



September 27, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1717-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Hospital Outpatient Prospective Payment System proposed rule, which includes a proposal on price transparency of hospital standard charges and the packaging policy as it relates to audiology services.

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.

Price Transparency of Hospital Standard Charges (pg. 39582)

ASHA notes that the Centers for Medicare & Medicaid Services (CMS) used the feedback it received during the 2019 rulemaking cycle to establish a requirement for hospitals to publish cost data on their websites to enhance price transparency for consumers. Under the proposal, hospitals would publish their standard charges and payer-specific negotiated charges in a machine-readable format. If CMS determines a hospital fails to comply with this requirement, the agency will apply a civil monetary penalty of \$300 for each day of noncompliance.

ASHA supports the goal of ensuring that consumers have access to meaningful price information in order to make informed choices about the hospital-provided care. In response to the request for information issued in 2018, ASHA supported the concept of price transparency, but also recommended specific types of charge information be made available. The current proposal does not align with ASHA's previous recommendations. ASHA is concerned that consumers will not have the most transparent and useful

information with which to make informed decisions about health care services. Therefore, ASHA reiterates its recommendations from 2018.

ASHA's recommendations are founded on the following tenets: 1) improving patients' access to information on the price of their care, and; 2) protecting patients from unexpected financial exposure. ASHA recommends that CMS adopt requirements similar to Section 7 (Requirements for Participating Facilities with Non-Participating Facility-Based Providers) of the National Association of Insurance Commissioners (NAIC) Health Benefit Plan Network Access and Adequacy Model Act.¹ The NAIC Network Adequacy Model Act offers financial protections to patients by limiting their out-of-pocket (OOP) costs in emergency and non-emergency situations. In non-emergency situations, the patient's costs *may* be reduced or eliminated. However, in emergency situations, where the patient does not typically have the ability to choose their preferred provider, the patient receives *guaranteed protection* from the unexpected bill. Health care consumers require action by Congress and/or federal oversight agencies to address this significant problem that can have devastating financial consequences on individuals and families.

When considering how to define "standard charges," various studies indicate that Medicare patients are more interested in knowing their OOP costs rather than the "standard charge" for a particular item or service.² ASHA maintains this holds true for the more than 90% of Americans who have health insurance coverage, including the 14% covered by Medicare.³ Given the structure of the U.S. health care system, the payer source ultimately determines an individual's financial obligations, which do not necessarily reflect "standard charges". Out-of-pocket costs also depend on whether the health plan covers the underlying service and what the cost sharing requirements of the health plan regarding in or out-of-network status and any applicable deductibles.

Because Medicare establishes uniform rates, **ASHA recommends that CMS create a consumer-friendly resource to highlight key aspects (e.g., national rates for Current Procedural Terminology (CPT)® codes with related descriptors) of Medicare reimbursement rates in hardcopy and on the internet in a machine-readable format and disseminate that resource to beneficiaries. Providers and suppliers could direct patients to that resource as needed.** If CMS finalizes the proposal to require hospitals to share rate information, then ASHA recommends that hospitals publish only the payer-specific negotiated charges and the lowest final private payment rate on the hospital's website.

Proposed Changes to Packaged Items and Services (pg. 39423)

Packaging Policy Status Indicator (SI) for Comprehensive Audiometry (CPT code 92557)

CMS proposes to maintain a status indicator (SI) of Q1 for several audiology services in APC 5721 (Level 1 Diagnostic Tests and Related Services), including the comprehensive audiologic evaluation (CPT 92557). CPT 92557 describes the primary evaluation to diagnose a hearing loss. The testing combines the pure tone air conduction and bone conduction, and speech threshold and recognition tests, which guide the audiologist to determine the other tests necessary to further define or confirm a diagnosis. After obtaining pertinent patient history through the medical record and interview with the patient, the

audiologist performs an otoscopic examination to ensure the ear canal is clear and open. The evaluation, which relies on the behavioral responses from the patient, requires the clinical judgment of the audiologist to obtain accurate thresholds and speech scores. After the completion of the audiometric evaluation, the audiologist will determine if additional testing is necessary to further establish the type, configuration, and possible etiology of the hearing loss. Ancillary tests, such as impedance measurements or reflex thresholds, augment the information provided by the comprehensive audiologic evaluation.

