Ten Years with the Medi-Cal Program: Advocate and Adversary

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This paper describes the function and duties of the author, who has served as a part-time consultant for the California Medicaid Program (Medi-Cal) at the Los Angeles Field Office for the past 15 years. A chronological sequence is employed beginning with the early years when the program was managed by the County of Los Angeles to the present management by the state. Interrelations with other departments and agencies are recounted to demonstrate the complexities of public programs. Some anecdotal data are presented in relation to the providers: audiologists, speech pathologists, otolaryngologists, and hearing aid dispensers.

Although the paper is chiefly retrospective in nature, statements are presented that may modify further development in California's state and federal program for the needy. The future of the program during these times of deregulation, fiscal conservatism, and political gobbledegook can only be surmised, and then most probably, erroneously.

The sixth and seventh decades of the twentieth century brought with them significant benefit increases to handicapped people. Concomitant with this was the rise of consumerism. Consumerism and health care benefits changed vital aspects of our profession; the former manifested by licensing laws, the latter by increased governmental support. Although increases in special benefits to the "exceptional child" were a continuation of prior legislation, the emergence of the concept of "individualized educational programs for all handicapped children in a least restrictive environment" significantly changed funding arrangements in U.S. education. The peculiar (or typically American) concept of a dichotomy between health care and special education has produced confusion in regulations, statutes, and funding. The decade of

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the eighties may present us not with expansion, but rather with consolidation, elimination, and further confusion among regulatory agencies. The present economy may appear stagnant with respect to the last decade, but undoubtedly the inevitability of change will manifest itself in ways that may appear alien to our recent period of affluence, particularly between the states and the federal government.

However frightening or beautiful our future will be, a retrospective view of our accomplishments in the tiny segment we term either "rehabilitation" or "habilitation" of hearing impaired persons seems appropriate for this occasion. We know where we've been, our mistakes and successes are behind us, and we can look forward with a modicum of confidence and a touch of apprehension.

An interesting phenomena of the late sixties was the rise of health services to the needy, aged, and disabled known as the Medicaid program. Starting in 1965 as amendments to the Federal Social Security Act (Title 19), funding was made available to the states on a shared basis. In California, for example, such services have been provided for 15 years prior to enactment of Title 19. Accordingly, California Administrative Code, Title 22, was enacted based on the existing California Welfare and Institution Code, and became the working document for the W & I Code.[1] Concurrently, a contractual agreement was made between the State of California and the fiscal intermediaries, Blue Cross-Blue Shield, for a claims payment mechanism for the program. In 1980, in response to pressures and advantages accruing for a computerized system, Computer Sciences Corporation (CSC) was awarded the contract for a period of four years.[2] The program itself is run by the Medi-Cal Operations Division, one of the 12 divisions in the department of Health Services. Within the division are eight field offices and four sub-field offices. The Los Angeles field office accounts for approximately one-third of the entire business transactions and has the largest staff of consultants, nursing supervisors, clerical support, and the only licensed audiology and speech pathology consultant in the state. In round numbers, the Los Angeles office serves approximately one million beneficiaries and an estimated 18,000 providers and their employees per day.

From its implementation in 1966 through 1971, categorical funding for services was extended to the medically needy, Old Age Security, permanently disabled, blind, families with dependent children (AFDC), and later the medically indigent. During this period, costs were rising by a rate of 15% per year, but tax revenues by only 6%. Actual costs rose from $299 million in

[1]Regulations cited in the paper are excerpted from the *California Administrative Code, Title 22, Social Security, Division 3 — Health Care Services.* This cumulative document is published by The Office of Administrative Hearings, Department of General Services, State of California.

[2]The Computer Sciences Corporation issues a series of guidelines to providers. The section pertaining to speech and hearing services is: *Medi-Cal Provider Manual for Allied Health Services.*

1966 to one billion in 1971. It was during this period that I was asked to participate in the program. In the discussion that follows, my participation in an exciting, albeit frustrating, program as a speech and hearing consultant from 1967 to the present is described. Observations and interpretations are personal and are not to be construed as official policy of the program.

THE EARLY YEARS (1967-1970)

From 1967-1970 the state program was administered by the Los Angeles County Department of Public Social Services. When the program started in 1966, two otolaryngologists and one audiologist were employed on a part-time basis to authorize requests for hearing aids. I was added in the Fall of 1967. A chief consultant-physician was responsible for the distribution of Treatment Authorization Requests (TARs) to each consultant. We were provided with the regulation (51319) of Title 22 and a copy of the approved list of hearing aids titled "Schedule of Maximum Allowances" (SMA) compiled by the California Department of Finance. This document contained the names of hearing aid manufacturers, the model, a description of the type, optional equipment, and the maximum payable allowance. Entries were arranged alphabetically, starting with the "Astro Bel" in-the-ear type hearing aid for $240 and ending with nine models of the "Vanco" ranging in cost from $152-204. These lists were updated until 1975 when the department decided to standardize an SMA for all models. (See Appendix A for the current SMA.)

