

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-02 Medicare Benefit Policy</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 106</b>	<b>Date: April 24, 2009</b>
	<b>Change Request 6381</b>

**SUBJECT: Speech-Language Pathology Private Practice Payment Policy**

**I. SUMMARY OF CHANGES:** Medicare shall pay for appropriate claims submitted by enrolled speech-language pathologists for services provided on or after July 1, 2009.

**New / Revised Material**

**Effective Date: July 1, 2009**

**Implementation Date: July 6, 2009**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
<b>R</b>	15/Table of Contents
<b>R</b>	15/230.3/Practice of Speech-Language Pathology
<b>R</b>	15/230.4/Services Furnished by a Therapist in Private Practice (TPP)

**III. FUNDING:**

**SECTION A:** For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**SECTION B:** For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

Pub. 100-02	Transmittal: 106	Date: April 24, 2009	Change Request: 6381
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**SUBJECT: Speech-Language Pathology Private Practice Payment Policy**

**Effective Date: July 1, 2009**

**Implementation Date: July 6, 2009**

## I. GENERAL INFORMATION

**A. Background:** Section 143 of the Medicare Improvements for Patients and Provider’s Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

**B. Policy:** SLPs in private practice may begin the Medicare enrollment process on June 2, 2009. Once enrolled, CMS will accept claims for services submitted by SLPs in private practice for services furnished on or after July 1, 2009.

## II. BUSINESS REQUIREMENTS TABLE

*Use “Shall” to denote a mandatory requirement*

Number	Requirement	Responsibility (place an “X” in each applicable column)								
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6381.1	Contractors shall process claim submissions submitted on behalf of an enrolled SLP in private practice for services furnished on or after July 1, 2009.	X			X					

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
6381.2	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X			X						

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: For all other recommendations and supporting information, use this space:**

### V. CONTACTS

**Pre-Implementation Contact(s):** For policy: Dorothy Shannon, 410-786-3396; for professional claims processing: Claudette Sikora 410-786-5618

**Post-Implementation Contact(s):** Payment Policy: Medicare Contractors

### VI. FUNDING

**Section A: For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: *For Medicare Administrative Contractors (MACs):***

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

# **Medicare Benefit Policy Manual**

## **Chapter 15 – Covered Medical and Other Health Services**

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*(Rev. 106, 04-24-09)*

230.4 - *Services Furnished by a Therapist in Private Practice (TPP)*

## **230.3 - Practice of Speech-Language Pathology**

*(Rev.106, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)*

### **A. General**

Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See Pub. 100-03, chapter 1, §170.3) *See section 230.4 of this chapter for benefit policies on speech-language pathologists in private practice (SLPP). See Pub. 100-08, Medicare Program Integrity Manual, chapter 10, section 12.4.14 for policy on enrollment in an SLPP.*

### **B. Qualified Speech-Language Pathologist Defined**

A qualified speech-language pathologist for program coverage purposes 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.

For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.

### **C. Services of Speech-Language Pathology Support Personnel**

Services of speech-language pathology assistants are not recognized for Medicare coverage. Services provided by speech-language pathology assistants, even if they are licensed to provide services in their states, will be considered unskilled services and denied as not reasonable and necessary if they are billed as therapy services.

Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

### **D. Application of Medicare Guidelines to Speech-Language Pathology Services**

## **1. Evaluation Services**

Speech-language pathology evaluation services are covered if they are reasonable and necessary and not excluded as routine screening by §1862(a)(7) of the Act. The speech-language pathologist employs a variety of formal and informal speech, language, and dysphagia assessment tests to ascertain the type, causal factor(s), and severity of the speech and language or swallowing disorders. Reevaluation of patients for whom speech, language and swallowing were previously contraindicated is covered only if the patient exhibits a change in medical condition. However, monthly reevaluations; e.g., a Western Aphasia Battery, for a patient undergoing a rehabilitative speech-language pathology program, are considered a part of the treatment session and shall not be covered as a separate evaluation for billing purposes. Although hearing screening by the speech-language pathologist may be part of an evaluation, it is not billable as a separate service.

