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April 30, 2014

Federal Trade Commission  
Office of the Secretary  
Room H-113 (Annex X)  
600 Pennsylvania Avenue, NW  
Washington, DC 20580

VIA ELECTRONIC SUBMISSION

**RE: Health Care Workshop, Project No. P131207**

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The American Academy of Audiology (the “Academy”) is the world's largest professional organization of, by, and for audiologists, representing over 12,000 members. The Academy promotes quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness, and support of research.

Below are the Academy’s remarks regarding the Federal Trade Commission (FTC) request for comment on Health Care Competition, published in the Federal Register on February 24, 2014. We commend the Agency on its commitment to improving the quality of care through adequate competition in the health care marketplace and appreciate the opportunity to provide input. Based on the general areas for which the FTC is seeking comments, the Academy offers information on: professional regulations which unnecessarily restrict scope of practice, telemedicine and measuring and assessing quality.

**Unnecessary Professional Regulations**

I. **Unneeded Medicare Referral Requirement**

The Academy appreciates the Agency’s interest in the implications of professional regulations on health care. As you review ways in which health care may be improved through access and competition, we urge you to consider the effect of eliminating current barriers to the services that audiologists provide within the Medicare system. Audiologists are doctoral- and masters-level professionals trained to evaluate, diagnose, treat, and manage hearing and balance disorders. Under the current system, diagnostic testing for hearing and balance services requires an unnecessary physician’s order. At present, to ensure coverage for hearing tests, Medicare patients must first seek a referral from their physician instead of being

allowed access to an audiologist as an entry point for hearing and balance care. Often, the physician (likely a primary care provider) will first refer to an otolaryngologist (ear, nose and throat specialist) who will ultimately have to refer to the audiologist. This system is inefficient and results in additional and unnecessary costs to the patient and duplicative services from an already fiscally challenged Medicare program. There are myriad examples of the efficacy and safety of audiologists as an entry point for hearing and balance care delivery (e.g. the military, the Veterans Administration). Although audiologists refer to a physician if a medical condition is present, the overwhelming majority of hearing loss, approximately 90-95%, may be treated through amplification alone (audiology services), while only 5-10% of hearing loss requires medical or surgical intervention by a physician. We strongly believe that the removal of these outdated barriers would greatly increase efficiency and would align with the type of delivery system the Agency seeks to achieve. As the size of the Medicare-eligible population continues to grow, and as private insurance plans often look to the Medicare model for guidance on their benefit design, the implications of a broader entry point may be far-reaching.

Hearing loss among the Medicare population is currently under-diagnosed and under-treated. If Medicare beneficiaries had direct access to an audiologist, more seniors with hearing loss might obtain the requisite tests and necessary treatments to allow them to continue their independent lifestyles and maintain their quality of life. Eliminating the referral requirement would improve Medicare beneficiaries' access to hearing care and, studies show, result in a cost-savings to the system<sup>1</sup>.

For over a decade, the Academy has sought to correct this inefficient and unwarranted model through legislation, most recently through the introduction of H.R. 4035/S. 2046 in the 113<sup>th</sup> Congress. Continued opposition by the physician community has presented challenges to these efforts.

## II. Restrictions on Billing Evaluation and Management and Treatment Codes

Under Medicare statute, audiologists are only recognized and reimbursed for diagnostic hearing and balance procedures. Diagnostic procedures, as defined by Medicare, do not reflect the full scope of practice that audiologists can perform under their state licensure laws. The components of evaluation and management procedures include examination, history taking, medical decision making, and coordination of care. Audiologists are also trained and allowed to perform treatment services such as balance treatment and cerumen removal under the majority of state licensure laws. While some public/government payers (e.g., Medicaid programs) and private/commercial payers, may pay for evaluation and management and treatment

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<sup>1</sup> Dobson, A., et. al., Determining Potential Medicare Savings by Streamlining Beneficiary Access to Audiology Services, Projected Impact of Direct Access for Audiologists (2013).

services that audiologists are authorized to render under State scope of practice laws, Medicare payment for health care services and items is limited by Federal statute to specific benefit categories. Since Medicare does not recognize these services when provided by audiologists, patients must currently pay out-of-pocket for these services which would otherwise be reimbursable when performed by another provider type. Unfortunately this may encourage patients to seek the more expensive physician-centric model.

## **Telemedicine**

Tele-audiology is currently not widespread because initial implementation is costly and requires highly specialized technology, software, and information networks, as well as pedantic consideration of space, in terms of size and layout, acoustics, lighting, and accessibility, to function seamlessly. Further, tele-audiology services are presently not commonly reimbursed by third party payers. Despite the barriers that audiology faces, however, telehealth continues to develop. Clinical literature contains many articles demonstrating tele-audiology applications such as aural rehabilitation<sup>2</sup>; cochlear implant programming<sup>3</sup>; hearing aid programming<sup>4</sup>; infant hearing screening programs<sup>5</sup>; and audiometry<sup>6</sup>. A systematic review of tele-audiology evidence published in 2010<sup>7</sup> reported a growing number of papers which demonstrate the feasibility and reliability of audiological services delivered through telehealth means. Current evidence shows that not only is tele-audiology technically feasible; it can also be an effective natural and integral part of audiology practice.