The instructions were simple; approve, deny, or defer the requests based on Regulation 51319. There were no guidelines and each consultant used the regulation and his own personal knowledge as criteria. Attached to the TARs were a prescription and a simple form containing spaces for the requested make, model, aided and unaided test results, and a short history. We picked up packets of TARs, took them home, processed them, returned them, and repeated the cycle several times a week. During this period, pick up locations changed three times from a location in East L.A., to South Central L.A., to West Central L.A. Until the present location was selected, there was virtually no communication with the organization — it was simply a pick-up and delivery of materials.

During the fall of 1970, the situation changed again. The state took over the management of the program, the other three consultants resigned, and I became the sole consultant for not only hearing aids, but also for audiology and speech "therapy". Along with this change came a physical move to the State Office Building in downtown Los Angeles. Retrospectively, those years are now remembered as confusing, frustrating, hurried, and with few contacts with either providers or fellow consultants. The work was accomplished during early mornings, late nights, and weekends.

THE SEVENTIES

Definitions, Operations, and Statistics

My position was formalized in 1970 as Special Consultant (Audiology, Speech Pathology, and Hearing Aids) for the Field Services Bureau, Southern Region, Department of Health Care Services. The place, the ninth floor of the State Office Building — and a desk. My office supervisor was a rough and tough lady pediatrician, but also a fierce ally with a driving ambition to cut through red tape. She also admitted that she knew nothing about speech and hearing disorders and hearing aids, but, in addition to her main task of processing medical TARs, stood ready to help, fend off the aggressors, and to act as advocate. All her verbal utterances were characterized by a colorful stream of profanity. A part-time clerk maintained the files, took telephone messages, and typed a summary sheet for each packet of TARs. Each sheet contained the beneficiary's name and I.D. number, provider identification, and type of service. Weekly trips to the office were sandwiched in between University classes — generally during the lunch period. The system still allowed for TAR processing outside the building.

The relation of the consultant to the program is largely restricted to the provider, thereby setting up an adversary situation. Seldom does the consultant contact the beneficiary, and then only by direction. The program regards the provider of services to be the link between the beneficiary and the consultant — a safeguard greatly appreciated by the latter.

Licensing

The '70's also brought provider licensing to the "allied" health professions. In 1971, licensing was mandated for hearing aid dispensers and in 1974 for speech pathologists and audiologists. Examining committees for all three were added to the Board of Medical Examiners (now called the Board of Medical Quality Assurance) in the California Department of Consumer Affairs. Accordingly, the definitions section of Title 22 was changed from *speech therapist* to *speech pathologist* and the basic requirement from certification by ASHA to state licensure.

I was appointed as public member-audiologist to the Hearing Aid committee in 1971 and served for eight years. This activity was of positive benefit to the position with the Medi-Cal program by providing a liaison with the two departments — Consumer Affairs and Health Services. Although there was no legal restriction against audiologists dispensing hearing aids, providing they were also licensed as hearing aid dispensers, the issue was then an ethical one with ASHA. When ASHA removed the restriction, the Department of Health Services welcomed the change, reasoning that it would reduce the number of providers. In the Los Angeles field office, we also decided that only otolaryngologists should perform the medical examination,

based on high population density and the number of otolaryngologists in Los Angeles County.

Forms and Trials

During this period I modified medical history forms, audiometric forms, and trial forms to be in compliance with new federal regulations set up by the Federal Drug Administration. Similarly, forms were also developed to verify trials and their supporting data. During the '70's the concept of a '30 day trial' had its ups and downs. For a brief period, trials were outlawed (a move that obviously delighted a good share of the providers). As criteria were so elusive — and still are, consultants varied in their interpretation of the requirement. Basically my requirements were based on the age of the beneficiary, first time user, place of residence (home or nursing facility), and low discrimination scores. In 1979 the Song-Beverly Consumer Warranty Act was amended to provide protection for persons who used assistive devices and specified a 30-day minimum warranty period including an *implied warranty* by the retail seller that the device was specifically fit for the particular needs of the buyer. Actually this protection plan did not include the trial period as title to the instrument did not become effective until it was authorized and placed on the beneficiary, who then became the owner. Interestingly enough, we did have dispensers who always placed hearing aids on trial!

Relations with Other State Agencies

During this period I learned that Medi-Cal beneficiaries may also be idenfied with the Department of Rehabilitation, with California Childrens Services (a branch with Health Services), and Regional Centers for the Developmentally Disabled. Section 51319 deals specifically with Rehabilitation and CCS in the matter of binaural hearing aids, but not with monaural fittings (see Appendix B). Documentation supporting the fitting from all three agencies is routinely required. Decisions tend to be sticky in the 18-21 year age group as the regulation specifies age 18, but the CCS age group extends to age 21!

