September 12, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05 7500 Security Blvd.
Baltimore, MD 21244-1850

Re: RIN 0938-AV50

Medicare and Medicaid Programs; CY 2026 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

By Electronic Mail: MedicarePhysicianFeeSchedule@cms.hhs.gov

Dear Administrator Oz,

The Academy of Doctors of Audiology (ADA) appreciates the opportunity to comment on the CY2026 Medicare Physician Fee Schedule (MPFS) Proposed Rule put forward by the Centers for Medicare and Medicaid Services (CMS).

The Continued Medicare Reimbursement for Landscape Audiology and Vestibular Services is Unsustainable

While ADA applauds the CY2026 Medicare Physician Fee Schedule (MPFS) Proposed Rule contains a 3.3% increase in the conversion factor for CY2026 (from $32.35 to $33.42) and proposed updates to geographical indices, we are concerned that 1) 2.5% of this increase is for one-year only and 2) numerous codes, including, potentially some audiology related codes, are slated to have work value adjustments, which could, ultimately, negatively affect provider reimbursement. This continued assault on Medicare reimbursement is unsustainable and devastating to practices as they grapple with inflation and increasing labor costs.[1] We respectfully request that CMS begin to explore alternative means of retaining budget neutrality other than solely through reductions in healthcare provider reimbursement. There are many alternatives (rescinding the requirement for budget neutrality and increasing patient deductibles and instituting co-payments for specialty services) that should be evaluated and explored.

[1] Inflation rate documentation: https://www.usinflationcalculator.com/inflation/current-inflation-rates/

ADA Commends CMS for Taking Steps to Improve Access to Audiology Services for Medicare Beneficiaries and for Identifying Statutory Challenges Impacting the Provision of Audiology Services Under Medicare

The CY2023 MPFS Final Rule contained provisions to allow audiologists to furnish certain diagnostic audiology services without a physician order through use of an AB modifier. ADA applauds CMS for confirming its administrative authority to remove the physician order requirement as a condition of coverage for audiology services via notice and rulemaking, for taking steps to align Medicare reimbursement policies with best practices in the delivery of hearing and balance services, and for creating and implementing the AB modifier. This was a large step forward for access to audiologic care.

ADA agrees with CMS' assessment that the classification of audiologists within the Medicare statute is incongruent with statutory classifications for similarly trained non-physician providers (NPP), who are categorized as practitioners under section 1842(b)(18)(C) of the Act. ADA also concurs with CMS' assessment that the statutory classification of audiology services as "other diagnostic tests" under section 1861(s)(3) of the Act prohibits coverage of audiology treatment services when delivered by audiologists. CMS documents the misalignment between CMS policies and audiology's scope of practice, in the Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services, as follows:

"F. Audiological Treatment. There is no provision in the law for Medicare to pay audiologists for therapeutic services. For example, vestibular treatment, auditory rehabilitation treatment, auditory processing treatment, and canalith repositioning, while they are generally within the scope of practice of audiologists, are not those hearing and balance assessment services that are defined as audiology services in 1861(ll)(3) of the Social Security Act and, therefore, shall not be billed by audiologists to Medicare."[2]

Members of Congress, with support from ADA and a broad coalition of audiologists, physicians, consumers, and industry representatives are seeking a legislative remedy to address Medicare's statutory deficiencies in the classification of audiologists and audiology services. This legislation, the Medicare Audiology Access Improvement Act (S.1996 and HR2757), seeks to amend the definition of audiology services to include Medicare-covered treatment services that audiologists are licensed to provide under their state scope of practice, to reclassify audiologists with similarly trained NPPs as practitioners under 1842(b)(18)(C) of the Act, and to remove the physician order requirement as a condition of coverage for all Medicare-covered audiology services.

ADA is pleased to provide supporting documentation as evidence that a physician order is not mandated for coverage for beneficiaries seeking audiology services under Medicare Part C (Advantage), Medicaid, the Veteran's Health Administration, Tricare, Federal Employee Health Benefit Plans, and commercial health plans[3]. None of these non-HMO health plans require a physician order for coverage of medically necessary, comprehensive, audiologic or vestibular items or services, irrespective of the relationship between the audiologist and the beneficiary's treating/attending physician or non-physician practitioner.

[2] Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services (Rev. 11426, 05-20-22) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

[3] https://www.amplifonusa.com/content/dam/ahhc/documents/downloadable-files/provider/2022%20Provider%20Resource%20Manual.pdf

Even your own data, from the CY2026 Proposed Rule (pages 387-389) show the incredibly low risk that audiologic diagnostic evaluation services pose to a beneficiary. Audiology has a risk index of .015, while our non-surgical physician colleagues in General Practice have a risk index of .723 and non-surgical Otolaryngologists have a risk index of .711, producing a 47.4% higher risk index. This is a perfect illustration of the unnecessary nature of the physician order.

