



# MEDICARE ENROLLMENT

Guidance for Audiologists and  
Speech-Language Pathologists  
Who Work in University Clinics



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION



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Are you an audiologist or speech-language pathologist (SLP) treating patients who qualify for Medicare by virtue of age or disability? If so, you may be required by law to enroll in and bill the Medicare program for services provided to these patients.

## INTRODUCTION

If you are providing outpatient services to patients who qualify for Medicare—by virtue of age or disability—under Part B of the Medicare program and you are working in a clinic, office, or private practice setting, **federal law requires you to enroll in and bill the Medicare program for covered services provided to Medicare beneficiaries.** This means audiologists and SLPs will need to get a national provider identifier (NPI) and complete the Medicare enrollment application(s). Once approved, in most circumstances, the clinician must submit claims to Medicare and can only collect applicable co-payments and deductibles from Medicare beneficiaries. Clinicians who work in facility-based settings, such as skilled nursing facilities, do not need to independently enroll and bill their services to Medicare

because their services are billed through the facility. SLPs may also bill “incident to” a physician when working under the physician’s direct supervision in an office or clinic setting. Audiologists are not allowed to bill their services “incident to” a physician.

ASHA has a Medicare resource center for audiologists and SLPs, which you may find helpful. (See <http://www.asha.org/practice/reimbursement/medicare/>.)



# SET YOUR RATES

## Accepting Cash From Medicare Beneficiaries

Choosing not to enroll in and bill Medicare for services provided to Medicare beneficiaries and, instead, billing the patient directly is often referred to as “opting out.”

Under law, only certain categories of providers (e.g., physicians) are allowed to opt out.

Audiologists and SLPs are not included on the list of clinicians who are allowed to opt out. Therefore, under most circumstances, they are required to enroll in and bill Medicare.

Even if the Medicare beneficiary is willing to pay you cash, you are not allowed to accept payment from them—with the exception of applicable co-payments and deductibles.

You can bill the patient for services that are not covered because they are excluded from coverage by law or they do not require the skills of a clinician. For example, under law, hearing aids are not covered by Medicare. As a result, the patient can be billed for hearing aids directly. Skilled services must also be medically necessary in order to meet Medicare coverage criteria.\*

Billable services are considered *skilled services*, which require the clinical experience and judgment of the clinician. If the services could be performed by the patient or by a family member, these services are considered unskilled and thus not billable to Medicare (and likely many private insurers). It is unlikely that audiologists or SLPs are providing unskilled services to their patients.

## Providing Free Services to Medicare Beneficiaries

You can provide free services only if you have a policy in writing that applies to all of your patients—regardless of payer. If you have such a policy, then you can provide free services to Medicare beneficiaries and would not need to enroll in Medicare. For example, you could

have a policy that stated you will provide free services to any patients that have an income below a certain dollar amount and then apply that to all your patients regardless of payer. You should consult an attorney to ensure that your free services policy complies with applicable state and federal laws.

## Offering Reduced Costs for Services or Charging a Flat Rate (e.g., \$20 per session/hour)

To offer services at a reduced cost or to charge a flat rate, you should establish a fee schedule rate for your services that considers a value for each of the Current Procedural Terminology (CPT) codes you will bill to insurers. Factors people often consider when developing fee schedule rates include (a) the cost of doing business (e.g., rent, utilities, supplies, salaries); (b) the ability to make a profit; and/or (c) charitable mission. These rates should apply to all of your patients regardless of payer. Medicare will pay a clinician the Medicare-allowed rate or the clinician’s rate, whichever is less. If your university clinic has determined that providing reduced-cost services to members of the community is core to its mission, you can establish fee schedule rates lower than the Medicare rate. This means that your reimbursement from Medicare will be lower.

Enrolling in and billing Medicare could be seen as an opportunity to secure a new or additional source of revenue to advance the mission of the university clinic. Perhaps these funds could be used to offset clinic operating expenses, hire more clinical instructors, expand services to additional patient populations, or provide scholarships to students.

For additional information on billing and coding, see the following helpful ASHA resources:

- Medicare Reimbursement of Audiology Services: <http://www.asha.org/practice/reimbursement/medicare/AUDMcareReimbursement/>
- Medicare and Speech-Language Pathologists in Private Practice: <http://www.asha.org/practice/reimbursement/medicare/SLPprivatepracticebilling/>

\* Medicare defines medically necessary as service that is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member.

# COMPLY WITH MEDICARE REQUIREMENTS

## Avoiding Medicare Requirements

If you have not implemented Medicare requirements (e.g., Medicare documentation, student supervision) and you are working with Medicare beneficiaries, then you are not in compliance. Failure to comply with Medicare requirements does not mean that you can “avoid” enrolling in and billing Medicare for your services.

