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September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1715-P
PO Box 8016
Baltimore, MD 21244-8016

RE: CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Updates to the Quality Payment Program

Comments submitted electronically via www.regulations.gov

Dear Administrator Verma:

The American Academy of Audiology (the Academy) appreciates the opportunity to comment on *CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Updates to the Quality Payment Program.* 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.

Computerized Dynamic Posturography (CPT Code 92548 and 92549)

CPT code 92548 (Computerized dynamic posturography) was identified via an AMA RUC screen for review. This code had not been reviewed since 1997 and since that time, the primary performer of the service has changed from AAO-HNS to audiology. In addition, audiologists are now permitted to bill directly to Medicare. Therefore, audiology time that was originally captured in practice expense has been moved over to the work component. As part of the recent review process, the Academy worked along with other interested professional societies to revise the extant CPT code 92548 and add a new CPT code 92XX0 (now CPT 92549) to more accurately describe the current clinical work and equipment necessary to provide this service. The revised codes are: CPT 92548 (*Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway) including interpretation and report* and CPT 92549 (*Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform*

and visual sway) including interpretation and report; with motor control test (MCT) and adaptation test (ADT).

CMS disagrees with the RUC's recommended work RVUs of 0.76 for CPT code 92548 and 0.96 for CPT code 92549. CMS proposes alternate work RVUs which more closely align with the current valuation 92458 than either the specialties or the AMA RUC recommended. CMS **has proposed to decrease the work RVU from 0.76 to 0.66 for code 92548 and 0.96 to 0.86 for code 92XX0.** CMS proposes that their alternate work RVUs more closely align with the valuation of these codes than the RUC recommendation. However, the RUC recommended work RVUs for these two codes are based on robust survey data. CMS should use valid survey data in establishing the work RVUs for both codes. The RUC thoroughly analyzed this family of codes by review of history, survey data and magnitude estimation to other similar services.

CPT 92548

For CPT code 92548, CMS disagrees with the RUC recommended work RVU of 0.76 and proposes a work RVU of 0.66 based on the intra-service time ratio. To get to this proposed work value, CMS divided the RUC recommended intra-service time of 20 by the current intra-service time of 15 and multiplied the product by the current work RVU of 0.50 for a ratio of 0.66. This is a flawed methodology to value a service. In addition, the Agency has chosen code 93316 *Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only* (work RVU = 0.60, 20 minutes intra-service time, and 35 minutes of total time) as a crosswalk to support a proposed work RVU of 0.66 for code 92548. However, CMS is using the term "crosswalk" incorrectly. As noted by the RUC, if CMS is directly crosswalking a service to another service, the crosswalk code must have identical work RVUs as the service being valued. CMS' choice of code 93316 (work RVU= 0.60) is not a crosswalk if the Agency proposes a work RVU of 0.66, but rather a reference service only. **The Academy and the RUC strongly disagree with CMS' methodology to alternatively value CPT code 92548.**

Further, the RUC notes the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. In many scenarios, CMS selects an arbitrary combination of inputs to apply, including: total physician time, intra-service physician time, "CMS/Other" physician times, Harvard study physician times, existing work RVUs, RUC-recommended work RVUs, work RVUs from CMS-selected crosswalks, work RVUs from a base code, etc. This selection process has the appearance of seeking an arbitrary value from the vast array of possible mathematical transformations, rather than seeking a valid clinically relevant relationship that would preserve relativity. The Academy urges CMS to use valid survey data and supportive relative reference services when valuing codes. The RUC thoroughly discussed the physician work, time, intensity and complexity required to perform CPT code 92548. **The Academy urges CMS to use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing work values for services and not foster flawed methodologies.**

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference code 95992 *Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day* (work RVU = 0.75, intra-service time of 20 minutes, total time of 30 minutes) and MPC code 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75, intra-service time of 20 minutes, total time of 26 minutes). **The Academy urges CMS to accept the RUC recommended work RVU of 0.76 for CPT code 92548.**

92549

For CPT code 92549, CMS disagrees with the RUC recommended work RVU of 0.96 and proposes a work RVU of 0.86 based by applying the RUC recommended incremental difference between codes 92548 and 92549, a difference of 0.20, to the Agency's proposed value of 0.66 for CPT code 92548 (**not code 93316 as it is misstated in the Proposed Rule)**. The RUC agrees that this methodology in valuing services is flawed. CMS accepts the RUC work RVU increment between these codes, yet they disagree with the RUC recommended work RVU for code 92549. The Agency argues that it is appropriate to reduce the work RVU for code 92548 based on the value proposed by the RUC, yet the Agency also agrees that it is appropriate to recalibrate the work RVU for code 92549 relative to the RUC's recommended difference in work between this code and code 92548. This is a flawed valuation methodology and should not be applied to code 92549. The Academy does not agree with the adjusted value for code 92549 which has been derived by an incremental difference. It is imperative that RUC survey data be used to correctly value this code. Using an incremental approach in lieu of survey data, strong crosswalks, and input from the RUC and physicians providing this service is unjustified. CMS does not provide any supporting rationale to their proposed work RVU other than the incremental difference between both codes and concluding their recommendation by listing two reference codes 95972 (work RVU = 0.80) and 38207 (work RVU = 0.89), stating that the Agency's proposed value for code 92XX0 of 0.86 falls between these service's values. The Academy urges CMS use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing work values for services and not foster flawed methodologies that solely focus on one element.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 95922 *Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt* (work RVU= 0.96, intra-service time of 20 minutes, total time of 40 minutes) and 99448 *Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician…* (work RVU= 1.05, intra-service time of 25 minutes, total time of 35 minutes). **The Academy urges CMS to accept a work RVU of 0.96 for CPT code 92549.**

