UNIVERSITY SPEECH AND HEARING CLINICS

Focus on VALUE Not Volume

AGENDA

- Medicare Requirements for University Clinics
- To Be Or Not To Be a Medicare Provider
- Billing Q & A
- 2012 Medicare Updates
- 2012 Medicare Physician Fee Scale
- New SLP Evaluation Code Proposals
- Available ASHA Resources
- Changing Landscape for Health Care Providers

NOTE: Legal counsel should assist corporate or organizational entities when determining whether Medicare enrollment should be sought.

TO BE OR NOT TO BE A MEDICARE PROVIDER

Pros

- Medicare patients may be seen for a wide range of speech and language services
- May have financial benefits

Cons

- Faculty must be adequately staffed with individual Medicare providers to provide 100% in-the-room supervision
- Advance Beneficiary Notice of Noncoverage (ABN-modified) will have to be signed whenever the services rendered clearly do not fall within the Medicare scope of coverage (e.g., insignificant functional progress from an ADL practical viewpoint)
- http://www.cms.gov/BNI/02_ABN.asp

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Q U A L I F I E D P R O V I D E R D E F I N E D

SPEECH-LANGUAGE PATHOLOGIST

- Meets one of the following requirements:
  - The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech-Language Hearing Association; or
  - Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.
  - Clinical Fellows are not licensed in AL, CT, HI, MA, NV, NY, ND, PA, TN, & UT
  - Request written acceptance from the carrier/MAC

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**QUALIFIED PROVIDER DEFINED AUDIOLOGIST**
- Masters or doctoral degree in audiology
- AuD 4th year students are not qualified
- Also must be licensed in state where audiologist provides services
- If the state does not license audiologists, must have:
  - Successfully completed 350 clock hours of supervised clinical practicum (or in the process of accumulating such supervised clinical experience), and
  - Performed not less than 9 months of supervised full-time audiology services after obtaining a master’s or doctoral degree in audiology or a related field, and
  - Successfully completed a national examination in audiology approved by the Secretary

**STUDENTS ARE NOT QUALIFIED PROVIDERS**
- Medicare requires 100% personal supervision of SLP or audiology students by qualified SLP or audiologist in an outpatient setting (Medicare Part B)
  - Must be in the room
  - Must be directing the service
  - Must not be engaged in other activities
- Most common reason for a clinic to be excluded from Medicare enrollment is if student services are provided without 100% supervision

**SLP STUDENT SUPERVISION**
- Only services of the therapist can be billed and paid under Part B
- Services of student are not reimbursed even if provided under "line of sight” supervision by the therapist
- Student considered extension of the therapist
- This does NOT apply to non-Medicare settings unless specified

**MANDATORY CLAIMS SUBMISSION**
- If an SLP or audiologist furnishes a Medicare-covered service to a beneficiary, then they are required to submit a claim on the beneficiary’s behalf (must be enrolled as Medicare provider) unless the patient, of their own free will, requests in writing that their claim not be submitted
- If a university clinic offers services that meet Medicare coverage guidelines, but the clinic will not be able to enroll as a Medicare provider (for whatever reason), then Medicare beneficiaries should not be served for “medically necessary” therapy services unless the patient, of their own free will, requests in writing that their claim not be submitted

**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**
- Official ABN at the top states: “NOTE: If Medicare doesn’t pay for…”
- When it is known that services are not covered, ABN may be used to explain & document with the patient why proposed services would not be covered by Medicare (e.g., services rendered by students, insignificant functional progress, service rendered for training purposes only)
- In this case, the ABN is not signed as a Medicare document because it has been modified as a tool to simply inform patients that services are not covered by Medicare
- Justifies charging the Medicare beneficiary a direct charge per visit
- Provider’s obligation to submit a claim is removed when patient signs a statement requesting that a claim or claims not be submitted to Medicare

**SLP STUDENT SUPERVISION**
- However, presence of student in the room does not make the service un-billable
  - Qualified practitioner present in room for entire session.
  - Student participates in delivery of services when qualified practitioner is directing the service, making the skilled judgment, and responsible for assessment and treatment
  - Qualified practitioner present in room guiding student in service delivery when student participates in provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time
Discuss this with Mark... people had lots of questions about this last year... see also Bernie's words about statutorial exclusions... Is the really an ABN if you change the wording on it?

