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REQUEST TO ADD EVALUATION FOR PRESCRIPTION FOR SPEECH GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE (CPT 92607 & 92608) AND THERAPEUTIC SERVICES FOR THE USE OF SPEECH GENERATING DEVICE (CPT 92609) TO THE LIST OF MEDICARE TELEHEALTH SERVICES

August 21, 2020

Respectfully Submitted by:

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Assistive Technology Law Center
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Brain Injury Association of America
Center for Medicare Advocacy
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Introduction

With this request, Medicare beneficiaries with complex communication needs who require and use speech generating devices (SGDs), seek relief as to two inter-dependent matters: one related to a set of tasks; the other to the provider of those tasks. They seek Medicare approval to add three speech-language pathology (SLP) procedure codes to the list of Medicare telehealth services. They also seek Medicare authorization of payment to SLPs for telepractice delivery of these services to Medicare beneficiaries.

The procedure codes that are one focus of this request are for SLP evaluation for speech-generating devices (SGDs) and for therapeutic treatment or services related to use of an SGD. The codes are defined as follows:

92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes
92609	Therapeutic services for the use of speech-generating device, including programming and modification

Medicare has established a set of instructions applicable to the first of these requests. (CMS, 2020a). They state:

> Each request for adding a service to the list of Medicare telehealth services must address the items outlined below.
>
> > Name(s), address(es) and contact information of the requestor.
>
> > The HCPCS code(s) that describes the service(s) proposed for addition or deletion to the list of Medicare telehealth services. If the requestor does not know the applicable HCPCS code, the request should include a description of services furnished during the telehealth session.

> A description of the type(s) of medical professional(s) providing the telehealth service at the distant site.

> A detailed discussion of the reasons the proposed service should be added to the definition of Medicare telehealth.

> An explanation as to why the requested service cannot be billed under the current scope of telehealth services, for example, the reason why the HCPCS codes currently on the list of Medicare telehealth services would not be appropriate for billing the service requested.

> Evidence that supports adding the service(s) to the list on either a category 1 or category 2 basis as explained in the section labeled "CMS [Review] Criteria for Submitted Requests."

Although that action is both appropriate and necessary, it is not sufficient. Medicare telepractice authority segregates tasks and providers. Thus, in order for the addition of these codes to the Medicare telehealth list to be meaningful, SLPs – the only practitioners who perform these tasks – must be authorized to provide them by telepractice.

This request also explains that SLPs' ability to provide these services in-person have been almost completely blocked by the Covid-19 pandemic. As a result, Medicare beneficiaries have not been able to gain access to vitally necessary SGDs or to the treatment to develop the competency to use these devices most efficiently and effectively. Absent action by Medicare to allow these services to be delivered by SLPs by telehealth, Medicare beneficiaries will continue to be denied access to long-covered Medicare benefits for the foreseeable future.

Thus, *both* of these requests must be granted for Medicare beneficiaries to have ongoing access to SGDs, durable medical equipment items recognized as covered Medicare benefits for 20 years.

Section I

Name, Address and Contact Information of the Requestor.

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Medicare beneficiaries with complex communication needs that include use of a speech generating device submit this request. Because it is true – in a literal sense – that at this time these individuals are unable to speak for themselves, the organizations and individuals named below do so on these Medicare beneficiaries' behalf. These organizations and individuals represent all parties interested in ensuring Medicare beneficiaries have access to both necessary speech generating devices and the treatment services required to aid their use and benefit. They include Medicare beneficiaries and their families; physicians; speech-language pathologists and other clinicians, educators and researchers; speech generating device manufacturers and suppliers; and advocates.

The individuals and organizations listed below whose names are marked by an asterisk (*) also participated in the coalition that submitted the *Formal Request for National Coverage Decision for Augmentative and Alternative Communication Devices* (Golinker, 1999)[1] which provided the information that persuaded Medicare to adopt Medicare SGD coverage, effective January 1, 2001.

Organizations:

American Academy of Physical Medicine and Rehabilitation

ALS of Michigan

Assistive Technology Law Center [*]

Association of Assistive Technology Act Programs (ATAP)

Brain Injury Association of America [*]

Center for Medicare Advocacy

CommunicationFirst

National Disability Rights Network [*]

Rehabilitation Engineering and Assistive Technology Society of North America [*]

Speech Generating Device Manufacturers and Suppliers:

Eye Gaze, Inc.

Forbes AAC

Lingraphica

Monroe Speech Designs

---

1 Hereafter: "Formal Request."

PRC-Saltillo

SmartBox

Talk To Me Technologies

Tobii Dynavox [*]

TASH

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Section II

The CPT Codes that Describe the Services Proposed for Addition to the List of Medicare Telehealth Services

As stated in the Introduction, this request seeks the addition of three speech-language pathology (SLP) procedure codes to the list of Medicare telehealth services and Medicare authorization of SLP delivery of these services. These codes relate to SLP evaluation for speech-generating devices (SGDs) and for therapeutic treatment or services related to use of an SGD. The specific codes are defined as follows:

92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes
92609	Therapeutic services for the use of speech-generating device, including programming and modification

Section III

Description of the Type of Medical Professional Providing the Telehealth Service at the Distant Site

The three CPT codes that are the subject of this request describe services that are provided – that must be provided – by **speech-language pathologists**.

Medicare's SGD coverage guidance states unequivocally that evaluations for prescription of SGDs and treatment services related to use of an SGD must be performed by a speech-language pathologist (SLP). The Regional Medical Review Policy (RMRP) initially issued in October 2000 was the first guidance to describe the substantive scope of and procedural requirements for Medicare coverage of SGDs, which began on January 1, 2001. (Hoover, R., Hughes, P., Metzger, P., Oleck, A., 2000; CMS, 2001b). The RMRP stated:

> A speech generating device is covered when all of the following criteria (1-7) are met:
>
> 1. Prior to the delivery of the SGD, the beneficiary has had a formal evaluation of their [sic] cognitive and communication abilities *by a speech language pathologist (SLP).* ....
>
> 7. *The SLP performing the beneficiary evaluation* may not be an employee of or have a financial relationship with the supplier of the SGD.
>
> If one or more of the SGD coverage criteria 1-7 is not met, the SGD will be denied as not reasonable and necessary. (CMS, 2001b).

The RMRP also defined the required characteristics of SLPs assigned these tasks:

> [SLPs] are licensed allied health professionals trained in the diagnosis and treatment of speech and language disorders. The SLP must hold a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association [sic: American Speech- Language-Hearing Association]. (CMS, 2001b).

The RMRP was subsequently replaced by a Local Coverage Determination (LCD) for SGDs. The LCD adopted the RMRP's procedural requirement of a SLP evaluation and carried it forward without change. (CMS, 2015b). An SLP

evaluation always has been and remains an absolute pre-requisite for Medicare SGD coverage and payment.

Just after the RMRP was issued, Medicare adopted unique SLP procedure codes applicable to SGD evaluation and treatment (services). The *Formal Request* (Golinker, L., 1999, at 38-46) described the multi-step sequential SLP evaluation leading to an SGD recommendation. The first few steps of this procedure mirror the elements of the SLP-conducted speech and language evaluations that lead to recommendation of treatment to improve speech and other natural communication methods, such as sign, writing, and gesture. Some individuals, however, will still not be able to meet daily communication needs with such treatments. For those, the SLP evaluation and clinical decision-making process turns to evaluation of AAC interventions, including use of an SGD. The new SLP procedure codes acknowledge this distinction among SLP tasks. The codes further acknowledge that SLP evaluation for prescription of SGDs requires different tools and different knowledge, skills, and experience as compared to SLP evaluation for prescription of other forms of speech language treatment. Also, only a small number of SLPs have made the investment in continuing their professional education and clinical practice to develop the skills required to perform SGD evaluation and provide SGD related treatment and services. The announcement of these codes stated:

> Because of the change in coverage policy on speech-generating devices, effective January 1, 2001, we needed codes that more specifically describe the services needed to evaluate and train patients to use these devices. As a result, we will be replacing CPT 92597, Evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communication device to supplement oral speech and 92598, Modification of voice prosthetic or augmentative/alternative device or supplemental oral speech, with the following new codes:
>
> G 0197 Evaluation of patient for prescription of speech generating devices. This code describes the services to evaluate a patient to specify the speech-generating device recommended to meet the patient's needs and capacity for use. This code involves face-to-face involvement of the practitioner (typically a speech and language pathologist experienced in the use of these devices) with the patient. …
>
> G 0198 Patient adaptation and training for use of speech-generating devices. This code describes the services delivered to the patient to adapt the device to the patient, and train him or her in its use. This code involves face-to-face

involvement of the practitioner (typically a speech and language pathologist experienced in the use of these devices) with the patient. ...

G 0199 Re-evaluation of patient using speech-generating devices. This code describes the services to re-evaluate a patient who has previously been evaluated for a speech-generating device, and either is currently using a device or did not have a device recommended. This code involves face-to-face involvement of the practitioner (typically a speech and language pathologist experienced in the use of these devices) with the patient. ... (65 Fed. Reg. 65376 (2000) at 65426-27).[2]

Medicare subsequently retired these "G" codes and replaced them with the three CPT codes that are the subject of this request. When these changes were announced, Medicare stated: "[s]ervices formerly billed under G 0197 will be billed using CPT code 92607... and if appropriate, CPT code 92608, ...; services billed using G 0198 will be billed under CPT code 92609 ...; services billed using G 0199 will be billed using CPT code 92607, using the -52 modifier if the service is less than 1 hour...." The new codes: 92607; 92608; and 92609, were stated to be effective January 1, 2003. (67 Fed. Reg. 79966 (2002) at 80016).

Because these codes are performed exclusively by SLPs, merely adding them to the Medicare telehealth list is a necessary but not sufficient response. Authorization of Medicare telehealth services is a two-step procedure. As a first step the codes applicable to the services must be added to the Medicare telepractice list. (85 Fed. Reg. 19230 (2020), at 19239) (adding CPT codes for SLP evaluation (92521; 92522; 92523; 92524 and SLP treatment (92507).

That one step clearly is not enough. Also required is authorization for Medicare payment of the practitioners or clinicians who will deliver these services. For the CPT codes listed above, Medicare initially stated:

"[W]e note that the statutory definition of distant site practitioners ... does not include ... speech-language pathologists, meaning that it does not provide for payment for these services as Medicare telehealth services when furnished by ... [SLPs]. (85 Fed. Reg. 19230 (2020), at 19239).

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2 Although the text includes the word "typically" the SGD coverage criteria stated in the RMRP and LCD make clear that only a SLP can provide these services. (CMS, 2015b).

Soon thereafter, Medicare waived this statutory limitation.

> CMS is waiving the requirements of section 1834 …which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. … This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including … speech language pathologists … to receive payment for Medicare telehealth services. (CMS, 2020d).

Because SLPs are the only practitioners who furnish SGD evaluation under CPT codes 92607 and 92608; because the Medicare SGD coverage guidance expressly *requires* SLPs to provide these services; and because SLPs are the only practitioners to furnish SGD treatment, it is essential that these CPT codes be added to the list of Medicare telehealth services *and* that Medicare state clearly that SLPs will be authorized to receive payment for telepractice delivery of these services to Medicare beneficiaries.

Section IV

An Urgent Need Exists to Add the SGD Evaluation and Treatment Services to the Definition of Medicare Telehealth

A. SGDs are Essential Tools to Address Vitally Important Beneficiary Needs

SGDs are defined by Medicare as "durable medical equipment that provide an individual who has a severe speech impairment with the ability to meet his or her functional, speaking needs. Speech generating devices are speech aids consisting of devices or software that generate speech and are used solely by the individual who has a severe speech impairment." (National Coverage Determination for Speech Generating Devices, 2015).

SGDs are an essential tool for the small number of Medicare beneficiaries who require and use them. The importance of SGDs was first explained to Medicare more than 20 years ago. This explanation remains true today:

> Severe communication impairments can affect every aspect of an individual's life: self-perception, independence, access to health care, and all the other routine activities of daily living that individuals without communication impairments can take for granted. Most importantly, these adverse impacts are as unnecessary as they are severe: because of the existence of [augmentative and alternative communication] AAC interventions, including [SGDs]. ...
>
> AAC interventions [including SGDs] are generally recognized as an essential, invaluable, treatment methodology for individuals with severe communication disabilities. This conclusion is based on the half-century long, generally accepted recognition by speech-language pathologists, neuroscience researchers, and the public at large, that the ability to speak and use language is the functional ability that distinguishes human beings from all other species. (*e.g.*, Batshaw and Perret, 1986; ASHA, 1991; USSAAC, 1991, S. Pinker, 1994; D. Bickerton, 1995; J. Light, 1997; J. Wilford, 1998). The federal Courts also recognize the fundamental importance of the ability to communicate, uniformly holding that state Medicaid programs must cover and provide AAC devices, because the ability to speak is "vital," and that the loss of the ability to speak is the most devastating aspect of any disability. (*Formal Request,* 1999, at

> App. I: Impacts of Severe Communication Disabilities on Individuals)[Golinker, 1999b]; *Fred C. v. Texas Health & Human Services Commission*, 1996, 1997; *Hunter v. Chiles*, 1996).[3]

Medicare's acceptance of SGDs as a covered benefit and its SGD coverage guidance, initially effective January 1, 2001, are evidence of its acceptance of SGDs' importance. Its continued recognition of this fact was confirmed in 2014-2015 when Medicare reconsidered its SGD coverage policy and guidance. At the conclusion of that effort, Medicare acknowledged that absent an effective means of communication, even ordinary, everyday activities such as a Medicare beneficiary's spouse or caregiver going to shop for groceries or to pick up a prescription from a pharmacy creates risks of harm or death. A Medicare beneficiary without an effective means to communicate urgent needs cannot safely be left alone at home. In response, Medicare expanded allowed SGD functionality to reflect new capabilities of SGD hardware and software:

> We believe it is appropriate to broaden coverage under the DME benefit category to cover speech generating devices that allow for more remote speech in the form of both audible and written communications (e.g., the generation of written messages, such as email and text messages, as well as the capability to interface electronically with a telephone to deliver speech via phone messages to individuals not in close proximity to the user of the device). We believe that a written message or phone message from an individual lacking the ability to speak serves the same purpose in communicating with individuals not in close proximity to the patient as generation of speech does in communicating with individuals who are in close proximity to the patient. For example, expressing an urgent need, such as when thirst or pain becomes unbearable, to a caregiver who is not in the home at the time serves the same purpose as expressing the need to a caregiver who is in the home at the time the message needs to be communicated. (Medicare Coverage Document for Speech Generating Devices, 2015) (CMS, 2015a).

