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

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- [Amy] Again, welcome to our webinar today, Payment for SLP Services, Navigating Payer Sources, Payment Systems, and Practice Settings. Our presenter today is Dr. Dee Adams Nikjeh, an ASHA fellow who co-chairs ASHA's Healthcare Economics Committee and also serves on the AMS relative value update and Healthcare Professionals Advisory Committees. And she is such an expert in this topic that I'm very pleased she could be with us here today. Dee, welcome.

- [Dee] Wow. Thank you. I'm just wanna tell everybody thank you very much for choosing this webinar to listen to. I'm kind of speechless at how many people have signed up to listen to this webinar. So that makes me feel really good and also very nervous. I'm gonna live up to the expectations now. So the title for today's presentation, let me tell you where that came from first. If I ask 10 different SLPs the same question about coding and payment for a particular procedure, I probably get 15 responses back. People frame their responses based on their own experiences and well, some of those experiences obviously differ depending on your payer sources, your payment systems and your practice settings, so that the responses that you give and the responses that you receive, may be inaccurate because of all of those variables.

Okay. Here's my disclosures. We've got that. So during today's course, at the end of this course, I hope that you will be able to identify and contrast multiple payer sources for SLP services, define and differentiate payment systems and practice settings and also describe SLP supervision requirements with respect to multiple healthcare practice settings. We're gonna begin with knowing your payers. So we have three main types of payers. We have self pay, or private pay. We have commercial payers, such as our private health care plans, and we have government payers, Medicare, Medicaid, and Tricare. So let's begin with private pay. Private pay obviously is when the client or the patient pays directly for the service. This is also called a Fee-for-Service payment.

When you are in private pay, your rate setting guidance remains the same. So your charges must be usual and customary. The rates are the same regardless of the payer and any discounts need to be standardized and uniformly applied. In other words, you need to have written policies and procedures, so that all your clients are treated consistently. You also are required to have a claim form. And I have an example of a ASHA model for you. And also self pay is usually not an option for Medicare or Medicaid beneficiaries. So you may wonder, well, why not? Well, the reason is, is because speech language pathology services are a covered benefit in Medicare and Medicaid. So if it's a covered benefit, then there's no reason for the beneficiary to be paying you out of pocket.

Now, there are examples to this and I wanna give you a current example of this, because of the public health emergency that we are in right now, and for those listening, this is November, or for those who will be listening in the future, I should say, this is November, 2020, currently SLPs and I should say temporarily as well, are approved providers for telepractice for Medicare and Medicaid patients. However, CMS did not, CMS stands for Centers for Medicare and Medicaid services, they did not include procedure codes, coverage of procedure codes for dysphagia treatment, because at this time, telepractice is not a covered service by Medicare for Medicare Part B. If you have a Medicare Part B beneficiary who requires telepractice services for dysphagia treatment, then in that case, you could bill that patient privately.

And if you do so, I would recommend that you have what we call an advanced beneficiary notice. This is a statement that explains the situation to the patient and that you have the patient signed giving written consent so that they are aware of this exception. So that's just one exception, but temporary, but usually that's very temporary. Usually self pay is not an option for Medicare or Medicaid. So here's an example for you of the superbill. I'm not gonna go over this. You have a reference for

this in today's materials. Self pay option is not an exemption from documentation, supervision or coding requirements. Sometimes I hear people say, well, I'm in private pay. I like being in private pay because I can just do what I want.

No, not really. If you have a certificate of clinical competence, then you are recognized as having a level of excellence in the field of speech, language, pathology and audiology. And that represents in quotes there, "Rigorous academic and professional standards typically going beyond the minimum requirements for state licensure, and you have the knowledge, skills and expertise to provide high quality clinical services." So when you are credentialed, you're holding yourself out to the public as an expert, and you can be held liable for negligence that causes harm. So SLPs who have their Cs, must abide by ASHA's code of ethics and the scope of practice, as well as a bide by applicable state and federal laws and regulations that govern our practice.

So you can't just do what you want just because you're in your own private practice. So here's something to think about. Does an SLP who accepts only self paying clients in a small practice need to have a physician referral or signature on the plan of care? And in parentheses I have here consideration does not apply to Medicare or Medicaid beneficiary since they should not be self pay. So what do you think? Well, we can't have a live discussion right now. So fortunately for you, I'm gonna give you the answer. Your state practice act may allow direct patient access by you, or on the other hand, a referral may be required. States are different. So you need to know your payer source.