## **2. Therapeutic Services**

The following are examples of common medical disorders and resulting communication deficits, which may necessitate active rehabilitative therapy. This list is not all-inclusive:

Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;

Neurological disease such as Parkinsonism or Multiple Sclerosis with dysarthria, dysphagia, inadequate respiratory volume/control, or voice disorder; or

Laryngeal carcinoma requiring laryngectomy resulting in aphonia.

## **3. Impairments of the Auditory System**

The terms, aural rehabilitation, auditory rehabilitation, auditory processing, lipreading and speech reading are among the terms used to describe covered services related to perception and comprehension of sound through the auditory system. See Pub. 100-04, chapter 12, section 30.3 for billing instructions. For example:

- Auditory processing evaluation and treatment may be covered and medically necessary. Examples include but are not limited to services for certain neurological impairments or the absence of natural auditory stimulation that results in impaired ability to process sound. Certain auditory processing disorders require diagnostic audiological tests in addition to speech-language pathology evaluation and treatment.
- Evaluation and treatment for disorders of the auditory system may be covered and medically necessary, for example, when it has been determined by a speech-language pathologist in collaboration with an audiologist that the hearing impaired beneficiary's current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient's

functional communication needs. Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologists may provide treatment.

Assessment for the need for rehabilitation of the auditory system (but not the vestibular system) may be done by a speech language pathologist. Examples include but are not limited to: evaluation of comprehension and production of language in oral, signed or written modalities, speech and voice production, listening skills, speech reading, communications strategies, and the impact of the hearing loss on the patient/client and family.

Examples of rehabilitation include but are not limited to treatment that focuses on comprehension, and production of language in oral, signed or written modalities; speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training, communication strategies, education and counseling. In determining the necessity for treatment, the beneficiary's performance in both clinical and natural environment should be considered.

#### **4. Dysphagia**

Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death. It is most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment.

The speech-language pathologist performs clinical and instrumental assessments and analyzes and integrates the diagnostic information to determine candidacy for intervention as well as appropriate compensations and rehabilitative therapy techniques. The equipment that is used in the examination may be fixed, mobile or portable. Professional guidelines recommend that the service be provided in a team setting with a physician/NPP who provides supervision of the radiological examination and interpretation of medical conditions revealed in it.

Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques.



## **230.4 - *Services Furnished by a Therapist in Private Practice (TPP)***

***(Rev.106, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)***

### **A. General**

*See section 220 of this chapter for definitions. Therapist refers only to a qualified physical therapist, occupational therapist or speech-language pathologist. TPP refers to therapists in private practice (qualified physical therapists, occupational therapists and speech-language pathologists).*

In order to qualify to bill Medicare directly as a therapist, each individual must be enrolled as a private practitioner and employed in one of the following practice types: an unincorporated solo practice, unincorporated partnership, unincorporated group practice, physician/NPP group or groups that are not professional corporations, if allowed by state and local law. Physician/NPP group practices may employ **TPP** if state and local law permits this employee relationship.

For purposes of this provision, a physician/NPP group practice is defined as one or more physicians/NPPs enrolled with Medicare who may bill as one entity. For further details on issues concerning enrollment, see the provider enrollment Web site at [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll) and *Pub. 100-08, Medicare Program Integrity Manual, chapter 10, section 12.4.14.*

Private practice also includes therapists who are practicing therapy as employees of another supplier, of a professional corporation or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of an institutional provider.

Services should be furnished in the therapist's or group's office or in the patient's home. The office is defined as the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in the practice at that location. If services are furnished in a private practice office space, that space shall be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. For descriptions of aquatic therapy in a community center pool see section 220C of this chapter.

Therapists in private practice must be approved as meeting certain requirements, but do not execute a formal provider agreement with the Secretary.

