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Payment for SLP Services: Navigating Payer Sources, Payment Systems, & Practice Settings

Dee Adams Nikjeh, PhD, CCC-SLP, ASHA Fellow

Moderated by:
Amy Natho, MS, CCC-SLP, CEU Administrator, SpeechPathology.com

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Payment for SLP Services: Navigating Payer Sources, Payment Systems, & Practice Settings

Dee Adams Nikjeh, PhD, CCC-SLP, ASHA Fellow
November 2020

Speaker Bio

- Dee Adams Nikjeh, PhD, CCC-SLP, ASHA Fellow, is an expert in health care coding systems, compliance requirements, and billing practices for the field of speech-language pathology. She co-chairs ASHA's Health Care Economics Committee and the American Medical Association's Relative Value Update Committee/Health Care Professionals Advisory Committee and is an Expert Witness in the field of speech-language pathology for the United States Department of Justice Civil Division-Fraud Section. Dr. Nikjeh's professional career in the field of communication sciences and disorders spans four decades as a clinician, supervisor, researcher, educator, mentor, consultant, and an advocate of the profession. She has served on ASHA's Legislative Council and the Executive Board of the Council of State Association Presidents. She is a past-president of the Florida Association of Speech-Language Pathologists and Audiologists.

- Presenter Disclosure: Financial: Dee Adams Nikjeh received an honorarium for this course by SpeechPathology.com. Non-financial: Dee is Co-Chair of ASHA's Health Care Economics Committee, a member of the AMA's Relative Value Update Committee, and co-chair of the AMA's Health Care Professionals Advisory Committee Review Board.

- Content Disclosure: This learning event does not focus exclusively on any specific product or service.

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Learning Outcomes

After this course, participants will be able to:

- Identify and contrast multiple payer sources for SLP services.
- Define and differentiate payment systems and practice settings for Medicare Part A, Part B (aka Original Medicare), and Part C (Medicare Advantage Plans).
- Describe SLP supervision requirements with respect to multiple healthcare practice settings and payer sources.

Know Your Payers

Private Pay (Self-Pay)

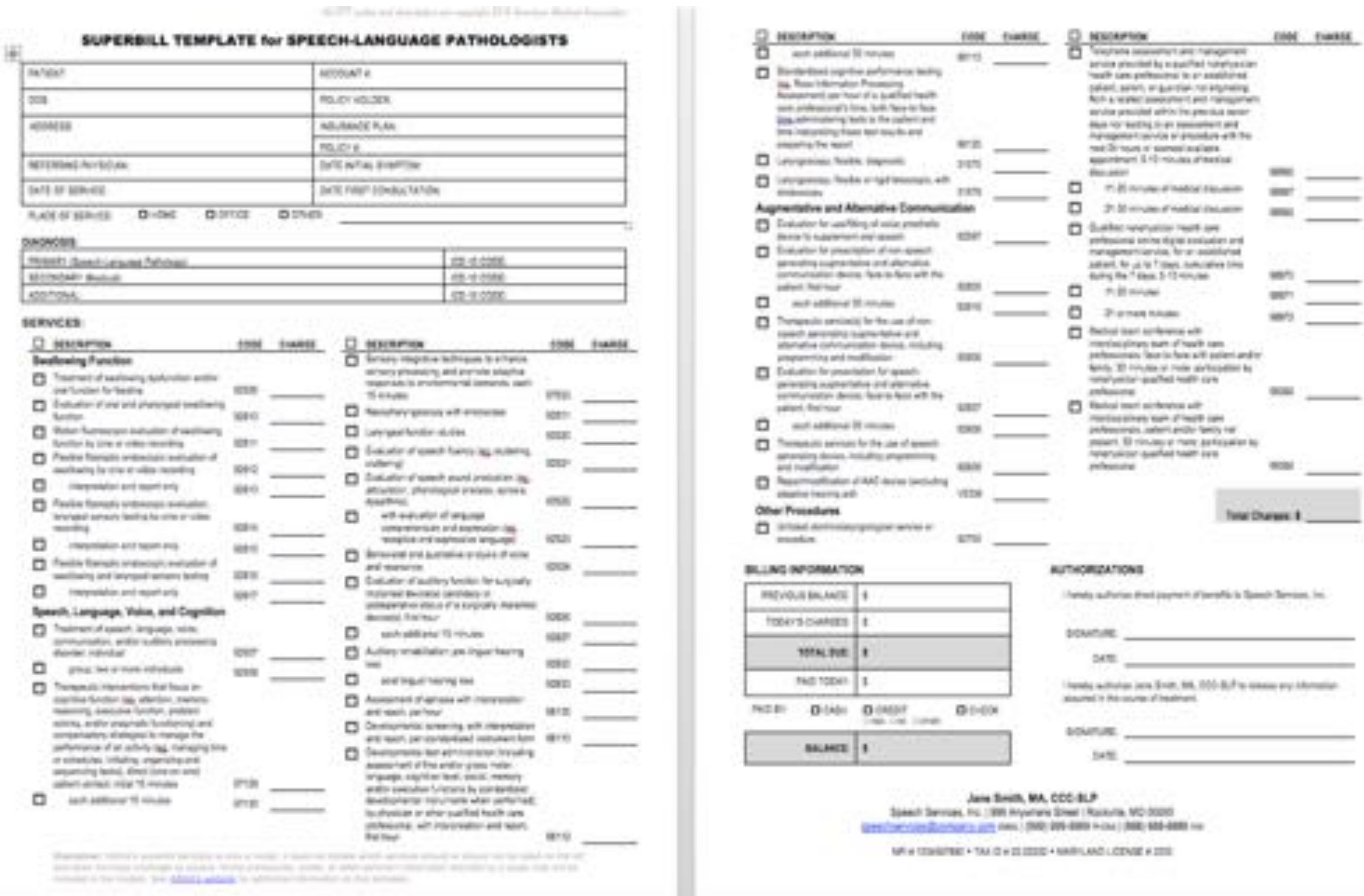
Commercial Payers (Private Health Plans)

