Medicaid Guidance for Speech-Language Pathology Services:

Addressing the “Under the Direction of” Rule

(Position Statement)

Working Group on Medicaid Reimbursement

This position statement is an official policy of the American Speech-Language-Hearing Association (ASHA) and was prepared by ASHA’s Working Group on Medicaid Reimbursement as part of the 2004 Focused Initiative on Reimbursement. Members of the Working Group include Melanie Frazek, Amy Lyle, Lissa Power-deFur (chair), Ruth Peaper, and Kathleen Whitmire (staff coordinator). Celia Hooper, vice president for professional practices in speech-language pathology (2003-2005), served as monitoring vice president. The Legislative Council approved the document as official policy of the Association in November 2004.

Position Statement

Medicaid guidance for reimbursement of speech-language services¹ provided in school settings is specific regarding the qualifications of the speech-language pathologist

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¹ Whenever the term “services” is used in this document, it refers to any speech-language pathology service (evaluation or intervention) covered by Medicaid, according to each state’s state plan requirements.
providing those services, but offers no specific direction regarding reimbursement for
services provided by clinicians not meeting those standards. Professionals who do not
meet the qualification standards may, according to state requirements, provide services
“under the direction of” a qualified speech-language pathologist. The various state
standards result in great differences nationwide in the qualifications of personnel who are
providing services for Medicaid billing in the schools and create the potential for several
untenable legal, ethical, and workload situations for speech-language pathologists.

It is the position of the American Speech-Language-Hearing Association that in
order to assure provision of quality services to students with speech-language
impairments, certain minimum qualification standards shall be met for both the qualified
speech-language pathologist (the supervisor) and the non-qualified clinician (supervisee)
providing speech-language services “under the direction of” the qualified speech-
language pathologist. The recommended minimum qualifications for supervisors are an
ASHA Certificate of Clinical Competence (CCC) and a contract with the employer of the
supervised speech-language pathologist(s). In addition, it is preferable for the supervisor
to have an active interest and training in supervision, two or more years of experience
after receiving the CCC, and a willingness to serve in this role.

ASHA recommends that, at a minimum, supervisees either hold a full state
education credential in speech-language disorders or be a student intern who is
participating in an ASHA accredited program and receiving supervision in accordance
with the supervision requirements of the Council of Academic Accreditation. This
standard excludes persons with emergency credentials from state department of education
(regardless of whether they have a degree in speech-language pathology) and paraprofessionals.

The nature, frequency, and length of supervision must be adequate to assure that quality speech-language services are provided. The following recommendations are considered to be minimum levels of observation, contact, and review needed to accomplish this goal:

- At the beginning of each school year, the IEP for each Medicaid-eligible student will be reviewed to determine that the speech-language service plan is appropriate;
- At least once a month, each Medicaid-eligible student receiving speech-language services will be directly observed;
- At least once a month, the supervisor will confer with the supervisee about each Medicaid-eligible student;
- At least once a month, relevant paperwork for each Medicaid-eligible student will be reviewed to determine that the services provided are consistent with those prescribed in the IEP.

In order to assure that the supervising speech-language pathologist provides appropriate direction to the supervisee, sufficient time shall be allocated within both the supervisor and the supervisee’s workload to address the requirements for both direct and indirect supervision. The time allocation necessary will vary based on the individual circumstances. In addition, it is critical that the supervisory contacts be documented.

A speech-language pathologist must keep in mind that participation in the Medicaid reimbursement program places him/her in a fiduciary position; i.e., the speech-
language pathologist is entrusted by the government to provide quality services and/or supervision of services and to bill appropriately for those services in accordance with Medicaid regulations. Further, the speech-language pathologist must comply with that state’s Medicaid plan as well as with the plethora of state licensure laws, state education agency credentials, and professional policy documents, including the ASHA Code of Ethics. The practitioner should be fully informed of the various federal, state, and local regulations affecting his/her professional practice as well as the ethical proscriptions involved. When there may be a potential conflict in requirements and ethical standards, the speech-language pathologist should adhere to the highest standard.


Index terms: speech-language pathology, supervision, reimbursement, Medicaid, ethics
Medicaid Guidance for Speech-Language Pathology Services:

Addressing the “Under the Direction of” Rule

(Technical Report)

Working Group on Medicaid Reimbursement

This technical report was developed by the Working Group on Medicaid Reimbursement of the American Speech-Language-Hearing Association under the 2004 Focused Initiative on Reimbursement. It was approved by ASHA’s Executive Board in 2004.

Members of the Working Group include Melanie Frazek, Amy Lyle, Lissa Power-deFur (chair), Ruth Peaper, and Kathleen Whitmire (staff coordinator). Celia Hooper, vice president for professional practices in speech-language pathology (2003-2005), served as monitoring vice president.


