Skilled and Unskilled SLP Services: Differentiation and Documentation

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Speakers - Disclosures

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Learning Objectives

1. Compare and contrast skilled and unskilled SLP clinical services.

2. Appropriately document clinical services to show that skilled services are provided.

3. Discuss clinical compliance requirements for out-patient services provided to Medicare Part B beneficiaries as specified in the Medicare Benefit Policy Manual, ASHA's Code of Ethics, and ASHA's Scope of Practice for Speech-Language Pathology.

Considerations on Implementation of Services What is *Reasonable and Necessary*?

"The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by the therapist."

" Services that do NOT require the performance of a therapist are not skilled and are not considered reasonable or necessary, even if they are performed by a qualified professional."

"The key issue is whether the skills of a therapist are needed to treat the patient, or whether the services can be carried out by nonskilled personnel."

"Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care."

Medicare Benefit Policy Manual (MBPM) on covered services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Considerations on Implementation of Services that are Reasonable and Necessary

- Determination of medical necessity ("referred by" is not medical necessity).
- SLP needs to include
  - chief complaint,
  - duration of symptoms,
  - prior medical history,
  - relevant diagnosis, etc.
- Understanding the difference between skilled and unskilled services

Resources:

- ASHA, Documentation of Skilled vs. UnSkilled Care for Medicare Beneficiaries
- ASHA, Examples of Documentation of skilled vs. unskilled services
- ASHA, Guideline on admission and discharge criteria in SLP

MEDICARE DEFINITIONS for SLPs 2018 MBPM Ch 15, Sec 220

ASSESSMENT - the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation is indicated.

- Determines changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified
- Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations

EVALUATION - a separately payable comprehensive service provided by a clinician that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities.

- Warranted for a new diagnosis or when a condition is treated in a new setting
- Judgments are essential to development of the plan of care, including goals and interventions.

MEDICARE DEFINITIONS for SLPs
2018 MBPM Ch 15, Sec 220

RE-EVALUATION - separately payable and periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care.

- Provides additional objective information not included in other documentation.
- Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, reevaluations must also meet Medicare coverage guidelines.
- Decision to provide a reevaluation shall be made by a clinician.

MEDICARE DEFINITIONS (2018 MBPM Ch 15, Sec 220.2) UNSKILLED SERVICES

- Provided by professionals or personnel who **do not** meet the qualification standards
- Provided by qualified persons but are **inappropriate** to setting or conditions
- Unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, **does not** make it a skilled service when a therapist furnishes the service.
- If service **can be self-administered** or safely and effectively furnished by an unskilled person, without the direct or general supervision of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service
- Services related to activities for the **general good** and welfare of patients do not constitute therapy services for Medicare purposes.
- If **ANYONE** else can provide the service other than a certified SLP, then it may be unskilled

MEDICARE DEFINITIONS (2018 MBPM Ch 15, Sec 220.2) **SKILLED SERVICES**

- Evaluations and reevaluations
- Establishing treatment goals specific to the patient's needs
- Design a POC specific to patient's needs and determine frequency and intensity of treatment
- Ongoing *assessment* and modification during therapy
- Instruction leading to establishing compensatory skills
- Selection of augmentative devices (e.g., electrolarynx, Passy-Muir speaking valves, AAC devices)
- Training of patient and caregivers to supplement therapy
- Establish a maintenance program

Skilled Restorative vs. Skilled Maintenance

Rehabilitative/Restorative therapy

- includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being (i.e. PLOF).

Maintenance Program (MP)

- a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress or to prevent or slow further deterioration due to a disease or illness

BOTH REQUIRE SKILLED LEVEL OF CARE

Skilled Services for Maintenance Programs Outpatient Services

- Medicare allows providers to provide maintenance therapy to prevent further deterioration and/or preserve current capabilities of the individual
- Requirements
  - Services are reasonable and medically necessary
  - Plan must be performed by a qualified provider
  - Documentation must clearly state that services are moving from restorative to maintenance
  - Re-evaluation is strongly recommended to document this transition with updated goals
- POC within 30 days of re-evaluation/transition is still required
- POC every 90 days is still required for recertification of maintenance therapy
- Section 220.2 of Medicare Benefit Policy Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

SKILLED THERAPY Related to a Reasonable and Necessary Maintenance Program

- Establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration
- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered
- If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.
- The therapy procedures required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure
- The patient's special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient's current function or to prevent or slow further deterioration

THINK QUALITY NOT QUANTITY

Evidence-based decisions – Are you integrating research evidence with clinical expertise and patient values to determine your plan of care?

Is professional intervention necessary?

Do SLP services provide meaningful and functional benefit to the individual?

Remember – It is not the number of sessions or number of therapy minutes that matter but the significant and positive impact of the intervention on the patient's quality of life (Nikjeh, D).