Government (Medicare, Medicaid, Tricare)

Private Pay (Self-Pay)

- Patient/client pays directly for service – Fee-for-Service payment
- Rate-setting guidance remains the same
  - Usual and customary charges
  - Rates are same regardless of payer
  - Any discounts need to be standardized and uniformly applied
- Claim form is completed for each client (see ASHA Model Superbill)
- Self-pay is usually not an option for Medicare or Medicaid beneficiaries but there are exceptions

ASHA Model Superbill



SUPERBILL TEMPLATE for SPEECH-LANGUAGE PATHOLOGISTS

PATIENT | ACCOUNT #
DOB | POLICY HOLDER
ADDRESS | INSURANCE PLAN
POLICY #
REFERRING PHYSICIAN | DATE INITIAL SYMPTOM
DATE OF SERVICE | DATE FIRST CONSULTATION

PLACE OF SERVICE: HOME OFFICE OTHER

DIAGNOSIS

PRIMARY (Speech-Language Pathology) | ICD-10 CODE
SECONDARY (Medical) | ICD-10 CODE
ADDITIONAL | ICD-10 CODE

SERVICES

DESCRIPTION CODE CHARGE

Swallowing Function

Speech, Language, Voice, and Cognition

Augmentative and Alternative Communication

Other Procedures

Total Charges: $

BILLING INFORMATION

PREVIOUS BALANCE $
TODAY'S CHARGES $
TOTAL DUE $
PAID TODAY $
PAID BY: CASH CREDIT CHECK
BALANCE $

AUTHORIZATIONS

SIGNATURE
DATE
SIGNATURE
DATE

Jane Smith, MA, CCC-SLP

Private Pay (Self-Pay)

- Self-pay option is not an exemption from documentation, supervision, or coding requirements
- Certificate of Clinical Competence (CCC)
  - Nationally recognized credential that represents a **level of excellence** in the fields of SLP and Audiology.
  - Represents “rigorous academic and professional standards, typically going beyond the minimum requirements for state licensure…and "the knowledge, skills, and expertise to provide high quality clinical services…”
- SLPs who have their CCCs must abide by ASHA’s Code of Ethics (COE) and Scope of Practice and abide by applicable state and federal laws and regulations that govern our practice

Private Pay (Self-Pay) Considerations

- Does an SLP who accepts only self-paying clients in a small practice (independent or group) need to have a physician referral or signature on the plan of care?
  - (Consideration does not apply to Medicare or Medicaid beneficiary since they should not be self-pay)

- May an independent SLP practitioner accept variable payment for services rendered; such as, “pay me what you can”?