Fraud

Few audiologists are in the unenviable position of being a party to litigation between the state and the provider. Such a "happening" occurred in the mid '70's when it was discovered that collusion was alleged to exist between a hearing aid dispenser and an otolaryngologist. Prescriptions signed in blank were found in the dispenser's office and allegations were made that the medical examinations were not performed and audiometric data were falsified. I was subpoenaed, the wrong questions were asked, the physician disappeared, neither party was jailed. Both parties were banned from engaging in the Medi-Cal program. According to the law, charges were first preferred in the courts

and finally before an administrative law judge. The episode does bring into focus, however, a basic problem of the prior authorization procedure. The consultant, the provider, and the beneficiary are all presumed to act in good faith. As my experience with the program developed, it also appeared that the beneficiary may be at fault, rather than the provider, particularly in the case of "lost" hearing aids. The only control in the system after the "loss" of a hearing aid is to keep track of the serial numbers. Some "losses" turn up as later repairs. One "found" hearing aid showed up in a nursing home. It took two months of calling to a manufacturer's agent, a wholesaler, and a retailer to track down the beneficiary, only to find out that the beneficiary expired several months before! Investigations for such small items are far too expensive when compared with other program benefits.

Miscellaneous

The Medi-Cal Reform plan of 1971 restricted the number of out-patient visits to two per month without prior authorization. Visits in excess of this maximum were then subject to prior authorization, including submission of an extended treatment plan countersigned by a physician. This plan included speech and hearing services which, although slowing the flow of approvals, apparently also slowed down the amount of "over utilization". That same year brought a hearing aid study that provided statistics about new hearing aids, hearing aid repairs, beneficiary characteristics, and a procedure code utilization based on a sample of Los Angeles authorization requests. These data are presented later in this paper.[3] The study led to a brief flurry of discussion of the feasibility of mass purchasing. The project was shelved abruptly. In like manner, the question of providing tinnitus maskers for the hearing impaired and typewriters for aphasic hemiplegics was summarily dismissed for a variety of reasons, chiefly because of their non-relevance to regulations.

As more providers of speech and hearing services became attracted to the program, the number of questions and gripes rose proportionately. A group of clinic directors began meeting at more or less regular intervals to discuss common problems, not the least of which were fiscal and Medi-Cal policies. The California Association of Speech Pathologists and Audiologists in Private Practice (CALSPAPP) also devoted more time on their agendas to problems of third party payment to the extent that they hired a part-time lawyer-consultant to keep track of state and federal legislation.

As many of the providers were also treating children, the emergence of PL 94-142 created more confusion and disappointment. Meetings were held at

[3]The Rates and Fees Bureau, Department of Health Care Services (now the Department of Health Services) issued an unpublished report (#422-1) titled "Hearing Aid TAR Study" (undated) which was prepared by Bill Cole. Data on *Categorical Aid* and the *Aged* for 1972 may be seen in Table 2.

which Medi-Cal providers, special education personnel, and Medi-Cal representatives tried to iron out rather touchy problems. The providers contended that the public school services were inadequate and should be supplemented, the public schools were not about to pay for "supplemental" services to Medi-Cal beneficiaries, and the Medi-Cal representatives contended that the program was illegal for school age children — who were already receiving "free" services from the public schools. To this date no satisfactory interagency agreement has been reached between the Medi-Cal branch of Health Services and the Department of Education. With some restrictions, the program does authorize extended treatment for children in the age category of two years, six months to four years, nine months.

As the decade drew to a close, several significant changes took place. The administration found no justification or precedent for consultants to leave the office with confidential material (TARs). The results were: (a) I had to arrange times to be present in the office. By now the maximum time had increased from the authority to work 40 hours per month to 86 hours, and (b) years of working as a "temporary-intermittent" employee without any fringe benefits finally produced some action in Sacramento to create a classification of "Speech Pathology and Audiology Consultant — Part Time" for me. The personnel branch petitioned the State Personnel Board to create this one-of-a-kind position; then the process got stalled. . . .

THE EIGHTIES

The Computer Sciences Corporation (CSC)

From a position requiring only the processing of an unending stream of provider requests virtually without interruption at home to a desk job, brought an unending number of phone calls as well as the ubiquitous stream of paper work. I had now become a true bureaucrat, junior grade. The new decade brought a new fiscal intermediary (CSC) and new forms designed for computer processing. By computerizing the system, the subsidy to the state was increased by the federal Social Security Agency. The groans from providers reached new heights and the consultants found that checking the new forms more than doubled the processing time.

By the Spring of 1981 consultants had fairly well adapted to the new procedures, but the providers found that a misplaced entry on the claims form might not only result in endless negotiation with CSC, but also in part, delayed, or token payment. One cent for a hearing aid? One hearing aid provider estimated that to do the book work alone for one request amounted to about five dollars! Some of the best providers, unfortunately for the program, retreated, left the program, and licked their fiscal wounds. Others, for whom the Medi-Cal business was their bread and butter, just dug in and trained themselves and their office staffs to be precise and accurate with their

requests and their billings.[4] Once the TAR was approved, the original copy went immediately to CSC, entered on the computer immediately if typed, or delayed somewhat if handwritten. The optical scanner processes only typewritten requests. One copy was filed in our office, and one copy returned to the provider. Despite the fact that consultants have no hand in the fiscal affairs of the program, phone calls still come in from providers, if for no other reason than to just complain.