You need to know their guidelines. If an SLP sees a patient without a referral, the patient needs to be informed upfront, in case the patient plans to submit for reimbursement and the insurance company requires a referral. So that's another reason to have a referral. I've been in clinical practice for a very long time and I always think that a referral is a good thing to have, whether it's a requirement or not. So how about the next consideration if you're in private pay? May an independent SLP

practitioner accept variable payment for services rendered, such as, "just pay me what you can"? Well, as much as we would like to say that sometimes, we really cannot. We need to have consistent policies.

And I think I just addressed that on a previous slide. You must have the same policy for the discounts across the board. It's very dangerous for you to say, just pay me what you can, but what you can do is you can develop a policy perhaps for a sliding scale based on income. The key is when you're in private pay, just please be consistent. So let's now switch over to commercial payers. And these are private health plans and there some of them right there in the artwork that's on this slide, some of the well-known ones. So these benefits may be accessed through individual purchase, employer based health plans or state exchanges. When you have a commercial payer, usually there is an out-of-pocket expense of some type for the patient or the client.

They may have a deductible. There may be a co-insurance and there may be a co-payment. Supervisions requirements will vary and we will talk about that at the end of the hour. Managed care possibilities. Oh, well we have all kinds of possibilities, but the four top ones are referrals, yes or no. Pre-auth, yes or no. How many SLP services are covered? How many treatment sessions can they have? Bottom line, know your payers. You will hear me say that a number of times in the next 50 minutes here. Know your payers because each one is different and their guidelines will differ. How about government payer sources? We have Medicaid and we have Medicaid Advantage. We have Medicare and Medicare advantage.

And within Medicare, we have Part A, B, C, and D. And then we also have Tricare, which is healthcare for military members and families. So there are many sources, payer sources, within the government. Let's talk about Medicaid first. Did you ever notice that the word Medicaid comes from medical aid? That's how it got its name. It's important to remember that Medicaid is a federal and state government partnership

and it's implemented based on state priorities. That is a very big reason right there why Medicaid differs so much from state to state? However, in all states, Medicaid provides free or low cost care, not only for low-income family and children, but also for pregnant women, for the elderly and for people with disabilities.

It is the nation's largest payer of mental health services, long-term care services and births. Did you know that four out of 10 births in the United States are covered by Medicaid? I had no idea until I prepped to do a presentation on Medicaid in the latest figures. 40% of all births in the United States are covered by Medicaid. Payment policies and rates for Medicaid and Medicaid Advantage plans, they vary widely and I like to say wildly as well, from state to state and within a state, depending on the setting. Medicaid Advantage plan, by the way, is a managed care plan through Medicaid, in case you didn't know that. But Medicaid also uses the same healthcare code sets that Medicare and most commercial payers use as well.

And that is what we refer to as ICD codes, International Classification of Diseases and Disorders and CPT codes, Current Procedural Terminology. So both Medicare and Medicaid use those procedure codes. Now, for Medicaid, the federal law requires states that participate in Medicaid to cover certain population groups and they call these mandatory groups and they give states the flexibility to cover other population groups and these are optional. So in the mandatory services, and includes comprehensive services for children, in the optional service, rehab therapy is optional. Dental care is optional. So again, this is why when we have a question about a Medicaid payment, you have to be very, very specific as to whom you direct that question to and give them the information that is specific to where you work and the service that you're providing.

The oversight for Medicaid is your state department of health. Now, I wanna switch gears now and talk about medical care, which we call Medicare. It is a federal program,

just federal program, administered by the federal government and it provides healthcare insurance. Medicare is the largest insurance company in the United States and it is the largest payer of inpatient hospital services for the elderly and people with end-stage renal disease. It serves people ages 65 and older, and according to the statistics for 2019, we had over 1.2 million physician providers, physician and healthcare providers. Now, as I spoke to you earlier, Medicare has different parts, A, B and C, and each one is different. They differ by payment system and site of service and supervision policies.

