of these recommendations. For the velocity-step-testing add-on code, however, CMS proposes a work RVU of 0.35, substantially below the RUC-recommended value of 0.48. The Academy respectfully disagrees with CMS's cited concern that the RUC recommendation results in intensity that is "significantly higher" than the base SHA service. The RUC-recommended value of 0.48 for CPT code 92XX6 is the product of a rigorous specialty survey and multi-specialty review process and appropriately reflects the incremental work associated with velocity-step testing. CMS's analysis places disproportionate emphasis on total time and does not sufficiently recognize the greater intensity, complexity, and concentration of intra-service work required for the add-on service. Although SHA and VST are both components of rotational chair assessment, VST requires additional testing, active analysis and interpretation of velocity-step responses, integration of those findings with the base rotational chair evaluation, and additional reporting. Work RVUs are intended to reflect not only time, but also the intensity, technical skill, mental effort and judgment, and stress associated with furnishing a service. A simple proportional comparison of minutes between the base and add-on codes therefore does not provide an appropriate basis for reducing the RUC-recommended value.

Moreover, the base code includes substantial preservice and post service time that is not directly comparable to the concentrated intra-service work associated with the add-on service. The fact that the calculated intensity of the add-on service is higher than that of the base service does not, by itself, demonstrate that the RUC recommendation is inappropriate. Rather, it reflects the nature of an add-on service in which a comparatively short period of work may require substantial professional attention, interpretation, and clinical judgment. The RUC considered these distinctions through its established valuation process and recommended 0.48 after multi-specialty review. The Academy therefore strongly urges CMS to finalize the full RUC-recommended work RVU of 0.48 for CPT code 92XX6.

Reducing the work RVU also has implications beyond the work component of payment. Because vestibular diagnostic services are generally personally performed by the audiologist and have little or no separately billable clinical-labor component, a reduction in work RVUs may also flow through the practice expense methodology and reduce associated indirect PE allocation. The result could be a compounded payment reduction—first through the reduction in work RVUs and again through the resulting PE allocation—for a service whose resource requirements were

already evaluated through the RUC process. This interaction further underscores the importance of accurately valuing the professional work associated with CPT code 92XX6.

Finally, the Academy strongly supports CMS's proposal to accept the RUC-recommended direct PE inputs for all four new codes without refinement and urges CMS to finalize those inputs. These recommendations reflect the equipment, supplies, and other resources necessary to furnish contemporary vestibular testing and were developed through the established CPT/RUC process. The Academy also encourages CMS to evaluate appropriate opportunities for Medicare telehealth coverage of these services as remote vestibular assessment capabilities continue to evolve.

Practice Expense (PE) Methodology Changes

CMS proposes a major, multi-year overhaul of the indirect PE RVU methodology built around four interrelated changes: (a) calculating indirect PE using the sum of work RVUs and clinical labor RVUs rather than the current "greater of" approach, for all services except those with 010- or 090-day global periods; (b) phasing out the Indirect Practice Cost Index (IPCI) over two years (50 percent applied in 2027, fully eliminated in 2028); (c) introducing a new PE "stabilization adjustment", not anchored to a fixed historical reference point, intended to cap annual PE RVU swings at approximately 5 percent as it phases in; and (d) incorporating a new approach to payment modifiers and special payment rules in the PE calculation. CMS also proposes to continue relying on current PE/HR survey data and the 2006-based Medicare Economic Index (MEI) cost-share weights rather than transitioning to updated, 2019-based cost shares, and separately seeks comment on whether the facility/non-facility PE payment differential remains appropriate. Each of these four changes carries a distinct, and in the Academy's view underappreciated, risk for audiology.

a. Sum-of-RVUs Indirect PE Allocation Basis

A substantial share of core audiologic and vestibular diagnostic codes are furnished personally by the audiologist with little or no billed clinical labor time. This is not a matter of practice discretion; audiologic and vestibular diagnostic tests have their own Medicare benefit category under section 1861(s)(3) of the Social Security Act and are therefore excluded from "incident to" coverage under 42 C.F.R. § 410.26(a)(7), instead governed by the diagnostic-test supervision framework at 42 C.F.R. § 410.32. Under that framework, an audiologist may personally perform the technical component of a diagnostic test but is not permitted to supervise a technician performing that same technical component; only a physician may supervise the technical component of an audiology-related diagnostic test, and audiologists themselves are not recognized as billable auxiliary-personnel supervisors under the "incident to" rules on which other non-physician practitioners rely. As a direct, structural consequence of this supervision restriction — and not of any shortfall in practice overhead — the great majority of audiology CPT codes carry little to no billable clinical-labor RVU input. The audiologist must personally furnish virtually the entire service rather than delegating technical-component work to supervised auxiliary staff as done routinely in physician, physical therapy, and occupational therapy practices.

