



September 27, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Attn: CMS-1717-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) proposed rule.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 204,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA's comments focus on the following areas:

- Changes to Direct Practice Expense (PE) Inputs for Specific Services: Equipment Recommendations for Scope Systems
- Methodology for the Proposed Revision of Resource-Based Malpractice (MP) Relative Value Units (RVUs)
 - Proposed Methodological Refinements
 - Steps for Calculating Malpractice RVUs: Low Volume Service Codes
- Proposed Valuation of Specific Codes for CY 2020
 - Computerized Dynamic Posturography (CPT Codes 92548 and 92XX0)
 - Auditory Function Evaluation (CPT Codes 92626 and 92627)
 - Cognitive Function Intervention (CPT Codes 971XX and 9XXX0)
 - Online Digital Evaluation Service (e-Visit) (CPT Codes 98X00, 98X01, and 98X02)
- CY 2020 PFS Impact Discussion: Estimated Impacts Related to Proposed Changes for Office/Outpatient Evaluation and Management (E/M) Services for CY 2021
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act
- CY 2020 Updates to the Quality Payment Program

Changes to Practice Expense (PE) Inputs for Specific Services: Equipment Recommendations for Scope Systems (pg. 40492)

ASHA recognizes CMS's continued efforts to standardize PE inputs for scope systems. Specifically, ASHA notes the following statement from the proposed rule:

For CPT codes 92612 Flexible endoscopic evaluation of swallowing by cine or video recording, 92614 Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording, and 92616 Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording, the current scopes in use are the FEES video system (ES027) and the FEESST video system (ES028). Since ASHA is proposing the use of a non-channeled flexible digital scope that requires a corresponding scope video system, ASHA is adding the ES080 equipment at the same equipment time to these three procedures rather than replacing the ES027 and ES028 equipment."

ASHA appreciates CMS's recognition of the existing specialized equipment that is required in addition to the proposed scope equipment. **ASHA supports the proposal to add ES080 and retain ES027 or ES028 at the same equipment time for CPT codes 92612, 92614, and 92616.**

Methodology for the Proposed Revision of Resource-Based Malpractice (MP) Relative Value Units (RVUs)

Proposed Methodological Refinements (pg. 40506)

In the *Interim Report for the CY 2020 Update of GPCIs and MP RVUs for the Medicare Physician Fee Schedule*, CMS proposes to crosswalk 16 specialties, including audiology and speech-language pathology, to Allergy/Immunology "as a matter of necessity." ASHA understands the challenges CMS faces when collecting data on malpractice premiums and appreciate its commitment to finding an equitable solution when insufficient information exists to develop an accurate recommendation for certain specialties. **ASHA supports CMS's proposal to crosswalk malpractice RVUs for the specialties of audiology and speech-language pathology to Allergy/Immunology.**

Steps for Calculating Malpractice RVUs: Low Volume Service Codes (pg. 40510)

ASHA appreciates CMS's ongoing efforts to improve the stability of PE and MP RVUs for low-volume services. ASHA agrees with the proposal to use service-level overrides for low-volume services to help mitigate annual fluctuations and provide greater stability in the valuation of these services. Several low-volume services provided by audiologists have been susceptible to large fluctuations in PE RVUs. **Therefore, ASHA provides comment on the proposed specialty overrides for those services listed in the following table.**

CPT Code	Descriptor	CY 2020 Anticipated Specialty	ASHA Comment
92572	Staggered spondaic word test	Audiologist	Agree
92596	Ear protector attenuation measurements	Audiologist	Agree

CPT Code	Descriptor	CY 2020 Anticipated Specialty	ASHA Comment
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	Audiologist	Agree
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	Audiologist	Agree
92621	Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)	Audiologist	Agree
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	Audiologist	Agree

Proposed Valuation of Specific Codes for CY 2020

Computerized Dynamic Posturography (CPT Codes 92548 and 92XX0) (pg. 40596)

CMS disagrees with the American Medical Association (AMA) Relative Value Update Committee's (RUC) recommended work RVUs for CPT codes 92548 and 92XX0 and proposes to decrease them from 0.76 to 0.66 for 92548 and from 0.96 to 0.86 for 92XX0. It should be noted that the narrative of the proposed rule erroneously states the proposed work RVUs as 0.67 for 92548 and 0.87 for 92XX0. However, CMS correctly notes the proposed values in Table 20 (pg. 40605) and in Addendum B, as outlined in the following table.