There's a couple of terms when we talk about Medicare that you need to be familiar with, and one is a MAC. What the heck is a MAC? A MAC is an acronym for Medicare Administrative Contractor. And basically these are commercial companies that are contracted by the federal government and they are responsible for a particular region in the United States. And what they do is they process Part A and B claims. They also, some of them also process claims for durable medical equipment, which we refer to as DME. Currently, we have 12 AB MACs and four DME MACs. The Macs process Medicare Fee-for-Service claims for about 70% of the total Medicare beneficiary population. So it's important for you to know who your MAC is, since there is no federal program for Medicare, it's not there, there's no central control, it is a federal program.

I meant to say, there's no central control. So you need to know who your regional contractor is. You actually want to know who is at that office because that's the person that you're gonna call when you have a question about a Medicare claim or a beneficiary. Now, another term that you will hear is LCD. What is an LCD? An LCD simply stands for Local Coverage Determinations. And these are decisions that are made by the MAC, whether to cover a particular item or a service within its jurisdiction. And unfortunately not all of the jurisdictions are consistent. So there again, if

somebody in one part of the country is on social media and asking SLPs, does Medicare cover this procedure?

And someone responds from another part of the country and says, oh yeah. Well, not necessarily. Maybe in your jurisdiction, but not in the jurisdiction from where the person is working, where they ask the question. The MAC decision is based on whether this service or items is considered reasonable and necessary. And they can specify in this LCD, which services are or are not covered. So you need to be familiar with the LCDs that pertain to your services. And I have resources for you so that you can look up your MAC and follow the links to get the LCDs and just become familiar with what that is, what that whole process is. Okay, so we've talked briefly about Medicare Part A and Part B, and now we have Medicare Part C.

Medicare Part C, I have to back up a second. I never realized, I should say, you know, I'm home now much of the time, which I didn't use to be and I have the television on more, much more than I used to and I see all these commercials on TV for Medicare, particularly now at this time of year, because this is the time between October 15th and the end of the year where people can make changes in their Medicare coverage and, or select a different type of plan. The thing is, I want you to really pay attention the next time you see those, because they're not really coming from the government, they're coming from commercial companies that are contracted and they're providing what they call Medicare Advantage Plans.

That's the same thing as Medicare Part B and these companies are Managed Care Contractors. These companies are also contracted by CMS and each Medicare Advantage Plan is managed by the administrator of the specific company, whether it's Blue Cross Blue Shield, Humana, United, I mean, there's just a whole lot of them out there. And so the company coverage determinations are going to vary based on which company has the particular Medicare Advantage Plan. So here again, you need to

know the managed care contractors. And here's another tip for you, when you have a patient that comes in and, or you're speaking to them on the phone, and you say, what insurance do you have? And they'll tell you all, I have Medicare.

Well, many times they don't know that there is a difference between Medicare Part B, which we now call original Medicare and Medicare Part C, which is the managed care plan. They don't even realize that they have a managed care plan. It's not until they come into your office and hand over the card that you see that it's not the Medicare Part B, original Medicare plan, but it is a managed care plan. So know about these Managed Care Contractors and know what their guidelines are. Now, I will tell you that many, many people, if you think all of this information is confusing and I feel like I'm giving it to you right now out of a fire hose, but if you think that this information is confusing, you're not alone.

Many, many people confuse Medicaid and Medicare. So I've tried to make it as simple as possible on this one slide. First of all, yes, they're both government sponsored healthcare programs. However, think of Medicaid, medical aid. It is an assistance program that covers low and no income families and individuals. Medicare is medical care. It is an insurance program that primarily covers seniors over the age of 65. In 2019, we had over 75 million Americans on Medicaid and 35 or more million of that were children, of those people were children. In 2019, we had 64 million Americans that were on Medicare and about 34% of Medicare are now enrolled in the Medicare Advantage Plans and that number is increasing. It seems to be every year that percentage of people in Medicare Advantage Plans is increasing.

And also remember that because they're two different types of government programs that some individuals may be eligible for both programs depending on their circumstances. So don't be surprised if they come into your office and you ask for insurance and they give you two cards, one for Medicaid, and one for Medicare. And

here are some resources for you that covers all of the information that I just gave you. And you can follow the link there to look for your MAC and your LCDs in your area. Now, the second factor that we wanna talk about are payment systems and the third is practice settings. But first we're gonna talk about payment systems. There are basically two types of payment systems, Prospective Payment System, which is mainly for inpatient services and fee for service, which is mainly for outpatients services.