ADA strongly recommends CMS allow the following procedures to have no limitations on the number of visits per 12 months without a physician order. These procedures are indicated in Table A. These procedures, by their very nature, 1) require physician involvement during candidacy and the required engagement of the implanting surgeon, 2) require an on-going, collegial relationship between the audiologist and implanting surgeon throughout the implantation process, 3) require limited physician involvement post-activation, and 3) require a re-evaluation time frame that typically exceeds once per 12 months.

The required physician order has always been an administrative nuisance and barrier to care for the beneficiary and the ordering physician. Also, given the numbers of auditory prosthetic device recipients, over-utilization should not be a concern as data can be tracked via the surgical procedure codes. In an effort to contain misuse and over-utilization, this AB modifier use could also be tied to specific ICD-10 diagnosis codes, such as H90 (conductive and sensorineural hearing loss), Z44 (encounter for fitting and adjustment of external prosthetic device), Z45 (encounter for adjustment and management of implanted device) and Z96.2 (presence of otological and audiological implants). These codes accompanying this modifier and, possibly, the associated ICD 10 codes, would be paid individually at their calendar year (CY) allowable rates and would not be subject to the one visit per 12 months limitations.

Table A: Audiologic Services Furnished Personally by an Audiologist Without a Physician/NPP Order For Evaluation to Determine Candidacy for a Surgically Implanted Hearing Device (for Example, a Cochlear Implant or an Osseointegrated Implant), for Post-Surgical Evaluation of Performance or for the Diagnostic Analysis and Subsequent Reprogramming of a Cochlear Implant or Auditory Brainstem Implant

CPT Code	Short Descriptor
92601	Cochlear implt f/up exam <7
92602	Reprogram cochlear implt <7
92603	Cochlear implt f/up exam 7/>
92604	Reprogram cochlear implt 7/>
92626	Eval aud funct 1st hour
92627	Eval aud funct ea addl 15
92640	Aud brainstem implt program
926X1	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
926X2	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each addnl 15 minutes

ADA Recommends Permanent Inclusion of Audiologists as Eligible Telehealth Providers

While ADA wholeheartedly supports the changes being considered regarding telehealth and the inclusion of audiology services and their associated codes, we are concerned that audiologists are not yet permanently classified as eligible telehealth providers.

Teleaudiology provides much needed access to audiologic services in rural and underserved communities. Given the risks associated with untreated hearing loss[4], access to audiologic services can decrease overall healthcare costs[5].

We encourage CMS to take all steps within their legal and regulatory authority to ensure that Medicare beneficiaries have continued access to telehealth services provided by audiologists.

ADA Expresses Significant Concerns About the Proposed Hearing Aid Service Codes 9X01X-9X13X

The Proposed Rule introduced the audiology community to 12 new hearing aid service codes. ADA is perplexed by the inclusion of these codes in the Proposed Rule given Medicare's long-standing, statutory exclusion to hearing aids and any services related to the fitting or modification of a hearing aid. Given this inclusion in the Proposed Rule, we felt we had an opportunity to formally document our concerns.

ADA harbors considerable concerns about the establishment of these codes, their bundled, inclusive, time-based descriptions, the elimination of 92590-92595, and the potential negative impact of these hearing aid service codes on audiologists, specifically those in private practice and who participate with insurance, and their patients. ADA shared its concerns with the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA), who have shepherded these codes numerous times. In fact, ADA became so gravely concerned about the consequences of this initiative that ADA and its expert volunteers rescinded their participation in the joint workgroup developing these codes in 2023 (almost a year before introduction of these codes at the CPT Editorial Panel), when it became clear that the establishment of this new hearing aid service code set was the final, determined direction, without consideration of the numerous concerns raised. ADA's workgroup rescission letter is attached to this comment.

ADA concerns include, but are not limited to the following:

- Potential scope of practice limitations may impact implementation of these codes. Several states' licensing laws do not explicitly authorize audiologists and hearing aid dispensers to perform all services contained in the bundled codes.
- Certain codes contain services that are not suitable for pediatric cases (as some of the aspects of some of the codes cannot be performed on children or developmentally challenged individuals)
- The bundled codes pose challenges for documenting medical necessity (as some of the required aspects of some of the codes will not be medically reasonable and necessary for every patient).

