Maryland Academy of Audiology
P.O. Box 710
Parkville, MD 21234
https://maaudiology.org/

February 27, 2024

Chair Joseline A. Pena-Melnyk
Room 241
House Office Building
Annapolis, Maryland 21401

RE**: HB 464** Health Occupations - Practice Audiology - Definition
Position: **SUPPORT**

Madam Chair Pena-Melnyk, Vice Chair Cullison, and Committee Members,

As a full-time practicing Doctor of Audiology in Howard County and a private practice, small business owner, I am deeply saddened to have to take time away from providing audiologic and vestibular (balance) healthcare to patients and write a letter of support for HB 464.

After earning a Bachelor of Arts degree from Michigan State University, I attended Gallaudet University in Washington, DC for my Doctor of Audiology (Au.D.) program. My fourth-year externship (residency) was completed at the Mayo Clinic Arizona. It was there that I saw the entire healthcare system worked efficiently to put the needs of the patients first. Providers at Mayo Clinic did not have egos that needed to be inflated by supervising or providing oversight of another provider. Each professional has her/his specialty and everyone worked together for the best outcome, not for individual income.

Providers at the Mayo Clinic focused on the top of their scope of practice to best utilize the expertise. Audiologists evaluated, diagnosed, managed, and treated audiologic and vestibular care as the point of entry. Mayo Clinic Florida[1] published an article in 2010 that highlighted the majority of adults (95%) required audiologic care and those were the **only** services required (i.e., the patient did not have to be referred/treated by ENT, neurology, PT, etc.). The article also emphasized that treatment plans did not differ between audiologists and otolaryngologists (ENT physicians) for the same conditions. Furthermore, there was no evidence that audiologists missed significant symptoms of otologic (ear) disease, and there was strong evidence that audiologists referred (managed) appropriately. This article is now more than a decade old and was completed at a world-renowned medical center. None of the audiologists were didactically trained at Mayo Clinic; they were trained in the same accredited programs that Maryland audiologists are trained. Yet, the Maryland otolaryngology (MSO) and medical (MedChi) associations cannot follow this peer-reviewed literature and work **with** audiologists.

The MSO edits struck the word ‘diagnose.’ However, the words ‘assessment/diagnosis/evaluation’ are already in COMAR 10.41.03.03 B.(4)(a) as it relates to [audiology] clinical training and the percentage of time a

[1] https://pubmed.ncbi.nlm.nih.gov/20701834/

MARYLAND ACADEMY OF AUDIOLOGY

Maryland Academy of Audiology
P.O. Box 710
Parkville, MD 21234
https://maaudiology.org/

[student] must have in these areas. The MSO nor MedChi have **not** been actively seeking to change this Regulation via Regulatory updates or legislation.

Federal entities, such as the Veterans Administration (VA) care for our service members who ensure our freedom. The VA wait times are monitored by Congress and when they are viewed to be too long, it makes national news. The VA has worked for the past few years to provide average appointment wait times of less than 44 days for any specialty. They can do this by utilizing providers to the top of their didactic and clinical training. In fact, the VA describes Audiologists this way:

> "Audiologists are licensed health care professionals who care for veterans and service members through the prevention, *diagnosis, and treatment* of hearing disorders that include hearing loss, balance impairment, and tinnitus. Audiologists counsel patients and families regarding good hearing health practices and advise them on appropriate *management strategies*." (Emphasis added)

Baltimore has a VA Medical Center with a few satellite offices throughout the state. Audiologists working within the VA system in Maryland currently have a more modern job description than the audiologists **not** working in the VA system.

According to a Johns Hopkins website discussing over-the-counter (OTC) hearing aids:

> "A diagnostic hearing test completed with an audiologist will provide accurate information on both the degree and type of hearing loss." [2]

Johns Hopkins acknowledges the audiologist is completing a diagnostic hearing test. The website further discusses how the audiologist can help manage the patient to determine if OTC or prescription hearing aids (treatment) may be helpful. Maryland law should be modernized to be consistent with the State's institutions that also recognize the level of care an audiologist provides. The only non-medical hearing test that has been studied on adults and children is the Whisper Test.[3] Whisper test instructions are:

1. Stand 1–2 feet behind the patient.
2. Have the patient cover one ear canal.
3. Whisper a word with two distinct syllables towards the patient's right ear.
4. Ask the patient to repeat the word back.
5. Whisper sets of either three digits or a combination of digits and letters.
6. Start with consonants, followed by vowels.
7. Whisper after a full, quiet expiration.

---

[2] https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/hearing-aids/over-the-counter-hearing-aids-faq

[3] https://geriatrics.ucsf.edu/sites/geriatrics.ucsf.edu/files/2018-06/whispertest.pdf

MARYLAND ACADEMY OF AUDIOLOGY

Maryland Academy of Audiology
P.O. Box 710
Parkville, MD 21234
https://maaudiology.org/

8. A positive test is a failure to repeat at least three of the sets.

The test is typically carried out in a quiet room (about 40 dBA or below). With 2024 technology and the validated hearing-quality of life questionnaires, any provider who is using a Whisper Test should be seriously questioned.

Finally, the suggested non-medical hearing evaluation is concerning for any provider who needs to make a diagnosis of hearing acuity. Without a medical evaluation, how will a diagnosis be made? If a diagnosis is made from a non-medical hearing test, is that provider completing malpractice?