The revised, and now current NCD for SGDs states:

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3 *See also, In re: Jeanine F.* (2000) at 5 (The Medicare ALJ stated: "The ability to communicate is one of the most vital physical functional abilities of an individual."). These administrative and judicial decisions are attached as Exhibit 2.

> Other covered features of the device include the capability to generate email, text, or phone messages to allow the patient to "speak" or communicate remotely .... (NCD for SGDs, 2015) (CMS, 2015c).

Allowing Medicare funded SGDs to support beneficiaries' "communicating remotely" with a partner "not in close proximity" instead of limiting SGDs to support of in-person speech is a paradigm of the request presented here. It is as important for SLPs to be able to evaluate and treat Medicare beneficiaries who are at a remote location as it will be for the Medicare beneficiary to use the SGD that may be the outcome of those SLP services to engage in communication with partners in a remote location.

The past two decades of Medicare SGD coverage also provided additional information relevant to Medicare's consideration of this request. First, SGDs are a rarely sought DME item. Available CMS data from 2001 to 2017 report that only approximately 200 Medicare beneficiaries per month have obtained SGDs. These figures reflect both the relatively small number of Medicare beneficiaries with SGD needs and the small number of SLPs able to provide SGD assessment and treatment services to Medicare beneficiaries.

Another relevant fact is that Medicare's SGD coverage has been and remains non-controversial. Medicare's SGD guidance states clearly the device characteristics required for Medicare coverage and payment. The 2001 NCD for SGDs required them to be "a device that generates speech, used solely by the individual who has a severe speech impairment," and they must be "dedicated speech devices." (NCD for SGDs, 2001) (CMS, 2001a). The NCD was later clarified to accept Medicare coverage of SGDs that are computer based if they "have been modified to run only AAC software." (Hoyer, 2001). The SGDs that existed in 2001 possessed these characteristics and SGD manufacturers have continued to meet these requirements as they have innovated and developed new models that take advantage of changes to SGD hardware and software. Medicare's 2015 reconsideration acknowledged the SGD manufacturers' compliance with these requirements by giving them greater discretion in SGD design:

> As long as the speech-generating device is limited to use by a patient with a severe speech impairment and is primarily used for the purpose of generating speech, it is not necessary for a speech-generating to be dedicated only to speech generation to be considered DME. .... (NCD for SGDs, 2015) (CMS, 2015c).

Equally true is that SLPs have had no difficulty completing the required evaluation and reporting procedure stated in the RMRP and LCD. That guideline outlines a professionally sound SGD evaluation. It also recognizes the essential and independent role of the SLP. The RMRP and LCD reflect the trust the DMERC medical directors developed in the nation's leading AAC researchers, educators and clinicians who wrote the *Formal Request* and then continued to offer input as these guidance documents were written. The medical directors were persuaded that SGD evaluation and treatment is provided by a small number of SLPs whose commitment to individuals with complex communication needs has led them to pursue the additional training and experience required to provide these services. In addition, these SLPs will be exercising professional and financial independence. They experience no pressure to recommend an SGD if no need exists. Alternately, when an SGD is recommended, the device will be the one most appropriate to meet Medicare beneficiaries' daily communication needs. SLPs exercise independent professional judgment because they have no financial relationship to SGD manufacturers. The RMRP and LCD make this clear: they require SLPs to certify they have no financial conflicts of interest. Based on this trust, the RMRP and LCD give SLPs the primary responsibility to establish beneficiaries' medical need for an SGD and to recommend the most appropriate device (and as necessary mounts and access aids) to meet their daily communication needs. For SGDs, in contrast to perhaps all other Medicare benefits, beneficiaries' physicians serve only a secondary role.

These conclusions about SLP commitment, skill, and independence were renewed in the 2014-2015 SGD coverage reconsideration. No changes were made to SLP roles and responsibilities related to SGD evaluation, recommendation or reporting. (LCD for SGDs, 2015) (CMS, 2015b).

Also noteworthy is that the period of current Medicare SGD coverage policy: post January 1, 2001, has been characterized by the normalization of SGD coverage and access policy among all sources of health benefits funding. By 2000, SGD coverage had been established among many of these sources, but after Medicare accepted SGDs, their coverage has become almost universal. Also, most Medicaid programs, Tricare, and countless insurers and employer-sponsored health benefits plans have adopted the Medicare SGD evaluation and reporting procedures in whole or substantial part for their own use. That procedure, including its requirement that SLPs certify their independence from SGD manufacturers and suppliers, has become the nationwide professional standard across all sources of health benefits funding. And, the SLP codes for SGD assessment and treatment have achieved almost uniform acceptance and adoption.

B. Effects of the Covid-19 Pandemic

Medicare's SGD coverage policy and guidance create extraordinary opportunities for the small number of beneficiaries with complex communication needs to acquire a tool necessary to help them meet daily communication needs. Medicare policy and guidance also have been the catalyst for these opportunities to be available to individuals who rely on other sources of health care benefits funding. However, this cornucopia of potential benefit can be accessed only if speech-language pathologists are able to provide both the required evaluation to support SGD access and the treatment services Medicare beneficiaries require to receive the full measure of benefit from their SGDs. Presently, SLPs remain ready and willing to fulfill these roles, but they are not able to do so.

The Covid-19 pandemic has profoundly interfered with Medicare beneficiaries' access to SLPs, and as a consequence, to SGDs and SGD treatment. First, individuals with the conditions most commonly associated with SGD need, such as Amyotrophic Lateral Sclerosis (ALS); cerebral vascular accident (CVA) or stroke; and cerebral palsy, are deterred from pursuing in-person SLP services because they are at heightened risk of infection, illness or death from the Covid-19 virus. As notice of these enhanced risks broadened, Medicare beneficiaries stopped visiting SLP offices, clinics or other settings or allowing SLP home visits for SGD evaluation or treatment. This choice became moot as state-wide stay-at-home and work-at-home orders led to closure of SLP practices, clinics and other settings in which in-person SLP evaluations and treatment services are delivered. Since March, it been all but impossible for SLPs to provide in-person SGD evaluation or treatment services. As Medicare has recognized:

> Given the exposure risks for beneficiaries, the health care work force, and the community at large, in-person interaction between professionals and patients poses an immediate potential risk .... This new risk creates a unique circumstance where health care professionals need to weigh the risks associated with disease exposure .... (85 Fed. Reg. 19230 (2020), at 19234).

As a result, the SGD manufacturers and suppliers report the number of new SLP evaluations for SGDs and the amount of SGD treatment has fallen significantly. One manufacturer reported its Medicare requests in May and June were 80 percent lower than a year ago. A recent ASHA survey reported that approximately 6 in 10 SLPs identified "delivering clinical services via telepractice" and "inability to provide necessary services to those who need them" are the most significant

challenges presented by the pandemic. (ASHA, 2020e). Moreover, the unpredictable course of the pandemic makes it impossible to state when barriers to SLPs to provide in-person SGD evaluation or treatment will be removed. For example, Amy Miller Sonntag, a Clinical Assistant Professor and Speech-Language Clinic Supervisor at the Ohio State University wrote:

> Our university clinic will remain open, but with several procedural changes necessitated by the ongoing pandemic. The clinic will offer a reduced number of on-site (in-person) appointments, including those for AAC services, such as SGD evaluation and treatment. The reduction is a necessary response to the decision to stagger staff schedules, to increase cleaning, and to accommodate other measures to reduce the possibility of infection. It is anticipated that these changes will remain in effect for at least the remainder of the calendar year and possibly into the beginning of 2021.
>
> Reducing the number of available in-person appointments will have an adverse effect on clients: some will be forced to wait longer for SGD evaluation and treatment; others may not be served at all. One way to mitigate the impact on clients is to offer SGD evaluation and treatment through an alternative service delivery method. Telepractice is one such alternative. For my clients, a majority of whom are adults, I will be offering only tele-services for AAC clients for evaluation and therapy for the remainder of the calendar year. I will be able to provide these services because they can be provided at no cost as our services are underwritten by the College of Arts and Sciences. (Miller Sonntag, 2020).

Other clinic directors offer similar reports about the impact of the pandemic on their service delivery capacity. For example:

> In the Northwest Center for Voice and Swallowing, where adult patients with AAC needs are evaluated and treated, we are conducting virtual visits. Since the AAC codes are not reimbursable, I am not evaluating adult patients for SGDs at this time. About 85 % of my patients present with neurodegenerative diseases, and timely device prescription is critical as they continue to lose their speech and language skills. (Fried-Oken, 2020).

A third example:

> I can report that in the Spring 2020 semester, the University of Utah Speech-Language-Hearing Clinic's initial response to the Covid-19

pandemic was to close for two weeks from mid-March until the end of March. During that period, we developed a plan and offered training so that we could convert all of our patients (who were able and consented to do so) to telehealth—this included over 90% of our patients. ... We expect to be primarily in telehealth for the remainder of the calendar year and possibly longer depending on the control of the pandemic in our state.

A complicating factor related to telehealth service delivery is that unlike many university clinics, our clinic, *does not* provide services for free. ... Therefore, we are required to follow the laws/rules for medical billing. During the pandemic we have worked with and sought advice from the University Medical Billing department, responsible for the clinic's billing, regarding coverage for telehealth services. Generally, the advice has been to continue providing services and expect that payers will adjust, which has happened with the majority of CPT codes and payers we bill. However, Medicare is an exception: we are not authorized to bill Medicare and seek payment for the SGD CPT codes. This has presented some challenges in serving patients needing AAC services.

Regarding SGD evaluation and treatment, so far we have been able to serve our patients who were receiving SGD treatment services who have Medicaid, private insurance or who are on the sliding-fee-scale. I was not able to provide SGD treatment services for a Medicare patient who just received his device in April. This patient, and his mother, who would need to bring him got in-person services, are both in the vulnerable category. Last week, given the uncertainty of when I would be able to see this patient in-person, I conducted a no-charge telehealth visit to help the patient and his mother set up his SGD to the recommended user vocabulary and provide basic training on customizing the device. Although I am technically not allowed to not charge for services, ethically, I felt I had no other choice but to at least get this patient started on being able to use his new SGD....

...[W]e receive frequent referrals for SGD evaluations for people who have ALS. Given the rapidly progressive nature of ALS and the need for these patients to maintain the ability to communicate their needs and wants in activities of daily living, it is clearly unethical in my view to postpone SGD evaluations for these patients until it is safe for them to receive in-person services. It should be noted even the MDA and ALS Association sponsored ALS clinic in the Neurology department in our medical system is currently conducting their clinic visits in telehealth due to the vulnerability of these

> patients. I have conducted three SGD evaluations in telehealth for people with ALS since April and am currently in the process of scheduling two more telehealth evaluations for patients with ALS.
>
> As reported by others, I also have found the process of conducting SGD evaluations in telehealth to be equally effective and in some aspects superior to in-person SGD assessments. … Because of their special medical status, most patients with ALS have Medicare as their primary insurance by the time they require an SGD evaluation. This was the case with the three patients I have seen so far. As mentioned previously, I felt ethically bound to complete these SGD evaluations in a timely manner, but I also had to find a way to bill for the evaluations. To date, I have received no feedback that identifies a way for the clinic to be paid for my SGD evaluations.
>
> Also worth noting is that so far, my SGD evaluation reports have raised no issues with funding sources. The manufacturer's funding department for the SGDs had no concerns with the fact that these evaluations were conducted in telehealth. One SGD has been approved and I expect the others to be approved soon.
>
> The bottom line is that while in the pandemic and beyond, the lack of ability bill the SGD codes for patients with Medicare who need to be seen in telehealth for health reasons or for best-practice reasons is causing these patients to be severely underserved and causing harm given the restriction in their ability to communicate their needs and wants in activities of daily living. (Mathy, 2020).