Because the new indirect PE formula uses a sum rather than a "greater of," codes with meaningful clinical-labor RVU inputs will draw a larger share of the finite, budget-neutral indirect PE pool, while codes that structurally carry zero or near-zero clinical-labor RVU — including the great majority of audiology codes — receive no offsetting increase. In relative terms, an effectively smaller share as the pool reallocates toward labor-intensive services elsewhere in the fee schedule. This occurs even though audiology practice overhead — sound-treated booths, calibrated audiometric and vestibular equipment, calibration and maintenance contracts, and specialized diagnostic software — is comparable to, or greater than, many labor-intensive specialties. In sum, the new allocation formula imports a supervision-authority restriction that is unrelated to

audiology's actual practice cost structure directly into audiology's PE valuation. The Academy submits that this outcome warrants correction before the rule is finalized.

Accordingly, the Academy respectfully urges CMS to:

- Hold audiology-type "personally performed, no-clinical-labor" diagnostic codes harmless from the redistributive effect of the sum-based formula until CMS completes and publishes a specialty-level and code-level impact analysis that separately identifies these codes;

- More fundamentally, evaluate, in coordination with Congress as needed, whether audiologists should be permitted to supervise qualified auxiliary personnel (for example, audiology assistants operating within their state scope of practice) for the technical component of audiologic and vestibular diagnostic testing, consistent with the supervision authority already extended to physicians for the same tasks. Modernizing this supervision framework would simultaneously improve access to care in underserved areas and produce future clinical-labor RVU inputs that reflect actual, permitted practice patterns rather than an artifact of a supervision structure that predates audiology's current scope of independent Medicare practice; and

- Retain reliance on validated AMA and specialty-society practice expense (PE) data, including code-level direct PE inputs for equipment, supplies, and clinical labor, rather than defaulting to allocation formulas that assume clinical-staff resources that audiologists are not permitted to separately bill. Audiology also participated in the CPCI survey process at its own expense, contributing specialty-specific data intended to capture contemporary practice costs, including indirect expenses. CMS should meaningfully incorporate these updated CPCI data into the PE methodology so that payments reflect the actual costs of furnishing audiology services rather than assumptions that do not align with audiology practice patterns.

b. Phase-out of the Indirect Practice Cost Index (IPCI)

The IPCI has functioned as one of the few remaining mechanisms tethering indirect PE allocation to actual specialty-level PE/HR survey data, however dated. Audiology is a small specialty with historically limited representation in the underlying PE/HR survey samples, and audiology practice costs are sometimes captured within broader "otolaryngology-allied" or generic outpatient categories rather than reported separately. Eliminating the IPCI over two years removes the one counterweight that has partially corrected for this small-sample volatility. The Academy respectfully requests that CMS decline to finalize full IPCI elimination for CY 2028 until it has published an audiology-specific PE/HR data-adequacy analysis, and that any interim (CY 2027, 50-percent) methodology explicitly disclose how services with statistically thin specialty-level data, such as audiology, are treated so that stakeholders may identify and comment on any resulting "double penalty" of thin data compounded by the formula transition itself.

c. New PE Stabilization Adjustment

A flat percentage cap on annual swings only slows, but does not correct, a decline driven by a flawed underlying allocation basis. Capping a mis-specified year-over-year change at roughly 5 percent still permits multi-year compounding losses for audiology if the sum-based indirect allocation basis systematically under-credits no-clinical-labor codes every year going forward, with no fixed historical anchor to prevent the cap from resetting each cycle against an already-eroded baseline. The Academy asks CMS to pair the stabilization adjustment with a permanent, not merely transitional, safeguard for codes whose PE RVU decline is attributable to the allocation-basis change itself rather than to

updated direct inputs, and to make public the stabilization adjustment's assumptions and code-level modeling for audiology-relevant codes specifically before finalizing CY 2027 or CY 2028 values.

d. New Approach to Payment Modifiers and Special Payment Rules

The proposed rule revises how payment modifiers and special payment rules are incorporated into the practice expense (PE) methodology. However, CMS has not provided sufficient code-level modeling to demonstrate how these changes would affect services billed with modifier 50 or professional/technical component modifiers 26 and TC, all of which are relevant to audiology diagnostic testing. The Academy urges CMS to publish representative audiology examples before finalizing the policy so stakeholders can assess the practical and financial implications of the revised methodology.