Commercial Payer (Private Health Plans)

- Benefits may be accessed through individual purchase, employer-based health plans, or state exchanges
- Out-of-pocket expenses for patient/client
  - Deductibles
  - Co-insurance
  - Co-payments
- Supervision requirements vary
- Managed care possibilities
  - Referrals
  - Pre-authorization
  - Limited coverage of SLP services
  - Limited number of treatment sessions
- Know your payers!

Government Payer Sources

- Medicaid and Medicaid Advantage
- Medicare and Medicare Advantage
  - Part A - inpatient
  - Part B - out-patient
  - Part C - managed care
  - Part D - pharmaceuticals
- Tricare - healthcare for military members and families

Medicaid (Medical Aid)

- Federal/state government partnership implemented based on state priorities
- In all states, Medicaid provides free or low-cost care for
  - low-income families and children
  - pregnant women
  - the elderly
  - people with disabilities
- Nation's largest payer of mental health services, long-term care services, and births
- Payment policies and rates for Medicaid and Medicaid Advantage plans vary widely from state-to-state and within a state depending on setting
- Use same International Classification of Disease (ICD) and Current Procedural Terminology (CPT) health care code sets as Medicare

Medicaid (Medical Aid)

- Federal law requires states that participate in Medicaid to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups)
- Mandatory service examples
  - Comprehensive services required for children (Early and Periodic Screening, Diagnosis, and Treatment)
  - Doctor visits
- Optional service examples
  - rehabilitation therapy
  - dental care
- Oversight: State Department of Health or equivalent

Medicare (Medical Care)

- Federal program administered by the Federal government
- Provides health care insurance
- Largest payer of inpatient hospital services for the elderly and people with end-stage renal disease
- Serves people aged 65 or older and certain people under 65 with disabilities
- Participation in the US (2019): > 1.2 million physicians & health care providers
- Parts A, B, and C differ by:
  - Payment system
  - Site of service
  - Supervision policies

Medicare Administrative Contractor (MAC) Part A and Part B claims

- MACs are regional contractors hired by the federal government
- Responsible for processing Medicare Part A and B claims and medical claims for Durable Medical Equipment (DME) for a defined geographic region or “jurisdiction” in the US
- Presently, there are 12 A/B MACs and 4 DME MACs
- MACs process Medicare Fee-For-Service claims for nearly 70% of the total Medicare beneficiary population
- KNOW YOUR MAC Guidelines!

Local Coverage Determinations (LCDs)

- LCDs are decisions made by a Medicare Administrative Contractor (MAC) whether to cover a particular item or service within its jurisdiction
- MAC's decision is based on whether the service or item is considered reasonable and necessary
- MAC may specify in the LCD which services are or are not covered
  - May also have an associated coverage article that includes a list of "covered" ICD-10 and CPT codes
- Be familiar with the LCDs pertaining to your services

Medicare Managed Care Contractors Part C claims

- Aka Medicare Advantage Plans (Medicare Part C)
- Commercial insurance companies contracted by CMS
- Each Medicare Advantage Plan is managed by the administrator of the specific company (e.g., BCBS, Humana, United)
- Company coverage determinations will vary
- Know the Managed Care Contractors

Medicaid vs Medicare

- Government-sponsored health care programs in the U.S. differ in the way they are governed and funded
- Medicaid is an assistance program that covers low- and no-income families and individuals
  - 2019 served 75+ million Americans (35+ million children)
- Medicare is an insurance program that primarily covers seniors age 65 and older and disabled individuals who qualify for Social Security
  - 2019 served 64 million Americans
  - 2019 34% of Medicare enrolled in Medicare Advantage plans
- Some may be eligible for both, depending on circumstances