These examples illustrate the adverse effects of the ongoing pandemic: they are reducing the number of clients able to be served resulting in delays for some clients; no service at all for others. Although telepractice is an available alternative method to perform SGD evaluation and treatment, only SLPs able to provide services without need for reimbursement or who are willing to break their institution's rules are able to do so. Moreover, these access barriers to SLPs and correspondingly, to SGDs and SGD training will continue for the foreseeable future. Because in-person evaluation and treatment services are and will remain unavailable, there is an existing and ongoing need for Medicare recipients to be able to receive SGD evaluation and treatment through telepractice.

In short, the Covid-19 pandemic has created an existential threat to Medicare beneficiaries' SGD access and support even though no change has been made to

Medicare SGD coverage policy or guidance. The pandemic has made Medicare authorization for telepractice delivery of SGD evaluation and treatment a matter of necessity, not preference: there simply is no available alternative delivery method for these SLP services. Equally clear is that for some if not all Medicare beneficiaries with SGD needs, especially for those with progressive impairments like ALS, time is of the essence. Just waiting for restoration of in-person SLP services is not an option.

C. Telepractice Services are a Readily Available, Equally Effective Service Delivery Model for SGD Evaluation and Treatment

The effects of the Covid-19 pandemic for Medicare beneficiaries with SGD needs are as devastating as they are avoidable. Telepractice is an established, safe, and effective accommodation to overcome the barriers to access to in-person SGD evaluation and treatment. Medicare has recognized that "[i]n some cases, use of telecommunication technology could mitigate the exposure risk, and in such cases, there is a clear clinical benefit of using such technology in furnishing the service." (85 Fed. Reg. 19230 (2020) at 19234). SLP telepractice delivery of SGD evaluation, treatment, consultation and supervision are appropriate examples. Collectively, these services are called "Tele-AAC." (Anderson, Boisvert, Doneski-Nicol, Gutmann, Hall, Morelock, Steele, & Cohn, 2012).[4] In addition, Tele-AAC and other SLP telepractice are recognized as alternative service delivery models for circumstances – like the present – "when in-person care is not available or possible for the consumer." (Cohn, 2012, at 10, ¶ 14).

As applied to Medicare beneficiaries with SGD needs, Tele-AAC will be a *procedural* accommodation: no change is required to the SGD evaluation's scope. In addition, the outcome of telepractice evaluation and treatment will be as substantively complete and of the same quality as if these services are delivered in-person. The key difference between in-person and Tele-AAC services is that the latter are able to be provided, while the former are not. Approving this request to add CPT codes 92607, 92608, and 92609 to the list of Medicare telehealth services allows continued access to the Medicare SGD benefit. It does ***not*** expand or otherwise change the scope of this benefit.

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4 Hereafter "Tele-AAC Resolution."

D. The SGD Evaluation and Treatment Codes Support Tele-AAC Service Delivery

Authorizing Tele-AAC services will be consistent with the code definitions applicable to SGD evaluation and treatment services. The definitions for the procedure codes originally issued: G 0197, G 0198, and G 0199, and for their replacements: CPT 92607 and 92608, **require SLPs to provide "face-to-face" evaluation and treatment services.** (The code definitions for G 0197, G 0198, and G 0199 are stated at 65 Fed. Reg. 65376 (2000), at 65426. The code definitions for CPT 92607; 92608 and 92609 are stated at 67 Fed. Reg. 79966 (2002), at 80016). **The codes do not require "in-person" SLP delivery of these services.**

A "face-to-face" requirement presents no impediment to the delivery of these services by telepractice. Medicare recognizes that "face-to-face" evaluation and treatment can be achieved through videoconferencing, which is a core element of telepractice service delivery. On April 6, 2020, Medicare stated:

> When furnished under the telehealth rules, … Medicare telehealth services are still reported using codes that describe "face-to-face" services but are furnished using audio/video, real-time communication technology instead of in-person. (85 Fed. Reg. 19230 (2020) at 19232).

Further support is provided by the professional literature. Cason (2017), addressed this specific topic:

> This Commentary contests the increasingly outdated and narrow use of the terminology 'face-to-face' (F2F) to connote clinical interactions in which both the client and the practitioner are physically present in the same room or space. An expanded definition is necessary because when delivered synchronously via videoconferencing, telehealth also provides face-to-face services (i.e., the practitioner and the client view each other's faces.). … [F]ace-to-face should include telehealth applications.

Still further support is found in CMS statements about Medicaid. For that program, CMS authorizes the required face-to-face physician encounter for Medicaid home health care services to be performed by telehealth. (42 CFR § 440.70(f)(6)). It also has discussed telehealth as an accepted service delivery method to satisfy face-to-face physician encounter applicable to DME and other components of the Medicare home health care services benefit. (81 Fed. Reg. 5530 (2016)).

In contrast to the two CPT codes for SGD evaluation, the code definition for SGD treatment services, CPT 92609 is "Therapeutic services for the use of speech-generating devices, including programming and modification." It does not include any reference to how this service is performed, i.e., face-to-face, in-person or otherwise.

E. The Existing Medicare SGD Guidance Support Tele-AAC Service Delivery

Approving these SLP procedure codes for telepractice delivery will be consistent with Medicare's SGD coverage guidance. The LCD for SGDs, which describes the SLP evaluation and report, requires a "formal evaluation" by a SLP but does not impose any requirements as to the manner in which this evaluation is conducted. (LCD for SGDs, 2015) Substantively, Tele-AAC services are recognized as "consistent with" (Boisvert, Hall, Andrianopoulos & Chaclas, (2012), at 13) and "equivalent to" (Hall & Boisvert, 2014) traditional, in-person evaluation and treatment sessions. Medicare authorization of Tele-AAC services will change only the services' delivery method, not their substance.

Equally true is that there will be no difference in the data collected or documentation reported from SGD treatment sessions if these services are provided in person or by Tele-AAC. (Hall, Boisvert, Jellison & Andrianopoulos, (2014) at 14).

F. Existing Medicare Policy Supports Telepractice Delivery of SGD Evaluation and Treatment but is Silent Regarding Tele-AAC Services

Medicare already accepts that evaluation and treatment services for speech and language impairments are appropriate for delivery by telepractice. It has identified the following procedure codes as eligible for telepractice delivery (85 Fed. Reg. 19230 (2020), at 19240):

CPT 92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
CPT 92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
CPT 92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of

	language comprehension and expression (e.g., receptive and expressive language)
CPT 92524	Behavioral and qualitative analysis of voice and resonance
CPT 92507	Treatment of speech, language, voice, communication and/or auditory processing disorder, individual.

It also has accepted these services as eligible for Medicare payment when delivered by speech language pathologists through telepractice. (CMS, 2020d).

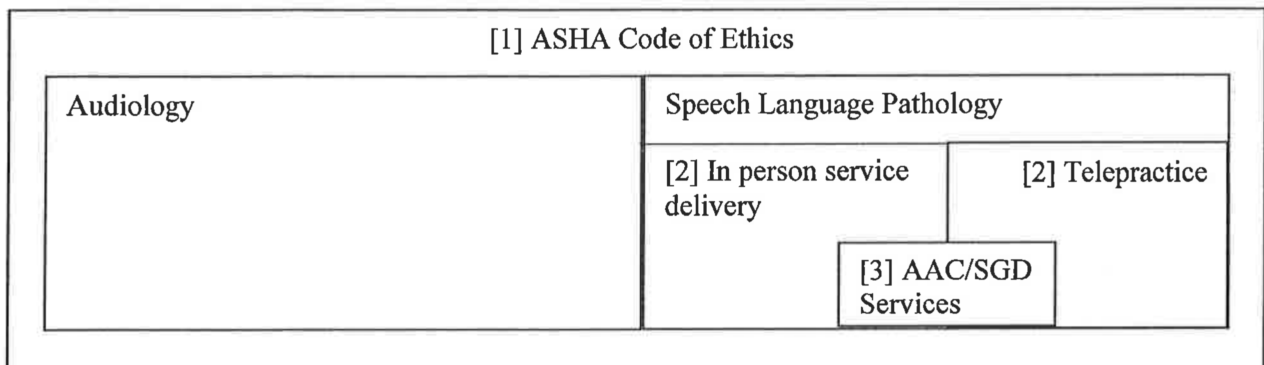
It is noteworthy that the three SLP CPT codes for SLP services related to SGD evaluation and treatment are not on the Medicare telepractice services list. The basis for the omission of these SGD services codes is not known.

No factual basis exists for this distinction.

G. The Same Professional Ethics, Policy and Practice Standards Apply to all SLP Services

As a matter of professional policy and practice standards, SLPs are authorized to deliver SGD evaluation and treatment by Tele-AAC services. This authority is illustrated in **Figure 1**. It shows that the ASHA's Code of Ethics applies to the entire professions of audiology and speech-language pathology ([1]). It also shows that ASHA recognizes both in-person and telepractice as available service delivery models for SLPs ([2]). Ten years ago, ASHA updated the Code to incorporate telepractice as an appropriate alternative to in-person delivery of SLP services. The Code of Ethics (2010) stated "Individuals may practice by telecommunication (e.g. telehealth/e-health) where not prohibited by law." (ASHA, 2010). The current wording states individuals "may provide services via telepractice consistent with professional standards and state and federal regulations." (ASHA, 2016e).

Figure 1: Telepractice is within the scope of all SLP services



ASHA laid the cornerstone of the foundation for SLP telepractice in 2005. In two policy documents: a Telepractice Policy Statement and a Technical Report, ASHA identified telepractice as "an appropriate model of service delivery" for the profession of speech-language pathology. (Cohn, 2012, at 8).[5] The "profession" of speech-language pathology includes AAC interventions, of which SGD evaluation and treatment are examples ([3]). AAC interventions have been within speech-language pathologists' scope of practice for approximately 40 years. (ASHA, 1981).[6]

The telepractice policy statement, technical report, and the Code of Ethics apply to the entire profession of speech language pathology. (Hall & Boisvert, 2014; Cohn, 2012). None states limitations or exclusions for specific forms of speech-language pathology services. As shown in **Figure 1**, professional ethics, policy and practice standards support SLPs' delivery of SGD evaluation and treatment services either in-person or through telepractice ([3]). They provide no basis for Medicare to distinguish – and in particular, to exclude – Tele-AAC from the SLP services for which telepractice has been authorized.

H. Medicare Beneficiaries Who Need and Benefit from SLP Telepractice and from Tele-AAC have the Same Communication Impairments

Tele-AAC services cannot be distinguished from other SLP evaluation and treatment on the basis of the Medicare beneficiaries' communication impairments. As shown in **Figure 2**, the communication impairments for which the evidence demonstrates SLP telepractice is a safe and effective service delivery model are the same conditions recognized as most closely associated with SGD need, use and benefit.

Figure 2: Comparison of Communication Impairments Associated with SGD Need, Use & Benefit and those for which SLP Telepractice has been established to be effective

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5 In 2010, ASHA expanded the opportunity for SLP professional development related to telepractice by creating a "special-interest group" (# 18) on telepractice. (Cason & Cohn, 2014). A sister ASHA special interest group (# 12) exists for AAC.

6 This position statement discusses "augmentative and alternative communication (AAC). SGD evaluation and treatment are forms of AAC intervention.

Formal Request discussion of conditions most closely associated with SGD need, use and benefit (*Formal Request,* 1999, at 18-37)	Professional literature discussion of conditions demonstrating effectiveness of telepractice delivery of SLP evaluation and treatment (Weidner & Lowman, 2020)
Dysarthria **Apraxia of Speech** **Aphasia** **ALS** **Cerebral Palsy** **Multiple Sclerosis** **Parkinson's Disease** **CVA** **Traumatic Brain Injury**	**Dysarthria** (Cason & Cohn, 2014; Mashima & Doarn, 2008; Theodoros, 2011) **Apraxia** (Mashima & Doarn, 2011; Theodoros, 2011) **Aphasia** (Cason & Cohn, 2012; Hall, Boisvert & Steele, 2013; Mashima & Doarn, 2008; Theodoros, 2011) **ALS** (Beukelman, Fager & Nordness, 2011) **Cerebral Palsy** (Mashima & Doarn, 2008) **Multiple Sclerosis** (Mashima & Doarn, 2008) **Parkinson's Disease** (Mashima & Doarn, 2008) **CVA** (Mashima & Doarn, 2008; Theodoros, 2011) **Traumatic Brain Injury** (Mashima & Doarn, 2008; Theodoros, 2011)

I. The Knowledge, Skills and Tools Required for SLP Telepractice and Tele-AAC Overlap

SLPs who engage in telepractice do so by self-selection. They must make a personal commitment to voluntarily pursue additional continuing professional education to acquire and develop necessary skills. As required by the ASHA Code of Ethics, SLPs must possess all of the skills to deliver their evaluation and ASHA, 2015 treatment services "competently." (Tele-AAC Resolution, 2012, at 80; ASHA, 2016b; 2016f; Cohn, 2012, at 5, 6). The generally accepted professional position is that "[i]t is vital for practitioners to be competent and comfortable implementing a telepractice service delivery model." (Cason & Cohn, 2014, at 11). In graphic form, practitioners who deliver SLP telepractice services must demonstrate:

For SLPs who engage in Tele-AAC, the required personal commitment is even greater. In addition to their SLP competence, these SLPs must make the commitment and investment required to be competent in delivery of AAC services,

including SGD evaluation and treatment services. Then they must make the *additional* commitment and investment required to develop competence in telepractice. (Cohn, 2012, at 6; Hall & Boisvert, 2014, at 19). The definition of Tele-AAC services captured this challenge:

> Tele-AAC is a unique cross-disciplinary clinical service delivery model that requires expertise in both telepractice and augmentative and alternative communication (AAC) systems. (Tele-AAC Resolution, 2012, at 80)

Practitioners who deliver SLP Tele-AAC services must demonstrate:

Just as it is true that only a small cadre of SLPs will pursue AAC and SGD skills development, it also is true that "Telepractice is not a good fit for all practitioners." (Cason & Cohn, 2014, at 11). It is therefore reasonable to estimate that only some of the small number of SLPs who offered SGD evaluation and treatment services before the Covid-19 pandemic are now or in the future will be ready and able to offer these services by telepractice if authorized by Medicare.