Student and Unlicensed Clinical Fellow Supervision

MEDICARE PART A, B, C

ASHA
Student Supervision

The ASHA Code of Ethics, the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) and the Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) concur that the level of student supervision should be based on:

- **Abilities** of the student
- **Complexity** of the case
- Ultimately, the **client's well being**

Medicare
Three Levels of Supervision

GENERAL	• **requires physician's involvement** • **certification of the plan of care** • **signature on the plan of care demonstrates the physician's involvement**
DIRECT	• requires that physician "immediately available" while procedure is performed • does not require physician to be in room, but must be on premises
PERSONAL	• requires that physician is present in the room during the performance of the procedure

Medicare Supervision Requirements
Students & Unlicensed CFs Across Environments

Part A Hospital Inpatient	Part B Hospital Out-patient	Part A SNF	Part A Home Health	Part B Out-Patient	Part C Medicare Advantage Plans
Presumed Direct	Personal	Direct	Unclear – caution	Personal	Verify with individual payer
Line-of-sight	Unlicensed professionals not recognized by CMS - considered extension of provider	Line-of-sight not required At discretion of supervising provider	Consider ASHA Code of Ethics Under general physician supervision	Unlicensed professionals not recognized by CMS - considered extension of provider	inconsistent

Although some supervision rules may be less stringent, responsibility of care remains 100% with supervising provider

Clinical Fellow
Provisional License versus No License

- Medicare policy requires providers to be state licensed or otherwise regulated in order to bill independently.
- In states where CFs are granted a **provisional license**, Medicare treats the CF as a licensed practitioner and allows the CF to bill
- In states **without CF licensure,** the CFs are treated as students; therefore, supervision requirement is 100% in-the-room personal supervision just like a student
- ASHA strongly advocates for states to pursue provisional CF licensure

- http://www.asha.org/practice/reimbursement/medicare/student_participation_slp/

Scenario – Student Supervision Question

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

A. Hospital Inpatient
B. Skilled Nursing Facility
C. University Out-Patient Clinic
D. Private Out-Patient Clinic

Scenario – Student Supervision Answer

The answer is **B**

In a skilled nursing facility, supervision of students is considered **Direct.** Line-of-sight is not required. This is at the discretion of supervisor.

COVERAGE CONDITIONS FOR MEDICARE MBPM CH 15, Sec 220.1

Services are or were required because individual needed therapy services

POC established by physician or therapist

Patient is under the care of a physician

POC is certified by a physician

Services must be reasonable and necessary

Services are appropriate to meet patient's needs; that is,
(The Right Service For The Right Person)

- Type
- Frequency
- Intensity
- Duration

Minimal Required Documentation (SLP)

Evaluation

Plan of Care

Certification/Recertification

Progress notes

Daily treatment note

Discharge notes

https://www.asha.org/practice/reimbursement/medicare/medicare_documentation/

https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935365&section=Key_Issues

Plan of Care - Goals should be measurable and pertain to identified functional impairments

Must be established before treatment begins

- Established when it is created (dictated/written)
- Must be certified by a physician within 30 calendar days of first treatment day

Must contain at a minimum

- Physician signature
- Speech-Language Pathologist's signature and credentials
- Patient's diagnosis
- Long term treatment goals
- Type of therapy services
- Amount of therapy services
- Duration of therapy services
- Frequency of therapy services

Clinicians may choose to make tx plans more specific in accordance with good practice and establish short term treatment goals to help track progress toward the long term goal for the episode of care.

Guide for Goal Writing: SMART GOALS

SMART

- **S**pecific
- **M**easurable
- **A**chievable
- **R**elevant
- **T**ime-bound

Goal Writing: SMART Goals

S – Specific: who, what, when, where, how, and why
- What skills are contributing to the patient's strengths and what skills are lacking?
- Which tasks and strategies will assist the patient in achieving the goal?

M – Measurable: Monitor progress towards goal over time
- Is the skill clearly defined?
- How will progress toward goal be measured?

A – Attainable: The goal is achievable
- Can the patient accomplish this goal within the given time-frame?

R – Relevant: The goal has a functional purpose
- Does the goal serve a communicative function?
- Will goal provide value to patient's life?

T – Timely: The goal should have a time frame for accomplishment
- Are there short-term objectives leading to the final goal?

Documentation Pitfalls

The NUMBER ONE documentation and compliance error is…

LACK OF PHYSICIAN SIGNATURE ON THE PLAN OF CARE

Documentation Pitfalls

- Lack of harmony between procedure code (CPT), diagnostic code (ICD-10-CM), report information and claim submission
- Lack of specifying/clarifying medical necessity (not building the case)
- Lack of flow from history to clinical findings (fails to accurately tell the patient's story)
- Generalized statements such as "doing well" or "improving"
- Lack of support for goals and recommendations
- Lack of documentation to show clinical assessment and decision-making
- Lack of treatment detail (What did SLP and Patient DO?)

Documentation Pitfalls

- Illegible signature by provider, supervisor, or physician
- Unknown abbreviations
- Missing credentials (e.g., MS, CCC-SLP)
- Copying and pasting errors
- Carrying forward previous visit note
- Listing procedures (e.g., neuromuscular reeducation) and modalities (e.g., ultrasound) as goals (means by which long and short term goals are obtained)

DOCUMENTATION OF SKILLED VERSUS UNSKILLED SERVICES

HTTPS://WWW.ASHA.ORG/UPLOADEDFILES/DOCUMENTATION-SKILLED-VERSUS-UNSKILLED-CARE-FOR-MEDICARE-BENEFICIARIES.PDF

Skilled or Unskilled? Practice #1

Is this a skilled or unskilled treatment note?