On the horizon are the possibility of reduction in profits, items, and aid categories.[5] As an aside, it is interesting to note that businesses and institutions that decry the federal "giveaway" programs are now being forced to take a position on the other side of the political "see-saw".

New Developments

Despite all the uncertainties of the future, children and adults subsidized by the program are being served. In the area of audiology, the advent of auditory brain stem response testing (ABR) and "Cribometry" have apparently given us tools for early though not clearly defined identification of hearing impairment. Computer manufacturers have produced a whole array of "augmentative communication aids" for the seriously disabled; however, these latter two developments have not been approved by regulation. Payment for ABR (not yet subject to prior authorization) has been erratic and subject to considerable review (see Appendix C. for the payment schedule of Section 51507.2; audiology and speech therapy). The code number, 0829, is a catch-all for all procedures not listed. Presently the Medi-Cal Policy and Standards Branch has submitted to CSC a list of new procedure numbers to cover auditory, visual, and somato-sensory evoked response tests for audiologists and a similar series of code numbers for physicians working under a Relative Value Scale (RVS) system. In addition, a new set of numbers for vestibular testing (including ENG) and the authorization of half hour therapy sessions for both speech and hearing has been included. Underlying all these advances, however, lurk the spectres of uncertainty and political maneuvering.

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[4]Appendix A is a copy of Title 22, Regulation 51517 and shows the current SMA. This schedule of fees is applicable not only to the Medi-Cal program, but also to the California Childrens Services (CCS) and to the Department of Rehabilitation. It may be interesting for the reader to compare costs to the program with the manufacturer's recommended retail prices.

[5]Since an abbreviated form of this paper was presented at the Summer Institute, *ARA*, in June, 1982, hearing aid batteries were removed as a program benefit, an allowable mark up on hearing aids was reduced by 10%, and Speech and Hearing evaluations in nursing homes became subject to prior authorization — effective 1 September, 1982. Categorical aid to the "Medically Indigent" and a portion of the "Aid to Families with Dependent Children" has been also removed from the state program. This latter reduction may become effective 1 January, 1983 and turned over to the counties for financing.

Miscellaneous

Although the new position of speech pathology-audiology consultant has been classified and funded, all funds were frozen in anticipation of the July 1, 1982 budget for 1982-83. Optimistically, the position is now scheduled for September 1, 1982. (Excerpts from the published statement of the position and its scope may be found in Appendix D.)[6]

This "temporary" position has, however, during the past two years, brought new dimensions to the job. When the other field offices became aware that an "in-house" rather than an "out-house" consultant was available, calls for interpretation of regulations became commonplace. Additionally, communications with other branches of the department increased and the calls from local agencies requesting information became a weekly occurrence.

Of particular interest were requests from physician consultants in the office for the author's interpretation of hearing test data. Listening to their calls with physicians and hospitals was an education in itself and, I suppose, an attitude of cynicism that is difficult for me to combat. Peer review is a messy business; it has been pointed out to be cost effective, yet leaves one with such a sense of futility that perspectives tend to be distorted. How can one be objective in defending a system of health care when it is the only large nationwide business in which, as knowledge and technology have increased, costs have risen disproportionately to inflation? On the other hand, the consultant is privy to not only the providers' squabbles with the system, but also with other providers of the same services and with other services which, although slowing the flow of approvals, apparently also slow down the amount of "over utilization."

The process of authorizing hearing aids requires information from a trio or duo of providers; the otolaryngologist who may also be the audiologist, the audiologist who may also be the dispenser, and the dispenser. If the request for the hearing aid is denied, the audiologist and the physician who performed the examination and evaluation will be paid for their services — as such services are presently not subject to prior authorization. The dispenser is left holding the bag. If the TAR is deferred, the dispenser may have to seek information that was deleted or forgotten by the audiologist or physician, wait for prior approval, or may find that despite the other sub-providers' findings, the beneficiary may already have a hearing aid. If the beneficiary resides in a nursing home, the dispenser must supply us with a document from the home stating that they will help the beneficiary with the care and use of the

[6]All positions with the state of California must be published in bulletin form by the State Personnel Board and distributed prior to any appointment. This particular bulletin was published 17 February, 1982, #TR37-8258. Prior to publication of this notice, several duty statements were written, but not official as the position was described as unique, part-time, and restricted to the Los Angeles Field Office.

instrument. In the event that the hearing aid has been lost or irreparably damaged, he must secure a satisfactory certified affadavit from the beneficiary before the request can be considered. Despite the fact that the system is based solely on documentation, the consultant can not be biased for or against the provider or the beneficiary.

Recently a dispensing audiologist went broke and had to declare bankruptcy, then had to be hospitalized with a severe coronary problem. The consultant was confronted with a flurry of calls ranging from the Department of Consumer Affairs (the dispenser had forgotten to renew his license), to an audiologist who had tested a patient some six months ago (and who was beset with calls from the patient's relative), to a former dispenser who was still involved in the sale of the business. Our department had no record of the beneficiary, although she did have a Medi-Cal I.D. card. The beneficiary was eventually referred to another dispenser. This episode was one of three that occurred within the past year in which all three had neglected to renew their licenses — one for the past two years, thus holding the dispenser in contempt of both the licensing board and the Medi-Cal regulations. It was evident that the hearing aid examining committee had not been adequately monitoring license fees.