SLPs who do commit to the development of Tele-AAC skills have a range of resources to draw upon, including:

- conference presentations, such as the biennial conference of the International Society for Augmentative and Alternative Communication (ISAAC), where the 2012 Tele-AAC resolution was developed (Hall & Boisvert, 2014, at 19)(discussing 2 presentations related to Telepractice at the ISAAC 2012 Biennial Conference. More recently, four telepractice presentations were delivered at the ISAAC 2016 and 2018 conferences).

- professional literature.

- webinar presentations and other on-line learning opportunities.

- peer-to-peer communication within two ASHA Special Interest Groups; (AAC (# 12) and Telepractice (# 18)) and within an American Telemedicine Association Special Interest Group on Telerehabilitation (Hall & Boisvert,

2014, at 12; Howard & Kaufman, 2018, at 475-76)(listing national and professional organizational resources related to telepractice).

- a federally-funded Rehabilitation Engineering and Research Center (RERC) on Telerehabilitation, established in 1998 (Seelman & Harman, 2009).

- several textbooks (*e.g.* Hall, Juengling-Sudkamp, Gutmann, and Cohn (Eds.) (2020); Houston, (Ed.) (2014); Kumar & Cohn (Ed.)(2013).

- on-line resources developed by the SGD manufacturers to help SLPs perform SGD evaluations by telepractice, (*e.g.*, Forbes AAC, 2020; PRC-Saltillo, 2020); and Tobii Dynavox, 2020). And

- an ASHA practice portal related to Telepractice that offers resources related to key issues; practice resources; and professional literature references related to telepractice (ASHA, 2020c).

J. Tele-AAC Services will be of the Same Quality as SGD Evaluation and Treatment Delivered In Person

A single standard of quality applies to all SLP services, regardless of the method of their delivery. The ASHA Code of Ethics requires SLPs to deliver *any* service "only when benefit can reasonably be expected." (ASHA, 2016d). This standard is explained further in regard to SLP telepractice. The Code states: "The quality of the [telepractice] service ***should <u>be equivalent to</u> in-person service***." (ASHA, 2016a) The ASHA practice portal on telepractice reinforces this obligation by stating: "[u]se of telepractice must be equivalent to the quality of services provided in person…" (ASHA, 2020c). Reminders of this obligation also are reported prominently in telepractice and Tele-AAC practice outlines published in the professional literature. For example, the Tele-AAC Resolution, recognized as the foundation document for this SLP service delivery method, states one of the core principles of Tele-AAC services is: "Tele-AAC, like other telepractice applications, requires adherence to the ASHA Code of Ethics …" (Tele-AAC Resolution, 2012, at 80). Likewise, a proposed clients' "bill of rights" for telepractice states that this service delivery method will be offered "only if it would offer comparable or superior results to in-person delivery of care or when in-person care is not available or possible for the consumer." (Cohn, 2012, at 14, ¶ 10).

The professional literature confirms this requirement is met in actual clinical practice. In relation to in person delivery of SLP services, telepractice has been described as

- "equally effective" or "as good" as" (Cameron, McPhail, Hudson, Fleming, Lethlean & Finch (2019); Hall, Boisvert & Steele (2013), at 32; Mashima, Birkmire-Peters, Syms, Holtel, Burgess & Peters (2003) at 437, 438);

- "equivalent to" (Hall, Boisvert & Steele (2013) at 32; Palsbo (2007);

- "comparable to" (Cotelli, Manenti, Brambilla, Gobbi, Ferrari, Binetti & Cappa (2019) at 78; Theodoros, Hill, Russell, Ward & Wootton (2008) at 557); and

- "not inferior to"[7] the delivery of the same services on an in-person basis.

- Outcomes and performance data show no significant differences between SLP telepractice or in-person service delivery. (Cotelli, et. al. (2019) at 78; Georgeadis, Brennan, Barker & Baron (2004), at 645; Hoffmann, Worrall, Eames & Ryan (2010) at 123-124; Mashima, et al. (2003) at 438; Theodoros, et al. (2008) at 557).

- Telepractice also has been described as a "viable alternative" (Caudill, Mamiya, MacLennan, & Riegler, (2020) in Hall, Juengling-Sudkamp, Gutmann, and Cohn (Eds.) (2020) at 246; Georgeadis, et al. (2004) at 647);

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[7] Gutmann, M. (2020); Weidner & Lowman (2020). Weider & Lowman reviewed 31 studies from 2014 to the present and found SLP telepractice for individuals with aphasia, Parkinson's Disease, dysphagia, and traumatic brain injury was not inferior to in-person SLP service delivery. They described this method of comparison as follows: "[n]oninferiority studies seek to determine whether an alternative intervention is not inferior to an established intervention…." They continue: "noninferiority may be one of the most appropriate telehealth study designs since the typical clinical question involves determining whether telehealth is inferior to another intervention model, such as in-person speech-language pathology service delivery." (at p. 328). *See also* Griffin, Bentley, Shanks & Wood (2018). Griffin *et al.* found that the effectiveness of telepractice delivery of treatment for 8 individuals with Parkinson's Disease was not inferior to provision of the same treatment through in person methods.

or

- as 'a substitute for' in person delivery of the same SLP services (Wertz, Dronker, Bernstein-Ellis, Sterling, Shubitowski, Elman, Shenaut, Knight & Deal (1992)(Wertz, et al., studied 72 adults with a range of impairments and concluded SLP telepractice could *be substituted for* face to face appraisal and diagnosis).

The same terms of comparison are reported in published literature describing Tele-AAC services: they are

- "as effective as" (Lasker, Stierwalt, Spence & Cavin-Root (2010) at 74);

- "similar to" (Hall (2013);

- "equivalent to" (Hall, et al., 2014) at 69);

- "comparable in clinical relevance and thoroughness to" (Allen & Shane (2014) at 49); and

- "a viable alternative to" (Anderson, Balandin, Stancliffe & Layfield (2014) at 57; Caudill, et al. (2020) at 246) in person SGD evaluation and treatment.

- No significant differences were found in outcomes or performance data between Tele-AAC or in-person service delivery (Hall, et al., 2014, at 68).

For example, Lasker, *et al.* (2010) successfully delivered by Tele-AAC a treatment protocol known as Motor Learning Guided (MLG) to a young adult with severe apraxia of speech and aphasia and who used an SGD following a stroke. (at 74). The results they observed were consistent with earlier research two of the authors had conducted that successfully delivered the same treatment protocol, in-person, to a client with profound apraxia following a stroke (Lasker, 2008). Comparing their earlier findings with those of the current study, the authors concluded: "the results suggest that using [Tele-AAC] as a treatment delivery method ***can be as effective as*** face-to-face sessions for a client with apraxia." (at 74).

The 2013 Ph.D. thesis of Nerissa Hall reported on an experiment that tested three hypotheses: (a) whether novice pre-professional SLPs, who had no prior

AAC training or experience, could learn to deliver an evidence based therapy program to clients through receipt of "active consultation," defined as a program of real-time consultative assistance or input provided by an experienced AAC clinician. (at 13). Also tested were (b) whether clients' communicative performance increased as a result of these services and (c) whether there was any difference in clients' performance if the services were delivered in-person or by telepractice. (at 13-14). After 8 treatment sessions, the data demonstrated that "active consultation" aided the pre-professional clinicians' abilities to provide therapy. "[N]ovice clinicians without prior AAC experience or training can deliver evidence-based AAC modeling services when offered supervisory guidance by telepractice." The data also established that all the clients' communicative performance with their SGDs improved when their direct service provider received active consultation. (at 69-72). Third, the data demonstrated there was "***no statistically significant difference*** between the [improved performance of] clients when receiving service on-site versus telepractice" (at 64; 66; 72); all clients "demonstrated ***similar treatment outcomes*** and data trends" regardless of service delivery method (at 72), and "[l]astly, the results ***demonstrate similar intervention success*** when services are provided on-site as compared to via telepractice." (at 76).

A case study by Hall, *et al.* (2014) reported that Tele-AAC services were a successful service delivery method for a child with complex communication needs to improve understanding and use of appropriate verb forms, such as progressive, past-tense and plural. Their study also compared delivery of the same services, in person, and they reported that the client "achieved and maintained target goals across intervention settings regardless of service delivery method." (at 67). Review of the data gathered demonstrated that "there was ***not a significant correlated difference*** between the probe data collected during the onsite intervention condition [in person] as compared to the telepractice intervention condition." (at 68). The authors concluded:

> This study demonstrates that the implementation of an evidence-based protocol during an AAC intervention program onsite as compared to a telepractice delivery method ***were equivalent***. This finding was evidenced by ***the non-significant correlated relationship*** between probe data during the onsite versus telepractice sessions. (at 69).

In contrast to Lasker, *et al.* (2010); Hall (2013); and Hall, et al. (2014), who all reported the effectiveness of SGD *treatment* delivered by telepractice, Allen & Shane (2014) reported on the successful implementation of an SGD *evaluation*

protocol implemented by telepractice. Their study compared in-person and telepractice implementation of an evaluation protocol for individuals with autism that had been developed by Boston Children's Hospital. (at 43). The evaluation protocol was delivered to two youths with autism: one received the evaluation in-person; and one by telepractice. Allen & Shane reported that the evaluation protocol was successfully applied to both clients: there were "***no discernable differences in amount or quality of information*** between the two clinical delivery approaches" (at 47-48); "the amount of clinical information gathered in all components of the evaluation …***was comparable*** across the two conditions [in-person and telepractice]" (at 48); and that "we were able to gather information that ***was comparable in clinical relevance and thoroughness***." (at 49).

Another study by Anderson, et al. (2014) reported on parent satisfaction with a pilot-program of Tele-AAC treatment services delivered to their children who were new SGD users. Training materials were provided to the parents of four children in advance of the training sessions. The materials explained the operational characteristics of the SGD software and instructed the parents how to encourage and support their child's development of language skills with their SGDs. The parents then conducted training sessions with their child, which were observed by an SLP through videoconferencing. During the training sessions, the SLP provided real-time comments and guidance. At the conclusion of each session, the SLP conducted a consultation session with the parents, answering questions, offering problem solving suggestions, and proposing future lesson topics. After the pilot program ended, the parents were asked to describe their experience. The parent feedback the authors received about the pilot was positive and included:

> The parents in this study viewed video-conferencing as the lynchpin to this program's success and acceptability ***as an in-person service alternative.*** (at 57).

The authors concluded "[u]ltimately, parents in the study reported that telepractice had been ***an empowering, effective and at times preferable alternative to in-person services***." (at 59).

Most recently, Caudill, et al. (2020) provided a detailed review of the "staging" model that describes the onset and progression of ALS as it relates to deterioration of communication functioning. (at 236-237). This model describes an ongoing SLP evaluation process as clients progress from stage to stage. The authors describe how each of these evaluations can be addressed by telepractice.

At stages 3 and 4 of the model, clients will have experienced a loss of speech intelligibility or a reduction of speaking rate such that speech is no longer an effective means of meeting daily communication needs. In response, SLPs will assess AAC interventions, including consideration of SGDs. (at 245-249). The authors report that "tele-AAC to the home ***is a viable means of assessment***" at these stages of ALS progression. (at 246). They subsequently provided a case review describing a client who successfully received hybrid program of assessment utilizing both Tele-AAC services and in-person services.(at 250-256).

Complementing the professional literature just discussed: that compared in person and Tele-AAC service delivery, are several additional published articles that describe successful implementation of Tele-AAC evaluation and both direct services (to the client) (Curtis, (2014), Burns, Crislip, Daviou, Temkin, Vesmarovich, Anschulz, Furbish, C. & Jones (1998)) and indirect services (to an on-site assistant or primary communication partner) (Boisvert, et al., (2012); Dimian, Elmquist, Reichle & Simacek (2018), Quinn, Beukelman & Thiessen (2011)) with no comparison. These articles span a period of twenty years and further support the conclusion that Tele-AAC is an effective alternative service delivery method to in-person SGD evaluation and treatment.