Resources

- Check with your state Medicaid agency for a fee schedule and provider manuals
- ASHA Medicare Information: www.asha.org/practice/reimbursement/Medicare/
- ASHA Medicaid Tool Kit: www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit/
- Affordable Care Act: www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html
- 2018 Medicare and Medicaid Basics: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProgramBasicsText-Only.pdf
- ASHA Model Superbill: https://www.asha.org/Practice/reimbursement/coding/Superbill-Templates-for-Audiologists-and-Speech-Language-Pathologists/
- Local Coverage Determination: https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx
- Medicare Administrative Contractors: https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List
- 2020 Medicare Costs: https://www.medicare.gov/Pubs/pdf/11579-medicare-costs.pdf

Know Your Payment Systems and Practice Settings

Prospective Payment Systems (Inpatient services)

Fee-For-Service (Outpatient services)

Prospective Payment Systems (PPS)

- Payment is based on a predetermined, fixed lump sum amount for inpatient services.
- Payment amount is determined on admission using a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs.
- Medicare Part A has a PPS for each in-patient site of service
  - acute inpatient
  - inpatient psychiatric facilities
  - inpatient rehab facilities
  - skilled nursing facilities
  - long-term care hospitals
  - home health agencies
  - Hospice

Prospective Payment Systems (PPS) Medicare Part A

- Diagnosis Related Groups (DRGs) – inpatient hospital services with exception of specific physician services; DRGs determined by organ system, surgical procedures, co-morbidities, and gender; actual billing does not rely on minutes of service or use CPT codes
- Inpatient Rehabilitation PPS (IRF PPS) – inpatient rehabilitation facility; uses IRF Patient Assessment Instrument (IRF-PAI)
- Patient Driven Payment Model (PDPM) – skilled nursing facilities; patients assigned to case-mix groups based on the primary diagnosis for admission and then other relevant clinical and functional factors; Minimum Data Set (MDS) 3.0 used for pt assessment; actual billing does not use CPT codes
- Patient-Driven Groupings Model (PDGM) – home health; patients are assigned to a weighted case mix payment group based on admission source, clinical grouping, functional impairment, and comorbidities; payment based on 30-day periods; the Outcome and Assessment Information Set (OASIS) used for functional skills assessment

Fee-for-Service (FFS)

- Payment model in which an amount is paid for each service provided
- For Medicare providers, fees for out-patient procedures are found in the Medicare Physician Fee Schedule (MPFS).
- Payment (fee) is determined by the costs of resources needed to provide the service including professional work, practice expense, and liability costs
- Medical procedures and services are represented by a CPT/HCPCS code (Current Procedural Terminology/Healthcare Common Procedure Coding System)
- Commercial payers typically base their fee-for-service payment for out-patient services on the Medicare Physician Fee Schedule
- Services provided in out-patient practice settings are paid in this way
  - Private and group practices
  - Out-patient clinics
  - Comprehensive Outpatient Rehabilitation Facility
  - Mental health
  - Durable medical equipment, ambulance service, clinical research

Fee-for-Service (FFS)
Medicare Part B - Outpatient

- Not everyone has Part B Medicare coverage (original Medicare) - Part B is voluntary program
- Requires payment of a monthly premium (typically deducted from Social Security payment)
- The standard Part B premium amount in 2020 is $144.60 or higher depending on your income.
- Individuals may refuse enrollment and coverage
- Yearly therapy threshold applies for combined SLP & PT services ($2,080 for 2020). KX modifier on the claim attests that continued service is medically necessary

Fee-for-Service (FFS)
Medicare Part C (Medicare Advantage Plans)

- Part C aka Medicare Advantage is an alternative fee-for-service coverage program
- Medicare Advantage Plans are a form of managed care.
- CMS contracts with commercial insurance companies to provide Part A and/or Part B benefits (e.g., BCBS, United, Aetna, etc)
  - Responsible for controlling Medicare costs
  - Act as a middle man between Medicare and service providers.
  - May determine if a procedure is medically necessary or not
- In 2019, one-third (34%) of all Medicare beneficiaries – 22 million people – were enrolled in Medicare Advantage plans

Fee-for-Service (FFS) Medicare Part C (Medicare Advantage Plans)