Motor-Speech Goal: Improve speech intelligibility of functional phrases to 70% with minimal verbal cues from listener.

- **Treatment note**: Pt continues to present with unintelligible speech. Treatment included conversational practice. Recommend continue POC.

Skilled or Unskilled? Practice #1

ANSWER: Unskilled

- Comment: This treatment note does not provide objective details regarding patient's performance.

Skilled treatment note: Pt continues to have unintelligible speech production; unable to consistently make needs known. Intelligibility at single word level: 60%; phrase level: 30%. Pt benefits from SLP's verbal cues to reduce rate of speech and limit MLU to 1–2 words. Listener has better understanding if patient points to 1st letter of word first. Pt demonstrated improved self-awareness of intelligibility relative to last week's session.

Skilled or Unskilled? Practice #2

Is this a skilled or unskilled treatment note?

Voice Short-term goal: Pt will vocalize at phrase level 10 utterances with appropriate vocal quality, pitch, and loudness level to communicate wants/needs.

- **Treatment note**: Speaking valve was placed to help facilitate verbal communication. Pt repeated 10 phrases without visible signs or symptoms of respiratory distress for 30 minutes. Pt's SP O2 level maintained 99%–100% during the entire session.

Skilled or Unskilled? Practice #2

ANSWER: Skilled

Skilled or Unskilled? Practice #3

Is this a skilled or unskilled treatment note?

Aphasia Short-term goal: Pt will produce one-word responses to functional wh- questions @ 80% accuracy with min cues.

- **Treatment note**: Pt produced word-level responses with 70% accuracy in treatment session with verbal cues.

Skilled or Unskilled? Practice #3

ANSWER: Unskilled

- Comment: This note does not include modification of the plan of care based on patient performance and does not detail skilled treatment activities. What value did the SLP provide?

Skilled treatment note: Word level responses to wh-questions to: 1) self and ADLs: 70% accuracy with one repetition of wh-question; 2) semantically abstract questions: 50% accuracy. Benefits from phonological (initial syllable) cues but unable to self-cue successfully. Naming nouns is better than verbs. Performance improves when pt attempts written response to augment verbal output to facilitate phone-grapheme associations.

Skilled Maintenance Therapy

S: 74 yo male, 18-months s/p dx of vascular dementia is seen today in clinic for 30-day maintenance follow-up appointment. He was accompanied by his wife. All homework assignments are completed. Wife reports that husband is having difficulty sequencing 3 or more steps to complete tasks such as using walker or feeding the dog.

O: Assess accuracy levels of current POC treatment goals and modify strategies as needed so that patient maintains communication with his family and continues home practice with spouse assistance

A: Patient completes verbal naming tasks (e.g., household objects, family photos) with 75% spontaneous accuracy and 100% accuracy when provided function cue; He completes organizational tasks such as sorting and categorizing with 80% accuracy; Sequencing 3- and 4-steps accurately requires auditory and/or visual assist; SLP provided 2 to 4-step sequencing tasks to practice daily living activities and educated spouse on use of verbal repetition and cueing strategies to assist when needed. Review of memory strategies indicate that patient has written in his daily journal 21 days of last 30 and finds this a helpful memory tool.

P: Patient encouraged to continue use of daily journal; Strategies to accomplish goals are updated in the POC; Homework material to assist with goals was provided. Follow-up assessment of goals and strategies recommended in 30 days

Scope of Practice in Speech Language Pathology

Includes the following statements:

- “Additional requirements may dictate that speech-language pathology services are prescribed and required to meet specific eligibility criteria in certain work settings, or as required by certain payers.”
- “Deliver the appropriate frequency and intensity of treatment utilizing best available practice.”
- “Utilize treatment data to guide decisions and determine effectiveness of services.”

Scope of Practice in Speech Language Pathology: https://www.asha.org/policy/sp2016-00343/

Standards for the Certificate of Clinical Competence in SLP

Standard IV-G

- The applicant must have demonstrated knowledge of contemporary professional issues.

  - Implementation: The applicant must have demonstrated knowledge of professional issues that affect speech-language pathology. Issues typically include trends in professional practice, academic program accreditation standards, ASHA practice policies and guidelines, and reimbursement procedures.

2014 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology: https://www.asha.org/Certification/2014-Speech-Language-Pathology-Certification-Standards/

ASHA Code of Ethics

Principle I

G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.

Q. Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.

M. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence based clinical judgment, keeping paramount the best interests of those being served.

Principle II

D. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.

https://www.asha.org/code-of-ethics/

ASHA Code of Ethics

Principle III

D. Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.

G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission.

Principle IV

B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or prescription prevents keeping the welfare of persons served paramount.

R. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.

https://www.asha.org/code-of-ethics/

Questions?