



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

July 22, 2011

Kathleen Sebelius  
Secretary  
Department of Health and Human Services  
Room 445-G  
Hubert Humphrey Building  
200 Independence Ave, SW  
Washington, DC 20201

**Re: CMS-9993-IFC2; Comments on Group Health Plans and Health Insurance Issues:  
Rules Relating to Internal Claims and Appeals and External Review Processes  
(*Federal Register*, June 24, 2011)**

Dear Secretary Sebelius:

The American Speech-Language-Hearing Association (ASHA) is the professional, scientific, and credentialing association for 145,000 members and affiliates who are audiologists, speech-language pathologists, and speech, language, and hearing scientists. We appreciate the opportunity to comment on the Group Health Plans and Health Insurance Issues: Rules Relating to Internal Claims and Appeals and External Review Processes interim final rules. ASHA applauds the efforts of HHS to assure that there is sufficient opportunity to appeal the decisions made by health plans. Our comments are limited to the area of medical judgment in the external review section.

ASHA supports the need for external review for those claims that involve medical judgment as provided in the examples noted:

1. One example cited was of a plan that generally provides 30 (physical) therapy visits but will provide more with an approved treatment plan. We agree that a health plan should allow medical review when the provider believes that additional visits are needed. That the health plan would reject a treatment plan submitted by a provider for the 31<sup>st</sup> visit based on failure to meet the plan's standard warrants medical review. This standard would apply, of course, to other therapy disciplines such as speech-language pathology and treatments, and certainly the limit of 30 visits – while potentially sufficient for some conditions – does not generalize to all conditions/clients. Medical necessity is required to justify all of the treatments provided, not just the 31<sup>st</sup>.
2. Another example addressed the appropriate health care setting for providing care. In consideration of the medical necessity, depending on the treatment, the setting should not be limited to one type of location (e.g., inpatient vs. home care vs. facility). If the treatment is medically justified and all other factors controlled (e.g., safety is managed), then the setting should not be a deciding factor.
3. A third example of interest to ASHA focused upon the determination of a medical condition that may be a preexisting condition. As expressed to you in a letter written in January, ASHA actively worked with Congress and other stakeholders for the inclusion of rehabilitative and habilitative services under the essential health benefit definitions.

Additionally, ASHA participated in the National Association of Insurance Commissioners (NAIC) Consumer Information Subgroup which recommended definitions for these terms. The inclusion of habilitative services for those with congenital or early acquired disorders is particularly important as these services have historically been omitted or excluded from health coverage. The result is that many children, who are primary recipients of habilitative services, are left without coverage for needed services such as speech-language pathology and audiology. Rehabilitative services, when covered, are often only for people who have lost skills due to an identified illness or injury. For children who have not yet developed the ability to speak and will not learn to speak on their own due to some medical condition or functional reason, payers erroneously argue that they have not lost any skills and, accordingly, are not eligible for insurance coverage. It is imperative that a congenital condition not be cited as a preexisting condition and, therefore, not subject to coverage. This would be tantamount to denying service for a condition that was present at birth, but covering the service for the same condition that may have presented itself at age two. The opportunity to appeal decisions based on the medical necessity of the treatment must be preserved.

4. Finally, the example presented of a general exclusion of an item or service parenthetically noted speech therapy (i.e., speech-language pathology services) which states “if the plan covers the item or service in certain circumstances based on a medical condition (such as, to aid in the restoration of speech loss or impairment of speech resulting from a medical condition),” it should be eligible for external medical review. Thus, the speech-language pathologist can provide the supportive information to demonstrate the medical necessity of the treatment. ASHA strongly supports this recommendation.

Thank you for the opportunity to present our concerns regarding health plan appeals. Should you need further information, please contact Laurie Alban Havens, ASHA’s director of Medicaid and private health plan advocacy, by phone at 301-206-5677 or by e-mail at [lalbanhavens@asha.org](mailto:lalbanhavens@asha.org).

Sincerely,

A handwritten signature in black ink that reads "Paul R. Rao". The signature is fluid and cursive, with the first name "Paul" being the most prominent.

Paul R. Rao, PhD, CCC, CPHQ, FACHE  
2011 ASHA President