## Supervising Requirements for Students

Under Part B, students require direct personal supervision, which means that the audiologist or SLP must be in the room and guiding the activities.

- Learn more about Medicare coverage of students and Clinical Fellows in speech-language pathology: [http://www.asha.org/practice/reimbursement/medicare/student\\_participation\\_slp/](http://www.asha.org/practice/reimbursement/medicare/student_participation_slp/)
- Learn more about Medicare coverage of students in audiology: [http://www.asha.org/practice/reimbursement/medicare/student\\_participation/](http://www.asha.org/practice/reimbursement/medicare/student_participation/)

## Myths About Medicare Coverage Exclusions

There seems to be some confusion or misinformation regarding Medicare coverage of services that exceed the therapy cap or that may fall under the category of “maintenance therapy.”

For 2016, the therapy cap amount is \$1,960. There is one cap for occupational therapy and a second combined cap for physical therapy and speech-language pathology services. Currently, there is an exceptions process in place through December 31, 2017. This means that a patient can continue to receive medically necessary services by applying the “KX” modifier on the claim form.

One point that is critically important to keep in mind is that the requirements for submitting claims are the same above and below the cap. Therefore, the services must be medically necessary and must require the skills of an SLP. If your services do not meet these requirements, then they should not be submitted to Medicare—regardless of the cap. The Centers for Medicare & Medicaid Services (CMS)

is monitoring providers that have a high discharge rate for patients who are near or who have exceeded the cap to determine if they are inappropriately discharging patients. In addition, there is a secondary review process, known as *manual medical review* (MMR), for therapy services that exceed a \$3,700 threshold. MMR requires the submission of the medical record to determine whether the patient can continue to receive services above the \$3,700 threshold. As with the cap, exceeding the threshold does not mean that the services are not covered or that additional criteria, above medical necessity, are in place.

With regard to “maintenance therapy,” a lawsuit was recently settled and even more recently re-affirmed between the U.S. Department of Health and Human Services, which oversees CMS, and the Center for Medicare Advocacy, an organization that advocates on behalf of Medicare beneficiaries. Under the terms of the settlement, if therapy is being provided to maintain a level of function or to prevent further deterioration, these services may be covered under Medicare. This is critically important to patients with conditions, such as Parkinson’s disease, in which therapy may prevent deterioration for a period of time. SLPs can also be paid to develop a maintenance program in which they train the Medicare beneficiary, or a caregiver, to perform certain activities.

- Learn more about the Medicare Part B Therapy Cap Exceptions Process: <http://www.asha.org/Practice/reimbursement/ExceptionProcess/>

## Getting Everyone Enrolled

In order to bill Medicare, every provider (i.e., audiologist or SLP) in university clinics and private practice settings\* is required to be independently enrolled because Medicare expects the NPI of the rendering provider (the clinician who delivered the services to the beneficiary) to appear on the claim. There is a provision that allows physicians—and a few other select groups of clinicians—to bill for the services delivered by another physician under the original physician’s NPI. This arrangement, known as locum tenens, is used when a physician is sick, goes on vacation, is on maternity

leave, or is involved in other exceptional or atypical circumstances. The list of clinicians who can use locum tenens is limited by law and does not include audiologists or SLPs.

If the clinic director, for example, was the only SLP enrolled in Medicare and all the services of the other SLPs in the clinic were billed under the clinic director’s NPI, it would raise a red flag. Medicare would wonder how one person was delivering so many services in a given day.

*\* Speech-language pathologists may bill “incident to” a physician without enrolling if they work under the direct supervision of that physician. Audiologists are statutorily prohibited from billing “incident to”. For more information, see ASHA’s resources on “incident to”: [http://www.asha.org/practice/reimbursement/medicare/physcn\\_bill\\_slp/](http://www.asha.org/practice/reimbursement/medicare/physcn_bill_slp/)*

### Utilizing the Advanced Beneficiary Notice (ABN)

An ABN is a voluntary form that the provider and beneficiary complete to ensure that the beneficiary is aware of a potential financial obligation to the provider if Medicare does not cover a service. CMS expects that this form would rarely be used. As a result, an ABN could not be used in an instance where an audiologist or SLP does not want to enroll in and bill Medicare in order to collect cash from the beneficiary. If an ABN is used routinely, it would raise an audit red flag.

An appropriate use of an ABN would be when a patient needs a hearing aid, which is not covered by Medicare, but is covered by the patient’s secondary insurance. The secondary insurance may need the denial from Medicare to trigger coverage. If you are submitting a claim to Medicare, you must indicate the use of the ABN on the claim form with a modifier.

