



Council of State Association Presidents

In This Issue

Reimbursement
Resources

Educational
Opportunities for
Reimbursement

Prospective
Payment

Medicare
Perspective

Volume 1
October, 2005

REIMBURSEMENT ISSUES: Resources and Solutions

FROM THE EDITOR

Lisa O'Connor, 2005 CSAP Past President

It is exciting to bring you the first issue of the CSAP on-line newsletter. This e-newsletter will be posted on the web for easy access by CSAP members. As each e-newsletter is posted, a broadcast message or e-mail blast will be sent to CSAP members to advise them of the posting. The plan is to issue these e-newsletters on at least a triannual basis but there is no subscription mechanism. You will receive each e-newsletter by simply being a member of CSAP and using the CSAP web site.

About two months ago I sent a survey by way of an e-mail blast requesting input on this new CSAP publication. About sixteen of you took the time to respond and, as a first order of business, what follows are the results of that survey:

1. Should each on-line newsletter have a theme?
10 responded "NO" and 6 responded "YES."
2. What topics or articles would you like to see published?

There were a wide variety of answers, but most fell under the following categories:

- NCLB and the change in service delivery in the schools
- Membership recruitment and retention strategies
- Association Management Issues, including handling finances
- Legislative Advocacy
- Marketing Strategies, or anything associations do that are successful
- Speech Assistants or the use of paraprofessionals
- Association web sites
- Professional Development activities put on by state associations.

The last question asked for interested volunteers to contribute an article for this newsletter. Please look over the above list and let me know if you are interested in submitting an article on one of these topics. Input from our members will be very important to the success of these newsletters. Please send me an e-mail (lisa_oconnor37@hotmail.com) if you are willing to contribute to the next edition, which we hope to release in January 2006! The deadline for this issue will be December 15, 2005.

This inaugural edition of the CSAP e-newsletter focuses on reimbursement issues. The first article is a [letter from Nancy Swigert](#), Chair the ASHA Health Care Economics Committee. This letter provides invaluable reimbursement related resources, as well as educational opportunities available to you and your state association membership. What follows is information about [ASHA convention short courses](#) that focus on private health plan reimbursement, as well as more information on ASHA web-based reimbursement resources. Mark Kander, from ASHA's Government Relations and Social Policy Division

talks about [Medicare prospective payment systems](#), and finally Robert Fifer, President-Elect of the Florida Speech-Language Hearing Association, discusses [Medicare Perspectives of Audiology and Speech-Language Pathology](#). The information in these articles can apply across work settings. I think they provide invaluable information pertaining to reimbursement issues. Please feel free to publish any of these articles in your state association newsletters.

REIMBURSEMENT RELATED RESOURCES AND EDUCATIONAL OPPORTUNITIES

(A letter from Nancy Swigert)

ASHA's Health Care Economics Committee (HCEC) is committed to educating audiologists and speech-language pathologists about the CPT coding system and related procedures and how to apply those procedures to obtain reimbursement for their services. As chair of the committee, I would like you to know about a number of valuable reimbursement-related resources and educational opportunities available to you and your state association members.

Coding Workshops

Members of the HCEC and ASHA staff are available to conduct coding and reimbursement workshops upon request. The content of these workshops can be based on your needs and preferences and include health insurance basics, current issues, procedure and diagnostic coding, outpatient reimbursement methodologies, billing, appeals, and advocacy. Typically, the workshops are conducted during meetings or the annual convention and require advance planning. There is no honorarium, but your Association would be responsible for the cost of travel and room and board, if necessary.

The ASHA Web site

The ASHA Web site contains a section for members devoted entirely to billing and reimbursement issues at <http://www.asha.org/members/issues/reimbursement/>. There is extensive information in this section including pages concentrating specifically on billing and reimbursement issues in Medicare, Medicaid, and private health plans. In addition, much of the content is formatted to be audiology or speech-language pathology specific, allowing members to obtain information that is most relevant to them. Feel free to use this link on your State Association webpage, where appropriate. You may also want to consider using the attached information about the ASHA Web site in your publications or newsletters to inform your members about this valuable resource.

Articles for Publication

Members of the HCEC and ASHA staff contribute regularly to a column in the ASHA Leader called the "Bottom Line." The "Bottom Line" is a continuing series on reimbursement questions, problems, and tips and can be found on ASHA's Web site at <http://www.asha.org/about/publications/leader-online/b-line/>. You can reprint specific articles in your association's publications or newsletters. We only ask that ASHA be credited for the contribution.