Dee Nikjeh, 4/9/2012
Refusal to submit billing and asking the patient to sign an ABN is not acceptable. There is no "opt out" privilege for audiologists or speech-language pathologists. Medicare "opt out" allows the practitioner to enter into a private contract with the patient without enrolling as a Medicare provider. "Opt out" only applies to physicians and certain other practitioners.

First submit an enrollment application to your regional Medicare Administrative Contractor (MAC). The electronic enrollment system (PECOS) is the most efficient way to apply. PECOS = Medicare Provider Enrollment, Chain, and Ownership System. See instructions on ASHA’s Website at www.asha.org/practice/reimbursement/medicare/SLPprivatepractice.

Congress controls the Social Security Act, which describes the Medicare law. Centers for Medicare & Medicaid Services (CMS) interpret the laws in the Code of Federal Regulations and Medicare Manuals. Medicare Administrative Contractors (MACs) interpret the manuals in Local Coverage Determinations. Insurance companies contracted by CMS to process Medicare claims. 15 MACs replaced over 50 intermediaries and carriers, who previously wrote the interpretations of Medicare regulations.

Since mid-2003, CMS has relinquished detailed coverage policies to each local intermediary and carrier. There are no national Medicare medical review guidelines for SLP services. Must refer to Local Coverage Determinations (LCDs) for your coverage policies.

LOCAL COVERAGE DETERMINATIONS

LCDs

- Policy documents written by the MAC
- May specify what is or is not covered
- Often contain list of “covered” ICD codes
-LCDs are NOT consistent
-Be familiar with YOUR MAC policies

WHAT ABOUT OTHER PAYERS?

- Medicare Advantage Programs
  - Requires individual contract between the provider and the Advantage program
- Private Insurance
  - Managed Care
- Medicaid
  - Many state Medicaid programs now use a managed care model
  - Many states have multiple managed care plans which may have different rules

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

- Passage of MIPPA by Congress July 2008
- Independent provider status for SLPs
- Able to directly bill Medicare for services July 1, 2009
- Recognized SLPs as professionals rather than technicians
- Prior to MIPPA, Current Procedure Terminology codes (CPT codes) used by SLPs were valued based primarily on practice expense only
- SLP procedure codes could now be valued to include professional work

SLP CPT CODES WITH PROFESSIONAL WORK VALUE

- 92507 Speech & language tx
- 92508 Speech & language tx, group
- 92526 Dysphagia Tx
- 92597 Voice prosthetic eval
- 92605 Non-speech generating device (SGD) eval, 1st hour
- 92618 each additional 30 mins
- 92606 Non-(SGD) tx services
- 92607 SGD eval, 1st hour
- 92608 each additional 30 mins
- 92609 Speech-generating device tx services
- 92610 Eval of swallowing function
- 92611 Motion fluoroscopy/swallow
- 92612 Endoscopy swallow test (FEES)
- 92614 Laryngoscopic sensory test
- 96105 Assessment of aphasia, per hour
- 96111 Developmental test, extended
- 96125 Standardized cognitive performance testing, per hour

WHAT ABOUT CPT 92506?

- Evaluation of speech, language, voice, communication, and/or auditory processing and anything else we can think of to put here!!
- All of our procedures codes completed the process, except for CPT 92506

SLP CODES IN DEVELOPMENT TO REPLACE CPT 92506

- Evaluation of language comprehension and expression
- Evaluation of speech sound production including oral structure and function
- Combined evaluation of speech sound production, oral structure and function, and language comprehension and expression
- Evaluation of speech fluency
- Behavioral and qualitative analysis of voice and resonance
FREQUENTLY ASKED QUESTIONS ABOUT MEDICARE AND UNIVERSITY CLINICS

QUESTION #1
- If a university clinic does not currently bill private insurance, Medicaid, or Medicare, can it continue to bill patients privately and not bill Medicare?