The Academy is also concerned about CMS's continued reliance on existing PE/HR survey data and 2006-based MEI cost-share weights. Audiology participated in the CPCI survey process at its own expense, specifically to help generate updated data reflecting contemporary indirect practice costs. Since 2006, audiology practices have experienced substantial growth in costs associated with diagnostic technology, equipment calibration and maintenance, specialized software, information technology, cybersecurity, and other resources necessary to furnish high-quality care.

If more recent survey data and 2019-based cost-share weights better reflect current practice costs, CMS should explain why continued reliance on older data remains appropriate or establish a clear timeline for transitioning to updated inputs. This is especially important for audiology, where diagnostic testing is frequently furnished in non-facility settings and practices bear the full cost of specialized equipment, supplies, technology, and clinical space without a separate facility payment.

In conclusion, the Academy urges CMS to pause implementation of the proposed sweeping changes to the practice expense methodology for CY 2027 and allow additional time for analysis, stakeholder review, and refinement. Any future revisions to PE should be transparent, supported by current and representative data, and fully evaluated for specialty-specific impacts before implementation. Audiology practices should not be disadvantaged by outdated cost assumptions or allocation formulas that fail to reflect the actual resources required to furnish contemporary diagnostic services.

To support meaningful stakeholder review, the Academy further requests that CMS publish complete specialty- and code-level impact analyses, including tables that isolate the effect of each proposed PE methodology change rather than presenting only the combined impact. At a minimum, CMS should separately model the effects of revised indirect PE allocation, modifier and special payment rules, MEI cost-share weights, facility/non-facility assumptions, and any stabilization or transition policies. CMS should also provide sufficient underlying data and methodology to allow stakeholders to replicate and assess these estimates. This level of transparency is essential to identify unintended consequences, understand which policy changes are driving payment shifts, and ensure that final PE values accurately reflect the costs of furnishing audiology services.

Requests for Information

Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

The Academy supports CMS's efforts to reduce unnecessary duplicate laboratory testing and imaging and to improve the timely exchange of diagnostic results across care settings. These goals are directly relevant to audiology, where patients may receive hearing and vestibular services across independent practices, physician offices, hospitals, and other sites of care.

Improved interoperability could help ensure that prior audiograms, vestibular studies, and related diagnostic findings are available to referring and treating clinicians, reducing repeat testing that occurs solely because earlier results cannot be accessed.

At the same time, CMS should avoid equating repeat testing with unnecessary or duplicative testing. In audiology and vestibular care, repeat testing is often clinically appropriate to evaluate changes in hearing or balance function, monitor disease progression, assess treatment response, confirm changes in symptoms, or support ongoing clinical decision-making. Any future policy should therefore distinguish between testing repeated because information is unavailable and testing repeated because the patient's clinical condition warrants reassessment.

The Academy urges CMS to engage audiologists and other specialty clinicians in developing any future policies or standards arising from this RFI. Audiology-specific use cases should include the secure transmission of audiometric and vestibular test results to referring clinicians and across care settings, while recognizing that many audiology practices rely on diagnostic platforms that are not fully integrated with hospital or primary care EHR systems. CMS should also avoid creating new documentation, prior authorization, or reporting requirements as a means of addressing duplicate testing.

Finally, improvements in result sharing will require investment in interoperability infrastructure. Small and independent audiology practices may face significant costs associated with interfaces, software upgrades, cybersecurity, data mapping, and vendor integration. If CMS establishes new interoperability expectations, the Academy urges the agency to pair those requirements with technical assistance, implementation grants, stipends, or other financial support so that small practices can participate effectively without jeopardizing access to community-based audiology care.