So we're gonna talk about the PPS first. And before we even talk about the specifics, we need to know, well, what the heck is a Prospective Payment System? A Prospective Payment System is based on a predetermined, fixed lump sum amount for inpatient services. The payment amount is determined on admission using a patient assessment instrument, which classifies patients into distinct groups. And these groups are based on clinical characteristics and the resource cost that are, the expected resources that on the cost of these resources to take care of that particular, those particular clinical characteristics. Now, Medicare Part A has a Prospective Payment System for each inpatient site of service. Wouldn't it be really nice if we just had one for all Part A but no, we don't know.

And I'm not certainly gonna go through each one of these types of services, but I'm gonna get the ones that you would probably be the most familiar with. It has been proposed by the way, by MedPAC, which is a Medicare Payment Advisory Commission, to invest in a PPS for all post-acute settings. I think that would be really nice, but at that, I don't see that happening in the future, in my future anyway. Okay. So here are some PPSs that you may be familiar with. So, we have a diagnostic related group. If you work in the hospital, I'm sure that you've heard of DRGs, right? Diagnosis Related Groups. This is for inpatient hospital services with the exception of some specific physician services in the hospital.

So the DRGs are determined by the organ system, the surgical procedure, the comorbidities and gender. Actual billing does not rely on minutes of service or CPT codes, because these buckets, these groups are predetermined. They have the factors and they are already predetermined. Now that doesn't mean that when you're in the hospital, you may not be asked to keep track of the number of minutes that you spend with a patient or the CPT code for the procedure that you use. But those are internal requests, as a request for data purposes. That's not what is sent to Medicare. The DRG number is what is sent to Medicare. Now we also have inpatient rehab services or IRFs, and they also have their own payment system.

We have, and this one, many of you may be familiar with, if you work in a skilled nursing facility, this is called the Patient Driven Payment Model. We've now been using that for one year. Patients are assigned to a case-mix group, based on the primary diagnosis for the admission, and then other relevant clinical and functional factors. I mean, we could spend, we could spend two days just talking about each one of these. The minimum data set, if you work in a nursing home, you're certainly familiar with that. That's what's used for the patient assessment. And again, here, actual billing does not use CPT codes. Again, that doesn't mean that you may not be asked to provide them, but actual billing is based upon the Patient Driven Payment Model and the case-mix groups.

And then home health also has Patient Driven Grouping Model. Home health patients are assigned to a weighted case mix payment group, based on the admission source. Did they come from the community? Did they come from the hospital? Did they come from the SNF? They are also based on clinical grouping, functional impairment and comorbidities. And payments are based on a 30 day period. And if you work in home health, you are certainly familiar with the outcome and assessment information set, or better known as the OASIS, because this is what is used for functional skills assessment. All right, so let me back up one second point something out to you. So

once again, I want you to pay attention that the, that Medicare Part A, falls under a Prospective Payment System.

So now we're gonna change and talk about Fee-for-Service. Fee-for-Service, one of the drawbacks for fee for service is that it gives an incentive for physicians and SLPs or anybody, any healthcare provider to provide more treatments because payment is dependent on the quantity of care, rather than on the quality of care. The payment model is one in which the amount is paid for each service provided. For Medicare providers, fees for outpatient procedures are found in the Medicare Physician Fee Schedule. And now, if you look at that fee schedule, the patient, the beneficiary, the Medicare beneficiary, who has original Medicare, Part B, is responsible for 80% of that fee and then the other 20%, sometimes they will have a supplemental insurance that will pay the other 20%, some of them pay the other 20% out of pocket.

I believe I had a question from Rita, saying Medicare covers 80% and Medicare advantage programs cover the other 20%. Is that correct? Not exactly. Medicare, original Medicare covers the 80% and then you can have a supplement that will cover the other 20%. A Medicare Advantage Program, again, Part C, may cover Part A and B, and it's a managed care plan. So the fee for services are set differently in the Medicare Advantage Program. The payment is determined by the cost of resources needed to provide that service, including professional work, practice expense, and liability cost. And if you've heard me speak before on coding and reimbursement, you've probably heard me speak a great deal on what goes in to the fee for each procedure that we provide.