Last year a beneficiary appealed a decision of denial of a hearing aid. I had to check all available records, called several dispeners who had provided previous hearing aids to this beneficiary, wrote a report detailing all the available transactions with the beneficiary (who had three hearing aids) and providers, and submitted the report to the department's liaison officer. Fortunately I did not have to testify at the hearing. Later I found out that the appeal had been denied and the beneficiary (a retired stockbroker, by the way) was only interested in knowing that one provider did not defraud the system! We had an idea that the "bene" wanted some excitement (and perhaps beat the system).

Approximately 15% of my case load consists of requests for extended speech or hearing therapy. By definition, such services must exceed two hours per month and be provided in approved rehabilitation centers, outpatient clinics, or through a home health agency. The usual authorization period consists of 30 hours in 120 days — either individual or group therapy. These services may be extended by sequential TARs up to a period of 18 months in some cases. Less than 10% of the requests are for hearing therapy. (The department has not yet caught up with the term "auditory rehabilitation".) Recently one provider, director of a clinic in a large private medical center, requested treatment for a post CVA beneficiary, describing as only a speech pathologist can, a complete set of statements regarding the auditory status and leading me to believe that an "auditory aphasia" was the problem. Our file showed that the patient had a severe bilateral sensori-neural hearing loss and had been authorized a hearing aid several years before the cerebal

insult. The request was deferred for further information. The provider did not contest the request . . . case closed. This incident is recounted only for the prophylactic reason that despite our training, the tendency in submitting requests demonstrates that the exigency of the occasion may tend to eliminate the one important reason for our existence: we are Communicologists, as Bob Goldstein used to say (and still does). The above instance is not an isolated one. Audiologists fitting hearing aids tend to disregard the patient's speech intelligibility as an important factor. If we must hang, let us hang together, not separately.

Fiscal Matters and Statistics

Perhaps the examples given above and throughout this paper may give the reader a flavor of the function of peer review on a large, though paper based, scale. This section consists of relevant statistics and fiscal matters cogent to the Medi-Cal program, some generated by the author and others by those mentioned in the acknowledgements. Table 1 may give the reader some idea of the size of the population of providers, facilities, and a few other population statistics. Table 2 presents data I derived from 100 TARs that passed across my desk in March, 1982 and a month's sample of 618 TARs in 1972. All figures relate to the Los Angeles Field Office. These figures clearly

Table 1
Some Relevant Statistics of Health Care
in Los Angeles County (1981)

Category	Number	
Providers		
Audiologists	166	
Audiologist-Hearing Aid Dispensers	39	
Otolaryngologists	257	
Speech Pathologists	1,500	(approx)
Hearing Aid Dispensers	250	
Facilities		
Nursing Homes (SNF & ICF)	434	
State Hospitals	3	
Acute Care Hospitals	191	
Certified Out Patient Clinics, Community Clinics, and Rehabilitation Centers	30	
Children enrolled in Speech, Hearing and Language Programs in Public Schools		
Los Angeles Unified School District	15,000	
Los Angeles County schools (80 Districts)	14,000	

Table 2

Percentage Sample of Hearing TARs Processed in 1972 (618) and 1982 (100)

Category	1972	1982
Hearing Aids		
New, approved	42.0	51.0
Denied	4.0	6.0
Refer to CCS	—	—
Trials	2.0	12.0
Deferrals	25.0	21.0
Repairs	27.0	10.0
Providers (Evaluations)		
Audiologists	10.0	80.0
Physicians	90.0	20.0
Hearing Aid Type		
Behind the Ear	88.0	86.0
Body	10.0	2.0
Binaural (BTE)	1.0	1.0
CROS types	—	—
In the Ear	0.0	11.0
Source of Manufacture		
Foreign	29.0	54.0
Domestic	71.0	46.0
Sex of Beneficiary		
Male	37.0	36.0
Female	63.0	64.0
Categorial Aid		
Aged (65 and over)	75.0	68.0
Blind	3.0	1.0
AFDC	6.0	21.0
Disabled	16.0	21.0
Medically Indigent	N.A.	7.0

suggest that in the past 10 years audiologists have taken over as the chief suppliers of auditory tests. Post auricular hearing aids still account for the majority of aids selected and now both foreign and domestic aids share the field equally. It should be remembered, of course, that many of the components for domestic aids are manufactured abroad. The aged female population accounts for the majority of users. Any strict interpretation for this latter statistic would be purely a conjecture on my part. Table 3, containing a three-month summary of providers of speech pathology and audiology, also contains data derived from otorhinolaryngology (ORL) and shows an estimate of expenditures. The data clearly show that diagnostic audiology procedures account for almost half the expenditures for both