ANSWER TO QUESTION #1
- If the university does not wish to enroll in Medicare, it is suggested that those who qualify for Medicare benefits should be refused treatment and referred to other practitioners in the community.
- Enrollment would also not be required if all Medicare patients voluntarily request that Medicare claims not be submitted.
- Unless the clinic is a free clinic (i.e., never charge for services), SLPs may only test and treat and audiologists may only test Medicare beneficiaries if they are enrolled as Medicare providers.

FREQUENTLY ASKED QUESTIONS ABOUT MEDICARE AND UNIVERSITY CLINICS

QUESTION #2
- What if the Medicare beneficiary instructs the provider NOT to submit a claim to Medicare and offers to pay out-of-pocket?

ANSWER TO QUESTION #2
- If a beneficiary, of their own free will, instructs a practitioner to not submit a claim to Medicare, the practitioner may treat the patient outside of Medicare.
- However, there are two significant complications:
  - All beneficiaries must make this demand truly of their own free will.
  - A beneficiary is free to change his or her decision at any time and request that a claim be submitted to Medicare for current and/or past services.
  - If the beneficiary includes dates of service in the signed agreement, they cannot change their decision during the time period specified in the agreement.

FREQUENTLY ASKED QUESTIONS ABOUT MEDICARE AND UNIVERSITY CLINICS

QUESTION #3
- May a university clinic bill a client privately if that person is a Medicare beneficiary who has exhausted Medicare funds?

ANSWER TO QUESTION #3
- Short answer is “no”
- Regarding “exhausted Medicare funds,” the annual therapy cap (combined SLP/PT services) has been largely circumvented by Congress by the “exceptions process” that allows coverage as long as documentation in the medical record clearly shows medically/functionally necessary services.
- 2012 combined therapy cap for SLP and PT services is $1,880
- Exceeding the cap does not automatically exclude speech-language services from Medicare coverage because of the exceptions process that allows coverage of medically necessary services beyond the cap.
Medicare benefits are never exhausted for audiology services as long as “medically necessary” diagnostics are required for patient treatment.

The rule of thumb is that the clinic should treat everyone the same with regard to providing services and charging for audiology services because of the “no opt out” provision for Medicare.

When can a Medicare patient be billed directly for services?

Services may be billed directly to Medicare recipient if:
- Service is Statutorily Excluded
- Denied for Reasons of Medical Necessity

This might include services such as hearing aid services or services from nonlicensed practitioners which might include unsupervised SLP students.

When an ABN is not provided in advance of the rendition of services and the claim is denied for reasons of medical necessity, the patient cannot be subsequently billed.

Many clinics choose not to accept Medicare beneficiaries. Does that require any specific type of notice?
ANSWER TO QUESTION #5

- No specific type of notice is required
- A sign may be posted informing clients that SLP or audiology services are not provided to Medicare beneficiaries in the clinic due to Medicare billing and coverage requirements.

FREQUENTLY ASKED QUESTIONS ABOUT MEDICARE AND UNIVERSITY CLINICS

- QUESTION #6
  - Do university clinics need to follow the Medicare student supervision rule (i.e., supervisor in the room all of the time and not engaged in other activities) if they provide a 100% discount to all Medicare beneficiaries?
  - Same type of question – Can a university clinic waive all fees for Medicare and Medicaid clients (do not charge anyone 65 or older for services), but charge others for services?

ANSWER TO QUESTION #6

- If all clients (not just Medicare clients) are seen free, the clinic need not enroll in Medicare and thus need not follow the supervision rules.
- Giving a 100% discount or not charging for anyone over the age of 65 is a practice that is discriminatory. This means private payers are subsidizing Medicare/Medicaid.

ANSWER TO QUESTION #7

- Private health plans selectively adopt Medicare coverage policies. All private plans require that services be rendered by a qualified health care practitioner. Rarely do they describe student involvement.
- It is wise to inform the third party payer of the degree of supervision of students. This will prevent a future audit that could demand thousands of dollars in repayment.

FREQUENTLY ASKED QUESTIONS ABOUT MEDICARE AND UNIVERSITY CLINICS

- QUESTION #7
  - Do private insurance companies follow Medicare regulations?