CPT Code	Descriptor	RUC Rec WRVU	CMS Proposed WRVU
92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;	0.76	0.66
92XX0	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, 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)	0.96	0.86

ASHA is extremely concerned that CMS did not provide a clear rationale for the proposed decreases, nor use a valid methodology to establish its proposed work RVUs. In a system founded on relativity, it is critical for CMS to: 1) consider the robust survey data based on clinical expertise; 2) review the actual relativity for all elements of the code valuation (e.g., professional work, time, intensity, and complexity); 3) use clinically appropriate crosswalk or reference

service codes, and; 4) refrain from employing arbitrary mathematical formulas to calculate work values. When CMS eschews these principles, it endangers the validity of work values across the constellation of services paid under the MPFS.

The RUC thoroughly discussed the professional work, time, intensity, and complexity required to perform CPT codes 92548 and 92XX0. For **CPT code 92548**, CMS uses a calculation based on the intra-service time ratio to propose a work RVU of 0.66. CMS divided the RUC recommended intra-service time of 20 minutes by the current intra-service time of 15 minutes and multiplied the product by the current work RVU of 0.50 for a ratio of 0.66. ASHA strongly disagrees with this methodology for determining a work RVU. Regrettably, this method ignores relativity and bases its calculation on the current work RVU and intra-service time, which were last valued in 1996 and do not reflect current practice. Additionally, CMS cites code 93316 *Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only* (work RVU of 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, it is important to note that a crosswalk code must have identical work RVUs as the proposed value. As such, CMS's use of CPT code 93116 as a crosswalk is inappropriate, as the work RVU of 0.60 does not mirror the proposed work RVU of 0.66 for 92548. In this case, 93316 is considered a *reference service*. **Proposing an alternate value, absent a valid crosswalk code or survey data, ignores the established process for ensuring relativity and ASHA strongly disagrees with this methodology to alternatively value CPT code 92548.**

The RUC based its recommendation on the 25th percentile work RVU from robust survey results and a favorable comparison to reference code 95992 *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day* (work RVU of 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 of 0.75, intra-service time of 20 minutes, total time of 26 minutes). **ASHA strongly urges CMS to accept a work RVU of 0.76 for CPT code 92548 to maintain the integrity of the relative value system and accurately value the procedure.**

For **CPT code 92XX0**, CMS also disagrees with the RUC recommended work RVU of 0.96 and proposes a work RVU of 0.86. CMS arrived at this value by applying the RUC's recommended incremental difference between codes 92548 and 92XX0, a difference of 0.20, to CMS's proposed value of 0.66 for CPT code 92548 (not code 93316 as it is misstated in the proposed rule). Again, ASHA disagrees with this flawed methodology and approach to valuing services. ASHA does not understand how CMS can accept the RUC's work RVU increment between these codes, which is based on the 25th percentile survey data, yet disagree with the RUC's recommended work RVUs for both 92548 and 92XX0, based on the very same survey data. **It is inappropriate to focus solely on one element of survey data to support an otherwise arbitrary work value, and as such, ASHA strongly disagrees with CMS's proposed value for 92XX0.** It is imperative for CMS to consider all RUC survey data to correctly value this code. Using an incremental approach in lieu of survey data, strong crosswalks, and input from the RUC and qualified health care professionals providing this service is unjustified. Additionally, CMS does not provide supporting rationale to their proposed work RVU other than using the incremental difference between both codes, listing the proposed reference codes 95972 (work RVU of 0.80) and 38207 (work RVU of 0.89), and stating that CMS's proposed value for code 92XX0 of 0.86 falls between these service's values. Again, **ASHA requests 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.