The combined deletion of existing CPT codes 92590-92595 further complicates the situation as the Veteran's Administration Community Care Program (VACCN[6]) and 21 state Medicaid programs currently recognize and allow this deleted code set. Unlike VACCN, in the case of the state Medicaid programs, for

[4] (https://www.hopkinsmedicine.org/health/wellness-and-prevention/the-hidden-risks-of-hearing-loss)
[5] (https://publichealth.jhu.edu/2018/patients-with-untreated-hearing-loss-incur-higher-health-care-costs-over-time).
[6] https://www.va.gov/COMMUNITYCARE/revenue-ops/Fee-Schedule.asp

these 21 state programs, there is no Healthcare Common Procedure System (HCPCS) code to use in the interim. Patient care and provider participation and reimbursement could be significantly impacted by the VACCN and Medicaid's program ability to operationalize 12 new codes (in place of six codes) by January 1, 2026.

ADA respectfully requests that CMS pause the deletion of 92590-92595 and the implementation of 9X01X-9X13X until the potential issues we have outlined can be addressed and editorial changes can be considered.

ADA Supports Merit-Based Incentive Payment System (MIPS) Changes

ADA has been a long-time, stalwart of quality and outcome measures and metrics. We support the proposed Audiology specialty set for 2026. Audiology's participation will continue to be negatively impacted by the low volume threshold (which the vast majority of audiologists cannot meet) and our profession's classification within the Medicare system (i.e. "other diagnostic services"), which does not allow us to bill Medicare for medically necessary treatment (which produces measurable outcomes) and limits are eligibility to participate in MIPS Value Pathways, including Ambulatory Specialty Models and Alternative Payment Models

ADA respectfully requests re-evaluation of the low volume threshold and the status of audiology and qualified audiologists within the Medicare system. We produce significant patient outcomes, especially related to the treatment of hearing loss and falls reduction, yet there are limited mechanisms afforded us to illustrate those outcomes, quality and scope of care and their impact on overall health and well-being.

Conclusion

ADA appreciates the opportunity to provide CMS with its detailed analysis of the CY2026 MPFS Proposed Rule and constructive recommendations for improvement and access to care. ADA will be pleased to offer further information or expertise in policy design or implementation in the provision of audiology services. Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org if you have any questions, or if we can assist you in any way.

Respectfully,

Amyn Amlani, Ph.D.,
President

Kim Cavitt, Au.D.
Director of Reimbursement

Stephanie Czuhajewski, MPH, CAE
Executive Director

Enc: Letter from ADA to AAA and ASHA regarding concerns related to new hearing aid service codes.

April 13, 2023

Kathryn Werner, MPA
COO
American Academy of Audiology
11480 Commerce Park Dr., Ste. 220
Reston, VA 20191

Neela Swanson
Director of Health Care Policy, Coding, & Reimbursement
American Speech Language Hearing Association
2200 Research Boulevard
Rockville, MD 20850
Sent via e-mail

Dear Ms. Werner and Ms. Swanson,

Effective immediately, the Academy of Doctors of Audiology (ADA) rescinds its participation in the informal coalition, "Audiology Organizations" (AO). ADA participated in AO with the intent to provide meaningful input to the American Academy of Audiology (AAA) and the American Speech Language Hearing Association (ASHA) on audiology-related activities for the American Medical Association (AMA) CPT© and RUC.

ADA representatives have shared their knowledge and consistently delivered relevant, insightful input to AAA and ASHA as an AO participant. AAA and ASHA have benefitted tremendously from access to ADA volunteers with vast expertise in coding and reimbursement. Despite the offering of knowledge and experience to AO, AO has failed to meet the reasonable expectation to provide transparency and meaningful collaboration.

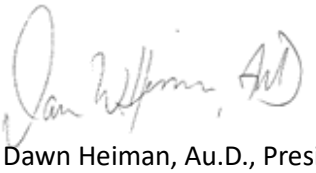
Recent actions by AAA and ASHA to withhold information regarding coding initiatives under consideration from ADA representatives, to exclude ADA representatives from key communications, and to dismiss and disregard input provided by ADA representatives who are recognized billing and coding experts, regarding risks and potential serious repercussions of such initiatives, undermine the stated purpose of AO. For example, the proposition to fast-track the hearing aid family of codes was made and advanced by AAA and ASHA in a manner void of transparency, collegiality, principled debate, and the pragmatism required for careful consideration of the potential impact to the profession of audiology and the patients we serve.

While it was noted by AAA representatives that "several stakeholders" support the new code proposals, numerous requests from ADA's representatives to review those comments went unanswered. Further, extensive comments provided by ADA representatives, separately via email, were also ignored. ADA is gravely concerned as this behavior by AO leaders is reminiscent of behavior demonstrated during the CROS and BiCROS code proposal debacle that resulted in significant, lasting harm to practicing audiologists and

their patients. ADA's continued participation in AO could be perceived as being complicit in decisions with which ADA and its members vehemently disagree.

AO has failed to provide a reliable platform for informed deliberation and meaningful input. Thus, ADA is forced to seek other opportunities to advocate for improved access, and optimal coverage and reimbursement of hearing aids and audiology services.

Sincerely,



Dawn Heiman, Au.D., President

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