MAHA Proposals for Primary Care and the Case for Integrating Audiology

The Academy takes note of the rule's "Redesigning Primary Care to Make America Healthy Again" section, which implements the President's Make America Healthy Again (MAHA) Commission executive order through three Requests for Information — on the relative valuation of primary care services, the payment implications of incorporating technology into primary care, and prospective primary care payment models — together with a concrete proposal to create new Shared Medical Appointment (SMA) coding and payment (proposed HCPCS code GSMAS)[4].

As currently drafted, these MAHA-aligned primary care proposals do not mention hearing or balance health, and the Academy believes this is a missed opportunity. Untreated hearing loss and undiagnosed vestibular dysfunction are established, modifiable contributors to the chronic disease burden the MAHA Commission was charged with addressing — both are independently associated with elevated fall risk, cognitive decline, social isolation, and depression in older adults, and falls remain a leading cause of injury-related morbidity, hospitalization, and Medicare spending. Comprehensive audiometric and vestibular evaluation is also the diagnostic gatekeeper for hearing aid, cochlear implant, and balance-therapy interventions that directly reduce downstream medical costs. The Academy accordingly recommends that CMS take the following action:

- Include hearing and vestibular screening as an explicit component of any prospective primary care payment model or advanced primary care management structure that emerges from the RFI process, recognizing audiologist-performed diagnostic testing as a covered, billable input rather than an out-of-scope specialty referral;

[4]CMS, "Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule" Fact Sheet, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-proposed-rule

- Permit audiologists to participate as furnishing or referral partners within Shared Medical Appointments and any future MAHA-aligned chronic disease management codes where hearing loss, tinnitus, or balance/fall-risk management is part of the beneficiary's care plan, consistent with the existing statutory scope of audiology practice under Medicare Part B;

- Ensure that CMS's companion proposal to add “Age-Related Hearing Loss: Comprehensive Audiometric Evaluation” to the MIPS audiology specialty measure set is harmonized with, and cross-referenced in, any MAHA-related primary care quality measure set, so that primary care clinicians are incentivized to screen for and refer suspected hearing and balance disorders; and

- Solicit specific comment, in any follow-on MAHA rulemaking, on integrating audiologist-performed falls-risk vestibular assessment into primary-care-led chronic disease and healthy-aging initiatives, given the direct alignment between vestibular dysfunction, fall injury, and the MAHA Commission's stated chronic disease goals.

The Academy would welcome the opportunity to serve as a technical resource to CMS and the MAHA Commission as these primary care redesign concepts are developed further, and requests that audiology be explicitly considered in any subsequent MAHA-related proposed rule or sub-regulatory guidance.

Current Procedural Terminology (CPT) and the RUC

The proposed rule includes a broad Request for Information on the AMA CPT coding and licensing framework and the RUC valuation process, including potential alternatives and concerns about their role in Medicare payment policy. The Academy welcomes the opportunity to respond, informed by its recent multi-year experience navigating the CPT/RUC process to establish updated vestibular and vHIT codes.

- The Academy believes that coding and valuation decisions should be led by clinicians who actually perform the services and understand the clinical work, resources, and patient-care considerations involved. Clinician-led processes help ensure that code descriptors, work values, and practice expense inputs reflect real-world clinical practice, rather than administrative assumptions or generalized payment models.

- The Academy respectfully disagrees that reliance on CPT and the RUC has contributed to a “sick care” model in audiology. Early identification of hearing loss and vestibular dysfunction is preventive care, helping address fall risk, cognitive decline, and social isolation in older adults. Undervaluing these diagnostic services would move Medicare policy further from—not closer to—the preventive health goals reflected in MAHA priorities.

- The CPT/RUC process already requires rigorous clinical evidence, detailed vignettes, and multi-specialty review before coding and valuation recommendations reach CMS. The Academy’s multi-year effort to establish four new vestibular and vHIT codes demonstrates that the process provides meaningful clinical and stakeholder scrutiny and functions effectively when its recommendations are appropriately recognized.

- The Academy cautions against replacing clinician-driven review with methodologies that rely primarily on claims data, formulaic comparisons, or centralized administrative determinations without sufficient specialty input. Any reform to the CPT/RUC process should preserve meaningful participation by practicing clinicians and specialty societies and maintain transparent opportunities for multi-specialty peer review.