The HCEC hopes that you will be able to use these resources to the benefit of your association. For questions or further information, please contact Neela Swanson at nswanson@asha.org or 800-498-2071, ext. 4387.

Sincerely,
Nancy B. Swigert, M.A., CCC-SLP
Chair
ASHA Health Care Economics Committee

You may want to consider posting the following information in a newsletter or on your Web site to give your members access to important billing and reimbursement resources.

Reimbursement Resources at Your Fingertips

Are you having trouble finding specific billing and reimbursement information that's relevant to audiology and speech-language pathology? Look no further! As a member benefit, reimbursement resources are at your fingertips on ASHA's Web site at <http://www.asha.org/members/issues/reimbursement>. Find extensive billing and reimbursement information all in one place, including pages focusing specifically on coding, Medicare, Medicaid, and private health plans. To make things easier for you, content is formatted to be audiology or speech-language pathology specific. It's all online, so log on today!

ASHA's State-Based Reimbursement Network

The State Advocates for Reimbursement (STARs) are ASHA-member audiologists and speech-language pathologists who are willing to advocate locally with legislators, state insurance commissioners, health plans, unions, and employers on matters related to private health plan reimbursement. They share their advocacy skills and help create coverage and reimbursement strategies with state associations. They are the link between your state and ASHA.

The STARs is a network in the true sense of the word - they are eager and willing to offer assistance, share information, and seek solutions to the reimbursement issues that challenge the financial viability of our professions. Network members must be able to count on their colleagues, to work with them to effect change in the private health plan system. They can't do it alone. The following states are not represented on the STAR network: DC, LA, MT, NH, NM, OK, RI, and VT. Is there anyone in your state who is willing step up to the plate and get involved?

So what do the STARs hope to achieve? Well, their mission is to advocate for consistent coverage and equitable reimbursement rates by private payers for speech-language pathology and audiology services. The STARs also engage in bimonthly conference calls, a STARs-only e-mail listserv, and an annual face-to-face meeting at the ASHA convention, which will take place on Friday, November 18th from 6:00 – 8:00 p.m. The location is still being determined.

For more information on the STAR network, contact, [Maureen Thompson](#), ASHA's Director of Private Health Plans Advocacy, at 800-498-2071, ext. 4431. For general reimbursement questions contact reimbursement@asha.org.

MORE ON EDUCATIONAL OPPORTUNITIES AND ASHA WEB-BASED REIMBURSEMENT RESOURCES

Maureen Thompson, ASHA's Director of Private Health Plans Advocacy

Two Short Courses at ASHA Convention Focus on Private Health Plan Reimbursement

Negotiating Private Health Plan Coverage – A Process (Short Course 29)

Coverage rules and reimbursement rates are increasingly affecting access to, and scope of services provided by audiologists and speech-language pathologists. This program will describe how to advocate and negotiate with private health plans for comprehensive coverage of and reasonable reimbursement rates for audiology and speech-language pathology services.

The Current Procedural Terminology (CPT) process will

Q: *What are these new web pages?*

A: ASHA has developed two new sites, both of which are located in the public section of the ASHA website at <http://www.asha.org/public/>. One page, called “Understanding Health Insurance,” specifically targets consumers who are in need of insurance coverage or improved coverage for speech, language or hearing services. The other, called “Adding Speech, Language, and Hearing Benefits to Your Policy,” was created to provide employers, insurers, and labor unions with the necessary information to help them add or improve speech, language, and hearing benefits in their health insurance policies.

be outlined to facilitate an understanding of how procedures become codes. Contract terminology and the benefits of incorporating national fee data into negotiations will be discussed. Participants will be introduced to the various reimbursement “players” and gain insight on the current state and federal health care environments. The elements of effective persuasion will be outlined along with the tools needed for initiating contact. Participants will work in groups to determine the best approach in their state.

Eliminating Your Reimbursement Fear Factor (Short Course 16)

Do you have the guts and determination to face your reimbursement fears? If you don't, the professions of audiology and speech-language pathology could be eliminated from the reimbursement arena. If you face your fears however, you will advance the professions and make a positive difference in the lives of individuals with communication disorders.