The RUC based its recommendation 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 of 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 of 1.05, intra-service time of 25 minutes, total time of 35 minutes). **ASHA strongly urges CMS to accept a work RVU of 0.96 for CPT code 92XX0.**

CMS also proposes to accept the RUC's recommended direct PE inputs for both CPT codes 92548 and 92XX0. ASHA appreciates CMS's acceptance of the recommended PE inputs determined through the standard RUC process. However, it is important to note the PE for 92548 and 92XX0 will decrease by 69% and 59%, respectively, when compared to the current PE RVU for 92548. This is due to the appropriate removal of audiology time as a clinical labor input since the audiologist's time is now captured in the work RVU. Although the change in PE is appropriate, it results in a significant total RVU reduction of nearly 50% for providers who complete computerized dynamic posturography. As such, **ASHA requests that CMS implement a phase-in of the reduced PE RVUs to minimize the immediate impact of such a drastic reduction to qualified health care professionals who provide computerized dynamic posturography testing to Medicare beneficiaries.**

ASHA maintains that provisions of the Protecting Access to Medicare Act (PAMA) of 2014 supports a phase-in. Specifically, the Act requires a two-year phase-in period for services that are not new or revised and for which the total RVUs will be decreased by 20% or more. CMS describes new or revised codes as "codes that describe different services in the current and update year."¹ ASHA notes that CPT codes 92548 and 92XX0 do not meet the definition of new or revised because they do not represent *different* services. They are now more clearly defined, in the interest of program integrity, but the services themselves have not changed. For this reason, the CPT Editorial Panel maintained the same code number for the base code, 92548. Again, **ASHA urges CMS to implement a phase-in of the reduced PE RVUs for 92548 and 92XX0, in accordance with PAMA.**

Auditory Function Evaluation (CPT Codes 92626 and 92627) (pg. 40596)

ASHA supports CMS's proposal to accept the RUC's recommended work RVUs and direct PE inputs for both 92626 and 92627. ASHA recognizes CMS's ongoing efforts to review work and PE RVUs and look forward to continuing our collaboration with CMS, the AMA, and other specialty societies to ensure the equitable valuation of services for Medicare beneficiaries with hearing and communication disorders.

Cognitive Function Intervention (CPT Codes 971XX and 9XXX0) (pg. 40601)

ASHA appreciates CMS's proposal to accept 971XX and 9XXX0—which replace 97127 *Cognitive function intervention, per day*—as payable CPT codes under the MPFS. However, CMS does not also indicate whether HCPCS G-code G0515 *Cognitive skills development, each 15 minutes* will be deleted. CMS established G0515 to replace 97127, which was given a status of *invalid* in the CY 2018 MPFS final rule. **ASHA respectfully requests CMS to delete G0515,**

given that CMS proposes to accept new CPT codes to describe the treatment of cognitive impairments. Acceptance of the new codes eliminates the need for the temporary G-code and deletion of G0515 alleviates the considerable confusion and administrative burden caused by multiple coding options for the same service.

CMS also proposes to accept the RUC's recommended work RVUs and direct PE inputs for both codes, and to designate the new codes as *sometimes therapy* services. **ASHA supports CMS's acceptance of the recommended work RVUs and PE inputs and agrees with the *sometimes therapy* designation for CPT codes 971XX and 9XXX0.**

Online Digital Evaluation Service (e-Visit) (CPT codes 98X00, 98X01, and 98X02) (pg. 40603)

ASHA supports CMS's ongoing efforts to modernize Medicare payment for technology-based communication services and initiatives to improve patient access to all members of the health care team, including qualified nonphysician health care professionals. Technology-based services can be leveraged to improve timely access to care and avoid overutilization and preventable adverse events.

CMS proposes to establish HCPCS G-codes GNPP1-GNPP3 in lieu of CPT codes 98X00-98X02 for online digital assessments performed by qualified nonphysician health care professionals. ASHA appreciates CMS's recognition that there are nonphysician specialties who do not have access to evaluation and management (E/M) codes under the Medicare benefit but perform these services within their scope of practice. However, ASHA is concerned that creating G-codes will cause significant confusion and administrative burden for providers, as they will be forced to manage multiple coding options to describe the same services, depending on individual Medicaid and other third-party payer policies. As such, **ASHA supports the AMA's recommendation for CMS to work with the CPT Editorial Panel to publish technical corrections for 98X00-98X02 that would be effective January 1, 2020.** This would negate the need for G-codes and eliminate provider burden while allowing CMS to implement e-visit services for providers who do not have access to E/M codes under the Medicare benefit.

