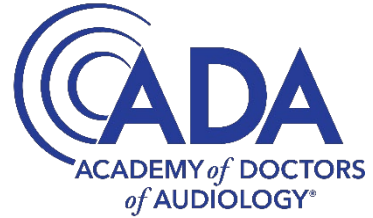


May 27, 2026

David Zapala Ph.D., President  
Erin Schafer, Ph.D., Editor, *Audiology Today*  
American Academy of Audiology  
11480 Commerce Park Drive  
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**RE:** "Valuing What We Do," President's Message, *Audiology Today*, March/April 2026, Vol. 38, No. 2<sup>i</sup>

Dear Dr. Zapala, Dr. Schafer, and Members of the AAA Board of Directors,

The March/April 2026 President's Message in *Audiology Today*, titled "Valuing What We Do," makes substantive claims about audiology's path to professional valuation and the Academy of Doctors of Audiology (ADA) that the public record, government and commercial insurance reimbursement policies, and state statutes do not support. ADA writes to correct them.

**"Valuing What We Do" incorrectly characterizes the current state of the state statutes dictating the scope of practice for audiology throughout the United States, and by extension, the landscape for advocacy efforts to modernize state audiology practice acts.**

The article portrays state audiology scope of practice modernization efforts as narrowly constructed to exclusively add the ordering of diagnostic tests such as imaging, bloodwork, and cultures for auditory and vestibular conditions, and the administering and prescribing of topical medications for conditions in the ear to the services that audiologists are authorized to perform under their state licensure acts.

In fact, the vast majority of state audiology scope of practice modernization efforts are grounded in the urgent need to update state statutes to explicitly authorize audiologists to perform services such as vestibular testing and rehabilitation, cerumen removal, conducting health screenings, programming surgically implanted devices, and prescribing hearing aids.

A September 2025 ADA state-by-state review<sup>ii</sup> of audiology practice statutes revealed the following:

- Only 13 states authorize audiologists to perform intraoperative monitoring services by statute.
- Only 22 states authorize audiologists to perform cerumen management services by statute.
- Only 43 states statutorily authorize audiologists to deliver vestibular services. However, two of those explicitly require a physician referral to do so.
- Only 23 states authorize audiologists to evaluate auditory or vestibular conditions by statute.
- Only 22 states authorize audiologists to diagnose auditory and vestibular conditions by statute. Of those, 10 states restrict the diagnosis to a "non-medical" diagnosis, and two (2)

additional state statutes omit “vestibular conditions” from those which audiologists are authorized to diagnose by statute.

- Only 9 states authorize audiologists to manage auditory or vestibular conditions by statute.
- Only 8 states authorize audiologists to perform health screenings by statute.
- Only 21 states authorize audiologists to program cochlear implants and other surgically implantable devices by statute.
- Only 13 states have statutorily authorized audiologists and dispensers to order/prescribe prescription hearing aids.

**Modernizing state licensing laws to ensure that they reflect contemporary training for audiologists does not pose a risk to audiologists. Quite the opposite—Modernizing state practice acts mitigates substantial financial and legal risks to audiologists that exist today.**

When an audiologist performs a service their state statute does not authorize, even one well within their training, their professional liability carrier is not obligated to defend or indemnify a resulting malpractice claim. Despite their extensive education and training, audiologists in most states are currently exposed to uncovered malpractice claims arising from evaluating, diagnosing, managing, and treating the very auditory and vestibular conditions that they are the most qualified to address.

Additionally, government and commercial insurers are increasingly scrutinizing licensing laws as part of their coverage determinations. Payers are not obligated to cover services delivered by providers who are not explicitly authorized to perform them under their state licensing acts<sup>iii</sup>.

It is also worth noting that the Medicare Audiology Access Improvement Act (MAAIA), a legislative initiative supported by ADA, AAA, and the American Speech-Language-Hearing Association (ASHA), among others, cannot be practically implemented until audiologists in every state are statutorily authorized to perform cerumen management and vestibular rehabilitation services.