Table 3
Three Month Summary: Speech, Hearing, ORL, 1980
By Procedure Number

Category	Expenditure	Percentage	Est. Annual Expenditure
Audiology			
0801-0829[a]	$ 330,193	49.0	$1,320,372
0820-0821[b]	13,556	2.0	54,225
Speech Pathology			
0831-0849[a]	124,864	19.0	499,456
0834-0835[b]	199.660	30.0	798,640
Total	668,173	100.0	2,672,692
Special ORL Serv. including SP & A[a]			
92504-92589	332,386	95.0	1,329,544
92601-92610 (ENG,VFT)[c]	16,011	5.0	64,044
Total	348,397	100.0	1,393,588
Grand Total	1,016,570		4,066,280

[a]Diagnostic procedures
[b]Therapy
[c]Electronystagmography, Vestibular Function Tests

speech pathology and audiology performed by our fellow communicologists It is unfortunate indeed that there is such a small showing for aural rehabilitation (Codes 0820, 0821) on an extended basis. Table 4 is included to compare the total expenditures of speech pathology and audiology with the large volume providers: physicans, hospitals, and nursing facilities. The provider (user) column refers to the number of personnel (by visit) involved for whom claims were paid. Table 5 shows the steady increased cost of the program over the years and my participation as a TAR processor. Incidentally, during the period of 1972 to the present, the fee schedule has been increased 74% for speech pathology and audiology and 44% for hearing aids.

CONCLUSION

In one sense, the tables reveal what health care services are all about. They show bits and pieces of the enormous cost of health care for only the poor and needy segment of the population. It would be tempting to extrapolate from these figures what expenditures would accrue from the entire country. Would a figure of $40 billion annually be too large?[7] If so, one would not

[7]$247 billion for all health services for 1980, according to *Health-1981*, a publication of Superintendent of Documents, U.S. Government Printing Office, Washington, D.C.

Table 4

Excerpts from 1981 Medi-Cal Annual Report on Services and Expenditures

Eligible Beneficiaries	2, 870,309
All Providers (Users)	18,901,519
Expenditures[a]	$4,140,441,819

Category	Users	Expenditures	Percentage
Speech Pathology and Audiology	40,984	$ 3,246,886	0.07
Hearing Aid Dispensers	156,501	7,894,475	0.19
Physicians	10,264,559	661,729,955	16.00
Total Hospitals	4,493,623	1,890,494,910	45.00
Rehabilitation[b] Hospitals & Facilities	32,926	11,968,967	0.28
Nursing Homes (SNF & ICF)	857,752	728,664,000	18.00

[a]Fee for service charges only.
[b]Does not include physical therapy, occupational therapy, or other physical medicine.

need to be surprised why cuts in the Medicaid program are so popular with our politicians. We may be at some sort of a crossroads now. What the crossroads are we shall certainly discover in this decade of the '80's. We hope that health programs will continue as undoubtedly they will. Our chief concern will be about our own tiny profession. Let us hope that the cuts that may come will be proportionate to the needs and not massive slashes that eliminate whole sections of the health care system. We can afford to be optimistic and we can work hard to bring our product to the attention of our legislators. I, in turn, will try to make my position permanent so that future speech pathologists-audiologists may enjoy the fruits of "participation in an exciting, albeit frustrating program" to quote from the introduction to this paper.

ACKNOWLEDGMENTS

The author wishes to acknowledge the following people for their contributions of unpublished statistical data: Bill Maxfield, Center for Health Statistics, Department of Health Services, State of California; Dr. Doris Soroky, Los Angeles Unified School District; and, Ms. Mary Higgins, Los Angeles County Schools.

Table 5

Total Annual Medi-Cal Expenses and Speech and Hearing TARs Processed at Los Angeles Field Office

Year	Total Expenses ($ Million)	TARs Processed	
		Hearing Aids	Speech & Hearing
1966	299	N.R.[a]	N.R.
1967	567	104	N.R.
1968	666	1,446	N.R.
1969	882	1,072	N.R.
1970	1,000	690	N.R.
1971	1,000	2,193	80
1972	1,259	5,791	102
1973	1,360	5,605	224
1974	1,491	5,219	358
1975	1,733	5,498	755
1976	1,992	5,117	885
1977	2,952	5,783	862
1978	2,847	6,963	913
1979	3,055	6,562	636
1980	3,501	6,532	927
1981	4,140	6,845	1,161
1982	N.R.	1,625[b]	302
Total	28,744	67,045	7,411

[a]N.R. = No Record.

[b]First quarter.

NOTE: Speech and Hearing TARs include only prior authorized and extended treatment (therapy).

APPENDIX A

51517. Hearing Aids.

(a) Reimbursement for hearing aids, accessories, and related services shall be the usual charges made to the general public not to exceed the maximum reimbursement rates listed in this section.

(b) The following conditions shall apply to the reimbursement of hearing aid services and equipment under this section.

(1) All hearing aids shall be guaranteed for at least one year exclusive of ear piece, cord and batteries. The guarantee shall cover the repair or replacement of any or all defective parts and labor on a new aid. Out of guarantee repairs shall have a minimum guarantee for at least six months. A separate charge may be payable for handling and postage during the guarantee period.