The medical procedures in the services are represented by a CPT or what we call hick picks code. Again, Current Procedural Terminology, which is a part of the Healthcare Common Procedure Coding System. Just to give you an example, I'm talking about CPT codes for speech and language therapy. Our CPT code is 92507, for dysphagia

treatment, it's 92526. You may be familiar with these procedure codes. If you're providing modified barium swallow studies, that's 92611, they're five digit codes and represent procedures, what we do with our patients and clients. Commercial payers typically base their Fee-for-Service payments on outpatient services, on the Medicare Physician Fee Schedule. Services are provided in outpatient practice settings are paid with a Fee-for-Service. Private and group practices, outpatient courts, et cetera.

Those are based Fee-for-Service. Now, let's talk a little bit about Medicare Part B. It is outpatient. Not every one has Part B Medicare coverage, or again, what they now call or refer to as original Medicare. Part B is a voluntary program. It requires a payment of a monthly premium, which is typically deducted from their social security payment. For example, the standard Part B premium amount in 2020 is $144 and 60 cents a month, but that is dependent on your income. It can be much higher than that, depending on what your income for the two previous years has been, the two previous years before you enroll. So individuals may refuse enrollment and coverage, and they may choose some other type of coverage such as like Medicare Part C.

One other thing that I put in here that is relevant to Medicare Part B, and particularly to speech language pathologist and physical therapist, we have a yearly therapy threshold that applies to combined SLP and PT services. So for 2020, that combined threshold was $2,080. If the charges go beyond that, and you can show that you are still providing skilled service, and your patient is benefiting from skilled services, then you put a KX modifier on your claim and that attests, that continued service is, that that particular service is medically necessary. Now, let's talk a little more about the Fee-for-Service under Medicare Part C. As I have said, it is Medicare advantage. It is an alternative fee for service coverage program, and it's a form of managed care.

And I've already told you that CMS contracts with commercial companies to provide either Part A or Part A and Part B benefits. It acts as a middleman between Medicare

and service providers. And right now we've got about one third of all Medicare beneficiaries who have a Medicare Advantage Plan. So these Medicare Advantage Plans must cover all Medicare services, except hospice care. Hospice care, if you go back to one of your slides, you'll see that that's covered under Medicare Part A. They may cover additional services or add-ons and hearing is one of those services. And if you start listening to some of these advertisements, it's just, oh my goodness, it's unbelievable what they claim that they cover and they'll say, and at no cost to you.

Well, they have to cover all Medicare services, but they don't have to cover them in the same way. So advantage plans may require a referral. They may require submission of prior authorization. They can limit the number of sessions and a determined stay does not mean that the criteria for an inpatient hospital stay and change it to an observation stay, which will impact the payment. Now, what does that sentence mean? All right, I don't wanna be too confusing here, but if you work in a hospital at all, you'll know what I'm referring to. When a patient comes into the hospital, when they're first admitted, sometimes they come in through the emergency room, sometimes they go into observation room and in those places that is still considered Part B, not Part A.

So supervision is different and payment is different and that's what this refers to. Also in a skilled nursing facility, the first hundred days are Part A. If the patient receives services beyond the first hundred days, then those are under Part B. So there are exceptions to everything. And again, that's why it is so important to know the payment setting and your practice setting, your payment system and your practice setting. But payment for Medicare Part C is also based on the Medicare Physician Fee Schedule and requires ICD and CPT codes. Now, let's talk about Medicaid and Medicaid Managed Care. First of all, this is, I'm hesitating here, because this one is also very confusing. It's a federal and state funded program, as I said before, and payment is based on the Medicare Physician Fee Schedule, but the payment varies by state and it also varies depending on the site of service within each state.

Medicaid Managed Care contracts are awarded by the states, not the federal government, and the payments may change depending on the state budget and on, depending on grants. Again, this is still fee for service, but it's very inconsistent. And when someone asks a question about Medicaid payment on social media, I just wanna cringe because I'm hesitant to provide any answer to Medicaid if I don't know all of the circumstances, again, the payer source and the payment system and the practice setting. So let's just take all this information that I've given you and let's just take a look at this scenario and see if we can figure out what's wrong here. Mrs. Jones has original Medicare. Okay. That's Medicare Part B.