If therapists who have their own Medicare National Provider Identifier (NPI) are employed by therapist groups, physician/NPP groups, or groups that are not professional organizations, the requirement that therapy space be owned, leased, or rented may be satisfied by the group that employs the therapist. Each therapist employed by a group should enroll as a **TPP**.

When therapists with a Medicare NPI provide services in the physician's/NPP's office in which they are employed, and bill using their NPI for each therapy service, then the direct supervision requirement for *enrolled staff* apply.

When the *therapist* who has a Medicare NPI is employed in a physician's/NPP's office the services are ordinarily billed as services of the *therapist*, with the *therapist* identified on the claim as the supplier of services. However, services of the *therapist* who has a Medicare NPI may also be billed by the physician/NPP as services incident to the physician's/NPP's service. (See §230.5 for rules related to *therapy* services incident to a physician.) In that case, the physician/NPP is the supplier of service, the NPI of the *supervising* physician/NPP is reported on the claim with the service and all the rules for *both therapy services and* incident to services (§230.5) must be followed.

## **B. Private Practice Defined**

Reference: **Federal Register** November, 1998, pages 58863-58869; 42CFR 410.38(b), *42CFR410.59, 42CFR410.60, 42CFR410.62*

The *contractor* considers a therapist to be in private practice if the therapist maintains office space at his or her own expense and furnishes services only in that space or the patient's home. Or, a therapist is employed by another supplier and furnishes services in facilities provided at the expense of that supplier.

The therapist need not be in full-time private practice but must be engaged in private practice on a regular basis; i.e., the therapist is recognized as a private practitioner and for that purpose has access to the necessary equipment to provide an adequate program of therapy.

The therapy services must be provided either by or under the direct supervision of the *TPP*. Each *TPP* should be enrolled as a Medicare provider. If a therapist is not enrolled, the services of that therapist must be directly supervised by an enrolled therapist. Direct supervision requires that the supervising private practice therapist be present in the office suite at the time the service is performed. These direct supervision requirements apply only in the private practice setting and only for therapists and their assistants. In other outpatient settings, supervision rules differ. The services of support personnel must be included in the therapist's bill. The supporting personnel, including other therapists, must be W-2 or 1099 employees of the *TPP* or other qualified employer.

Coverage of outpatient therapy under Part B includes the services of a qualified *TPP* when furnished in the therapist's office or the beneficiary's home. For this purpose, "home" includes an institution that is used as a home, but not a hospital, CAH or SNF, (**Federal Register** Nov. 2, 1998, pg 58869). Place of Service (POS) includes:

- 03/School, only if residential,
- 04/Homeless Shelter,

- 12/Home, other than a facility that is a private residence,
- 14/Group Home,
- 33/Custodial Care Facility.

### **C. Assignment**

Reference: Nov. 2, 1998 **Federal Register**, pg. 58863

See also Pub. 100-04 chapter 1, §30.2.

When physicians, NPPs, *or TPPs* obtain provider numbers, they have the option of accepting assignment (participating) or not accepting assignment (nonparticipating). In contrast, providers, such as outpatient hospitals, SNFs, rehabilitation agencies, and CORFs, do not have the option. For these providers, assignment is mandatory.

If physicians/NPPs, *or TPPs* accept assignment (are participating), they must accept the Medicare Physician Fee Schedule amount as payment. Medicare pays 80% and the patient is responsible for 20%. In contrast, if they do not accept assignment, Medicare will only pay 95% of the fee schedule amount. However, when these services are not furnished on an assignment-related basis, the limiting charge applies. (See §1848(g)(2)(c) of the Act.)

**NOTE:** Services furnished by a therapist in the therapist's office under arrangements with hospitals in rural communities and public health agencies (or services provided in the beneficiary's home under arrangements with a provider of outpatient physical or occupational therapy services) are not covered under this provision. See section 230.6.