DOCUMENTATION REQUIREMENTS

If it wasn’t documented, it wasn’t done!
PRINCIPLES OF DOCUMENTATION

ACUTE

- Accurate: describes the care provided
- Code-able: describes services so well that the Current Procedural Terminology (CPT) codes and Diagnostics Codes (ICD) are supported and are appropriate for each other
- Understandable: clear to reader (and not just to another SLP)
- Timely: completed soon after the encounter
- Error-free: stands alone as a legal document

WHY IS ACCURATE DOCUMENTATION IMPORTANT?

- Facilitates communication and continuity of care among professionals
- Essential for proper coding and billing
- Enhances utilization review (analysis of the kinds of services provided)
- Stands of a legal document
- Provides proof of compliance

WHAT IS REQUIRED TO ENSURE ACCURACY?

COMPLIANCE

- Billing codes (ICD and CPT) must match documentation
- Documentation must support the scope and level of service (complexity or time)
- CPT codes must be appropriate for diagnosis codes (ICD codes)
- Code and bill for services performed by eligible practitioners for eligible patients
- Inadequate/incomplete documentation may mean claims denials upon medical review
- IF IT WAS NOT DOCUMENTED, IT WAS NOT DONE

PRINCIPLES OF DOCUMENTATION

THE DON'TS

- Do not choose a procedure or diagnosis code that “will get paid” if that code does not represent actual service or diagnosis
- Do not over-abbreviate or use jargon
  - Many facilities have a list of approved abbreviations (or a list of unacceptable abbreviations)

MEDICARE GUIDANCE ON SLP DOCUMENTATION

- Medicare requires that therapy services are of appropriate type, frequency, intensity, & duration for the individual needs of the patient
- Documentation should establish:
  - Variables that influence the patient’s condition
  - Objective measurements of progress toward goals
- Documentation should include:
  - Evaluation
  - Plan of Care/Certification of Plan of Care
  - Progress Reports
  - Treatment Notes
  - Discharge Note
- Medicare Benefit Policy Manual Publication, 100-02, Chapter 15, Section 220.3

PRINCIPLES OF DOCUMENTATION

THE DON'TS

- Do not copy/paste notes (note must be personalized)
  - However, some templates can be used to increase efficiency. You then fill in that patient’s specific information
- Do not “make up” information
  - Include only factual information
- Do not document when it was someone else who provided the service

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BASIS FOR FUNCTIONAL GOALS

- Use the International Classification of Functioning, Disability, and Health (ICF; World Health Organization, 2001) as a framework
- Ask these 4 Key Questions (N. Nelson, 1996)
  - What does the individual's communicative context require?
  - What does the individual currently do in that context?
  - What might the individual do differently to increase communicative success in the future?
  - How might the context (environment) be modified to increase success?

SNFS AND OUT-PATIENT THERAPY NOTE

THERAPY DOCUMENTATION

S: Subjective statements (e.g., client reports he has completed practice voice exercises, client reports he is tired and does not feel well)
O: Objective data about what happened in therapy session
Include measurable statements
A: Analysis of how the session went
Did the client do better? What worked?
P: Plan
When is the next visit? What will be addressed? What should the client practice in the meantime?

WHAT'S WRONG WITH THIS NOTE?

S: “Hi”
O: Breakfast - scrambled eggs, bacon, toast, juice; Pt ate bkft w/ rare ver cues; 5 cues given
A: Pt conts to improve; Eats reg diet
P: Cont POC
- CPT 97110 Therapeutic exercises, each 15 mins, times 2

CHECK YOURSELF – CAN YOU ANSWER THESE QUESTIONS ABOUT YOUR DOCUMENTATION?

- Is the reason for the encounter stated?
- Are all services correctly documented?
- Does the record provide basis for medical necessity, rationale for services, and choice of setting?
- Does the condition require skilled professional intervention?
- Does the condition show that the condition was evaluated, or show information about progress and results of treatment?
- Does the record show plan of care?
- Is the record complete enough that another practitioner could assume the care?
- Can you code CPT (procedure) or ICD (diagnosis) codes from the documentation?
- Does the treatment note support skilled professional intervention?
- Is the record legible and comprehensible to others?

CHECK YOURSELF – CAN YOU ANSWER THESE QUESTIONS ABOUT YOUR DOCUMENTATION?