She has original Medicare and she was hospitalized for six days following admission for an acute CVA. Following her discharge from the hospital, Mrs. Jones received a bill from the hospital for one aphasia evaluation and four treatment sessions provided to her by an SLP while an inpatient. Okay. So I just flip the next slide, just think about that a minute. Think about the site of service, think about the payment system and think about the payer source and can you tell me what's wrong with that? Okay, so the site of service is hospital inpatient and the payment system is gonna be a Prospective Payment System. Okay. And she's, this is Medicare Part A, so there would be no bill for SLP services because the beneficiary was an in-patient and Medicare covers part A hospital inpatient services through a lump sum payment.

All right. And this slide right here, is just a summary of some of the things that I've said to you. It's kind of puts it all in one place. It's kind of like a little cheat sheet for you to use. It distinguishes the payer source, the payment system and the practice setting for you. Okay. Now let's talk about supervision and we're going to talk about supervision maybe a little differently than others will talk about supervision. I'm talking about it in terms of payment and being compliant with it. So billing compliance and payment depends on your knowledge of the provider qualifications and payment guidelines and

practice setting policies, because they differ. Now this particular slide, I actually don't like the title on this slide, and I've already redone it on my own notes.

I think it's a little confusing. So I would want you to think of this as just supervision guidelines, because it's not either ASHA's standards or payer guidelines, but it's both. Payer supervision guidelines, they may differ from ASHA supervision standards for students and clinical fellows and SLP assistants. And the supervision requirements are also going to vary by payer and by the site of service. Just for a quick example here, Medicare Part B outpatient requires 100% in the room supervision of unlicensed clinical fellows and students, but Medicare Part A, inpatient services, allows facilities to develop their own policies for direct supervision of students and unlicensed clinical fellows. So what does all of this mean and how do we maneuver this?

All right, well, let's start, let's start by considering who does the centers for Medicare and Medicaid services consider a qualified provider. Now I'm not talking about an enrolled provider, I'm just talking about a qualified provider. So, according to CMS, they consider a qualified provider as someone who is licensed by the state, or who has the credentials such as the CCCs and clinical fellows that have been granted a temporary or provisional state license, and are fully qualified to provide services then, according to Medicare regulations. But who is not considered a qualified provider by the Centers for Medicare and Medicaid? Clinical fellows without temporary or provisional licensure are considered students and student interns are considered extensions of the credentialed SLP supervisor and are not considered qualified providers.

Speech language pathology assistants are not considered qualified providers for Medicare. Now, some Medicaid programs in some school settings and some commercial payers may accept SLP assistants. Requirements for a qualified provider are determined not only by federal regulation and state licensing boards, but also by the payer entities, including Medicare, Medicaid and commercial payers. So know your

payers guidelines. Okay. How does the Centers for Medicare and Medicaid Services define levels of supervision? They have three levels of supervision defined. The first and the least restrictive is general. General supervision requires the physician's involvement. And that can be done by a referral and certainly by a signature on the plan of care. Now I have referral for and evaluation. Sometimes we will get a patient referred to us and we will only do an evaluation and the patient doesn't require any more, any further services, or we may be referring them elsewhere.

The referral, in that case, since we don't have a plan of care that the physician will sign, the referral in that case serves as the physician's involvement. And again, I think, if you recall, right at the beginning of this presentation, I told you, I always feel more comfortable if I have a referral, a referral and a signature on the plan of care for any Medicare patient. Okay. Then Medicare has, the second level is direct supervision. And that requires that the physician is immediately available while the procedure is being performed. Does not require the physician to be in the room, but they must be on the premises. Now, I want you to put an asterisk on a piece of paper or on the slide, because during this time of the public health emergency temporarily, during this time, direct supervision does include virtual availability.

And then we asked to it prior to this, and we were told no, but during this, during the public health emergency, we can now provide services and without the physician or the SLP supervisor being on the premises, they can be virtually available. Remember the public health emergency has been extended at this time until January 20th, 2021. So all of the courtesies that we have right now are temporary. We just have to keep, stay tuned to how the developments proceed, because we just don't know. And the third one is personal supervision, which I mentioned. This requires that the physician is present in the room and physician in this case also means supervising SLP, is present in the room during the performance of the procedure 100% of the time.