- Must cover all Medicare services except
  - Hospice care: Hospice care is covered by Medicare Part A
- May cover additional services as add-ons
  - Hearing, vision, dental, and health & wellness programs
- Contract with providers to develop provider networks
- Advantage plans may
  - Require a referral to see a specialist.
  - Require providers to submit for prior authorization.
  - Limit number of sessions authorized during the prior authorization review.
  - Determine a stay does not meet the criteria for an inpatient hospital stay and change it to an observation stay impacting payment
- Coverage determinations differ among the plans
- Payment based on the Medicare Physician Fee Schedule

Fee-For-Service
Medicaid & Medicaid Managed Care

- Federal and state funded program
- Payment based on the Medicare Physician Fee Schedule but payment varies by state and sites of service within each state
- Medicaid Managed Care contracts are **awarded by the states** not federal government (CMS)
- Payments may change depending on state budget cuts and grants

Consideration

What's wrong with this scenario?

Mrs. Jones has original Medicare and was hospitalized for 6 days following admission for an acute CVA.

Following her discharge from the hospital, Mrs. Jones received a bill from the hospital for 1 aphasia evaluation and 4 treatment sessions provided to her by an SLP while an in-patient.

Discussion

- ✓ Think about the site of service

  Hospital inpatient
- ✓ Think about the payment system

  PPS – DRG
- ✓ Think about the payer source

  Medicare Part A

Answer: There would be no bill for SLP services because beneficiary was an inpatient. Medicare covers Part A hospital inpatient services through lump sum payment (PPS).

Part A — Hospital & Facility-Based Services

- ACH, IRF, SNF, HH, LTCH, Hospice
- Prospective payment systems (PPS)
- Pay for all services in a predetermined lump sum for the stay

Part B — Outpatient Services or "Original Medicare"

- Private practice, group practice, outpatient clinic, university clinic, etc.
- Fee-for-Service (ie, Medicare Physician Fee Schedule)
- Typically reimbursed for service as represented by CPT/HCPCS codes

Part C — Medicare Advantage or "Managed Medicare"

- Run by plans like Aetna, BCBS, United, etc.
- Required to cover all "traditional" Medicare benefits at lower cost
- Can use cost savings to offer additional benefits (e.g., hearing aids)

Part D — Prescription Drugs

Supervision

Compliance depends on knowledge of provider qualifications, payer guidelines, and practice setting policies.

Supervision
ASHA Standards and Payer Guidelines

- Payer supervision requirements may differ from ASHA supervision requirements for students, clinical fellows (CFs), and SLP assistants
- Supervision requirements will vary by payer *and* by site of service.
  - For example, Medicare Part B (outpatient) requires 100% in-the-room supervision of unlicensed CFs and students.
  - **But**…Medicare Part A (inpatient) allows facilities to develop their own policies for direct supervision of students and unlicensed CFs.

Centers for Medicare and Medicaid Services Qualified Provider

- Qualified Provider must be licensed by the state or have a credential such as the ASHA Certificate of Clinical Competence (CCC) in those states that do not have licensure
- Clinical Fellows that have been granted a temporary or provisional state license are fully qualified to provide services according to Medicare regulations
- Clinical Fellows WITHOUT temporary or provisional licensure are considered students and as such all Medicare supervision regulations and restrictions apply
- Student interns are considered extensions of the credentialed SLP supervisor and **are not** qualified providers.
- Speech Language Pathology Assistants are not considered qualified providers for Medicare. Some Medicaid programs in some school settings and some commercial payers may accept SLPAs
- Requirements for a qualified provider are determined by federal regulation, state licensing boards, and payer entities including Medicare, Medicaid and commercial payers
- KNOW YOUR PAYER GUIDELINES

Centers for Medicare and Medicaid Services Three Levels of Supervision Described

- General supervision requires physician's involvement
  - Referral for an evaluation AND/OR
  - Signature representing certification of the plan of care
- Direct supervision
  - requires that physician is "immediately available" while procedure is performed
  - does not require physician to be in room, but must be on premises
- Personal supervision
  - requires that physician is present in the room during the performance of the procedure

Medicare Part A – Hospital Supervision Regulations

- Hospitals are paid under the Diagnostic Related Group PPS.
- Claims submitted by hospitals typically list the attending physician as the provider of record, not the individual service providers such as therapists since these services are bundled into the payment
- Since physicians are on-site in the hospital and readily available in cases of emergency, CMS requires DIRECT supervision guidelines.
- Responsibility of care remains 100% with the supervising SLP provider