Software as a Medical Service

As CMS continues to develop and expand its Software as a Medical Service (SaMS) framework, the American Academy of Audiology (AAA) encourages the agency to consider the unique implications of AI- and software-enabled technologies in audiology. Medicare policy should not presume that algorithmic assistance necessarily reduces practitioner work, practice expense, or overall resource requirements.

First, CMS should clearly distinguish between AI functionality embedded within diagnostic equipment and already reflected in existing practice expense inputs, and a standalone, separately furnished algorithmic analysis performed downstream from test acquisition. Separate payment may not be appropriate where software functionality is already incorporated into equipment or maintenance costs; however, distinct analyses that are separately ordered, performed, and reported may warrant separate coding and payment. Clear criteria are needed to avoid both duplicative payment and inappropriate bundling.

Second, CMS should examine the professional liability implications of proprietary AI outputs. Audiologists may be expected to rely on analyses they cannot independently audit, reproduce, or validate. CMS should consider whether the malpractice RVU methodology adequately reflects this exposure and clarify the respective responsibilities of the clinician, software developer, and entity furnishing the analysis when an erroneous result contributes to patient harm.

Third, AAA cautions against assuming that AI adoption reduces practice expense. These technologies may instead create significant recurring costs, including software licensing, system integration, training, cybersecurity and HIPAA compliance, quality assurance, clinician review, vendor management, and additional testing resulting from false-positive, false-negative, or indeterminate outputs. CMS should therefore rely on actual resource and cost data rather than assumed efficiencies.

AAA also encourages CMS to assess whether the existing Medicare Physician Fee Schedule (MPFS) practice expense methodology can adequately recognize recurring software-, data-, and technology-related costs. Subscription fees, per-test licensing, cloud processing, data storage, cybersecurity, and interoperability expenses do not fit neatly within traditional clinical labor, supply, and equipment categories. Moreover, because the MPFS operates under statutory budget neutrality, adding increasingly costly SaMS services to the existing practice expense pool could place additional downward pressure on payment for other physician and practitioner services. CMS should consider whether certain separately furnished SaMS services warrant a distinct payment methodology or another mechanism insulated from the traditional MPFS budget-neutrality framework.

Finally, if audiology-specific SaMS codes emerge, AAA strongly recommends a consistent national payment methodology rather than reliance on individual Medicare Administrative Contractor pricing. Contractor pricing could create substantial geographic variation for essentially identical nationally marketed services. A standardized methodology—potentially informed by approaches such as the Clinical Laboratory Fee Schedule crosswalk process or another national framework tailored to SaMS -would improve consistency, predictability, and beneficiary access.

Accordingly, AAA urges CMS to:

- distinguish embedded software from separately furnished algorithmic services;
- evaluate liability implications;
- avoid assuming AI reduces practitioner work or practice expense;
- collect actual cost data;
- recognize recurring software and infrastructure expenses; and
- establish a consistent national payment methodology for separately payable SaMS services.

Quality Payment Program

The Academy supports CMS's efforts to reduce unnecessary burden within the Quality Payment Program (QPP) and urges the agency to ensure that future changes to the Merit-based Incentive Payment System (MIPS) remain workable for small, specialty practices such as audiology. Audiologists often practice in small, independent settings with limited administrative staff, health IT resources, and access to the infrastructure available to larger health systems. Accordingly, QPP policies should be designed to promote meaningful quality improvement without imposing disproportionate reporting, technology, or implementation costs.

Merit-based Incentive Payment System (MIPS)

The Academy supports policies that preserve flexibility for small practices, including continued relief from requirements that may be difficult or impractical to implement in low-volume specialty settings. CMS should maintain the low-volume threshold and related small-practice protections and avoid policies that would bring small audiology practices into MIPS solely because of changes to eligibility methodology or reporting structure.

As CMS continues to evolve MIPS, the Academy urges the agency to evaluate the cumulative administrative and financial impact of quality reporting, improvement activities, cost measurement, interoperability requirements, technology upgrades, and data-submission obligations. For a small audiology practice, even a seemingly modest new requirement can represent a significant investment when the practice lacks dedicated compliance, IT, or quality-reporting staff.