Proposed Valuation of GNPP2/98X01 and GNPP3/98X02

CMS proposes a work RVU of 0.25 for HCPCS G-code GNPP1, which reflects the RUC Health Care Professionals Advisory Committee's (HCPAC) recommended work RVU for CPT code 98X00. For **codes GNPP2 and GNPP3**, CMS believes that the 25th percentile work RVU associated with CPT codes 98X01 and 98X02 respectively, better reflects the intensity of performing these services, as well as the methodology used to value the other codes in the family, all of which use the 25th percentile work RVU. As such, CMS proposes a work RVU of 0.44 for HCPCS code GNPP2/98X01 and a work RVU of 0.69 for HCPCS code GNPP3/98X02.

ASHA disagrees with CMS's proposed values for GNPP2/98X01 and GNPP3/98X02 because they disregard the values for the equivalent physician codes (9X0X1-9X0X3). The work and time required to provide these services are the same, whether provided by a physician or a qualified nonphysician health care professional. Additionally, robust survey data supports the HCPAC's recommended values. As such, **ASHA recommends that CMS accept the work RVUs of 0.50 for GNPP2/98X01 and 0.80 for GNPP3/98X03.**

Implementation of e-Visit Codes for Qualified Nonphysician Health Care Professionals

ASHA appreciates CMS's efforts to provide a reporting mechanism for online digital assessments for providers who do not have access to E/M codes under the Medicare benefit but perform these services within their scope of practice. However, the proposed rule does not offer guidance regarding reporting criteria or eligible providers who may report these services. Therefore, ASHA offers the following considerations for implementation, including scenarios to illustrate how audiologists and speech-language pathologists can appropriately provide and report online digital assessments within their Medicare benefit category and scope of practice.

Criteria for Reporting

According to the AMA's criteria for CPT codes 98X00-98X02, a qualified nonphysician health care professional may report these codes when an established patient initiates an online digital communication through a HIPAA-compliant platform (e.g., an electronic health record portal) and the interaction requires the clinical decision making of the qualified health care professional.² These codes should not be reported for time spent on administrative activities (e.g., scheduling a follow-up appointment). However, it is not clear whether these services may also be reported for interactions with the family/caregiver(s). **ASHA requests clarification from CMS whether online communications initiated by the patient's family/caregiver(s) qualify for reporting of the new e-visit codes.**

Additionally, **ASHA requests confirmation from CMS that these codes are not considered Medicare telehealth services**, which are defined as "a discrete set of services, all of which must ordinarily be furnished in-person, when they are instead furnished using interactive, real-time telecommunication technology". ASHA maintains that the e-visit codes should be categorized as technology-based communication services, which CMS defines as "a discrete set of services that are defined by and inherently involve the use of communication technology" that are not subject to the limitations of Medicare telehealth services.³ An example of a technology-based communication service, as defined by Medicare, is the virtual check-in (HCPCS code G2012). Similar to G2012, CPT codes 98X00-98X02 (and GNPP1-GNPP2) describe interactions between the patient and provider that rely on communication technology, are not conducted in real-time, and would not normally be furnished in-person. As such, **ASHA asserts that the new e-visit codes are technology-based communication services that may be reported outside of the telehealth benefit.**

It is important to note that the new e-visit codes do not represent evaluation or treatment services described by existing CPT codes, nor should they replace face-to-face interactions with the nonphysician qualified health care professional or involvement from the physician, as required under the Medicare benefit for audiology and speech-language pathology services. ASHA offers the following clinical scenarios to illustrate how audiologists and speech-language pathologists may appropriately provide and report online digital assessments within the Medicare benefit to improve timely access to care and avoid potential overutilization of in-person office visits.

Audiology Services and Clinical Scenarios

Audiologists provide audiologic testing under the Medicare diagnostic benefit category. They may provide online digital assessments as diagnostic services for patients when a physician or nonphysician practitioner orders an assessment of hearing and/or balance that requires a battery of tests. ASHA understands that the statutorily established Medicare benefit classifies audiology services as diagnostic tests. However, ASHA maintains that the examples outlined

below describe services that appropriately involve the referring physician and stay within the Medicare diagnostic benefit.