Medicare Part A
Inpatient Rehabilitation Facilities (IRFs)

- CMS has no requirements or interpretive guidance prohibiting students from providing patient care as part of their respective training programs.
  - including, but not limited to, therapy students, medical students, nursing students, and other allied health students
- CMS expects that all student therapy services will be provided by students under the supervision of a licensed therapist allowed by the hospital to provide such services.
- Since physicians are on-site in the hospital and readily available in cases of emergency, CMS requires DIRECT supervision guidelines.
- Responsibility of care remains 100% with the supervising SLP provider

Medicare Part A – Skilled Nursing Facilities (SNFs) Supervision Regulations

- Each SNF may determine its own manner of student supervision consistent with ALL federal, state and local laws and professional practice guidelines.
- CMS clarifies that the supervising clinician CANNOT treat another resident or supervise another student while the student is treating a resident.
- The SLP supervisor must be on the premises and immediately available.
- Part A care in SNFs follows DIRECT supervision guidelines
- Responsibility of care remains 100% with the supervising SLP provider
- https://www.asha.org/Practice/reimbursement/medicare/student_participation_slp/

Medicare Part B – Outpatient Supervision Regulations

- Requires 100% PERSONAL supervision of students by qualified SLP
- Only difference between Part A and Part B supervision is that the SLP supervisor must be in the room with the student at all times directing the service and not engaged in other activities.
- Only one billable service can be provided at one time by the supervisor; that is, the supervisor may NOT be treating and billing another patient or supervising any other student at the same time
- Rules apply to both individual and group therapy

- Personal Supervision requirement does NOT apply to non-Medicare beneficiaries in out-patient settings unless specified by the payer source

Medicare Part C & Commercial Payers - Outpatient Supervision Requirements

- Medicare Part C = Medicare Advantage Plans = Medicare Managed Care
- Payment is fee-for-service using Medicare Physician Fee Schedule
- Supervision Policies
  - determined by each individual insurance company
  - most Commercial Payers and Medicare Advantage contractors require DIRECT supervision level of students and unlicensed clinical fellows and defer to professional practice guidelines
- VERIFY WITH EACH PAYER SOURCE

MEDICARE	PART A	PART B	PART C
SETTING	Acute Care Hospital Post Acute - Inpatient Rehab Facility (IRF) - Skilled Nursing Facility (SNF) (first 100 days) Home Health Agency Hospice	AKA "Original Medicare" Outpatient Care - Private practice, clinic - Hospital observation status, not admitted - Preventive services SNF beyond first 100 days Long-Term Care Mental Health Services	AKA Medicare Advantage Managed Care Plans Option to original Medicare Private companies under Medicare contract May provide Part A & B benefits Plans are required to have at least same coverage as Original Medicare
BENEFICIARY ENROLLMENT	Most people age 65+ are eligible for free Medicare hospital insurance (Part A) if they have worked and paid Medicare taxes long enough	Not everyone 65+ has Part B, Voluntary enrollment, monthly payment	Voluntary enrollment Original Medicare serves as the foundation for private Medicare Advantage
PAYMENT SYSTEM	Prospective Payment Systems Diagnostic Related Groups – Acute Inpatient Rehab PPS– Acute IRF Patient Driven Payment Model – SNF Home Health – Patient-Driven Groupings Model	Fee-For-Service Medicare Physician Fee Schedule	Fee-For-Service Medicare Physician Fee Schedule
SUPERVISION	SLP Assistants not allowed Direct supervision of unlicensed CFs and students Requirements may vary among settings	SLP Assistants not allowed Unlicensed CFs and students require Personal - 100% in-the-room supervision	Depends on the insurance carrier contracted by CMS

Medicare Payment Systems Summary

Medicaid and Medicaid Managed Care Supervision Requirements

- Each state Medicaid agency determines provider qualifications
- Supervision requirements and billing procedures vary by state, district, and practice setting
- Student-provided services may not be billed in most settings; however, there may be exceptions.
- Clinical Fellows need to confirm state requirements for billing specific to the setting where services will be provided
- SLPAs are usually not covered by Medicaid in health care settings but may be covered in public school systems
- When dealing with Medicaid, you must know not only state policies, but also Medicaid requirements specific to the practice setting.
- Refer to ASHA's Medicaid Toolkit for general assistance

Payer Sources, Payment Systems, and Practice Settings

Scenario: Supervision of Clinical Fellow Question

- My administrator has asked me to sign off on treatment provided by a **Clinical Fellow** so they can bill **Medicaid** for the services.