So those are the three levels, general, direct and personal. For the most part, we fall under direct. So Medicare Part A. What are the supervision requirements in Part A. Hospitals are paid under as you know, the DRGs. So the claims submitted by the hospital, typically list the attending physician as the provider of record, does not have the individual service providers list on it, such as therapist. The physicians are onsite and in the hospital and readily available in case of an emergency. And for that reason, CMS has determined that hospital supervision is direct supervision, but always, always, and you'll see it on the next slides, and I'm not gonna read it every single time to you, but responsibility of care remains 100% with the supervising SLP provider.

How about an IRF? Well, CMS has no requirements or interpretive guidance prohibiting students from providing patient care as part of their training programs, but they expect all student therapy services will be provided by students under the supervision of a licensed therapist. Okay. And once again, you're in a hospital environment. So CMS requires direct supervision guidelines. Now, how about SNFs? What about SNFs? Each SNF may determine its own manner of student supervision consistent with all federal state and local laws and professional practice guidelines. You always have your ASHA guidelines there. CMS clarifies that the supervising clinician cannot treat another resident or supervise another student while the student is treating a resident. And that the SLP supervisor must be on the premises and immediately available.

And this again is under the direct supervision guidelines. And if you would like to find a direct reference, if you need to say, Dr. Nikjeh said this, and somebody says, well, where did she get that idea? There's a reference for it right there. Now, Medicare Part B outpatient supervision regulations. And I cannot tell you that this makes any sense to me, but outpatient supervision is 100% personal supervision of students by the qualified SLP supervisor. The only difference between Part A and Part B supervision is that the SLP supervisor has to be in the room with the student at all times directing the service. Now, for some reason, I always think of our Part A patients, you know, in acute

care, maybe needing a little more supervision than I do outpatient, but I didn't make the regulations.

Only one billable service can be provided at one time by the supervisor. That means that that supervisor may not be treating and billing for another patient or supervising any other student at the same time. And that rule applies to both individual and group therapy. But what I want you to remember, is that this personal supervision rule does not apply to non-Medicare beneficiaries. This is only Medicare Part B beneficiaries that this personal supervision rule applies. Now, how about Part C and commercial payers for outpatient? I just said the other one is 100% only applies to Part B. Almost all Medicare Part C plans require direct supervision, not personal, but direct supervision, but there again, you need to verify that with each one of those contracted payers.

And on this, this is another chart for you that is kind of a summary. This one has beneficiary enrollment information on it and supervision information and a breakout of the Medicare parts A, B, and C for you. And I can, after listening to me speak about Medicaid, you probably can already surmise what the slide is going to say. So what are the supervision requirements for Medicaid? Each state agency, Medicaid agency, determines its own provider qualifications. Supervision requirements, and billing procedures, again are going to vary not only by state, but by district and by practice setting. Student provided services may not be billed in most settings, I will tell you that, but there are exceptions. Clinical fellows are gonna need to confirm the state requirements for billing specific to the setting where the service is.

Speech-language pathologies assistants are not usually covered by Medicaid and healthcare settings, but they may be covered in public school systems. So when dealing with Medicaid, you must know not only the state policies, but also the Medicaid requirements specific to the practice setting. And I have another resource for you, ASHA's Medicaid toolkit that can give you some general assistance and other

resources for you. So now we're gonna just do some fun Q&A and I won't know how you're doing. I hope you're doing well. I hope you're still with me. When you're not talking to a live audience, you just hope that people are still there and haven't dozed off in the meantime. This isn't the most exciting information to present or to listen to, I know.

Okay, so here's the first one. And these are, these questions have all come to me at some point in time. I'm looking at Rita's comment and she says, my brain is fried. Okay, well, relaxed Rita 'cause we're just gonna do some Q&A now, no more new information, I don't believe. 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? Huh? Well, let's see. Remember, Medicaid determinations are inconsistent and they vary considerably. So what I can give you as information based on Medicare, but you would definitely need to check to see if it would be the same for Medicaid.

So the first thing you would wanna consider, is does the CF have a provisional state license? And if yes, then for Medicare in states where they have a provisional license, they're treated as a licensed practitioner and allowed to bill. So the supervision signature probably wouldn't be necessary in that case. But if, no, then for Medicare, if the CF doesn't have a provisional license, they're considered the same as a student. And you may sign those notes though only if you're the one who's provided the 100% supervision of the CF. But again, within Medicaid, you've got to check specifically for that particular case in Medicaid. Now, here's probably the easiest question. Which treatment setting or facility has the most restrictive supervision requirements of students and unlicensed clinical fellows providing services to Medicare beneficiaries?