**“Valuing What We Do” inappropriately characterizes state scope-of-practice modernization initiatives to add diagnostic test ordering or the prescribing of topical medications for conditions of the ear as being ‘all risk and no reward,’ financially, because in AAA’s view, ‘the effort, appears to increase the breadth of non-reimbursed services audiologists are expected to provide.’**

Reducing the time to diagnosis and treatment for patients with hearing and balance problems should be an imperative for every audiologist, and a reward in its own right. The vast majority of other clinical doctors and advanced practice providers (APPs) are already authorized to order medically necessary diagnostic tests and prescribe medically necessary medications for their patients, and they embrace the responsibility to do so, without being paid for those activities.

In fact, federal and state anti-kickback statutes, the False Claims Act, and other laws and codes of ethics governing healthcare service delivery rightly prevent providers from receiving remuneration or reimbursement in exchange for the acts of making referrals, ordering tests, and/or prescribing

medications. None of those activities constitutes a payable/billable service for *any* provider under government or commercial insurance plans or private pay models.

Obtaining diagnostic test results timely and making subsequent differential diagnoses will allow audiologists to more effectively and efficiently deliver the services for which they are reimbursed. The Accreditation Commission for Audiology Education (ACAE), the AAA-controlled audiology training program accrediting body, includes several [accreditation standards](#) that implore universities to train audiology students on the interpretation of diagnostic tests and the pharmacological management of conditions related to the ear.<sup>iv</sup> ACAE Standard 22: Required Knowledge & Competencies, 1-4, states that audiology students must be trained to:

1. Diagnose, triage, treat and manage auditory and vestibular/balance conditions and diseases for patients over the lifespan, including newborns, infants, children, adolescents, adults, elderly, and special needs individuals.
2. Apply audiologic diagnosis, treatment and management principles in diverse settings including, for example, private practice-based, educational, and occupational/industrial environments.
3. Apply critical thinking skills to assess the patient’s auditory and vestibular status.
4. Prescribe, perform, and interpret clinical, laboratory and other diagnostic procedures and tests in consultation with other health professionals as may be required for proper management of the patient.

ACAE also requires that Doctor of Audiology graduates be prepared to, *“Discuss pharmacological treatment options with the patient, parent or guardian, family or other health care or service providers as it relates to the prevention of hearing and balance disorders and, specifically, as it relates to appropriate vestibular system functions.”*

AAA’s position on state audiology practice act modernization conflicts with ACAE’s standards for academic audiology training programs. It is also inconsistent with the U.S. Department of Education (DOE) Classification of Instructional Programs (CIP), which defines Audiology (Au.D.) programs as:

*“A program that prepares individuals to diagnose and treat hearing loss and other disorders involving the ear, advise patients on means to use their remaining hearing, and select and fit hearing aids and other devices. Includes instruction in acoustics, anatomy and physiology of hearing, hearing measurement, auditory pathology, middle and inner ear analysis, rehabilitation therapies and assistive technologies, and pediatric and other special applications.”<sup>v</sup>*

“Valuing What We Do” underestimates the risk of doing nothing and miscalculates the risk of modernizing state scope-of-practice acts to ensure that the practice of audiology achieves professional parity with other clinical doctoring and advanced practice professions. The article presents inaction on state-defined scope of practice as the financially prudent course. The evidence does not support that conclusion.

Recent actions by the U.S. Department of Education (DOE), omitting audiology from the list of professional degrees, should be an urgent call to reevaluate the value of the Doctor of Audiology (Au.D.) against the state-defined scope of practice for audiologists throughout the United States.<sup>vi</sup>

If state practice statutes continue to lag behind audiologists’ doctoral training, the pipeline of Au.D. students will wane. Prospective students do not enroll in expensive doctoral training programs to be statutorily limited to a fraction of what they are trained to do. The contrast with optometry, podiatry, psychology, physical therapy, chiropractic, and advanced-practice nursing, professions that aggressively modernized state scope and subsequently grew, is stunning.

At the same time, hearing instrument specialists (HIS) are aggressively seeking to expand their state licensing acts to authorize them to perform services such as cerumen removal, tinnitus treatment, and aural rehabilitation, with some success.

The lessons learned from those professions are unambiguous. Audiology must advance and fully achieve its potential as a clinical doctoring profession, or risk becoming obsolete.

**“Valuing What We Do” includes a call to action that requires the very state scope-of-practice modernization that AAA dismisses as unworthy of audiologists’ efforts.**

The central practical recommendation of “Valuing What We Do” is that audiologists should recognize the uncompensated evaluation and management work they already deliver and bill for it. Unfortunately, the AAA AMPLIFY-Your-Value strategy, outlined in the article, may serve only to amplify audiologists’ legal exposure in as many as 41 states.