With regard to practice expense, the Academy urges CMS to phase in the proposed cuts under the authority provided by the "Protecting Access to Medicare Act of 2014" (P.L. 113-93) which requires a two-year phase-in of payment reductions that exceed 20 percent. CPT code 92548 is a 69 percent cut in practice expense and CPT 92549 reflects a 59 percent cut in practice expense RVUs. These codes define services that are not new, rather they were clarified by CPT as noted by the retention of the same CPT code.

CPT	RVW	PE RVU	PLI RVU	Total RVU	%PE RVU change
92548 (2019)	**0.50**	**2.19**	**0.03**	**2.72**	
92548 (proposed)	0.66	0.69	0.03	1.38	-69%
92548 (recommended)	0.76	0.69	0.03	1.48	
92549 (proposed)	0.86	0.89	0.03	1.78	-59%
92549 (recommended)	0.96	0.89	0.03	1.88	

CPT Codes 92626 and 92627 – Auditory Function Evaluation

For CY 2020, CMS proposes the HCPAC-recommended work RVU of 1.40 for CPT code 92626 (Evaluation of auditory function for candidacy or post-operative status of surgically implanted devices or other auditory treatment interventions; first hour) and 0.33 for the add-on code CPT code 92627 (each additional 15 minutes (List separately in addition to code for primary procedure). CMS also proposes to accept the RUC-recommended direct Practice Expense (PE) inputs for these codes. **The Academy supports CMS' proposed adoption of the HCPAC-recommended work RVUs and PE inputs.**

Evaluation and Management (E/M) Services

In the CY 2019 final rule, CMS finalized several coding, payment, and documentation changes for office/outpatient E/M visits (CPT codes 99201-99215). In response to these finalized policies, the AMA/CPT established a Joint AMA CPT Workgroup on E/M to develop an alternative solution. The CPT Editorial Panel adopted revisions to the E/M code descriptors and revised the CPT prefatory language and interpretive guidelines that instruct practitioners on how to bill these codes. CMS is proposing to retain 5 levels of coding for established patients, reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and revise the E/M code definitions. These changes will have a direct impact on all specialties billing under Medicare due to the redistribution of a limited pool of funds. CMS issued a proposed impact table that shows payment for audiology would decrease by -6 percent in 2021.

The Academy is extremely concerned about the proposed E/M restructuring and its impact on reimbursement across specialties. Table 111 in the MPFS proposed rule illustrates the specialty payment impacts if CMS finalizes the proposal on E/M value increases without modification. Of primary concern is the potential reimbursement cut to services furnished by our providers due to the redistribution of the E/M code value increases. In modifying the values to accommodate increases for the E/M codes, it appears CMS may not have considered the overall impact that the E/M value increases would have on budget neutrality, resulting in consequential payment decreases for health care professionals who do not bill E/M codes. Audiologists are not permitted to bill E/M services and may not opt out of the Medicare program, yet the overall reimbursement landscape would result in a projected -6 percent cut to audiology reimbursement. Medicare margins for our providers are already low and have challenged the viability of practices. This proposed policy not only has ramifications for the near term but sets a precedent for valuation of services to come leaving specialties such as audiology at a significant disadvantage moving forward. **We ask CMS to consider the magnitude this cut would have on patient access to medically necessary Medicare services as the cut further jeopardizes the sustainability of our providers' health care practices. We request that this policy not be adopted.**

Reimbursement for Online Digital Evaluation Services (E-Visits)

CMS is proposing 3 new G-codes to parallel the CPT E-visit codes. We appreciate that CMS recognizes that there are statutory requirements that govern the Medicare benefit that are specific to which practitioners may bill for E/M services. As such, when codes are established that describe E/M services that fall outside the Medicare benefit category of the practitioners who may bill for that service, CMS' proposed HCPCS G-codes that refer to the performance of an "assessment" rather than an "evaluation". These services describe patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office. The Academy supports the activation and payment for these services described by CPT codes 98X00, 98X01, and 98X02, as well as GNPP1, GNPP2 and GNPP3 which are codes for practitioners who cannot independently bill E/M services.