Hmm. Is it a hospital inpatient, skilled nursing facility, outpatient rehab clinic, or long-term care hospital? I know you're just all shouting the answers out, aren't you? The answer of course is C, in and outpatient clinical setting, 100% personal

supervision for Medicare Part B. Which is outpatient, yes, which is outpatient. Okay. Next one. I've heard that less supervision is required for students who work in skilled nursing facilities. What level of supervision is required for student interns who work in SNFs? Well. Now you may think that that's just gonna be an easy one, right? I've been saying direct student supervision for Part A Medicare beneficiaries in a SNF, right? But also remember, that that's only for the first hundred days in the SNF.

If skilled services are continued beyond that hundred days, then they are paid under Medicare Part B. And in which case, the same, the same therapist could go from being direct supervision. Now has to have 100% supervision, go figure. But this is what I would do. If you're ever in doubt, always go with the more stringent application of supervision. Better to have too much than not have enough. I am an SLP clinic supervisor in an outpatient clinic that has multiple payer sources. Each semester, we supervise graduate student interns. Our SLP supervisors allowed to sign off on documentation by students that they have not personally supervised. Well, the SLP signature confirms that this SLP directed and supervise the treatment.

The supervisor must review and co-sign the student's documentation and that signature says that you are taking full responsibility for the care of the patient. If claims are for Medicare Part B, remember that the student is simply considered an extension of the supervising SLP. So you may not want to do that if you really have not been the supervisor for that student. Okay. One more consideration here. Another little story to tell and you guys can, well, I wish you could tell me what you think. Let's see. Dr. Harrison, CCC, SLP, is the owner of a private practice and employees one other certified and licensed SLP and two SLP assistants. Their 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. SLPAs provide all individual and group treatment based on the plan of

care. 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. Huh? What happened? What happened? Well, first of all, the SLP did not adhere to federal law, because Medicare does not reimburse services provided by assistants. And what about False Claims Act violations? Well, there are a couple of violations that could have, or may have occurred. One is providing patients with substandard care, because they do not consider the assistant as qualified provider, right?

And the other would be billing for services provided by an unqualified Medicare provider. And then this is the question I always get. Well, why did Medicare pay then? Well, Medicare and most other payers, they pay first. Medicare pays first and then they review and ask questions. I know it doesn't make any sense, but that's the way it is. They pay up front and then they do the reviews and they ask the questions and then they take their money back. Before using speech language pathology assistants, please check your state laws for what they may or they may not do in which practice settings, for example, school versus healthcare, because there's a difference there. And for which payer sources?

Is it Medicare? Is it Medicaid or is it a commercial payer? Know your payer guidelines? So the bottom line, of all the things that you've been listening to over the last 60 minutes and for the last 20 years of me speaking, it is the ethical responsibility of an ASHA credentialed SLP to have knowledge of payer guidelines, payment systems and practice settings. Thank you all for listening. I hope that Rita is not the only one that is, or maybe the only one whose brain is fried. But again, Amy thank you for inviting me. It's certainly my pleasure. And I'm looking, I don't think I have, oh, here's a couple of questions. Let me just see. Jennifer, you mentioned 100 days for services.

However, is this always accurate? In my facility the payment is driven by progress. Absolutely. A need for services via periodic reevaluation. Yes Jennifer. You're absolutely correct. It doesn't mean that everybody's gonna have a hundred days of service, but if it should progress beyond a hundred days, then it is no longer covered under Part A, it will be covered under Part B, but you're correct. And not everybody stays a hundred days. They may only stay a week or a month. You're right. It depends on their progress. Absolutely. And I think, I think that's the only questions that I have.

- [Amy] I think you are right.

- They all fell asleep.

- [Amy] Well, thank you so much. I know it's a little, it's always a little odd trying to do a Q&A type conversation with a virtual audience, but you did a great job. So thank you. And thanks again. This is complicated stuff and I really feel like you do a great job of making it nice and clear, even for me who struggles with this type of information. So thank you so much for being here today and thanks to our audience too. We appreciate you spending an hour of your day with us. So we hope to see you in another webinar again before too long. And do you have a great day and thanks again for being here.

I will wrap up the meeting everybody.

- Yes. Thank you very much. Be safe everyone. Stay healthy.