The article stipulates that the preferred pathway to payment for audiologists and appropriate valuation for audiology services is via the charging of office visit fees and/or the billing of evaluation and management (E&M) codes. Unfortunately, audiologists are only statutorily authorized to deliver *both* E&M services in nine (9) states: Alabama, Arkansas, Colorado, Georgia, Illinois, Maryland, Ohio, Rhode Island, and South Dakota. The other 41 states must modernize their state audiology practice acts to include one or both of these services before they could be legally performed or billed by audiologists.<sup>vii</sup>

**“Valuing What We Do” states that *‘there is no knight in shining armor, who will right the world for audiology.’***

On that point, ADA agrees. ADA contends, however, that there are actually thousands of ‘knights.’ They do not wear armor or wield a sword. They wear scrubs and white coats, and they wield an otoscope. They are convening in droves on state capitals across the country to advocate for their patients and their profession. They are insisting, without reservation or hesitation, that their state audiology licensing statutes align with their education and training. They are dismantling systemic health inequities to achieve better access to care for their patients. They are, in practice, demonstrating the courage and compassion that is expected of audiologists as clinical doctors.

**“Valuing What We Do” states that advocacy efforts to modernize state scope of practice efforts are organically driven, with the encouragement of the ADA.**

Thank you for publicly acknowledging ADA’s support of these state-driven efforts to modernize audiology practice acts across the nation. However, ADA is doing more than encouraging. ADA is making heavy investments of time, money, and other resources to fight alongside state advocates to ensure that both audiology and audiologists achieve their full potential.

ADA is also working to advance professional and public policy initiatives to ensure improved coverage and reimbursement for audiology services. [Audiology 2050<sup>viii</sup>](#), a comprehensive strategic roadmap, identifies seven mutually reinforcing principles for the profession's future:

- Scope of Practice Consistent with Other Clinical Doctors
- Standardized, Evidence-Based Clinical Practice
- Professional Workforce Including Extenders
- Audiologists Advance Professional Socialization Initiatives
- Audiologists Are Advocates and Activists for the Profession
- Achieve Medicare LLP Status
- Primary Care Entry Point for Auditory & Vestibular Conditions

These principles commit ADA to working with interested state organizations to ensure audiology practice laws include the language of *evaluate, diagnose, manage, and treat*; and to "expand and intensify education and training in pharmacology, imaging, and other areas of clinical focus to ensure provider readiness. ADA proposes that training *and* licensure laws should evolve together.

ADA’s 2025 position paper, [A Call to Action on Coverage of Hearing Care: Principles for Public Policies that Optimize Patient Outcomes](#),<sup>ix</sup> represents ADA’s robust advocacy efforts to ensure that hearing coverage policies foster beneficiary access, transparency, fair reimbursement, and the autonomous clinical decision making for audiologists. That is the same destination the President's Message advocates. The "two efforts," framed as alternatives in “Valuing What We Do,” are, in ADA’s published vision, two integrated principles within a single strategy, each made possible by the other.

**ADA's reimbursement public policy and advocacy record is well documented.**

“Valuing What We Do,” implies, by omission, that ADA is uninvolved in reimbursement advocacy. Yet the public record is clear. ADA has filed substantive formal comments on every major Medicare Physician Fee Schedule proposed rule for the past five consecutive years, including CMS-1770-P (CY 2023 MPFS, September 2022, accompanied by a legal memorandum from outside counsel), CMS-1784-P (CY 2024 MPFS), CMS-4205-P (Medicare Advantage, January 2024), CMS-1807-P (CY 2025 MPFS), and CMS-1832-P (CY 2026 MPFS, September 2025)<sup>x</sup>. ADA’s most recent CMS advocacy efforts included [recommendations against<sup>xi</sup>](#) the implementation of new bundled hearing aid service CPT® codes and the sudden elimination of existing codes, resulting from an ill thought initiative driven by AAA and the American Speech Language Hearing Association (ASHA), over [ADA’s](#)