- Learn more about using an ABN for Audiologists: <http://www.asha.org/Practice/reimbursement/medicare/audiology-medicare-ABN-FAQs/>

### Limiting Charge Example

AMOUNT	EXAMPLE
PFS Allowed Amount for Procedure “X”	\$200.00
Nonparticipating Provider or Supplier Allowed Amount for Procedure “X”	\$190.00 (\$200.00 x .95 = 5% lower than PFS allowed amount)
Limiting Charge for Procedure “X”	\$218.50 (\$190.00 x 1.15 = 11.5% of PFS allowed amount)
Beneficiary Coinsurance	\$38.00 (\$190.00 x 0.2 = 20% of PFS allowed amount)
Limiting Charge Portion	\$28.50 (\$218.50 - \$190.00 = limiting charge less nonparticipating provider/supplier allowed amount)
Beneficiary Coinsurance Plus Limiting Charge Due to Provider or Supplier	\$66.50 (\$38.00 + \$28.50)

Source: Department of Health and Human Services; Center for Medicare and Medicaid Services. *Medicare Learning Network; Medicare Enrollment and Claims Submission Guidelines*. ICN 906764, August 2015. PFS = Physician Fee Schedule.

### Billing Medicare as a Nonparticipating Provider

Regardless of whether you elect to be a participating or nonparticipating provider under Medicare, you are still required to enroll in Medicare, and a claim must be submitted. ASHA recommends that audiologists and SLPs who enroll in Medicare should elect to be participating providers because it is less administratively complex than enrolling as a nonparticipating provider. Nonparticipating providers can collect cash from the beneficiary, and the beneficiary can then submit the claim for reimbursement. There is also an opportunity to achieve a slightly higher co-payment (known as the limiting charge) from the beneficiary; however, given that many Medicare beneficiaries are on a fixed income, collecting this extra money can be challenging.

### Electing Not to Treat Medicare Beneficiaries

If you determine that your university clinic or private practice is unable to enroll in and bill Medicare or that you cannot meet the student supervision requirements, then you can tell Medicare beneficiaries that you do not accept Medicare. However, that means that you will not be able to treat Medicare beneficiaries.

### Realizing That Your University Clinic/Private Practice Is Not in Compliance With Medicare Requirements

Medicare billing requirements went into effect in 2009. If you believe that your university clinic or private practice is not in compliance, you will need to consult legal counsel to determine how best to proceed.

# FOLLOW THE STEPS FOR ENROLLING IN MEDICARE

There are three steps required to enroll in Medicare. First, each clinician in the university clinic will need to obtain an individual NPI number. The clinic itself will also likely need its own NPI number. Second, each clinician will need to fill out the 855-I (I for “individual”) enrollment application. The clinic will need to complete the 855-B (B for “business”) enrollment application. Third, each clinician will need to reassign their Medicare payments to the clinic using the 855-R (R for “reassignment”) application form.

We highly recommend that the application forms be completed online using the Provider Enrollment Chain and Ownership System (PECOS). After all of your applications have been acknowledged as received,

you can begin seeing Medicare beneficiaries, but remember to hold all claims until you are officially approved. Once you are approved, you can submit claims for services provided during the time period between when your application was received and when you were officially approved.

- Learn more about Medicare enrollment for audiologists: <http://www.asha.org/Practice/reimbursement/medicare/audiology-medicare-enrollment-FAQs/>
- Learn more about Medicare enrollment for SLPs: <http://www.asha.org/practice/reimbursement/medicare/SLPmedicareenroll/>

## ACHIEVE COMPLIANCE

In addition to applying for and enrolling in Medicare, there are numerous other factors to consider when determining how to come into compliance with Medicare regulations. Unfortunately, there is no “single fix” list of instructions to provide because each university program is structured differently. For example, some university clinics are associated with a university hospital; others are not. It will require leaders within the university’s system, including the university’s legal counsel, to determine how to proceed. Here are some key factors to consider.

1. How many Medicare beneficiaries do you treat annually? If you treat only a handful of beneficiaries each year, you may choose not to see these patients. If Medicare beneficiaries make up 50% or more of your patient population, turning away Medicare beneficiaries may not be an option.

2. How will you submit claims? Will you hire an internal billing person, use a billing service, or be nonparticipating and have beneficiaries submit their own claims?
3. How will you meet the student supervision requirements? Determine if your clinic already has or can put into place sufficient clinical education staffing to provide 100% student supervision for the number of Medicare beneficiaries who will be seen at your university clinic.
4. Can you partner with skilled nursing facilities or private practices in your area to provide the clinical training and maintain the Medicare student supervision requirements? Such partnerships could provide students with clinical experiences serving Medicare beneficiaries through facilities that have an infrastructure in place for Medicare billing and student supervision.





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