Patient with a cochlear implant: A Medicare beneficiary recently received a cochlear implant (CI)—a surgically implanted device to help with severe hearing loss. The physician refers the patient to an audiologist for CI analysis and programming (CPT codes 92601-92604). The audiologist has been seeing the patient to activate the external sound processor post-surgery, and to perform the diagnostic analysis and programming of the implant. Initial programming typically occurs over a series of visits and is individualized to each patient based on the results of the diagnostic analysis of auditory perception. Additional programming may also be necessary to adjust the sound processor to accommodate improvements or decline in the patient's ability to hear and understand speech.

The patient contacts the audiologist through the secure patient portal after the initial programming has occurred to report that she is not hearing well with the CI. After finishing clinical care for the day, the audiologist reviews the message received through the portal and responds with a series of questions to assess if it may be a malfunction with the CI equipment, a change in health status that may require medical attention, or a need for the audiologist to adjust the programming of the CI. The patient answers the initial questions and a few follow-up questions through the portal. Based on the patient's description of the problem and examples of specific situations in which hearing is most challenging and any precipitating events, the audiologist determines that the hearing difficulties are likely due to equipment malfunction and recommends the patient contact the CI manufacturer's consumer line directly to troubleshoot the CI processor for possible repair or replacement. The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the portal. This scenario illustrates a shorter interaction that could be reported with GNPP1/98X00 (5-10 minutes cumulative).

However, if the initial exchange points to issues unrelated to equipment malfunction, the audiologist will proceed to ask additional questions to assess whether this is a potential change in health status or a need for further analysis and programming of the CI. This involves reviewing relevant medical history such as recent head trauma or injury to the site over the implant, illness, hormonal changes, and/or medications. This can lead to a consult with the referring physician that results in the patient's follow-up office visit with the physician, a recommendation for additional CI programming with the audiologist, or a discussion of strategies the patient can implement before returning for a regularly scheduled follow-up appointment for diagnostic analysis and programming. The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the portal. This scenario illustrates a lengthier interaction that could be reported with GNPP2/98X01 (11-20 minutes, cumulative) or GNPP3/98X02 (21 minutes or more, cumulative), depending on the patient's ability to describe symptoms and the level of follow-up probing required.

Patient with tinnitus: A Medicare beneficiary has previously been evaluated by the physician and audiologist with a diagnosis of tinnitus. This includes the audiologist's diagnostic testing of tinnitus severity, current level of tinnitus handicap, and impact on daily function (CPT code 92625). The testing may also include a brief depression screening, as required by Measure #134 of the Medicare Merit-Based Incentive Program (MIPS).⁴ The

physician has reviewed the results of the audiologic testing and discussed treatment options with the patient.

The established patient contacts the audiologist through the secure patient portal four months later, reporting a sudden increase in tinnitus loudness, severity, and impact on concentration and sleep. The audiologist responds with a series of questions about health and medication changes and administers standardized questionnaires such as a tinnitus handicap inventory (THI) and/or tinnitus function inventory (TFI) via the portal to assess the amount of tinnitus the patient is currently experiencing. The patient answers the initial questions and completes and returns the questionnaires. The audiologist compares current results to initial measures. Based on the patient's description of the problem and amount of tinnitus change and medical history, the audiologist determines that a referral to an otolaryngologist is needed. The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the secure patient portal. This scenario illustrates a shorter interaction that could be reported with GNPP1/98X00 (5-10 minutes cumulative).

However, if the initial exchange points to potentially complicated personal, emotional, or psychosocial issues being involved, the audiologist will proceed to ask additional questions to assess the patient's depression level and risk of harm to self and others. If the patient is reporting severe—but not emergent—changes the audiologist will consult with the referring physician, which may lead to referring the patient to an appropriate physician or behavioral health professional for intervention. If emergent needs are identified, the audiologist, as a mandatory reporter, is required to proceed with additional referrals (such as psychiatry, psychology, and/or primary care) and recommendations to ensure the safety of the patient. The audiologist saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the secure patient portal. This scenario illustrates a lengthier interaction that could be reported with GNPP2/98X01 (11-20 minutes, cumulative) or GNPP3/98X02 (21 minutes or more, cumulative), depending on the patient's ability to describe symptoms and the level of severity that is being reported.

Speech-Language Pathology Services and Clinical Scenario

Speech-language pathologists (SLPs) provide evaluation and treatment services under a physician-certified plan of care as part of the Medicare therapy benefit category. They may provide online digital assessments to periodically engage with patients and family/caregiver(s) to assess functional performance during an episode of care. The following example illustrates a typical scenario.