[well-founded objections](#).<sup>xii</sup> ADA also actively engages on advocacy issues related to Medicare Advantage,<sup>xiii</sup> and other commercial payers on behalf of audiologists. For example, ADA’s attorney recently engaged with Anthem on the issue of Anthem’s [Unlawful Denial of Medically Necessary Audiologic Diagnostic Services— Medicare Advantage Claims](#).<sup>xiv</sup>

**ADA welcomes the opportunity to discuss Audiology 2050 and organizational advocacy initiatives with AAA leaders.**

ADA believes that in order for audiologists to be fully valued for what they do, the following must occur:

- Audiology program graduates must be well prepared clinical doctoring professionals,
- State and federal laws must accurately reflect the education, training, and qualifications of audiologists,
- Reimbursement structures must match the value of the services that audiologists deliver,
- Consumers must have streamlined access to the audiology services that they need for their good health and quality of life; and
- Hearing and balance conditions must be recognized as medical conditions and must be addressed along the continuum of care, beginning with preventive care.

ADA believes that Audiology 2050 provides a framework for success. It is not a single strategy, but seven interconnected pillars with numerous extended strategies that work together towards the objectives of patient well-being, audiologist well-being, and growth of the audiology profession.

ADA is grateful for the opportunity to correct the public mischaracterization of its strategy as was presented in “Valuing What We Do.” ADA would further welcome the opportunity to meet with AAA leaders to discuss the Audiology 2050 framework and its organizational advocacy initiatives in more detail.

Respectfully,

Jill Davis, Au.D., President

Erica Person, Au.D., President-Elect

Amy Amlani, Ph.D., Immediate Past President

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Sarah Curtis, Au.D., Director-at-Large

Alexandra Tarvin, Au.D., Director-at-Large

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Cc: Brandon Pauley, Esq.

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<sup>i</sup> “Valuing What We Do,” *Audiology Today*, March/April 2026, Vol. 38, No. 2

<sup>ii</sup> Cavitt, Kimberly M. ADA state-by-state review of Audiology Practice Acts, September 2025

<sup>iii</sup> <https://www.provider.wellpoint.com/docs/gpp/MULTI-WLP-CR-ScopePrctce.pdf?v=202312170356>

<sup>iv</sup> <https://acaecaccred.org/wp-content/uploads/2016/07/ACAE-Standards-5.11NEW-WEB-2.pdf>

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<sup>v</sup> <https://nces.ed.gov/ipeds/cipcode/cipdetail.aspx?y=56&cip=51.0202>

<sup>vi</sup> <https://www.federalregister.gov/documents/2026/05/01/2026-08556/reimagining-and-improving-student-education-federal-student-loan-program-final-regulations>

<sup>vii</sup> See ii above.

<sup>viii</sup> <https://audiologist.org/resources/advocate/audiology-2050>

<sup>ix</sup> [https://audiologist.org/\\_resources/documents/advocacy/audiology-2050/Call-to-Action-on-Coverage-of-Hearing-Care.pdf](https://audiologist.org/_resources/documents/advocacy/audiology-2050/Call-to-Action-on-Coverage-of-Hearing-Care.pdf)

<sup>x</sup> ADA formal comment letters to CMS, 2022–2025 (CMS-1770-P, CMS-1784-P, CMS-4205-P, CMS-1807-P, CMS-1832-P), which can be found at [www.regulations.gov](http://www.regulations.gov).

<sup>xi</sup> <https://www.regulations.gov/comment/CMS-2025-0304-12117>

<sup>xii</sup> [https://mcusercontent.com/59d85b4d8bff8b5eb5cebbd43/files/39e358cc-ca85-986b-2f4d-33b80d265327/ADA\\_Communication\\_to\\_AO\\_04132023.pdf](https://mcusercontent.com/59d85b4d8bff8b5eb5cebbd43/files/39e358cc-ca85-986b-2f4d-33b80d265327/ADA_Communication_to_AO_04132023.pdf)

<sup>xiii</sup> <https://www.regulations.gov/comment/CMS-2024-0008-0268>

<sup>xiv</sup> [https://audiologist.org/\\_resources/documents/news/2025/ADA-Demand-Ltr-to-Anthem-RE-Medicare-Advantage.pdf](https://audiologist.org/_resources/documents/news/2025/ADA-Demand-Ltr-to-Anthem-RE-Medicare-Advantage.pdf)