The foregoing demonstrates that Tele-AAC services satisfy the SLP ethical mandate that "[t]he quality of [telepractice] services should be equivalent to in-person service." (ASHA, 2016a). In addition, Tele-AAC services can offer unique benefits beyond those achievable through in-person service delivery. For example, Tele-AAC services will "promote and advance the development of [clients'] highest level of communication competence." (Tele-AAC Resolution, 2012, at 80) Supporting clients' development of "communication competence" is the long recognized goal of all SGD treatment.[8]

Specifically, Tele-AAC services will provide opportunities for spouses, parents, other family members, and other caregivers – collectively, clients' primary communication partners – to have greater interaction with clients by serving as direct participants in or as observers of SGD evaluation or treatment sessions. (Anderson, et al. 2014, at p. 56; Cason & Cohn 2014, at p. 7; Curtis, 2014, at 42; Mashima & Doarn, 2008, at 1106; Theodoros (2011)). All who participate will

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[8] The "ability to efficiently and effectively engage [communicate] in a variety of interactions and participate in activities of their choice" has long been recognized as both the "ultimate goal of AAC intervention," and as the definition of "communicative competence." (Beukelman & Light (2020), at 9-12).

receive training in the operational characteristics of clients' SGDs and both participants and observers will receive training in or be exposed to the communication strategies that will support clients' development of communicative competence with the SGD. The value of such communication partner instruction – whether active or passive – is recognized as an essential element of AAC assessment and intervention. Increasing skills of clients' closest communication partners and increasing their interaction with clients has been shown to support more effective and efficient use of the SGD on an ongoing basis. A meta-analysis by Kent-Walsh, Murza, Malani & Binger (2015) concluded:

> The central finding of this review is that a body of evidence consistently indicates that communication partner instruction positive effects on communication performance of individuals using AAC. In other words, including communication partner instruction within AAC intervention plans will likely assist in yielding improvements in the communication skills of individuals with complex communication needs.
>
> This finding has important ramifications for clinical practice and related policy. Partner instruction should be viewed as an integral part of AAC assessment and intervention. … (at 9.)[9]

Also, Tele-AAC services will most likely be delivered to clients in their homes, an "authentic, naturalistic environment." (Curtis, 2014, at 42; Theodoros, 2011). Providing treatment services in naturalistic settings has been shown to support long-term benefits in the form of application of skills learned and practiced beyond the treatment session. (Beukelman & Mirenda (1992) at 150; Cason & Cohn, 2014, at 7).

> A further benefit [of telepractice] is the capacity to deliver SLP services to the child or adult in his /her own environment.... Strong evidence exists to support the fact that interventions delivered in the person's natural environment or specific context (e.g., workplace, school) are more effective than the same approaches delivered in the clinic. [citation omitted]. These positive effects have been seen in generalization of behavior, functional outcomes, and patient satisfaction and self-management in various conditions, including stroke [citation omitted]; and severe brain injury. [citation omitted]..... (Theodoros, 2011, at 11.)

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9 *See also* Beukelman and Light, 2020, at 125-155; Quinn, Beukelman & Thiessen, 2011, at 99; Tele-AAC Resolution, 2012, at 80.

By contrast, these benefits are not equally available in a typical in-person setting, *i.e,* when evaluation or treatment services are provided 1:1 between the client and clinician in the SLP's office or clinic. The opportunities for greater family involvement and support and for greater generalization and long-term benefits from treatment are examples that explain the reference in the Tele-AAC Resolution, which stated: "telepractice leads to similar or *even better clinical outcomes* when compared to conventional interventions." (Tele-AAC Resolution, 2012, at 80; Cohn, 2012; Cason & Cohn, 2014).

In general, consideration and implementation of SLP telepractice and Tele-AAC have been in response to impediments to services access such as the chronic shortage of SLPs ready and able to provide SGD evaluation and treatment (Bloomberg & Johnson, 1990, at 50; Cohn, 2012; Hall, 2013; Hall, et al., 2014; Mashima & Doarn, 2008; Mashima, et al., 2003); geographic factors such as the clients' residence at a location that is a great distance from a clinic or office where in-person services are provided (Cason & Cohn, 2014, at 6; Cohn, 2012; Curtis, 2014 at 42; Georgeadis, et al., 2004); health factors that may affect clients' ability to travel (Cason & Cohn; Curtis, 2014, at 42; Georgeadis, et al, 2004; Theodoros, 2008); and environmental factors, such as inclement weather (Cason & Cohn, 2014).

Equally true is that these or other barriers can make services access more than just difficult: they can make access impossible. This risk was acknowledged in the "bill of rights" proposed in 2012 for clients who are being considered for all forms of SLP telepractice services. One of the rights stated:

> telepractice [will be employed] only if it would offer comparable or superior results to in-person delivery of care ***OR when in-person care is not available or possible for the consumer.*** (Cohn, 2012, at 14, ¶ 10).

But even when in-person care is not otherwise possible, which may arise following a natural disaster such as a hurricane (Cason & Cohn, 2014, at 7), or as at present, when in-person SLP service delivery is expressly prohibited or as a practical matter is inaccessible due to the Covid-19 pandemic, if SLPs provide Tele-AAC services there will be no exception to the required quality of services to be delivered. Even "[i]n this better-than-nothing option, *it would nonetheless be expected that the scope and content of the therapy is consistent with current in-person clinical practice.*" (Cohn, 2012, at 14).

K. Tele-AAC: How It Works

Tele-AAC services share a common foundation with other forms of SLP telepractice, such as the SLP services Medicare already authorizes for telepractice delivery, and which in turn, share a common foundation with other forms of tele-rehabilitation and tele-medicine services. In addition to the features they share, Tele-AAC has two unique characteristics related to equipment and personnel that are needed to deliver successful SGD evaluation and treatment services. (Hall & Boisvert, 2014, at 19). By contrast, there are no relevant differences between Tele-AAC and traditional AAC evaluation and treatment. As stated previously in this request, at page 21, Tele-AAC requires only a *procedural* modification of the manner of delivery of SGD evaluation and treatment: it does ***not*** require substantive change to those tasks. "These services are consistent with traditional in-person sessions; however, the mode of delivery incorporates the use of videoconferencing and screen-sharing software." (Boisvert, et al., 2012, at 12).

Because the SGD evaluation and treatment will be substantively the same when delivered in-person or by telepractice, the factors unique to Tele-AAC occur in the pre-service planning phase. For Tele-AAC, planning is required to address 4 key topics and a long-standing, generally accepted outline or template guides SLPs through these tasks. (Boisvert & Hall, 2020; Boisvert, et al., 2012; Cason & Cohn, 2014; Hall & Boisvert, 2014). They include: a needs assessment; implementation planning; equipment procurement and set-up; and training of an on-site assistant. (Tele-AAC Resolution, 2012, at 81).

The **needs assessment** is a client-specific (case-by-case) inquiry leading to a threshold SLP judgment whether the client is an appropriate candidate for receipt of Tele-AAC services. (Boisvert & Hall, 2020, at 120-121; Cason & Cohn, 2014, at 6, 11; 12; Cohn, 2012, at 7). Just as not all clients require AAC interventions, not all clients are suitable candidates for Tele-AAC services. (Cason & Cohn, 2014, at 11). Among the topics to be considered are clients' physical, cognitive, sensory and communication skills and abilities (Cason & Cohn, 2014, at 12; Hall & Boisvert, 2014, at 19), the physical environment, including the quality of the clients' internet service; and the availability, abilities and skills of an on-site assistant who most often is a spouse, family member or caregiver. (Tele-AAC Resolution, 2012, at 80).

Implementation planning requires SLPs to consider for each client, how the Tele-AAC service, i.e., SGD evaluation or treatment will be delivered. Needed tools will be identified and then inventoried. Specifically, SLPs will ask whether

they or clients already possess the hardware or software identified as needed. If not, SLPs must consider the sources from which these items can be obtained. For SGD evaluation, SLPs also must consider the types of devices and software to be presented to clients for demonstration purposes and the types of access aids clients may require.

Equipment needs: All SLP telepractice requires adequate and appropriate technology, including hardware, secure video-conferencing software, Internet connectivity and telecommunications items. Tele-AAC also requires items such as web-enabled cameras and other peripheral devices to enable SLPs to observe clients' and other equipment items' positioning and movements. (Boisvert & Hall, 2020, at 120-126; Curtis, 2014, at 43-46; Hall & Boisvert, 2014, at 23). Screen-sharing software is required to enable SLPs to observe clients' SGD use and to make adjustments, add content, and offer instruction and suggestions for more efficient and effective communication. (Curtis, 2014, at 44; Boisvert, et al., 2012, at 13; Cason & Cohn, 2014, at 11; Hall & Boisvert, 2014, at 20-21, 23; Tele-AAC Resolution, 2012, at 80). These items are available off-the-shelf and are readily available. (Hall & Boisvert, 2014, at 22).

In addition, SLPs will develop a plan and identify the resources necessary to respond to a possible short-term technology malfunction or failure, such as the loss of internet connectivity during a Tele-AAC session. Specifically, SLPs' pre-session "to-do" lists will include a procedure for troubleshooting and problem solving. (Boisvert & Hall, 2020, at 131) The professional literature provides examples of practical steps to avoid these adverse events and other steps to overcome them. A common precaution is to establish a back-up method of communication, such as a cell phone, in the event of interruption of the videoconferencing connection. (Cohn & Cason, 2019 at 708).

Personnel needs: Another planning requirement is training for on-site assistants (spouse, family, caregivers), who are essential personnel during Tele-AAC evaluations and treatment sessions. (Hall & Boisvert, 2014, at 21). "Technological competence [of both the SLP and the on-site assistant] is pivotal in the successful delivery of telepractice." (Boisvert, et al., 2012, at 13). SLPs will consider whether training related to the telepractice equipment or related to the SGD is needed. (ASHA, 2016c). If needs are identified, SLPs will develop the training materials and identify the most effective and efficient method to deliver them, such as direct instruction by the SLP or manufacturer's representative (Curtis, 2014 at 43); written materials (Burns, et al, 1998, at 128); video (Allen &

Shane, 2014 at 49; Anderson, et al., 2014, at 54; or a combination. (Allen & Shane, 2014 at 50; Cason & Cohn, 2014, at 11; Hall & Boisvert, 2014, at 19; 22-23). Most often, these tasks will be completed before the Tele-AAC session, including a possible "dry-run" to ensure all the equipment is in proper working order. (Curtis, 2014, at 43; Hall & Boisvert, 2014, at 21-23).

The third preparatory step focuses on the logistics of **equipment procurement and set up.** For SGD evaluation via Tele-AAC, SLPs who own the needed equipment can ship it to the clients' location. (Burns, et al., 1998, at 128). For traditional in-person SGD evaluations, other needed items typically are loaned by SGD manufacturers and suppliers. Notwithstanding the Covid-19 pandemic, this opportunity remains available. The largest SGD manufacturers and suppliers have committed to continuing to provide field-staff assistance to deliver to and if permitted, to set-up equipment at clients' locations and to serve as a troubleshooting resource during the Tele-AAC session. Communication from Eye-Gaze, Forbes AAC, Lingraphica, PRC-Saltillo, Talk to Me Technologies, and Tobii Dynavox confirming the continued availability of these services are attached as Exhibit 1.

Equipment set-up: Once the equipment arrives at the client's location, it must be set-up for use during the Tele-AAC session. The ASHA Code of Ethics specifically requires SLPs to "ensure that all technology and instrumentation used to provide services … are in proper working order and are properly calibrated." (ASHA 2016g; Cohn, 2012, at 6). In a traditional in-person circumstance, the SLP would perform this task, perhaps with assistance from SGD manufacturers' field staff. But at present, with SLPs at a remote location and manufacturer's representatives unable to perform set-up services in clients' homes, equipment set-up will most often be the responsibility of the person designated as the on-site assistant. For this reason, SLPs will be required to provide whatever instruction is needed for the on-site assistant to accomplish this task.

The final task prior to the Tele-AAC session is **training on-site assistants** regarding their roles and responsibilities during the session. This task imposes another duty on the SLP: in addition to competence about AAC and telepractice, Tele-AAC requires SLPs to be competent at supervision of the on-site assistant (Cohn, 2012, at 13). During Tele-AAC sessions, on-site assistants will deliver direct services to the client, subject to the SLPs' real-time advice, consultation or direction (Allen & Shane, 2014; Anderson, et al., 2014; Dimian, et al., 2018; Hall, 2013;) or they will assist the SLPs' provision of direct services, by "serv[ing] as the 'virtual hands' of the therapist" during the Tele-AAC session (Burns, et al.,

1998, at 128). In this latter role, the SLP will direct the on-site assistant to make adjustments to the client's positioning, move or substitute devices or access aids being considered, and reposition other technology being used in the session. (Curtis, 2014, at 46; Hall & Boisvert, 2014, at 20-23).

In sum, the Tele-AAC professional literature identifies the necessary methods and materials SLPs must gather and the tasks they must perform to deliver Tele-AAC services successfully. It also offers SLPs reinforcement that these services will be delivered at the same level of quality as if they were provided in-person. The literature describes these 4 preparatory elements in a matter-of-fact manner: they are just a set of tasks that must be and that are completed. None is identified as an impassible barrier.

L. Current SLP Clinical Practice Establishes Medicare Coverage of Tele-AAC is Appropriate

Tele-AAC services have not yet been authorized for Medicare reimbursement. Nonetheless, Medicare's SGD guidance, notably the evaluation and reporting protocol stated in the LCD for SGDs, is being used to support funding requests being submitted to – and approved by – other health-based systems of benefits. Stated another way: although Medicare is not allowing telepractice use of its SGD guidelines, other funding programs have authorized their use and are relying on telepractice-based SLP reports to approve SGD funding requests.