Patient with swallowing difficulties: A Medicare beneficiary has been seeing an SLP for treatment of swallowing difficulties following a stroke. The plan of care has been certified by the physician, as required by Medicare. Treatment of swallowing dysfunction may include training on how to use muscles for chewing and swallowing, identifying ways to position the head and body when eating, teaching strategies to help swallow better and safer, and making recommendations regarding food texture and consistency to make swallowing easier for the patient. Families and caregivers are often actively engaged in strategies to ensure the patient is swallowing safely and effectively at home by helping with exercises, making food and drinks the patient can swallow safely, and keeping track of how much the patient is eating and drinking.

A few weeks after initial therapy, the patient and/or family contacts the SLP through the secure patient portal, noting that they are having trouble implementing the exercises and safe swallowing strategies that the SLP worked on with the patient in treatment. After finishing therapy for the day, the SLP reviews messages that have come in through the secure patient portal. The SLP responds to the message with follow-up questions regarding the patient's response to exercises and probes for more information regarding specific situations or foods the patient may be having trouble with. After response from the patient and/or family the next day, the SLP provides some strategies to address the functional impairment and sends links to online videos that demonstrate those strategies in practice. The SLP saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician. This scenario illustrates a shorter interaction that could be reported with GNPP1/98X00 (5-10 minutes, cumulative).

After a few more sessions of face-to-face therapy, the SLP instructs the family to closely monitor how much food and how many calories the patient consumes over a two-week period and what types and textures of foods the patient can tolerate. After two weeks of monitoring, the family uses the secure patient portal to report this information to the SLP, who assesses the patient's progress and asks probing questions. Based on the assessment, the SLP consults with the referring physician regarding concerns with changes in health status, which could lead to recommending the patient schedule an appointment with their physician, return to the clinic for additional therapy with the SLP, or implement additional at-home safe swallowing strategies and exercises before returning for a regularly scheduled treatment session. The SLP saves the clinical documentation of the assessment to the medical record and forwards a copy to the referring physician through the secure patient portal. This scenario illustrates a lengthier interaction that could be reported with GNPP2/98X01 (11-20 minutes, cumulative) or GNPP3/98X02 (21 minutes or more, cumulative), depending on the family's ability to track and describe symptoms and progress, and the level of follow-up probing required.

Audiologists and SLPs already provide e-visit services within their scope of practice and the Medicare benefit. The ability to report and receive equitable payment for these e-visit services promotes timely and collaborative care, potentially reduces the need for unnecessary office visits, and ensures that additional referrals are made to the most appropriate health care professional. As such, **ASHA urges CMS to include audiologists and speech-language pathologists as eligible providers for reporting e-visit services (HCPCS G-codes GNPP1-GNPP3 or CPT codes 98X00-98X02).**

ASHA also encourages CMS to continue its efforts to appropriately reimburse all members of the health care team for using other technology-based communication services (e.g., G2012 for virtual check-in) to ensure timely access to care and to monitor—on an ongoing basis—for the appropriate inclusion of other health care services.

CY 2020 PFS Impact Discussion: Estimated Impacts Related to Proposed Changes for Office/Outpatient Evaluation and Management (E/M) Services for CY 2021 (pg. 40885)

Although CMS is not proposing changes to E/M coding and payment for CY 2020, the Agency provides a brief discussion of the projected impact of the proposed changes to E/M services for CY 2021. ASHA is dismayed by the scale of the negative impact estimated for several specialty groups—including audiologists and speech-language pathologists. Many of these specialties do

not currently have access to E/M services as part of their Medicare benefit category to help potentially offset the proposed reductions in reimbursement in 2021.

Other Medicare payment reductions, such as the multiple procedure payment reduction (MPPR) applied to therapy services, sequestration, and expected negative payment adjustments associated with MIPS compound the proposed reduction and cannot be considered in a vacuum. In Table 114 of the proposed rule, CMS estimates that 13% of MIPS-eligible clinicians will receive a negative payment adjustment. Nearly 25% of small practices, including audiology and speech-language pathology practices, will be subject to negative payment adjustments under MIPS.