Whether you are an audiologist or speech-language pathologist who wants to navigate the changes in public and private payers, comply with Medicaid in a school setting, or thrive in a private practice, this seminar will help you face your reimbursement fears and finally have the courage to break through them.

This seminar will provide an overview of the health care delivery reimbursement cycle, describe and work through common reimbursement obstacles, direct you to a plethora of advocacy resources at both the state and national levels, and encourage you to become an advocate at whatever level you dare! No eating of rat stew required!

Take Advantage of ASHA Web-Based Reimbursement Resources

ASHA continues to work on improving reimbursement and coverage for audiology and speech-language pathology services through its Focused Initiative on Health Care Reimbursement. As a result, two new areas on the ASHA website have been created to target groups of people who can have a direct effect on the coverage and payment of speech, language, and hearing services. The following questions and answers provide more information on these new web pages, including why they are important to you, as an audiologist or speech-language pathologist, and to those you serve.

Put Your Health Plan to the Test!

- Will your health insurance plan be there for you if

Q: *What kind of information can be obtained on these pages?*

A: On the “Understanding Health Insurance” web page, consumers are given a number of resources to help them understand their current health plans, advocate with their employers and health insurance plans to obtain better coverage, and find alternative sources of funding to enable them to receive the speech, language, or hearing services they need.

The web page called “Adding Speech, Language, and Hearing Benefits to Your Policy” was designed to provide employers, insurers, and labor unions with answers to questions they might have about the value of these benefits, who are qualified to provide these services, and what ideal speech, language, and hearing benefits would look like. It also provides contact information to ASHA staff members who can help them develop comprehensive benefits for their employees and members.

Q: *Why are these new pages important?*

A: Consumers, employers, insurers, and labor unions can all have an impact on the coverage and payment of services you provide as an audiologist or speech-language pathologist. Consumers who need your services can become strong and effective advocates for comprehensive coverage of speech, language, and hearing services. The “Understanding Health Insurance” web page gives them the necessary guidance and tools to do so. Employers, insurers, and labor unions are the decision makers who will hear from the consumers and determine whether or not your services will be covered under their health insurance policies. The “Adding Speech, Language, and Hearing Benefits to Your Policy” web page provides them easy access to the resources and contact information that will help them understand the value of your services and the benefits of adding them to their health insurance policies.

Q: *How can I help spread the word about these new pages?*

A: Tell those you serve that the “Understanding Health Insurance” web page at <http://www.asha.org/public/coverage/> is a resource for them, especially if they need help getting your services covered under their health insurance plan. Also tell them to send their employers or insurers to the “Adding Speech, Language, and Hearing Benefits to Your Policy” web page at <http://www.asha.org/public/coverage/>.

Q: *What resources are available to assist ASHA members?*

A: The two new areas supplement the valuable reimbursement information ASHA provides for

- Your ability to communicate is impaired?
- Your parent suffers a stroke and can't swallow food or liquids?
- Your child is born with a hearing loss and needs rehabilitation and hearing aids?

At some point in your life, you may need to seek the very services you provide for yourself or a loved one. Could you afford to pay out of pocket for such services? Don't wait for a crisis to find out if vital speech, language, and hearing services are included in your health plan!

Take a few minutes now to review your health plan. It's easy! Just fill out two very short questionnaires: one on your health plan's coverage of speech and language services, the other on coverage of hearing services. You can access the questionnaires by clicking on the following link: <http://www.asha.org/public/health-plan-quest-intro.htm>. The information you provide will assist the ASHA in advocating with health plans and employers for improved coverage of these very important services.

In order to fill out the questionnaires, you will need a summary of your health insurance benefits.

Thank you for your time. Your assistance is vital to ASHA's advocacy efforts for individuals with communication disorders.

audiologists and speech-language pathologists on its members' only section. ASHA redesigned its reimbursement website not only to provide more helpful information to members, but also to make it easier to access the information you need, when you need it. The reimbursement site is divided into four main topics: Medicare, Medicaid, Private Health Plans, and Coding for Reimbursement. Under each of these topics, information is available to provide not only general information, but also information specific to audiology and speech-language pathology.