(2) Hearing aid maximum allowances listed in this section are for new instruments and include up to six post-sale visits for training, adjustments and fitting, a cord, receiver, and such other components normally required for use of the instrument.

(3) Dealer charges on repairs, subsequent to the guarantee period, may be reimbursed. Repair facility reports shall be available for review upon request.

(4) Retail sales tax is payable in addition to the allowances listed in (c). Tax shall be itemized separately using the appropriate code.

(5) Hearing aid provider billings shall include the provider's usual and customary charges for services provided.

(6) Items 3014 and 3015, when included with the purchase of a hearing aid, shall be paid at manufacturer's wholesale cost and shall be billed separately. Items 3014 and 3015, when not included with the purchase of a hearing aid, shall be paid using the same payment formula applied to Items 3016-3018.

(c) The maximum reimbursement rates for hearing aids, accessories, and related services shall be as follows:

Code Number		*Maximum Allowance*
3001	Standard custom ear mold, when not included in the price of the hearing aid and client does not have one.	$17.76
3002	Silhouette or ring ear mold, when not included in the price of the hearing aid and client does not have one.	20.25
3003	Postage and handling for repairs during the guarantee period.	2.12
3004	Repairs, subsequent to the guarantee period.	The lesser of: (1) The invoice cost to the dealer plus a 100% markup. (2) $35.30 plus invoice cost. (3) The factory retail price for the repair service. (4) The billed amount.
3005	Hearing aid rental, any type per day.	1.43
All	Monaural hearing aids (3006-3009).	The lesser of: (1) $412.45. (2) The one-unit wholesale cost plus $184.02. (3) The billed amount.
3006	Monaural in-the-ear aid.	
3007	Monaural behind-the-ear aid.	
3008	Monaural body aid.	
3009	Monaural eyeglass aid.	
All	Binaural hearing aids (3010-3013).	The lesser of: (1) $693.40. (2) The one-unit wholesale cost plus $236.59. (3) The billed amount.
3010	Binaural in-the-ear aid.	
3011	Binaural behind-the-ear aid.	
3012	Binaural body aid.	
3013	Binaural eyeglass aid.	
CROS/BICROS (3014-3015).		See Section 51517(b)(6).
3014	CROS	
3015	BICROS	

Code Number		*Maximum Allowance*
All Batteries (maximum three-month supply).		The lesser of: (1) Retail Price. (2) Dealer wholesale cost plus $1.91 per standard package. (3) The billed amount.
Codes 3017-3018.		The lesser of: (1) Retail price. (2) Dealer wholesale cost plus 60%. (3) The billed amount.
3017	Cords.	
3018	Other authorized accessories.	
3019	Sales Tax.	By Report

NOTE: Authority cited: Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14105, Welfare and Institutions Code; Items 426-106-001 and 890, Budget Act of 1981.

APPENDIX B

51319. Hearing Aids.

(a) Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.

(b) Prior to prescribing a hearing aid, the otolaryngologist or attending physician shall perform a complete medical examination.

(c) Prior authorization is required for the purchase or trial period rental of hearing aids, and for hearing aid repairs which exceed a cost of $10.00 per repair service. Claims for individual repair services shall not be cumulative for the purposes of determining the need for prior authorization.

(1) Hearing aid batteries, cords, receivers, ear molds, and hearing aid garments are covered without prior authorization.

(2) Binaural hearing aids may be authorized under any of the following conditions:

(A) The hearing loss is associated with legal blindness.

(B) For beneficiaries 18 years of age or under, tests of each ear reveal a hearing loss level of 30 dB or greater (ISO) for 500, 1,000, and 2,000 Hertz (Hz) by pure tone air conduction. The case shall be referred to California Crippled Children Services for evaluation, consultation, or case management for patients eligible for such coverage by California Crippled Children Services.

(C) For beneficiaries over 18 years of age, tests of each ear reveal a hearing loss level of 35 dB or greater (ISO) for 500, 1,000, or 2,000 Hertz (Hz) by pure tone air conduction. Where the provision of a binaural hearing aid is the basis for employment, beneficiaries with the above hearing loss shall be referred to the California Department of Rehabilitation for evaluation, consultation, or case management as provided in Section 51014.

(d) Requests for authorization for hearing aids must include the results of the following tests:

(1) Pure tone air conduction threshold test of each ear at 500, 1,000, 2,000, and 4,000 Hertz (Hz) with effective masking as indicated.

(2) Speech tests, aided and unaided, shall include the following:

(A) Speech Reception Threshold (SRT) using Spondee words.

(B) A Speech Discrimination Score (SDS) derived from testing at 40 decibels (dB) above the SRT or at the Most Comfortable Loudness (MCL) using standard discrimination word lists (such as PB or W22) utilizing either recorded or live voice.

(C) Sound Field Aided and Unaided, Speech Scores (SRT and SDS) shall be established.