Medicaid: All 50 state Medicaid programs, plus the D.C. Medicaid program, have authorized SLP telepractice. (Center for Connected Health Policy, 2020; ASHA, 2020d). Some Medicaid programs authorized telepractice for all covered services; others were more specific and identified the services, including SLP services, for which telepractice delivery is authorized. Once SLP telepractice is authorized, as a matter of law, the scope of SLP services for telepractice delivery must include Tele-AAC. (*V.L. v. Wagner,* 2009; *B.Z. v. Zucker,* 2018)[10] A third

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[10] *V.L. v. Wagner* (2009) interpreted the Medicaid Act "comparability" mandate, 42 U.S.C. § 1396a(a)(10)(B)(i)) to prohibit Medicaid programs from limiting access to covered services for reasons unrelated to medical need. There is no medical justification to deny access to SGD evaluation or treatment by telepractice while authorizing other SLP telepractice evaluation and treatment services. In addition, *BZ v. Zucker*, (2018) recognized that Medicaid coverage policies can create significant risks of institutional placement and thereby violate

group of states eliminate all uncertainty. They identified Tele-AAC services as authorized for telepractice delivery, referencing the CPT codes for SGD evaluation (92607; 92608) or SGD treatment (CPT 92609). These states include

Alabama	Maine
Alaska	Maryland
Colorado	North Carolina
Florida	Ohio
Idaho	South Dakota

SGD manufacturers and suppliers report that these telepractice authorizations have caused no change in Medicaid review or approval of SGD requests. Since March 15, new Medicaid SGD funding requests continued to be received and approved.

Insurers: Several state Governors have issued executive orders that direct insurers authorized to sell health insurance policies in their states allow telepractice delivery for all covered services (E.g., Pritzker, 2020) These executive orders extend Tele-AAC authorization to all policies in which SLP services are a covered benefit. Since these executive orders were issued, SGD manufacturers and suppliers report they continue to receive SGD funding requests and insurers continue to approve them.

It is not disputed that distinctions exist among Medicare, Medicaid and insurance. Nonetheless, reference to Medicaid and insurer policy and practice is relevant here because both have SGD coverage criteria that copy the Medicare LCD for SGDs in full or substantial part. Among the nation's largest insurers, Aetna (2019) and CIGNA (2020) have SGD coverage guidance that copy the LCD's outline of the SLP evaluation and reporting requirement. Other insurers, such as Anthem Blue Cross (2020), which operates in 14 states, have done so as well. The same is true for Medicaid programs. For example, the Florida, (2020); New York, (2019); North Carolina (2019); and Ohio (2020) Medicaid SGD coverage guidelines incorporate all of the LCD's evaluation requirements, although each state lists them in a different order. New York Medicaid has for years been the largest or one of the largest sources of Medicaid SGD funding. As noted above, Florida, North Carolina and Ohio Medicaid specifically authorize the SGD CPT codes for telepractice delivery.

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the ADA integration mandate, 28 C.F.R § 35.130(d), when recipients are denied access to needed SGDs. The *V.L.* and *B.Z.* decisions are attached as Exhibit 2.

The conclusion to be drawn from these facts is that current SLP practice is confirming that the Medicare SGD guideline for SGD evaluation is amenable to and appropriate for telepractice delivery and the outcome of that practice has satisfied many other funding sources. (*See also* Mathy, 2020).

Also true is that SLPs throughout the country are providing Tele-AAC SGD *treatment* based on other funding sources' responses to the Covid-19 pandemic. Indeed, this opportunity also is being extended to some *Medicare* beneficiaries. The American Medical Association reports that Medicaid Advantage Plans are authorizing *Medicare funding* for SLPs to deliver SGD treatment under CPT 92609. (American Medical Association, 2020). Medicare Part A also authorized SLPs in nursing facilities to provide their services – both evaluation and treatment – via telepractice. Even though Medicare does not cover or provide DME items such as SGDs to beneficiaries residing in nursing facilities, SLPs may provide evaluations identifying SGD need and recommending SGDs that may be purchased by other funding programs or by Medicare upon the beneficiaries' discharge to home. (ASHA, 2020b)

As a capstone to this request that Medicare authorize Tele-AAC services, four speech-language pathologists who made the dual investment in developing competence in SGD evaluation and treatment and telepractice report about their personal clinical experience using the Medicare LCD for Tele-AAC SGD evaluations. Their reports reinforce the key points made throughout this request, such as:

the access-severing impact of the Covid-19 pandemic;

Annette Stone, who directs an AAC clinic at the University of Wisconsin, and Sarah Marshall, a staff SLP at the clinic who also is the current President of that state's Speech-Language-Hearing Association, each wrote:

> However, at present, telepractice is the only practical and safe way to deliver these crucially important services [referring to SLP evaluation and treatment and Tele-AAC services]. Not accepting SGD assessment and treatment delivered via telepractice will make it all but impossible for SLPs to provide these covered services to Medicare beneficiaries with complex communication needs. (Stone, 2020, at 1; Marshall, 2020, at 1).

Amy Roman, an SLP with more than 20 years' experience serving individuals with ALS reported the same risk:

> Without these codes, speech generating devices, a type of durable medical equipment Medicare first covered 20 years ago will be unattainable for my patients who have urgent need for them. (Roman, 2020, at 1-2).

> **that Tele-AAC services require *procedural* adaptations to how SGD evaluations are conducted, but require no sacrifice of the scope or quality of the task;**

> SLPs are able to meet these requirements [of the Medicare LCD] by making some procedural adjustments in the assessment process. Both service delivery methods [in-person and Tele-AAC] result in a 'formal evaluation' that meets LCD guidelines and are equally comprehensive and safe, utilize the same clinical measurements and put no undue burden on the patient. Both 'in-person' and telehealth SGD evaluations result in a 'formal written evaluation' that provides the data Medicare requires to justify medical necessity of an SGD and fund the DME recommended within. (Roman, 2020, at Att. A-1).

Lisa Bardach, an SLP with 30 years' experience serving individuals with a wide range of impairments, concurred. She wrote:

> The observations I am able to make and the data I am able to collect with assessments by telepractice, the quality of my recommendations, and the completeness of my reports are no different than what I am able to learn and report with I person assessments and treatment. (Bardach, 2020, at 5).

> **that Tele-AAC is not for everyone, and more generally, that SLPs will exercise their independent judgment to determine whether to proceed with an SGD evaluation or make an SGD recommendation by telepractice;**

> But if something that makes it impossible for me to get the information I need to reach a conclusion, there will be no device recommendation and no funding request. It is not ethical or practical for me - or for any SLP – to make recommendation on the basis of inadequate information or a lack of certainty the patient can use the device or benefit from its use. (Bardach, 2020, at 3; Roman, 2020, at Att. A-6).

that Tele-AAC offers unique benefits beyond what will be delivered by in-person evaluations in an SLP office or clinic;

> Not only were possible challenges overcome but most study participants found numerous benefits to telehealth service delivery provided in the patient's home where the systems and strategies would actually be used. (Roman, 2020, at 1).
>
> Furthermore, observation of the patient within his or her natural environment via videoconferencing may allow for additional observation of the patient's communication modalities, strengths and challenges in comparison to direct in-person observation in the unnatural clinical environment. (Marshall, 2020, at 2).

that Tele-AAC requires SLPs to rely on an on-site assistant during the evaluation;

The SLP letters identify several modifications to in-person procedures that are required for successful Tele-AAC evaluations. The most significant among them is the essential role filled by an on-site assistant.

> An e-helper is an individual who is with the patient and provides assistance with the telehealth visit. An e-helper may be directed by the SLP to assist with the videoconferencing technology, movement of cameras, positioning of the patient, and positioning of AAC equipment. The e-helper serves as the hands of the SLP. An e-helper is directed by an SLP and does not require prior training. E-helpers are typically caregivers and or vendor representatives. If a patient has any level of physical disability and at times even when they do not, SLPs usually require that a caregiver attend both in-person and telehealth SGD assessments because it is essential that a caregiver or potential caregiver is familiar with the equipment the patient will need to rely on. The SLP must also determine that a caregiver has the physical and cognitive abilities required to set the communication system up independently for the patient on a daily basis which includes tasks such as lifting and properly position equipment or making some software adjustment. For this reason, a person who can serve as an e-helper is already involved in almost all SGD evaluations so the requirement of an e-helper is typically simple to accommodate.)

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In this situation, the e-helper and/or an able bodied patient bring the sanitized equipment into the home [delivered to the doorstep by the manufacturer's representative] and connect with the vendor rep, typically sitting outside in his or her car, via a HIPPA compliant teleconference connection accessed through a laptop or tablet in the home. … Once the teleconference connection is established, the vendor rep, or pre-arranged vendor tech support person, direct the patient and e-helper through a pre-evaluation equipment set up. The e-helper or able bodied patient is instructed to place the laptop/tablet to the side of the patient and far enough back so that the patient's upper body and the mount, if required, placed in front of the patient can be viewed. The rep, walks the e-helper through attaching an SGD to a mount and positioning it in front of the patient. When the SGD is turned on the rep directs the e-helper how to connect to the same teleconference on the SGD that they are using on the laptop/tablet/ smartphone. The rep, who now has two views of the patient (the SGD's camera from the front and the laptop/tablet/smartphone to the side) can now also view the patient's screen and therefore see an image of the patient's eyes in the on-screen eye tracking monitor if eye tracking is to be trialed. The rep has the e-helper raise the device on the mount so that the patient's eyes are positioned in the center of the monitor if eye tracking will be trialed or simply at a comfortable height otherwise. If eye tracking will be part of the evaluation, once the monitor image indicates the distance and height are correct, the rep can be given remote access to the SGD and can remotely clicks on the button to calibrate the device to the patient's eyes. The rep now has the e-helper look at the other boxes that were dropped off. Each of which is labeled with the name of the piece of access equipment the SLP may be trialing during the evaluation. Once the e-helper is comfortable with the set up and equipment, the SLP joins them via the same teleconference line. (Roman, 2020, at Att. A-5, 6).

One difference will be that telepractice will require the SLP to rely more on a client's caregiver to assist in presenting, positioning, and making any needed adjustments to the equipment as advised by the SLP. The use of a facilitator is common and accepted in the practice of teletherapy. When an in-person assessment is conducted the SLP may perform these tasks him or herself. …. (Marshall, 2020, at 2).

In short, a telepractice evaluation will require greater reliance on the patient's caregiver who must be present in the evaluation setting, and it may require the use of additional hardware tools, such as supplemental cameras. These possible needs represent no more than a minor addition to the pre-evaluation checklist.... (Bardach, 2020, at 3).

And

that Tele-AAC will provide the same quality of information as in-person evaluations.

Telepractice is one such accommodation. It can be used to provide SGD assessment and treatment services – consistent with Medicare's requirements – as safely, comprehensively, and effectively as in-person services. Telepractice can be provided to Medicare beneficiaries of all conditions and diagnoses where there is an SGD need, and SGD coverage should not be related to a specific condition or diagnosis. Telepractice is supported by professional practice guidance and standards and by resources explaining the practical tasks for SGD assessment and treatment services delivery.... (Stone, 2020, at 2).

In regard to SLP assessment and treatment related to SGDs, telepractice is an accommodation to the method of the delivery of these services, but it does not require substantive changes to the tasks required, does not result in a qualitative change to the data gathered, and does not affect the credibility of the recommendations that result. Telepractice is a way to deliver 'face-to-face' services through videoconferencing instead of 'in-person.'.... (Marshall, 2020, at 1, 3).

Looking at the Medicare LCD for SGDs, it is clear that each component can be done equally effectively in a remote manner as in the same room.

* * * * *

The observations I am able to make and the data I am able to collect with assessments by telepractice, the quality of my recommendations, and the completeness of my reports are no different than what I am able to learn and report with in person assessments and treatment. (Bardach, 2020, at 2, 5).

In summary the LCD requirements for SGD evaluation can all be met, some with procedural modifications described above, as comprehensively and completely through telehealth as through in-person evaluation if the person has internet capabilities. … I hope the above comparison has demonstrated that telehealth services offered in the patient's home are comparable to in-person outpatient service delivery and even offer some strong advantages. …. (Roman, 2020, at Att A-9).

Section V

The Tele-AAC Codes: 92607, 92608, and 92609 Cannot be Billed Under the Current Scope of Telehealth Services

The fifth topic CMS requires to be addressed in a telepractice coding request is:

> An explanation as to why the requested service cannot be billed under the current scope of telehealth services, for example, the reason why the HCPCS codes currently on the list of Medicare telehealth services would not be appropriate for billing the service requested. (CMS, 2020a).