  - History
  - Description of service and findings
  - Clinical assessment
  - Recommendations
  - Signature and date of service

AUDIOLOGY DOCUMENTATION
Harmony between procedure, code selection and documentation

Documentation supports code selection
- Justifies reporting specific code
- Clarifies medical necessity
- Records special circumstances

Often inadequate
- Consists of audiogram with some notes
  - Ex: Referred by Dr. Razzelfratz for hearing test.
  - Recommend hearing aids
- Fails to meet federal guidelines for minimum documentation standards for covered services

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Name of referring physician
Reason for referral
- Referral
- Audiological report
- Patient’s medical record

Indicate that the test was ordered,
that the reason for the test results in coverage,
that the test was furnished to the patient by a qualified individual.
Records that support the appropriate provision of an audiological diagnostic test shall be made available to the contractor on request.

Medical necessity for why the patient is there
- “Referred by” is not medical necessity
- Requires a history covering the following areas as appropriate
  - Chief Complaint
  - Duration of symptoms
  - Family history
  - Social / occupational history
  - Prior medical history
  - Relevant diagnoses

This section justifies all that is done

Describing what was done
- The audiogram cannot stand on its own
- Most professionals don’t know what it is or what it means
- Description of procedures and observations
  - Procedure description can be “canned”
- Description of what was found (results)
**DOCUMENTATION REQUIREMENTS**

**Issue**
- **Clinical Assessment**
  - Must have a clear statement of practical and clinical significance
  - Must flow logically from the history and the findings
- **Recommendations**
  - Logical conclusion to the matter.
  - Based on these outcomes, the following recommendations are offered: …
  - Each recommendation must be supported by history, findings, and interpretation
  - Do not list unsupported recommendation

**ADDITIONAL NOTES ON RECOMMENDATIONS**

**Issue**
- **Medical Necessity**
  - All recommendations must be supported by the concept of "medical necessity”
  - Recommendation should not be offered that is for the convenience of audiologist or patient
  - Automatic annual re-checks without justification not appropriate.
  - Justification may include:
    - Known or suspected risk for change in status
    - Unrelated diagnosis that may impact patient's status
    - Change in symptoms
    - Presentation of new symptoms

**OTHER REQUIREMENTS**

**Issue**
- **Signature**
  - If a paper report, must be an original signature
  - Facsimile or stamped signature is not appropriate
  - If electronic medical record (EMR), your login constitutes your signature
- **Date**
  - Date of service must be specified and prominent in report
  - Other dates may include date of review, date of "signing", date of dictation. These must be distinguished from date of service.
  - Date requirement re EMR

**ASHA RESOURCES FOR UNIVERSITIES**

Developed by ASHA’s Health Care Economics Committee, Government Relations and Public Policy Board, and School Finance Committee

**ASHA CODING, REIMBURSEMENT, AND ADVOCACY MODULES**

ASHA Health Care Economics Committee
- Introduction to main elements of speech-language pathology and audiology health care reimbursement
- 6 modules presented in a narrated PowerPoint format to help explain rudimentary aspects of billing and coding

ASHA Government Relations and Public Policy Board
- Educate students and new members on advocating for the professions.

ASHA School Finance Committee
- Educate students and new members, especially those in school-based practices, on how school funding works and how members can advocate for themselves and their students in the workplace.

**CODING AND REIMBURSEMENT MODULES DEVELOPED BY ASHA’S HEALTH CARE ECONOMICS COMMITTEE**

  - Procedural coding – codes reported for services rendered
- **Module Two: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - Using Codes to Report Patient Diagnoses** (15:34 minutes)
  - ICD-9-CM – Diagnostic coding – codes reported for speech, language, swallowing, hearing and balance disorders
- **Module Three: Documentation of Speech-Language Pathology Services in Different Settings** (16:52 minutes)
  - Speech-language pathology documentation requirements
Module Four: Documentation of Audiology Services in Different Settings (14:12 minutes)
- Audiology documentation requirements

Module Five: Application Module for Speech-Language Pathology (20:07 minutes)
- Applications of coding and documentation related to speech-language pathology

Module Six: Application Module for Audiology (18:58 minutes)
- Applications of coding and documentation related to audiology

Module Seven: Advocating for Our Professions (15:10 minutes)
Developed by ASHA’s Government Relations and Public Policy Board
- Advocating for the professions