(e) Authorization for hearing aids may be granted only when:

(1) Tests of the better ear, after treatment of any condition contributing to the hearing loss, reveal an average hearing loss level of 35 dB or greater (1964 International Standards Organization (ISO)), for 500, 1000, and 2000 Hertz (Hz) by pure tone air conduction, or:

(2) The difference between the level of 1000 Hz and 2000 Hertz (Hz) is 20 dB or more; the average of the air conduction threshold at 500 and 1000 Hertz (Hz) need only be 30 dB hearing level ISO, and

(3) Speech communication is effectively improved in the environment in which the beneficiary exists.

(f) Replacement of a hearing aid may be authorized only if:

(1) The prior hearing aid has been lost, stolen, or irreparably damaged due to circumstances beyond the beneficiary's control. The Treatment Authorization Request shall include each of the following:

(A) A statement describing the circumstances of the loss, theft, or destruction of the hearing aid, signed by the beneficiary and the otolaryngologist or the attending physician where there is no otolaryngologist available in the community.

(B) An audiological evaluation, if other than a duplicate of the prior hearing aid is required.

(2) A change in the hearing impairment requires greater amplification or correction than within the capabilities of the beneficiary's present hearing aid. The new aid shall be prescribed in accordance with (a) above.

(g) Eyeglass hearing aids are covered when the requirements of this section and Section 51317 are met at the same time.

NOTE: Authority cited: Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132, and 14133, Welfare and Institutions Code.

APPENDIX C

51507.2 Speech Therapy and Audiology

Reimbursement for speech therapy and audiology services shall be the usual charges made to the general public not to exceed the following maximum reimbursement rates.

AUDIOLOGY
Basic Procedures

Code Number		*Maximum Allowance*
0801	Diagnostic audiological evaluation, including pure tone audiometry, speech reception threshold and discrimination	$47.44
0803	Pure tone audiometry (with complete audiogram)	25.70
0813	Audiometry screening (including infant screening)	12.98
0822	Audiometry during surgery	By Report
	Pediatric Evaluation (0-7 Years)	
0814	First visit	55.33
0815	First diagnostic follow-up	30.26
0816	Second diagnostic follow-up	30.26

	Evaluation for Site of Lesion (Following Procedure 0801)	
0807	Bekesy Audiometry	$27.03
0808	Short Increment Sensitivity Index (S.I.S.I.)	10.81
0809	Loudness balance test	10.81
0810	Tone decay test	10.81
	Other Audiological Services (Following Audiological Evaluation Procedures)	
0820	Hearing therapy (individual) per hour	32.60
0821	Hearing therapy (group) each patient over one, add	19.08
0823	Impedence audiometry (bilateral)	23.80
0802	Evaluation for use of hearing aid (following procedures 0801 or 0814, 0815, 0816)	37.84
0825	Electroacoustic analysis of hearing aid (monaural)	16.75
3001	Standard custom ear mold	17.76
3002	Special custom ear mold	20.25
0827	Out-of-office call (Payable only for visits to the first patient receiving services at any given location on the same day)	5.94
0829	Unlisted audiological services	By Report
	SPEECH—LANGUAGE SERVICES	
0831	Speech evaluation	$47.44
0833	Language evaluation	47.44
0834	Speech—Language therapy (individual) per hour (following procedures 0831 or 0833)	32.49
0835	Speech—Language therapy (group) each patient over one, add	19.08
0837	Out-of-office call (Payable only for visits to the first patient receiving services at any given location on the same day)	5.94
0849	Unlisted speech therapy services	By Report

NOTE: Authority cited: Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14105, Welfare and Institutions Code; Items 426-106-001 and 890, Budget Act of 1981.

APPENDIX D

EXCERPTS
Published California bulletin for the position of Audiology and Speech Pathology Consultant (TR37-8258) 2/17/82

The Position

An Audiology and Speech Pathology Consultant, under general direction, reviews, evaluates, and authorizes requests for hearing aids and for speech and language and hearing services under the California Medical Assistance Program; provides professional advice and guidance on matters relating to audiology, speech pathology, and language pathology; recommends policies and standards for the audiology and speech pathology aspects of the California Medical Assistance Program; and performs other related work as required.

Scope

In addition to evaluating the competitors' relative abilities as demonstrated by quality and

breadth of experience, emphasis in the examining interview will be on measuring competitively, relative to job demands, each competitor's:

A. Knowledge of:
   1. Principles and methods of speech and language pathology and audiology.
   2. Conditions of persons handicapped by speech, language, and hearing dysfunctions.
   3. Interrelationships of Federal, State, and local professional and voluntary public health, education and welfare agencies, and of speech and hearing programs and services of such agencies.
   4. Various functions of all providers of speech, language, and hearing services.

B. Ability to:
   1. Interpret and apply the speech, language, and hearing policies and standards of the California Medical Assistance Program.
   2. Recognize, assess, and develop solutions to problems involved in the speech, language, and hearing aspects of the California Medical Assistance Program.
   3. Evaluate the quality and scope of the speech, language, and hearing services provided.
   4. Establish and maintain effective working relationships.
   5. Analyze situations accurately and take effective action.
   6. Analyze the effect of proposed changes in the speech, language, and hearing phases of the California Medical Assistance Program.
   7. Write effectively.
   8. Speak effectively before professional and lay groups.