The Medicare telepractice list includes 237 CPT codes. (CMS, 2020c). From this list, the ones most similar to the codes subject to this request: CPT 92607; 92608; and 92609,[11] are six codes applicable to other speech-language pathology services. They include:

LIST OF MEDICARE TELEHEALTH SERVICES (CMS, 2020c)			
Code	Code Description	Status	Can audio-only interaction meet the requirements?
92507	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes
52508	Speech/hearing therapy (group)	Temporary Addition for the PHE for the COVID-19 Pandemic-—Added 4/30/20	Yes
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes

[11] Hereafter, the "Tele-AAC" codes.

	expression (e.g., receptive and expressive language)		
92524	Behavioral and qualitative analysis of voice and resonance	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes

As explained below, for more than 20 years, and notwithstanding several re-alignments of SLP services coding, SGD evaluation and treatment have been – and remain – recognized as tasks distinct from the SLP services for which Medicare telepractice is authorized. In addition, for the past 20 years, SLP evaluation and treatment related to SGDs have been – and remain – subject to higher Medicare payment rates than the SLP services codes authorized by Medicare for telepractice deliver.

These facts make it categorically ***NOT*** reasonable for the Tele-AAC CPT codes 92607; 92608; and 92609 to be merged into SLP services codes which for a generation, Medicare has concluded they do not fit. It is equally categorically ***NOT*** reasonable for these Tele-AAC codes to be down-coded for payment purposes, *i.e.,* to be subject to a significantly lower payment rate, especially when telepractice imposes several additional responsibilities on SLPs as compared to traditional in person delivery of the same services. In short, the SGD evaluation and treatment codes clearly meet the criterion CMS has stated: "the HCPCS codes currently on the list of Medicare telehealth services ***would not be appropriate*** for billing the service requested."

A. SGD Evaluation and Treatment are Distinct SLP Services As Compared to Other SLP Evaluation and Treatment Services

SGD evaluation *always* has been recognized as a unique SLP service, distinct from the SLP evaluation codes currently authorized by Medicare for telepractice. Even before Medicare adopted its initial SGD coverage guidelines, indeed, even before Medicare coined the phrase "speech generating device," a CPT code existed for "evaluation for use and/or fitting of augmentative/alternative communication devices to supplement oral speech." This SLP task was incorporated into CPT code 92597, which also included evaluation for use and/or fitting of voice prosthetic devices. (65 Fed.Reg. 65376 (2000), at 65426). Another code, CPT 92598, applied to "modification of voice prosthetic or augmentative/ alternative communication devices to supplement oral speech. (at 65427). These codes were created and added to the CPT code set in 1996. 60 Fed.Reg. 63124 (1995), at 63166-67).

On November 1, 2000, just after the regional Medicare DMERC medical directors released the draft "Regional Medical Review Policy for Speech Generating Devices," (Hoover, et al., 2000), Medicare announced that CPT 92597 and 92598 were being replaced. New codes were being created for SGD evaluation, SGD training, and SGD re-evaluation, and were designated as G 0197, G 0198 and G 0199. The notice explained that these new codes were required because Medicare coverage policy related to SGDs was about to change. Medicare's official notice stated:

> Speech-Generating Devices
>
> Because of the change in coverage policy on speech-generating devices, effective January 1, 2001, we needed codes that more specifically describe the services needed to evaluate and train patients to use these devices. As a result, we will be replacing CPT 92597, Evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communication device to supplement oral speech) and 92598, Modification of voice prosthetic or augmentative/ alternative communication device or supplemental oral speech, with the following new codes:
>
> G0197 Evaluation of patient for prescription of speech-generating devices. This code describes the services to evaluate a patient to specify the speech-generating device recommended to meet the patient's needs and capacity for use. This code involves face-to-face involvement of the practitioner (typically a speech and language pathologist experienced in the use of these devices) with the patient. The work and malpractice RVUs for this new code will be cross-walked to the ones used for CPT code 92597, the code it replaces. For practice expense, we have crosswalked the inputs to CPT code 92527 for these codes.
>
> G0198 Patient adaptation and training for use of speech-generating devices. This code describes the services delivered to the patient to adapt the device to the patient, and train him or her in its use. This code involves face-to-face involvement of the practitioner (typically a speech and language pathologist experienced in the use of these devices) with the patient. The work and malpractice RVUs, as well as the practice expense inputs for this new code, will be crosswalked to the ones used for CPT code 92598, the code it replaces.

G0199 Re-evaluation of patient using speech-generating devices. This code describes the services to reevaluate a patient who has previously been evaluated for a speech-generating device, and either is currently using a device or did not have a device recommended. This code involves face-to-face involvement of the practitioner (typically a speech and language pathologist experienced in the use of these devices) with the patient. The work RVUs for this new code will be 75 percent of the value for CPT code 92597, reflecting that it is likely to be less intensive than the initial evaluation. The malpractice and practice expense inputs are also crosswalked to CPT code 92957. (65 Fed.Reg. at 65426-427).

In 2003, Medicare made another coding adjustment. It replaced the "G" codes with the Tele-AAC CPT codes that are the subject of this request. (67 Fed. Reg. 79966 (2003), at 80016). As part of this action, Medicare designated SGD evaluation as a timed task, assigning two codes: 92607 for the first hour of an SGD evaluation and 92608 for additional units of 30 minutes. By accepting SGD evaluations as timed procedures, Medicare acknowledged that SGD evaluations will vary in time, equipment and necessary SLP skill based on the infinite range of severity and complexity of relevant client characteristics. (It is noteworthy that the SLP evaluation code in effect at that time: 92506, had been and remained "a procedure code," which provided a set fee regardless of the amount of time or other differences that arise in the delivery of SLP evaluations.)

Coding For SLP Services: SGD Evaluation and Treatment	
Calendar Years 2001 & 2002	Calendar Years 2003 – Present
G 0197	CPT Code 92607 and 92608
G 0198	CPT Code 92609
G 0199	CPT Code 92607 and 92608

Eleven years later, Medicare made changes to the SLP evaluation code, CPT 92506. In addition to being a "procedure code" for payment or billing purposes, it had been an 'umbrella-code' that encompassed several forms of SLP evaluation. Beginning in 2014, Medicare replaced this code with codes: 92521; 92522; and 92524, each applicable to a single form of SLP evaluation. A fourth code, 92523 applies to two evaluation procedures, most often performed together, and therefore, they are bundled. (78 Fed. Reg. 74230 (2013), at 74263, 74342). The types of evaluation assigned to each code are identified above.

The coding evolution just recounted is significant because each change represents a point in time when Medicare focused on the characteristics of SLP

evaluations. However, at none of these times did Medicare ever propose the merger of SGD evaluation with any other form of SLP evaluation. In fact, the historic record shows that the opposite occurred. Beginning in 1996, there has been a trend of disintegration of SLP evaluations into procedure-specific codes. The first type of evaluation to be subject to this fission was SGD evaluation. In 1996, Medicare segregated SGD evaluation from all other SLP evaluations and created a distinct CPT code for this task. (CPT code 92597). In the next quarter century, the codes for SGD evaluation have been re-numbered, but substantively, its status as a distinct SLP evaluation task has remained unchanged. Then, in 2013, the omnibus CPT code for other SLP evaluations (92506) was divided into 4 distinct procedures, each with its own CPT code. No rationale exists for abandoning this quarter century of coding practice just because authorization is being requested to deliver SGD evaluation by telepractice.

The same observations apply to SGD treatment *vis a vis* other SLP treatment services. As an initial matter, the Medicare decision to cover SGD treatment enables SLPs to meet one of the essential elements of AAC professional policy and practice:

> The ultimate goal of AAC intervention is not to find a technological solution to communication problems but to enable individuals to efficiently and effectively engage in a variety of interactions and participate in activities of their choice.
>
> *   *   *   *   *
>
> Certainly, assistive communication technology can change people's lives. However, AAC technology is not magic. A piano alone doesn't make a pianist nor does a basketball make an athlete. Likewise, AAC alone doesn't make one a competent proficient communicator. [citation omitted] Those who rely on AAC begin as novices and evolve in competence ... with appropriate support, instruction, practice and encouragement. (Beukelman & Light, 2020, at 9, 11).

Medicare's decision to cover SGD treatment was made in 2000, when it first accepted SGDs as a covered Medicare benefit. Beginning in 2001, SGD treatment was designated as code G 0198. Two years later, in 2003, this temporary "G" code was replaced with a permanent CPT code: 92609. These decisions confirm Medicare recognition of SGD treatment as distinct from other forms of SLP treatment, which were (and remain) coded as CPT 92507. Since 2003, there have

been no relevant changes to the SLP treatment code 92507 or to the SGD treatment code 92609. Thus, for the entire time that Medicare has covered SGDs and SGD treatment, it never has concluded that SGD treatment should be merged with other forms of SLP treatment services. As stated for SGD evaluation, no rationale exists for abandoning this long-standing coding practice just because authorization is being requested to deliver SGD treatment by telepractice.

B. SGD Evaluation and Treatment have had Consistently Higher Payment Rates than Other SLP Evaluation and Treatment Services

The professional literature related to SLP telepractice and Tele-AAC services has discussed funding source payment and reimbursement policies and practices as the bellweather of telepractice acceptance. (Tele-AAC Resolution (2012), at 80; Cason & Cohn (2014), at 10; Dudding (2013); Mashima & Doarn (2008) at 1106-1107). Payment and reimbursement also have been identified as a "core hurdle" to telepractice expansion. (Theodoros, (2011), at 18).

This long-standing attention to SLP payment and reimbursement reinforces the lack of rationality of a possible decision to merge the Tele-AAC codes into the SLP services codes presently authorized for Medicare telepractice delivery. Doing so will so substantially reduce SLP payments for these services that the Medicare decision to authorize the delivery of these services by telepractice will be meaningless to Medicare beneficiaries.

In all but one of the past 20 years, the Medicare payment rates for SLP evaluation for speech fluency; speech sound production; speech sound production and language comprehension; and behavioral and qualitative analysis of voice and resonance have been lower than the payment rate available to SLPs for SGD evaluation. SGD evaluations typically require at least 2 hours, so the payment rate for an SGD evaluation will be at least the sum of the payment rate for CPT code 92607 + 2 units of 92608.

Table 1 provides payment rate data for 19 of the past 20 years: from 2001 – 2020.[12] It confirms that Medicare has paid SLPs more to perform SGD evaluation (CPT code G 0198; 92607 and 92608) than for any of the SLP evaluation codes now authorized to be delivered by telepractice (CPT 92506; 92521; 92522; 92523; or 92524).

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12 Payment rate data for calendar year 2015 has not been located.

- Between 2001 and 2013, SLP evaluation was designated as CPT code 92506. In every year but one during this period, the payment rate for SGD evaluation (CPT code G 0197; 92607 and 92608) was higher.

- In 7 of those years, the Medicare payment rate for just one hour of SGD evaluation – typically only one half of the time SLPs required to complete the SGD evaluation – was higher than the comparable SLP evaluation code (2001-2003; 2008-2011).

- From 2014 to the present, SLP evaluations performed under CPT code 92506 have been (and are) billed under CPT codes 92521 – 92524. Among these codes, the payment rate for CPT code 92523 has been and still is the highest. For every year since 2014, the payment rate for a typical 2 hour SGD evaluation has been greater.

Table 1: Medicare Payment Rates for SLP Evaluation Codes, 2001 – 2020

SLP Evaluation // SGD Evaluation										
CPT Code	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
92506	81.87	94.84	87.52	131.43	131.88	132.26	138.33	145.77	147.15	157.82
92521										
92522										
92523										
92524										
92597										
G0197	126.25	126.70								
92607			102.74	122.09	118.62	119.00	129.99	148.54	150.40	161.87
92608			20.41	26.88	22.74	22.74	25.77	29.33	29.21	32.82
CPT Code	**2011**	**2012**	**2013**	**2014**	**2016**	**2017**	**2018**	**2019**	**2020**	
92506	167.16	165.42	217.16							
92521				114.27	112.14	112.69	116.28	115.69	115.85	
92522				92.78	93.51	93.31	93.60	93.70	94.55	
92523				192.73	195.98	199.18	201.60	199.66	198.49	
92524				96.72	90.29	90.08	89.64	90.46	92.39	
92597										
G0197										

92607	176.34	142.62	119.13	130.04	127.55	129.56	133.56	132.98	132.09	161.87
92608	52.32	45.95	47.65	53.73	53.38	53.83	53.64	52.98	53.05	32.82

Summarizing the payment rate data reported at **Table 1**, it is clear that the merger of the Tele-AAC codes with the SLP codes Medicare already has authorized for telepractice delivery is inappropriate. Such a merger will result in "down-coding" of SGD evaluation services and the reduction of their payment rate. Moreover, the payment rate reduction will be extreme. Since 2011, for example, the payment rate for SGD evaluation has been greater than the highest payment rate for other SLP evaluation by an average of *26 percent*. **Table 2** reports the year by year payment rate differences.

Table 2: Comparing Payment Rates for Evaluation of Speech Sound Production and Language Comprehension and SGD Evaluation, 2011-2020

CPT Code	2011	2012	2013	2014	2016	2017	2018	2019	2020
92523	167.16	165.42	217.16	192.73	195.98	199.18	201.60	199.66	198.49
92607	176.34	142.62	119.13	130.04	127.55	129.56	133.56	132.98	132.09
92608	52.32	45.95	47.65	53.73	53.38	53.83	53.64	52.98	53.05
Total SGD[*]	280.96	234.55	214.43	237.50	234.31	237.22	240.84	238.94	238.19
% SGD > 92523	68	42	0	23	20	19	20	20	20

[*] Σ [92607 + (2 x 92608)]

Table 3 confirms a comparable payment rate hierarchy has been and remains in place for SGD treatment as compared to other forms of SLP treatment services. The comparison between CPT code 92507, which is the one SLP treatment code now authorized for telepractice delivery, and CPT codes G 0198 and 92609, the SGD treatment codes, reveals that for 15 of the past 20 years, including every year since 2007, the Medicare payment rate for SGD treatment has been greater than the payment rate for other SLP treatment.