At the present time, CMS limits telepractice services to certain originating sites located in rural health professional shortage areas or in counties that are not included in a Metropolitan Statistical Area and limits coverage to: consultations, outpatient office visits, psychotherapy, pharmacologic management, psychiatric interview, individual health and behavioral assessment, neurobehavioral status exams, end-stage renal disease services, nutrition therapy, and inpatient telehealth consultations and follow-ups by designated telehealth practitioners. Furthermore, only physicians,<sup>8</sup> physician assistants, nurse practitioners, clinical nurse specialists, nurse-midwives, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals are among the list of eligible telepractice providers under Medicare (42 CFR 410.78).

Conversely, the Department of Veterans Affairs (VA) recognizes the value of, and has subsequently increased the presence and use of, tele-audiology practice. Following a 2011 10-

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<sup>2</sup> Polovoy, 2009; Yates and Campbell, 2005

<sup>3</sup> Wasowski et al., 2002

<sup>4</sup> Campos and Ferrari, 2012; Dennis et al. 2012; Galster and Abrams, 2012

<sup>5</sup> Krumm et al., 2005, 2007; Lancaster et al., 2008; Hayes et al., 2012

<sup>6</sup> Crowell et al, 2011; Givens and Elangovan, 2003; Givens et al, 2003; Krumm et al. 2007; and Swanepoel, 2012

<sup>7</sup> Swanepoel & Hall, 2010

<sup>8</sup> A doctor of medicine or osteopathy, including an osteopathic practitioner, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, a doctor of chiropractic

site pilot project to investigate the feasibility of remote hearing aid programming and verification via telehealth, tele-audiology sites were greatly expanded in FY 2012. The VA increased tele-audiology encounters from 356 in FY 2010 to over 7,200 in FY 2013, making audiology one of the top 15 VA telehealth programs. This growth clearly demonstrates the success of tele-audiology practice in the VA.

Given the empirical data which evidences the efficacy of tele-audiology, restrictions imposed by Medicare statute are unnecessary and impede access to hearing health services for beneficiaries in underserved areas. Moreover, the aforementioned Medicare physician referral requirement adds an additional challenge to audiology's inclusion in the Medicare benefit and stands to negate the intent of telehealth services, aimed at streamlining and expanding access to care.

### **Challenges to Measuring Quality**

Much of audiology's quality measurement is presently within the Medicare Physician Quality Reporting System (PQRS). Audiology does not currently have a nationally-recognized data reporting or collection system, nor do we have a registry under which to report, thus participation in the PQRS serves as the primary repository for data related to quality. Although audiology was among the last to be added to the list of qualified providers who may report under the PQRS, audiologists are consistently among the most successful among accurately reporting professions. The audiology community worked with CMS contractors to develop four audiology measures for the PQRS in 2009. However, two of those four measures were recently retired by CMS without explanation and the National Quality Forum (NQF) recommended retirement of a third audiology-specific measure, leaving audiologists with one audiology-specific measure, and two additional multidisciplinary measures, on which to report in 2014. Additionally, audiologists are currently not among the list of eligible providers who may qualify for the electronic health records (EHR) incentive, ergo EHR adoption among audiologists is also not yet widespread.

Audiologists are providers of cost-efficient, high quality care and want to be effective participants under quality programs but do not currently have the resources or tools to expedite the measures development process. We believe some onus should be on the facilitator of these programs to assist smaller specialties who wish to participate in these programs to develop quality measures that meet the evidence-based, scientifically sound criteria of the NQF.

Due to the aforementioned hindrances, audiology's quality reporting is, at present, largely limited to the Medicare program. The reporting challenges outlined in this section, as well as the restrictions on the services audiologists may provide referenced above, renders participation in the PQRS in the full sense of the spirit in which it was conceived problematic at best. Adequately measuring the quality and efficacy of the services provided by audiologists under a program in which so many barriers impede performance and restrict practices remains challenging to the profession of audiology. As Congress looks to permanently repeal the Sustainable Growth Rate (SGR) and transition Medicare from a fee-for-service to a pay-for-performance model, the

consequences to smaller professions such as audiology have the potential to be expansive and unjustly punitive. Without resources to develop additional measures, and an inadequate number of existing measures, successful participation in current and future value-based programs is at risk.

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Limiting patient access to and choice of qualified, licensed health care providers reduces competition and concentrates market share. The result is economic benefit for other providers, at an increased cost and sacrifice of quality for consumers. The Academy appreciates the opportunity to offer input on this request for comments and holds a keen interest in any opportunities to work with the FTC in its efforts to improve consumer access and choice in the health care marketplace. Please contact Melissa Sinden, Senior Director of Government Relations, at 202.544.9335 or by email, [msinden@audiology.org](mailto:msinden@audiology.org) if you should need additional information or clarification regarding the Academy's comments.

Sincerely,

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President, American Academy of Audiology