To prepare our members, ASHA requires an understanding of how the cost of the proposed changes will be distributed across the MPFS. ASHA requests CMS provide additional information and data to support the projections and discuss in further detail how and why some specialties that do not bill E/M services under the Medicare benefit are affected.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (pg. 40517)

In the proposed rule, CMS states it did not receive recommendations for adding new codes to the list of approved telehealth services for 2020. Therefore, CMS determined that it has identified all telehealth services. ASHA disagrees that all appropriate services have been identified, and will submit additional codes for consideration as telehealth services for the 2021 rulemaking cycle in advance of the February 2020 deadline.

CY 2020 Updates to the Quality Payment Program (pg. 40730)

Audiologists and SLPs first became eligible for MIPS in the 2019 performance year and related 2021 payment year. CMS proposes several changes to MIPS of direct interest to ASHA's members including modifications to the audiology and speech-language pathology specialty measure sets and the development of MIPS Value Pathways (MVPs). **ASHA seeks clarification regarding the application of the cost performance category to audiologists and SLPs and CMS's current position regarding any potential changes to the low-volume threshold.**

Modifications to the Audiology and Speech-Language Pathology Specialty Measure Sets

In the proposed rule, CMS adds additional measures to the specialty measures sets for audiologists and SLPs. For audiologists, CMS proposes to include three new measures including Measure 181: Elder Maltreatment Screen and Follow-Up Plan; Measure 182: Functional Outcome Assessment; and Measure 318: Falls: Screening for Future Fall Risk. For SLPs, CMS proposes adding two new measures including Measure 181: Elder Maltreatment Screen and Follow-Up Plan and Measure 182: Functional Outcome Assessment. ASHA fully supports the addition of these measures because it will allow audiologists to meet the minimum reporting threshold of six measures and it provides SLPs the opportunity to move closer to meeting the reporting threshold. ASHA recommends the following specific Current Procedural Terminology (CPT) codes for reporting purposes as outlined in the following tables.

Measure 181: Elder Maltreatment

	CPT codes that trigger reporting	Rationale
Audiology	92550, 92557, 92567, 92540, 92541, 92542, 92587, 92588, and 92625	These codes represent the full spectrum of audiologic evaluation services and such a screening should take place at evaluation. Additionally, audiology services are restricted to diagnostic testing under statute.
Speech-Language Pathology	92529, 92521, 92523, 92524, 92610, 92626, 92627, 96105, 96112, 96113, 96125	These codes represent the full spectrum of speech-language pathology evaluation services and such a screening should take place at evaluation.

Measure 182: Functional Outcome Assess.

	CPT codes that trigger reporting	Rationale
Audiology	92537, 92540	As structured, this measure assesses function in terms of physical function. As a result, the codes represent physical function associated with balance (vestibular).
Speech-Language Pathology	92610, 92611, 92612, 92613, 92614, 92615, 92616	As structured, this measure is associated with physical function, most appropriately tied to swallowing function.

Measure 318: Screening Future Fall Risk

	CPT codes that trigger reporting	Rationale
Audiology	92540, 92541, 92542, 92548	Assessment of future falls risk should align with existing falls measures 154 and 155.

However, **ASHA opposes the removal of Measure 131: Pain Assessment from the speech-language pathology measure set.** While CMS proposes to remove this measure due to concerns that an emphasis on pain management can unintentionally lead to unnecessary opioid prescriptions and might further complicate the opioid addiction crisis, the proposal fails to recognize that not all clinicians who report this measure prescribe medication. SLPs are not authorized under any state law to prescribe medications; therefore, there is no increased risk when an SLP completes the pain assessment measure because they would not prescribe opioids or any other medication to the patient.

MIPS Performance Categories

In the proposed rule, CMS clarifies that the promoting interoperability (PI) category will not apply to audiologists and SLPs in the 2020 performance year. ASHA supports redistributing this category's score to other performance categories because the PI performance category remains difficult for ASHA's members to participate in effectively. Many of the current measures for the PI category do not apply to our members; particularly because audiologists and SLPs do not prescribe medications.