Table 3: Medicare Payment Rates for SLP Treatment Codes, 2001 – 2020

SLP Treatment // SGD Treatment										
CPT Code	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
92507	62.74	75.29	72.64	62.35	62.53	62.53	63.29	62.76	61.31	65.27
G0198	79.19	78.19								
92609			55.69	61.23	61.77	61.77	68.59	78.46	80.07	87.76
CPT Code	**2011**	**2012**	**2013**	**2014**	**2016**	**2017**	**2018**	**2019**	**2020**	
92507	82.22	74.88	71.14	80.60	79.90	80.03	79.92	80.37	81.20	
G0198										
92609	115.86	101.09	98.37	112.48	111.78	111.97	111.96	111.00	111.16	

Looking beyond this direct comparison of the payment rates, an existing billing practice may cause the payment reduction to be much greater. Medicare authorizes SLPs to bill for one of the SLP evaluations now authorized for telepractice (CPT code 92521-92524) and for SGD evaluation (CPT Code 92607 and 92608) on the same day. (ASHA, 2020a). In other words, an SLP who performs and bills for a "speech sound production and language comprehension evaluation" (CPT code 92523) *and* a typical SGD evaluation (92607 + 92608 x 2) in 2020 will receive the following Medicare payment:

SLP evaluation 92523	+	SGD Evaluation	=	Total Payment
$ 198.49		$ 238.19		$ 436.68

However, to merge the SGD evaluation codes with the codes now authorized for telepractice may eliminate the separate billing for the SGD evaluation. If both evaluations are performed, but the SGD evaluation is performed by telepractice, the total payment for these evaluations will be $ 198.49 instead of $ 436.68. The effect will be to eliminate *more than half* the SLP's possible reimbursement for providing these two services.

A decision that will cause this result is not reasonable. Tele-AAC services already have been described as imposing additional responsibilities on SLPs as compared to in-person evaluations. To then reduce possible Medicare payments for SGD evaluation to such an extreme degree: by 26 to more than 50 percent, will result in little if any Tele-AAC service delivery. Rather than advance service delivery options for Medicare beneficiaries, such a decision will turn the clock back to the period before 2003, when for payment purposes SGD evaluation was an untimed "procedure" code. At that time only a very small number of SLPs were willing to provide SGD evaluations. The reason: the payment rate set for SGD evaluation was grossly inadequate to the task. Although the then-new SGD guidance presented no coverage barriers for Medicare beneficiaries who required SGDs, too few were able to take advantage of this opportunity. In the Fall 2001, ASHA, which participated in the coding and payment rate discussions with Medicare, was told about this problem and asked to help resolve it:

> It's like laying out the greatest spread of food and no one shows up for the party. ... It seems that all the work we did to get Medicare to cover AAC devices is not making that much of a difference....
>
> We are going to need help, ongoing help, to address the barrier ... that the assessment rate is not reflective of the costs associated with the activity. (Golinker, 2001).

A final point about the possible merger of Tele-AAC services with the SLP procedures currently authorized for telepractice delivery is that during the past 20 years, Medicare revisited the structure of SLP and SGD evaluation and treatment codes on an annual basis. At no time did Medicare conclude that the Tele-AAC codes and the other codes for SLP evaluation and treatment are sufficiently similar, or are so frequently billed in tandem that they warrant being bundled into the same codes. Just as it has been inappropriate to consider these procedures together when they are delivered in-person, it is inappropriate now to consider them as merged to allow them to be delivered through telepractice.

Section VI

Evidence Supports Adding Tele-AAC Services to the Authorized Telehealth Services List on Either a Category 1 or a Category 2 Basis

The final item to be addressed in a request to Medicare for additional services to be added to its telepractice list is:

> Evidence that supports adding the service(s) to the list on either a category 1 or category 2 basis … (CMS, 2020a; 85 Fed. Reg. 19230 (2020) at 19233-34).

Medicare defines categories 1 and 2 as follows:

> Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.
>
> Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests will include an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient. Requestors should submit evidence indicating that the use of a telecommunications system in delivering the candidate telehealth service produces clinical benefit to the patient. The evidence submitted should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit will not include minor

or incidental benefits. Some examples of clinical benefit include the following:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in person diagnostic services.

- Treatment option for a patient population without access to clinically appropriate in person treatment options.

- Reduced rate of complications.

- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).

- Decreased number of future hospitalizations or physician visits.

- More rapid beneficial resolution of the disease process treatment.

- Decreased pain, bleeding, or other quantifiable symptom.

- Reduced recovery time. (CMS, 2020b)

The 3 Tele-AAC codes: CPT code 92607; 92608; and 92609 should added to the Medicare telehealth services list either on a Category 1 or a Category 2 basis.

These codes have been defined by Medicare as follows:

92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes
92609	Therapeutic services for the use of speech-generating device, including programming and modification

The Tele-AAC codes meet the description of Category 1 codes because as described in this request, SGD evaluation satisfy the common meaning of "similar to" (i.e., resembling without being identical to) the four SLP evaluation codes (CPT codes 92521; 92522; 92523; 92524) approved by Medicare for telehealth delivery on April 6, 2020. 85 Fed. Reg. 19230 (2020) at 19234, 19240). Both are forms of *SLP evaluation*, i.e., they are similar tasks, performed by practitioners with the same degree, certification and licensure. But they are not identical because these evaluation tasks are performed for distinct purposes; they use distinct procedures and tools; and they require distinct SLP knowledge, skills and experience.

Likewise, CPT code 92609 and CPT code 92507 are similar because both are forms of *SLP treatment*. But, they too also have the same distinguishing characteristics: distinct outcomes; arising from use of distinct procedures and tools; and requiring distinct SLP knowledge, skills and experience.

This "similar, but distinct" relationship also extends to the "roles" and "interactions" between the beneficiary and practitioner at the distant site, i.e., SLP.

Another similarity is that the secure "telecommunications system used to deliver the proposed service" can be the same for both of these types of SLP services. The professional literature describing the requirements for SLP telepractice and Tele-AAC services do not state that unique telecommunication systems are necessary for each type of SLP evaluation or treatment. (Cason & Cohn, 2014, at 11-13; Hall and Boisvert, 2014, at 20). Instead, they note that Tele-AAC requires an *additional* link: screen-sharing of the SGD being presented in the evaluation or the client's SGD being used during a treatment session. The other forms of SLP evaluation and treatment do not require this tool because clients receiving those services do not require or use SGDs.

Because of these similarities between the Tele-AAC services and the SLP services already on the Medicare telehealth services list, it is reasonable to conclude that the Tele-AAC services should be added to the list on the basis of Category 1. This conclusion is appropriate notwithstanding the discussion in Section V that these similarities do not justify or support the merger of the Tele-AAC codes with these SLP codes for billing purposes. It is reasonable to assume that this apparent "contradiction" will exist for all services for which authorization on the basis of Category 1 is sought.

On the other hand, if Medicare concludes the Tele-AAC services are "not similar to the current list of telehealth services" and therefore do not qualify for approval under Category 1, the Tele-AAC services nonetheless satisfy the characteristics outlined in Category 2. On this point, it is noteworthy that Medicare relied on Category 2 to authorize the 5 other SLP services codes. 85 Fed. Reg. 19230 (2020) at 19234, 19240).

Review under Category 2 includes several focal points. One is "an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth." As explained in Section V, only 3 changes have been made to the codes for the Tele-AAC services in more than 24 years.

- 2001: the SGD "evaluation" code that existed since 1996 (CPT code 92597) was rewritten. The SGD related tasks were removed and were replaced by temporary codes for SGD evaluation, and SGD re-evaluation (G 0197; and 0199, respectively).

- 2001: the SLP treatment code, 92507, which is an umbrella code for many different forms of SLP treatment that are not otherwise specified, had SGD related treatment carved out. SGD treatment was assigned a unique code: G 0198.

- 2003: the three "G" codes were withdrawn, and 3 CPT codes were issued. Substantively, only 1 change was made: since 1996, SGD "evaluation" (and after 2001, re-evaluation) had been "procedure" codes, offering a single rate regardless of the differences in time, equipment required or complexity of the procedure. Medicare changed this: since 2003, SGD evaluation has been a timed task, and 2 CPT codes were assigned ((92607 and 92608). No material change was made to the SGD treatment code.

In the years since 2003, no changes to these code definitions have been identified as appropriate or necessary and none has been made. During this almost 20 year period, Medicare had the opportunity to re-examine the appropriateness of these codes on an annual basis as part of its payment rate-setting procedure and it never concluded that coding changes were needed. Also, in 2014-15, Medicare reconsidered its entire SGD coverage policy and once again no coding changes were made. *See* Section IV, sub-section A.

In short, no basis exists to question the ongoing appropriateness of the Tele-AAC services codes.

The second focus of the Category 2 analysis is whether there is any potential conflict between the existing code definition and its delivery by telepractice. There is none. This point was discussed in Section IV, sub-section D.

Section IV, sub-sections G, H, I, J, K, and L address the last focal point of the Category 2 analysis: that telehealth delivery of Tele-AAC services will "produce[] demonstrated clinical benefit to the patient." The answer is an unconditional "yes." Moreover, as described in Section IV, sub-section A, the benefits clients receive from SGD access and training are extraordinary (*Formal Request,* 1999). They are most definitely ***not*** "minor or incidental." Section VI also requires discussion and production of professional literature to support these assertions. The text of Section IV provides a detailed review of the professional literature describing the characteristics and benefits of Tele-AAC services and their comparability to the SLP services already authorized by Medicare for SLP telepractice delivery. A copy of the references relied on is attached to this request.

Finally, as explained in Section IV, sub-sections B, J, and L, the Covid-19 pandemic makes it essential for telepractice delivery of SGD evaluation and SGD treatment to be authorized because Medicare beneficiaries will not otherwise have access to clinical evaluation to identify their SGD need or to treatment necessary for them to use their SGDs efficiently and effectively.

> Without these codes, speech generating devices, a type of durable medical equipment Medicare first covered 20 years ago will be unattainable for my patients who have urgent need for them. (Roman, 2020).

Conclusion

The Medicare beneficiaries who submit this request have established 6 key points:

- That Tele-AAC services meet all the criteria required for their CPT codes to be added to Medicare's list of authorized telehealth services.

- That the delivery of SGD evaluation and SGD treatment by telepractice will be a procedural accommodation only. It will not change the evaluation or treatment tasks performed, not diminish the quantity or quality of the evidence gathered and subsequently reported, and will not otherwise be distinguishable in a meaningful way from the in-person delivery of the same services.

- That the authorization of telepractice delivery of SGD evaluation and treatment is consistent with the Tele-AAC code definitions, Medicare's SGD guidance, SLP professional standards of ethics and practice, and current SLP practice to beneficiaries, recipients and participants in other systems of health benefits funding, and Medicare beneficiaries enrolled in Medicare Advantage Plans, and those who receive SLP services under Part A.

- That the need for authorization of the Tele-AAC codes is urgent because a vital, rarely-needed, but long-covered Medicare DME item – SGDs – and the treatment necessary for clients to use SGDs efficiently and effectively have become almost inaccessible due to the reduction and elimination of in-person SLP clinical services in response to the Covid-19 pandemic.

- That there is no rational alternative to enable Tele-AAC services to be delivered to Medicare beneficiaries based on the codes Medicare has authorized to be delivered by telepractice. The Tele-AAC services cannot be merged for billing purposes into any of those other procedure codes. To do so will only substitute one barrier (no access to SLPs) for another (no willing providers due to a grossly reduced payment rate). And

- That SLPs are the only practitioner who provide Tele-AAC services and therefore, in addition to the authorization of telepractice delivery of SGD evaluation and SGD treatment services, SLPs must be authorized to bill for the delivery of these services to Medicare beneficiaries by telepractice.

The two requests presented here ask Medicare to enable ongoing coverage of SGDs and SGD treatment, both Medicare benefits since 2001. No expansion of the existing benefits is sought: only additional flexibility in the method of their delivery, necessitated by the Covid-19 pandemic.

Because of the importance of SGDs to the Medicare beneficiaries who need and use them, it also is requested that Medicare review these requests immediately, and if approved, that March 1, 2020 be the effective date for the authorization of SLP delivery of these services by telepractice, the same effective date set for the other SLP evaluation and treatment services which were added to the telehealth services list. 85 Fed. Reg. 19230 (2020) at 19234). The Medicare beneficiaries who need and use SGDs simply cannot wait to regain access to in-person evaluation and treatment services. They include individuals with ALS and other progressive impairments. For these Medicare beneficiaries in particular, and for all others who Medicare acknowledges cannot safely be left alone at home without an effective means of expression, time is of the essence.

Please contact the undersigned if you have any questions or need any additional information.

Thank you.

Ithaca, New York
August 21, 2020

Lewis Golinker, Esq.