Module Eight: Advocacy and School Finance (11:49 minutes)
Developed by ASHA’s School Finance Committee
- Advocacy and school finance

Students who view the entire Coding, Reimbursement, and Advocacy modules program will be able to:
- Identify the appropriate codes from which to select procedure codes
- Identify the appropriate codes from which to select diagnostic codes
- Describe documentation requirements for either audiology or speech-language pathology procedures
- Describe the legislative and regulatory process and be prepared to participate in advocacy for the professions
- Describe the funding process for schools

Each of the modules include resources for the student available on ASHA’s Web site
- Billing and Reimbursement: www.asha.org/practice/reimbursement
- Advocacy: www.asha.org/advocacy
- School Funding Advocacy: www.asha.org/advocacy/schoolfundadv

The modules themselves may become a resource – we hope you find the program useful

Speech-Language Pathology Medical Review Guidelines: www.asha.org/Practice/reimbursement/SLP-medical-review-guidelines/
- provide an overview of the profession of speech-language pathology including qualifications, standard practices, descriptions of services, documentation of services, and treatment efficacy data
- serve as a resource for health plans to use in all facets of claims review and policy development
**CMS QUALITY IMPROVEMENT ROADMAP**

- Vision - The right care for every person every time.
- CMS must support the transformation of the health care system to one in which patients and doctors can make informed decisions together about the most effective care, based on timely access to the latest evidence, and in a way that delivers the highest value care.

**PRIMARY ISSUE**

- Cost inflation
  - Risen 78% since 2000 vs. 20% for salaries
  - Average 9% per year with range of 7%-13%
  - Defensive medicine (malpractice)
  - Unnecessary treatment
  - Inefficient service delivery models
  - Pharmaceuticals
  - End of life care*
    - $55 Billion Medicare dollars/$11 Billion Medicaid dollars in last 2 months of life

**MEDICARE / CMS ACTIONS**

- Value-Based Purchasing
  - Based on Medicare vision of “the right care for every person every time”
  - Aligns payment to efficiency and quality of care delivery
  - Rewards providers for measured performance; that is, OUTCOMES
    - E.g., PQRS (FCMs)

**VALUE-BASED PURCHASING**

- Promote evidence-based medicine
- Require clinical and financial accountability across all settings
- Focus on episodes of care
- Focus on effectiveness of treatment
- Bundled payment models will incorporate payment based on diagnosis and expected outcome. Pilot projects are already underway in diabetes treatment.

**INCREASED CLINICAL ACCOUNTABILITY**

- How do we know, and how do we show, that what we do in therapy makes a difference?” (R. Douglass, 1993)
- CMS is calling for increased professional self-scrutiny
- Evidence-based practice → comparative-effectiveness research
- Recovery audit contractor (RAC) and other Medicare & Medicaid auditing programs
- Auditing by commercial payers
- Payment systems based on outcomes, not fee-for-service

**CHANGING LANDSCAPE AFFORDABLE CARE ACT (ACA)**

- The Patient Protection and Affordable Care Act (ACA) aims to ensure that all Americans have access to quality, affordable health care and would create the transformation within the health care system necessary to contain costs.
- ACA requires development of essential health care benefits
- ACA requires establishment of Health Insurance Exchanges
- Each state has an organized marketplace for the purchase of health insurance
- Target is for uninsured Americans and small employers to use the exchanges
- Exchanges do not specify the scope and nature of the coverage within each plan

**REFERENCE**

By January 1, 2013, the legislation requires CMS to implement a claims-based data collection strategy to collect data on patient function so that the agency can better understand the patient’s condition and outcomes. Data collection shall include “patient function during the course of therapy services in order to better understand patient condition and outcomes.”

Speech-language pathologists and audiologists will be paid for managing outcomes (value-based purchasing) not volume of visits or number of sessions or number of tests. Think... VALUE NOT VOLUME

Speech-language pathologists and audiologists who provide service in the most efficient manner and obtain the best outcomes for the people they serve will thrive under this model!

SLPs need to be successful in showing value of services as rules change
A move from “we want more visits” to “we can show you how the patient will function better”

ARE WE ESSENTIAL?
WILL WE BE ABLE TO PROVE IT?