You can access the members' only reimbursement website by clicking on the following link: <http://www.asha.org/members/issues/reimbursement/>

MEDICARE PROSPECTIVE PAYMENT SYSTEMS (PPS)

A Summary

Mark Kander, ASHA Government Relations and Social Policy Division

Prospective payment systems are intended to motivate health care administrators to deliver patient care effectively, efficiently and without overutilization of services. The concept has its roots in the 1960s with the birth of health maintenance organizations (HMOs). The HMO receives a flat dollar amount (i.e., monthly premiums) and is responsible for providing whatever services are needed by the patient. Thus, there is a built-in incentive for administrators to create management patterns that will allow diagnosis and treatment of the patient as efficiently as possible. In contrast, conventional fee-for-service payment systems may create an incentive to add unnecessary treatment sessions for which the need can be easily justified in the medical record.

There are only a few changes to make in the HMO model to describe the Medicare PPS systems for hospitals, skilled nursing facilities, and home health agencies. Instead of receiving a monthly premium to cover the whole family, the health care facility receives a single payment for a single Medicare beneficiary to cover a defined period of time or the entire inpatient stay. The payment amount is based on diagnoses and standardized functional assessments, but the payment concept is the same as in an HMO; the recipient of the payments is responsible for rendering whatever health care services are needed by the patient (with some exceptions).

Some common characteristics of Medicare PPS are:

- Prepayment amounts cover defined periods (per diem, per stay, or 60-day episodes).
- The payment amount is based on a unique assessment/classification of each patient.
- Applies only to Part A inpatients

PPS Summary by Provider Setting

Provider Setting	Classification System	Summary Description
Inpatient acute care hospital (1982)	Diagnosis-Related Groups (DRGs)	<ul style="list-style-type: none"> ◆ Primary diagnosis determines assignment to one of 535 DRGs. ◆ The DRG payment rate is adjusted based on age, sex, secondary diagnosis, and major procedures performed. DRG payment is per stay. ◆ Additional payment (outliner) made only if length of stay far exceeds the norm.
Inpatient rehabilitation hospital or distinct unit (2002)	Case-Mix Groups (CMGs)	<ul style="list-style-type: none"> ◆ Patient Assessment Instrument (PAI) determines assignment of patient to one of 95 Case-Mix Groups (CMGs). ◆ CMG determines payment rate per stay. Rehabilitation Impairment Categories (RICs) are based on diagnosis; CMGs are based on RIC, patient's motor and cognition scores, and age. ◆ Discharge assessment incorporates comorbidities. PAI includes comprehension, expression, and swallowing.
Skilled Nursing Facility (1998)	Resource Utilization Groups, Third Version (RUG-III)	<ul style="list-style-type: none"> ◆ Fifty-three groups ◆ Each beneficiary assigned a per diem payment based on Minimum Data Set (MDS) comprehensive assessment. ◆ A specified minimum number of minutes per week is established for each rehabilitation RUG based on MDS score and rehabilitation team estimates.
Home Health Agency (2000)	Home Health Resource Groups (HHRGs)	<ul style="list-style-type: none"> ◆ Eighty HHRGs. The Outcome & Assessment Information Set (OASIS) determines the HHRG and is completed for each 60-period. ◆ A predetermined base payment for each 60-day episode of care is adjusted according to the patient's HHRG. ◆ No limit to number of 60-day episodes ◆ Payment is adjusted if the patient's condition significantly changes.

MEDICARE PERSPECTIVES OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Robert C. Fifer, Ph.D.

At first glance, someone might say, "What does it matter?" with regard to Medicare's perspective of audiology and speech-language pathology. Many individuals think of Medicare as "just" another third party payer. In fact, Medicare is not only a third party payer with its own set of rules, Medicare sets the standard for covered care, reimbursement cost basis, and service limitations that many private third party payers have adopted.

The Center for Medicare and Medicaid Services (CMS), at the direction of Congress, has worked with the American Medical Association to refine the CPT coding system that we use to describe what

we do, developed a Correct Coding Initiative to decrease fraud and “gaming” of the reimbursement system, established guidelines for service delivery, and influenced scopes of practice for each health care discipline. Audiology and speech-language pathology may come from common roots dating back to the 1960’s and earlier, but they are very different professions now. This is no truer than what one will find from the Medicare perspective.