Because a hearing screen is recommended as a part of the Medicare Annual Wellness Visit, and due to the high incidence of hearing loss in adults (25% of adults aged 65-74, 50% of adults aged 75 and older), it is typical for a patient to be referred to an audiologist for the comprehensive evaluation.^{4,5} The evaluation is usually scheduled in advance in the hospital clinic, is the primary reason for the appointment, and consumes most of the audiologist's time and clinical resources.

According to CMS's data file, *Costs for Hospital Outpatient Services by HCPCS Code for CY 2020*, 92557 is billed with other services 53% of the time. Additionally, in previous comments in response to the CY 2016 Proposed Rule, ASHA submitted an analysis of 2014 OPSS claims data, which showed that the comprehensive audiologic evaluation was the primary and only service billed for 47.4% of the total claims. However, of the remaining 52.6% that were billed on the same date of service with other procedures that resulted in a "bundled" payment, 60.2% of the services billed together with 92557 were unknown or unrelated. The table below delineates the highest numbers of services that inappropriately resulted in the "bundled" payment of CPT 92557.

Top 4 Unrelated Procedures Billed with CPT 92557

Procedure Code	Description	Number Billed
G0463	Hospital outpatient clinic visit for assessment/management of a patient	27,498
31575	Diagnostic laryngoscopy	973
31231	Nasal endoscopy	611
70553	MRS of brainstem with & without contrast	414

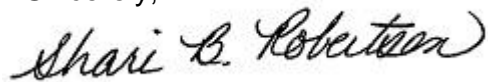
The hospital clinic visit, G0463, is a general code that does not distinguish the physician specialty. Because diagnosis codes or reason for the visit was not captured, it was not possible through this analysis to determine if the hospital clinic visit was related to the hearing evaluation, or simply scheduled for the convenience of the patient for time and travel.

Given this data, ASHA is concerned that the SI of Q1 for 92557 continues to pose significant difficulty for hospital audiology clinics, as a comprehensive audiologic evaluation is *the primary evaluation* of hearing performed by audiologists in conjunction with other ancillary services. It is comparable to the basic vestibular evaluation (CPT 92540), which

combines subparts of the vestibular evaluation and acts as the primary procedure for the diagnosis of a balance disorder. Appropriately, CPT 92540 is assigned an SI of S. **As such, ASHA strongly urges CMS to assign CPT 92557 an SI of S.**

Thank you for considering ASHA's comments on this proposed rule. If you or your staff have any questions regarding the price transparency for standard hospital charges section, please contact Sarah Warren, MA, ASHA's director for health care policy, Medicare, at swarren@asha.org. For questions regarding packaging policies for audiology services, please contact Neela Swanson, ASHA's director for health care policy, coding and reimbursement, at nswanson@asha.org.

Sincerely,



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

¹ National Association of Insurance Commissioners. (2015). *Health Benefit Plan Network Access and Adequacy Model Act*. Retrieved from <https://www.naic.org/store/free/MDL-74.pdf>.

² Comments from Richard Besser, MD, on Proposed Rule Related to Standard Charges by Hospitals and Transparency Around Out-of-Pocket Costs, Robert Wood Johnson Foundation, June 25, 2018. Retrieved from <https://www.rwjf.org/en/library/articles-and-news/2018/06/comments-from-richard-besser-on-proposed-rule-related-to-standard-charges-by-hospitals-and-transparency-around-out-of-pocket-medical-costs.html>.

³ Henry J. Kaiser Family Foundation. (2017). *Health Insurance Coverage of the Total Population*. Retrieved from <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁴ Centers for Medicare and Medicaid Services. (2018). *Annual Wellness Visit*. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf.

⁵ National Institute on Deafness and Other Communication Disorders. (2016). *Quick Statistics About Hearing*. Retrieved from <https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing>.