Quality measures should also be clinically relevant to the services audiologists actually furnish. Small specialty practices should not be required to report measures that have little relationship to hearing, balance, vestibular assessment, auditory rehabilitation, or the other services within the audiologist's scope of practice, simply to satisfy program requirements. Additionally, the proposed addition to the audiology specialty measure set of one developed by the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) is not feasible for reporting by audiologists based on its limitation to providers eligible to bill Evaluation and Management (E/M) codes. While the measure may contemplate audiology involvement conceptually, the construct does not appear to support audiologist participation since audiologists cannot bill E/M codes.

For these reasons, the Academy strongly urges CMS to **maintain the existing MIPS low-volume threshold and other exemptions, exclusions, reweighting policies, and hardship protections that shield small and low-volume practices from disproportionate administrative burden**.

MIPS Promoting Interoperability

The Academy supports CMS's proposed simplification of the Promoting Interoperability (PI) performance category, including alignment of the Certified EHR Technology definition with ONC requirements and increased flexibility around certain reporting measures. These changes are particularly important for audiology practices, many of which use practice-management systems, audiometric platforms, and vestibular diagnostic equipment that are not uniformly integrated with hospital or referring-provider EHRs.

Future interoperability requirements should be practical and specialty appropriate. The Academy encourages CMS to incorporate audiology-specific use cases, such as secure transmission of audiometric and vestibular test results directly to referring clinicians, while avoiding requirements that create new administrative barriers for routine diagnostic services. If CMS expects small practices to make substantial investments in EHR interfaces, diagnostic-system integration, cybersecurity, software upgrades, or related infrastructure, the Academy urges CMS to consider implementation stipends, grants, technical assistance, or other targeted financial

support. Without such assistance, interoperability requirements could disproportionately burden independent practices and accelerate consolidation.

Transition from Traditional MIPS to MVPs.

As CMS moves toward transitioning clinicians from traditional MIPS to MIPS Value Pathways (MVPs) by 2031, the Academy urges CMS to ensure that audiologists have access to an MVP that includes clinically relevant quality measures, improvement activities, and cost measures before participation becomes mandatory. Audiologists should not be forced into a pathway designed primarily for another specialty or broader patient population simply to satisfy program requirements. CMS should work directly with audiology stakeholders to develop an appropriate pathway and provide sufficient lead time, education, testing, and technical assistance before any mandatory transition.

More broadly, the Academy urges CMS to evaluate QPP requirements through the lens of small-practice feasibility. Audiology practices frequently bear the full costs of specialized equipment, software, calibration, clinical space, and health IT while lacking the economies of scale available to large systems. CMS should therefore consider targeted transition protections and financial assistance when new QPP or interoperability requirements impose material implementation costs. These safeguards will help ensure that efforts to modernize quality reporting and data exchange strengthen, rather than undermine, beneficiary access to independent community-based audiology care.

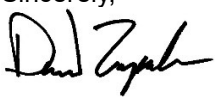
Conclusion

The American Academy of Audiology appreciates CMS's continued attention to accurate, evidence-based valuation of audiologic and vestibular services, including the long-awaited establishment of dedicated vHIT codes. The Academy respectfully urges CMS to:

1. Mitigate the disproportionate impact of the conversion factor decline on non-QP clinicians and small practices;
2. Revise the PE methodology to avoid systematically disadvantaging diagnostic services with little or no clinical-labor input, including reconsideration of supervision policies that contribute to structurally low clinical-labor RVUs for audiology;
3. Adopt the full RUC-recommended work RVU of 0.48 for the velocity-step-testing add-on code;
4. Explicitly incorporate hearing and vestibular health into MAHA-aligned preventive and primary care priorities;
5. Address current limitations in MVP participation so audiologists have access to clinically relevant pathways while preserving appropriate small-practice exemptions;
6. Tailor interoperability requirements to the operational and financial realities of small audiology practices, including appropriate implementation support; and
7. Quantify and mitigate the cumulative impact of proposed payment and quality policies on small audiology practices in the final rule.

The Academy thanks CMS for its consideration of these comments and remains available to provide additional data or clinical context at the Agency's request. Please direct any questions regarding these comments to the Academy's Chief Operating Officer, Kathryn Werner, MPA at kwerner@audiology.org or 703-226-1044.

Sincerely,



David Zapala, PhD
President