In 1998, Medicare determined classifications of various health care disciplines and placed them into therapeutic, diagnostic, or physician categories. Audiology was classified as a diagnostic discipline which means that the audiology scope of practice for conducting therapeutic activities (aural rehabilitation, vestibular rehabilitation, etc.) have been severely limited. In contrast, speech-language pathology was classified as a therapeutic discipline that may perform both diagnostic procedures (voice, language, and swallowing) and intervention services. In many cases, the diagnostics service the purpose of justifying and establishing a therapeutic plan of care. In addition, by virtue of a quirk in Medicare law, physical therapy and speech-language pathology are viewed as being “connected at the hip” and having a much closer relationship than actually exists. This was the reason for the combined PT/SLP cap while occupational therapy had a cap of its own. It is not known exactly why and how Medicare placed scopes of practice limitations on SLP and Aud services, but many commercial third party payers have followed these guidelines with regard to allowable billing for each respective area.

Medicare Provider Qualifications. Section 1102 of the Social Security Act (42 U.S.C. 1302) provides that a “speech pathologist” is an individual who meets one of the following conditions:

- i. Has a certificate of clinical competence from the American Speech and Hearing Association (sic).
- ii. Has completed the equivalent educational requirements and work experience necessary for the certificate
- iii. Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

The statute states that a “qualified audiologist” means an individual with a master’s or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:

- i. The state in which the individual furnishes audiology services meets or exceeds state licensure requirements in(ii)(A) or(ii)(B) of this section, and the individual is licensed by the state as an audiologist to furnish audiology services.
- ii. In the case of an individual who furnishes audiology services in a state that does not license audiologists, or an individual exempted from state licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions:
 - A. Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.
 - B. Have successfully completed a minimum of 350 clock-hours of supervised practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master’s or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

The Issue of Medical Necessity. The requirement of medical necessity applies to all aspects of health care within the Medicare system such that a physician must be actively involved with the ongoing care and treatment of the individual. Moreover, any care provided, whether by an audiologist or speech-language pathologist, must be justifiable as being not only beneficial to the patient but also medically necessary, a standard that goes beyond simply being beneficial to the patient. For audiology, the diagnostic evaluation must be for the purpose of determining an “as yet unknown” diagnosis based on presenting symptoms and complaints. If the diagnosis is

already known and the requested procedures are simply for the purpose of repeating the original test, Medicare should not be billed. However, having said that, if the patient already has a known diagnosis but reports a change in symptoms, then a repeat diagnostic evaluation could be justified. In contrast to audiology, speech-language pathology may be authorized to repeat the diagnostic evaluation on a periodic basis for a different “medical necessity” purpose. The rationale for these repeated evaluations is to document the patient’s status as justification for termination or continuation of intervention services. The plan of intervention care must be based on diagnostic findings and must be reviewed and approved by a physician before intervention begins. For both audiology and speech-language pathology, services must not be rendered if it is for based on the desire or convenience of the professional instead of the necessary medical care and welfare of the patient.

Speech-Language Pathology Billing Restrictions. Medicare has decreed that speech-language pathologists may not bill the agency directly. Rather, they must bill as “incident to” in a physician’s office or through a rehabilitation agency. “Incident to” services have been a source of frustration for speech-language pathologists for several years because it causes them to be virtually invisible in the process of evaluation and intervention in the physician’s office. Under this arrangement, the speech-language pathologist performs the diagnostic or intervention procedure, but the reporting of the services for billing and reimbursement is under the name and provider number of the “supervising” physician. This arrangement makes it hard for a speech-language pathologist in an independent private practice to maintain independence when providing services to Medicare patients. These individuals must find (read: enter into contract with) a “sponsoring” physician or rehab agency in order to be reimbursed for services rendered. When services are provided in a hospital setting, the hospital becomes the biller through Part A and the DRG reimbursement system or through the Outpatient Prospective Payment System (OPPS) for patients seen as outpatients.

Speech-language pathologists who provide services in conjunction with a rehab agency must allow the rehab agency to process charges and provide the designated provider number for Medicare billing. This does not mean that Medicare doesn’t want to know who you are and ensure that you also have a provider number. It is necessary to apply to your state Medicare carrier in order to obtain a Medicare provider number. This is the method that Medicare (and the entity that processing your billing) uses to ensure that you may be a qualified provider.

Audiology Billing Restrictions. In contrast to speech-language pathologists, audiologists may bill Medicare directly. In like manner, audiologists must have their own Medicare provider number obtained from the state level Medicare carrier. Again, this is to ensure qualified provider status. There exist several myths that if an audiologist bills Medicare directly, reimbursement will be reduced in a manner similar to nurse practitioners and physician assistants. In truth, however, audiologists are reimbursed at the same rate as physicians for their services and in accordance with the Medicare physician fee schedule.