Additionally, healthcare is more difficult to access outside the "triangle" between Washington, D.C., Baltimore, and Annapolis. My practice is in Howard County and parts of Howard County are more rural. Patients cannot or choose not to travel into cities to receive any type of care. Audiologists who are accessible in these more rural areas can provide some healthcare for individuals, and some healthcare is better than no healthcare. At my practice in Howard County, I see patients of all ages for evaluation and diagnostic testing. Many patients find my office in Highland more accessible for tinnitus evaluations and treatment, auditory implantable pre- and post-surgical diagnostic and treatment services, and occupational and recreational hearing protection management. In fact, patients in Howard and Frederick counties can save more than an hour, roundtrip for cochlear implant testing, programming (MAPping), and counseling compared to their prior requirement to drive to Baltimore, deal with traffic, and pay for parking at the Greater Baltimore Medical Center (GBMC), Johns Hopkins University (JHU), and University of Maryland Medical Center (UMMC).

Outside the Senate and House walls, audiologists are providing valuable diagnostic and treatment services that ENTs are unable to provide. The Board of Examiners for Audiologists, Hearing Aid Dispenser, Speech-Language Pathologists (and now Music Therapists) published a May, 2016 newsletter that stated any person not licensed by the Board who completes a hearing test in Maryland is breaking the law, under the Health Occupation Statute 2-401. According to the State of Maryland, physicians **cannot** complete a hearing test without being a licensed audiologist. Additionally, it would be ludicrous to ask a surgical specialist to complete a 20–50-minute diagnostic audiologic evaluation and receive the average third-party payor (CMS) reimbursement of $37.28.[4]

Many private insurance companies look to the Centers for Medicare and Medicaid Services (CMS) for guidance of payment. Medicare classifies Audiologists as 'Diagnostic-Other.' Ironically, the only other provider in that category is Radiologist, a specialized physician. The fact that Maryland Statute does not recognize audiologists to diagnose, when CMS- located in Baltimore, MD does, seems outdated.

The CMS has also been requiring all providers to report outcome data to provide better patient care. Audiologists have been eligible providers for the (now) Merit-Based Incentive Program (MIPs) as a 'Medical

[4] https://www.audiology.org/wp-content/uploads/2023/11/AudiologyMPFS-Final-CY-2024_Table.pdf

MARYLAND ACADEMY OF AUDIOLOGY

Maryland Academy of Audiology
P.O. Box 710
Parkville, MD 21234
https://maaudiology.org/

Specialist.'[5] The audiology profession when required and eligible to participate has one of the highest participation and highest outcome percentages across the MIPS (previously PQRS) system. Not only are audiologists evaluating and diagnosing appropriately, they are also providing some of the best quality of care and managing the patients appropriately.

Additionally, the language passed in 2023 that allows audiologists to

> "Prescribe, order, sell, dispense, or fit hearing aids to an 11 individual for the correction or relief of a condition for which hearing aids are worn"[6]

describes 'manage' and 'treat.' The MSO and MedChi were upset with the language in 2023 are opposing again this year, despite the fact the Food and Drug Administration (FDA), ***the*** most conservative government agency, was the driving force of the words "prescribe, and order" hearing aids. Hearing aids are the treatment for sensorineural hearing loss. The 2024 legislation does not Practice Medicine- defined in Maryland as diagnose, **heal**, treat, or **perform surgery**. (Emphasis added)

Physicians and surgeons are essential to my practice and patients. However, the MSO addition on page 2, line 28 (V) is completely inappropriate and unethical. The amendment provided implies that Maryland audiologists can only refer (manage) to a physician or *their* physician assistant (PA), or nurse practitioner (NP). Audiologists see patients for a variety of concerns. Requiring all referrals to go back to a physician creates a true Health Maintenance Organization (HMO). Physicians are already in dire demand; this amendment **increases** the pressure on the system for audiology patients who need a referral to a non-physician (e.g., optometry, physical therapy, dentist). In rural areas, nurse practitioners (NP) often serve as a patient's medical home. However, with this amendment, audiologists would not be able to refer the patient back to her/his NP for medical management (e.g., ear infection medication prescription) unless the NP was supervised by a physician. Again, is the edit about the MSO's members practice incomes that they require all the referrals so they can charge an office visit code?

Finally, at Designer Audiology, referrals to specialized providers are difficult and often comes with a significant waiting period. Within the past year, the office identified a hearing loss that required radiographic imaging to rule-out a serious medical condition that may have required surgery. Two audiologists from the practice had to call mutiple ENT offices to request an appointment, as the patient was unable to obtain an appointment at any office within a 20-mile radius of Designer Audiology for 5 weeks! The window for successful treatment is 48 hours-7 days. Due to the short opportunity-period for treatment, the audiologist called the patient's primary care physician (PCP) to request the order for radiographic imaging, which was sent from the PCP to the patient directly who obtained the procedure from a radiographic imaging center. There are multiple (and sometimes extreme) causes that can be explained; but it does not seem unimportant when it happens to you.

---

[5] https://www.cms.gov/mmrr/Downloads/MMRR2014_004_02_a04.pdf
[6] HB 401/SB 449.

MARYLAND ACADEMY OF AUDIOLOGY

Maryland Academy of Audiology
P.O. Box 710
Parkville, MD 21234
https://maaudiology.org/

This situation could have been resolved with the proposed, modern language of ordering radiographic imaging and benefited the patient, the audiologist, the PCP, and the outcomes.

The fears from the MSO's proposed amendments are unfounded with audiologists extensive didactic and clinical education. As a non-physician doctor, audiologists have an important role to evaluate, diagnose, manage, and treat patients; they are simply not "the girl down the hall" anymore. With the population as a whole aging and individuals not entering the healthcare professions due to the time and expense of the educational requirements, along with the poor return on investment, all providers need to have modern licensure laws consistent with instruction. HB 464 used the other clinical doctors' (e.g., dentist, optometry) language to harmonize the Statute.

I ask for your favorable report on HB 464.

Sincerely,

Alicia D.D. Spoor, Au.D.

Alicia D.D. Spoor, Au.D.
Doctor of Audiology
MD License: #00145