Audiologists do perform assessment services for an established patient via written modality, especially when communication is an issue. It is common to communicate with a patient with impaired hearing via email to ensure all issues of concern are addressed and questions answered. These digital assessment codes would allow audiologists to consider changes or inquiries that may arise post visit. Per the definition of these codes interaction does not have to be performed via synchronous communication mode, rather through email and could be cumulative time over 7 days. We urge CMS to include audiologists as part of the practitioner groups who may bill for these services.

Further, we recommend that CMS work with the CPT Editorial Panel to address issues with the descriptors for 98X00, 98X01 and 98X02 by seeking technical corrections that could be effective by January 1, 2020. This would alleviate the necessity to create separate G codes which often

lead to confusion and administrative burdens for providers responsible for using two different sets of codes depending on payer policy. **We urge CMS to utilize the RUC valuation data and recommendations for the CPT codes and to utilize the RUC valuation data and recommendations for all codes.**

Quality Payment Program (QPP)

The current Medicare regulatory definition places audiologists in the "Other Diagnostic Procedures" benefit classification, which is limited to the exclusive diagnostic-only areas of hearing and balance healthcare. Developing measures of quality and outcomes for this narrowly defined benefit classification, as well as participating in interdisciplinary measures that require outcomes or treatment management of the patient, is challenging within these regulatory confines. While we strongly support, the delivery of high-quality patient care, the audiology services category is restricted to diagnostic tests. There is no provision for patient management beyond the diagnostic test. Creating plans of care and follow-up plans is beyond the scope of what audiologists can be reimbursed under the current Medicare benefit. As quality reporting will be moving into the "penalty" adjustments, CMS should exempt audiologists for negative payment adjustments if they are unable to complete these measures. We urge the Agency to recognize that this will remain an ongoing problem until audiologists have parity with other professionals who participate in the program and are reimbursed for E/M services

The Academy appreciates the appropriate inclusion of audiologists in quality measurement reporting. We believe it is important to demonstrate quality care as the healthcare marketplace continues to underscore the importance of value. We support the inclusion of a specialty measures set for audiology and appreciate the multiple options for participation in MIPS that take into consideration the unique care provided by audiologists to Medicare beneficiaries.

Under this proposed rulemaking, CMS proposes a new specialty measures set for Audiology for the 2022 MIPS payment year and future years. Of note, CMS proposes inclusion of the following new measures that are in addition to the six available now for audiologists.

The six measures currently available for audiologists include:

#130 Documentation of Current Medications in the Medical Record

#134 Screening for Clinical Depression and Follow-Up Plan

#154 Falls Risk Assessment

#155 Falls Plan of Care

#226 Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention

#261 Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness

Proposed New Measures:

#181 Elder Maltreatment Screen and Follow-Up Plan: Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.

The Academy supports the inclusion of the following codes for this measure.

CPT 92550 *(Tympanometry and reflex threshold measurements)*

CPT 92557 *(Comprehensive audiometry threshold evaluation and speech recognition)*

CPT 92567 *(Tympanometry (impedance testing)*

CPT 92570 *(Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing)*

CPT 92540 *(Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording*)

CPT 92541 *(Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording)*

CPT 92542 *(Positional nystagmus test, minimum of 4 positions, with recording)*

CPT 92587 *(Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report)*

CPT 92588 *(Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report)*

CPT 92625 *(Tinnitus assessment (includes pitch, loudness, matching, and masking)*

#318 Falls: Screening for Future Fall Risk: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

The Academy supports the inclusion of the following CPT codes for this measure:

CPT 92540 *(Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording*)

CPT 92541 *(Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording)*

CPT 92542 (*Positional nystagmus test, minimum of 4 positions, with recording)*

CPT 92548 *(Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway) including interpretation and report)*

#182 Functional Outcome Assessment: Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.

The Academy believes that Measure #182 would most appropriately apply to a limited subset of audiology codes for vestibular function, including:

CPT 92540 *(Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording*)

CPT 92542 (*Positional nystagmus test, minimum of 4 positions, with recording)*

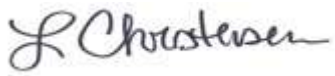
CPT 92546 *(Sinusoidal vertical axis rotational testing - rotary chair*)

CPT 92548 *(Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway) including interpretation and report)*

These CPT codes represent audiology procedures that are most consistent with the functional capacity of patients referenced in Measure #182. A broad approach to the application of Measure #182 to other audiology CPT codes would not reflect the nature of the measure as written and would place undue and excessive burden on audiology providers. We hope you consider our recommendation of limited audiology CPT codes for Measure #182.

Thank you for your consideration of these views. If you have questions or require additional information, please contact Kathryn Werner, MPA, Vice President of Public Affairs, American Academy of Audiology kwerner@audiology.org or 703-226-1044.

Sincerely,



Lisa Christensen, AuD
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