The most significant restriction on billing actually focuses on patient referral procedures and required documentation. Because of the “medical necessity” requirement, Medicare requires physician referral in order to provide services to eligible patients. Audiologists do not have the authority to initiate diagnostic care and must coordinate such with the patient’s primary physician. For example, if a patient entered an audiologist’s private practice audiologist and desired a hearing test (and wanted Medicare to pay for it), the audiologist could not provide services and bill Medicare. Services provided based on patient desire or audiologist’s convenience are not eligible for reporting and reimbursement. If the patient entered the audiologist’s office and stated that he/she has noticed symptoms of hearing loss or tinnitus, an evaluation could be justified based on the symptoms but could not yet be provided due to absence of physician referral. The primary physician must be brought into the picture early in the process, before audiological services are provided, in order to justify diagnostic hearing services to derive an appropriate diagnosis. The physician must examine the patient and document in the patient’s medical chart that the patient was referred for diagnostic services. Then the audiologist must document in his/her patient chart from whom the patient was referred and for what reason.

The above scenario assumes that the physician and audiologist are in separate facilities and are independent of one another. In the event that they are co-located in the same office, the referral must still come from the physician but the reporting may vary depending on who bills for the audiological services. Medicare has declared that audiological services should not be bill as “incident to” physician care if performed by an audiologist (Program Memorandum B-01-28 and Medicare Carrier’s Manual Transmittal 1793) because, as diagnostic services, they qualify for their own benefit category. As such, they would not be appropriate for “incident to” classification. Meanwhile, back in the “real world”, audiologists’ services are billed as “incident to” with significant frequency.

When this occurs, the audiologist is responsible for the documentation associated with the diagnostics (i.e., audiogram form); the physician is responsible for all other aspects of documentation. More on documentation later.

Supervision of Students. Medicare clarified that students for both audiology and speech-language pathology may participate in the diagnostic evaluation of the patient. However, there are severe restrictions with regard to supervision of students. For Medicare patients, the audiologist or speech-language pathologist must be in the room with the student and engaged only in that patient's care at all times. This issue is particularly important in light of some recent discussions over provisional licensure for fourth year AuD. students. Arguments have been put forth that licensure will permit the student to see Medicare patients without direct supervision, thus providing income for the practice. But the Medicare statute states that both licensure AND a graduate degree are necessary in order to be a Medicare provider. Fourth year AuD. students do not yet possess a graduate degree although they may hold provisional licensure in some states. Consequently, in the eyes of Medicare, fourth year AuD. students are still students and must continue under the direct, line of sight supervision.

Use of Assistants. In contrast to state licensure laws and policies of some third party payers, the use of assistants in speech-language pathology is not automatically accepted. The fiscal intermediary (FI) of Medicare for each state has the determining authority whether assistants can be utilized in the therapeutic care of Medicare patients. As such, the FI must be contacted to determine what its policy and limitations are concerning SLP assistants. As stated in the Federal Register of May 28, 2004, Medicare does not allow the provision of services under the supervision of a qualified audiologist. Consequently, the audiologist may not bill Medicare for services rendered by an audiology assistant.

Documentation. In the event of an audit, audiologists and speech-language pathologists are held to the same documentation standards as physicians. The elements of the documentation must include the reason the patient was present in the professional's office (chief complaints, symptoms, previous diagnosis), a description of what was done, a clinical assessment of the patient's status and outcomes, and recommendations. The details of the documentation may be discipline specific with regard to audiology or speech-language pathology. For example, audiologists must document the patient's referral source, the presenting complaints and symptoms plus any relevant history, the diagnostic procedures that were executed, a description of the test outcomes and clinical assessment, and recommendations. The report must also be signed and dated.

For speech-language pathologists, the diagnostic report contains the same elements as described above. Therapy notes must contain the same elements but may be abbreviated compared to a diagnostic report. For example, a therapy note should contain a brief note with patient's diagnosis and (optional) session number as the justification for why the patient was seen, what was done during the session, the patient's status at the end of the session, and recommendations (i.e., patient will return on (date) for next session). An original signature and date are also required. It is not acceptable for a sign-in sheet to serve as the primary documentation that the patient was present. More complete documentation is required to justify the billing of services rendered.