- Should I do this?
- Considerations?

Scenario: Supervision of Clinical Fellow Discussion

- REMEMBER – **Medicaid** determinations are inconsistent and vary considerably
- Consider, does the CF have a provisional state license?
- If yes, then…For Medicare, in states where CFs are granted a **provisional license**, the CF is treated as a licensed practitioner and allowed to bill. **Check** to see if this policy holds true for Medicaid in that state. If yes, then supervision signature may not be necessary
- If no, then…For Medicare, if CF does not have a provisional license, the CF is considered same as a student and you may sign notes only if you have provided 100% supervision of the CF.
- **Check** to see if this policy holds true for Medicaid in that state

Scenario: Clinical Supervision of Students Question

Q: Which treatment setting/facility has the most restrictive supervision requirements of students and unlicensed clinical fellows providing services to Medicare beneficiaries?

A. Hospital Inpatient
B. Skilled Nursing Facility
C. Out-Patient Rehab Clinic
D. Long-term Care Hospital

Scenario: Clinical Supervision of Students Answer

- The answer is C

- In an out-patient clinical setting, supervision of students is considered PERSONAL.
- Supervision is required to be100% in the room with the student.

Scenario: Clinical Supervision of Students Question

- I've heard that less supervision is required for students who work in skilled nursing facilities (SNFs).
- What level of supervision is required for student interns who work in SNFs?
- It depends…

Scenario: Clinical Supervision of Students Answer

The first 100 days in a SNF fall under Medicare Part A coverage. After that time, if skilled services are required, services are paid under Medicare Part B. Supervision requirements in the SNF depend upon the payment system.

CMS Regulations

- Direct student supervision for Part A Medicare beneficiaries in a SNF; that is, supervisor must be on the premises and immediately available during treatment.
- Personal student supervision for Part B Medicare beneficiaries may come into play in a SNF if beneficiary has surpassed 100 days under Part A provision.

When in doubt, follow this general rule: When more than one supervision requirement applies, the most stringent requirement should be followed.

Scenario: Clinical Supervision of Students Question

- I am an SLP clinic supervisor in an outpatient clinic that has multiple payer sources.
- Each semester we supervise graduate **student externs**.

- Are SLP supervisors allowed to sign off on documentation by students that they have not personally supervised?

Scenario: Clinical Supervision of Students Discussion

- SLP signature confirms that this SLP directed and supervised the treatment
- The SLP supervisor must review and co-sign the student's documentation and retains full responsibility for the care of the patient
- If claims are for Medicare Part B, remember that the student is considered an "extension" of the supervising SLP.

Consideration

- Dr. Harrison, CCC-SLP, is the owner of a private practice and employs one other certified and licensed SLP and two SLP Assistants (SLPAs). The credentialed SLPs are enrolled Medicare providers. In Dr. Harrison's practice, all clients are evaluated by an SLP who also establishes the plan of care (POC). SLPAs provide all individual and group treatment based on the POC.
- Medicare has paid the submitted claims for the past two years.
- Dr. Harrison was shocked when she was investigated for violation of the False Claims Act and faces possible fines and/or imprisonment.
- What happened?

Discussion

- SLP did not adhere to federal law
  - Medicare does not reimburse for services provided by assistants
- FCA violations?
  - Providing patients with substandard care
  - Billing for services provided by unqualified Medicare providers
- Why did Medicare pay?
  - Medicare (and most other payers) pays first and then reviews and asks questions
- Before using SLPAs, check state laws for what SLPAs may or may not do in which practice settings (e.g., school vs health care) for which payer source (e.g., Medicare vs Medicaid vs Commercial payer)

It is the ethical responsibility of an ASHA-credentialed SLP to have knowledge of payer guidelines, payment systems and practice settings.

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