However, CMS does not explicitly propose to redistribute the cost category of MIPS to other performance categories for audiologists and SLPs. While the episode-based cost measures proposed in the rule do not include the coding (procedural or diagnostic) associated with our members' services, ASHA requests that CMS explicitly clarify that the cost category's score will also be redistributed to other performance categories for audiologists and SLPs in the 2020 performance year. Given that audiologists and SLPs do not have the authority—under Medicare policy—to control the trajectory and total cost of care for patients, ASHA opposes application of the cost performance category to our members. ASHA welcomes the opportunity to work with CMS to identify mechanisms that might appropriately address cost performance for ASHA members in the coming years.

Development of MIPS Value Pathways

CMS proposed the concept of MIPS Value Pathways (MVPs) to streamline the MIPS reporting requirements and facilitate the transition to alternative payment models (APMs). While ASHA appreciates CMS's efforts to improve the Quality Payment Program and clinicians' experiences, MVPs will not likely serve our members well as proposed. Currently, very few APMs include audiologists and SLPs and the services they provide. As structured in the proposed rule, no incentives exist to include our members and their services in APMs. The redistribution of PI compounds the challenge of including audiologists and SLPs in MVPs. While a streamlined process sounds ideal in the future, it is not applicable to our members and other nonphysician specialties because of incompatibilities with PI, cost, and other population health claims-based measures.

In a stakeholder listening session held in August 2019, CMS suggested MVPs could be built based on quality and improvement activities alone until PI and cost measures were developed. This seems to contradict the intent of MVPs and ASHA is unclear how this would resolve the various outstanding issues identified. CMS staff also suggested that specific PI measures could potentially be pulled out and included in an MVP for audiologists or SLPs. If there is flexibility in the PI category to report specific measures—rather than all measures—ASHA would fully support this as a mechanism to facilitate inclusion in more categories for MIPS and MVPs.

ASHA has significant concerns with the MVP concept as written because of its poor fit with our members' needs. **ASHA does not support the MVP concept but express our commitment to working with CMS to identify streamlined solutions for our members' participation.**

Low-Volume Thresholds

CMS does not appear to modify the low-volume thresholds for the 2020 performance year. ASHA requests that CMS confirm that the low-volume threshold will remain the same for 2020. Additionally, ASHA recommends that CMS proactively announce any potential plans for modifying the low-volume threshold over time so that clinicians can prepare appropriately for their inclusion in MIPS.

Qualified Clinical Data Registries (QCDR)

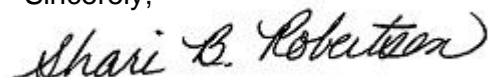
The proposed rule modifies the way CMS will evaluate and approve QCDR measures. ASHA is considering self-nominating its QCDR in the near future. To fulfill CMS's expectations regarding measures addressing a performance gap, ASHA requests clarification on whether a performance gap needs to be demonstrated by data collection via a registry over a specified period of time (e.g., two years), or if a health care survey would sufficiently demonstrate evidence of a performance gap.

Also, in determining a performance gap, the proposed rule states that QCDR measures must address a significant variation in performance. ASHA seeks additional clarification on what constitutes "significant variation" in order to ensure the ASHA proposed measures meet CMS's expectations.

Conclusion

The 2020 MPFS proposed rule contains several provisions of significant importance to audiologists and SLPs in the areas of coding and payment policy as well as quality reporting. ASHA appreciates the opportunity to submit our comments for your consideration. If you have additional questions about the coding and payment policy aspects of ASHA's comments, please contact Neela Swanson, ASHA's director for health care policy for coding and reimbursement, at nswanson@asha.org. For questions about ASHA's recommendations related to quality reporting, contact Sarah Warren, MA, ASHA's director for health care policy for Medicare, at swarren@asha.org.

Sincerely,



Shari B. Robertson, PhD, CCC-SLP
2019 ASHA President

¹ U.S. Department of Health and Human Services. (2016). Rules and regulation. Federal Register, 81. 80259. Retrieved from <https://www.govinfo.gov/content/pkg/FR-2016-11-15/pdf/2016-26668.pdf>.

² American Medical Association. (2019). *CPT Professional 2020*. 747-748. Chicago, IL: American Medical Association.

³ U.S. Department of Health and Human Services. (2018). Rules and regulation. Federal Register, 83. 59482-59483. Retrieved from <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>.

⁴ Centers for Medicare and Medicaid Services. (2018). *Quality ID #134 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan*. Retrieved from https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_134_MIPSCQM.pdf.