Index terms: speech-language pathology, supervision, reimbursement, Medicaid, ethics

Document type: Technical report
Background

Medicaid guidance for reimbursement of speech-language services provided in school settings is specific regarding the qualifications of the speech-language pathologist providing those services, but offers no specific direction regarding reimbursement for services provided by clinicians not meeting those standards. According to the Centers for Medicare and Medicaid (CMS), the federal agency that administers Medicaid, professionals who do not meet the qualification standards may, according to state requirements, provide services “under the direction of” a qualified speech-language pathologist. CMS has enabled individual states to establish standards for those persons who do not hold the speech-language pathology qualification standards specified by CMS and guidance for what entails “under the direction of.” As a result, there are great differences nationwide in the qualifications of personnel who are providing services for Medicaid billing in the schools and the expectations of the supervising speech-language pathologists.

This situation raises the potential for several untenable legal, ethical, and workload situations for speech-language pathologists. Information gathered from the Department of Health and Human Services Office of Inspector General (OIG) audits of 18 states’ Medicaid school-based programs (2003) revealed a variety of procedural errors

Whenever the term “services” is used in this document, it refers to any speech-language pathology service (evaluation or intervention) covered by Medicaid, according to each state’s state plan requirements.
in the areas of provider qualifications and appropriate documentation, including insufficient documentation to show that an unqualified provider was under the direction of a qualified provider. Furthermore, as Medicaid billing for school-based special education services has increased, ASHA members have voiced more frequent concerns regarding supervision of and “signing off” for Medicaid reimbursement for other speech-language clinicians in their school districts. Respondents to the ASHA 2003 Omnibus survey and to questionnaires distributed to Special Interest Division 16 members and to ASHA 2003 Schools Conference participants expressed a need for ASHA guidance on this issue.

In order to minimize any adverse effect on students receiving services in the school and any legal, ethical, and workload impact on the supervising speech-language pathologist, this document specifies the recommended minimum qualification and supervisory requirements for both the supervising and the supervised speech-language clinicians.

**History of Medicaid Billing for School-Based Speech-Language Pathology Services**

Medicaid is a federal program, with certain requirements that apply nationwide. However, it is also a federal-state partnership. Each state prepares a plan outlining its program, including provider qualifications and services. Before implementation, each state plan must be approved by CMS. CMS is organized by regions, with approval occurring at the regional office. As a result, despite CMS’s oversight authority, the
policies and procedures regarding Medicaid implementation vary from state to state. In some cases, a policy approved in one state would not be approved in another.

In 1988, the Medicare Catastrophic Coverage Act prohibited restricting Medicaid funds to reimburse services provided to a child with a disability because services were outlined in the IEP. The Conference Committee Report specified that, while the state education agencies are financially responsible for educational services, in the case of a Medicaid-eligible child with handicaps, state Medicaid agencies remain responsible for the “related services” identified in the child’s IEP if those services are covered under the state’s Medicaid plan.

The 1997 Reauthorization of the Individuals with Disabilities Education Act (IDEA, 1997) recognized the ability of school districts to bill Medicaid for certain special education services and included parental protections regarding access to special education services. IDEA assures that any IEP-specified service will be provided to the child by qualified special education providers, as defined by that state’s education agency. IDEA does not address specific qualification standards nor does it require state education agencies to establish the same standard as the state’s Medicaid agency.

Provider Qualifications

The state-to-state variability in Medicaid programs is evident in the definition of personnel who are qualified to provide speech-language pathology services and the services that are to be provided by personnel who don’t meet the qualification standards. Each state establishes its own requirements for personnel qualifications, using the federal standard as the basis for state laws and regulations. States may also define the provision of services by non-qualified personnel when they are “under the direction of” qualified
personnel. Further, states are authorized to establish the qualification standards of persons who determine the medical necessity of the service.

**Professional standards**

Medicaid guidance establishes the federal standard for qualified speech-language pathologists as “… an individual who--

(i) Has a certificate of clinical competence from the American Speech-Language Hearing Association;

(ii) Has completed the equivalent educational requirement and work experience necessary for the certificate; or

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.” (U.S. Department of Health & Human Services [DHHS], 2004; 42 CFR 440.110 (c) (i))

As states establish their own standards for “equivalent,” they generally use criteria developed by the state Board of Audiology and Speech-Language Pathology for licensure or by the state Board of Education for teacher certification or licensure.

**“Under the direction of” Rule**

Federal Medicaid guidance addresses provisions of services by non-qualified speech-language pathologists (or audiologists):

“Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech[-language] pathologist or audiologist for which a patient is referred by a physician or other licensed practitioner of the healing arts within the
CMS has offered minimal guidance to states regarding implementation of the “under the direction of” provision. On May 28, 2004, CMS published the Final Rule on Medicaid Audiology Qualifications (U.S. DHHS, 2004). This rule offers language to clarify when services are furnished by or “under the direction of” a federally qualified audiologist (see Appendix A for the complete language).

CMS has not offered comparable guidance for services provided “under the direction of” a qualified speech-language pathologist. In 2001, a regional notice was offered by the Health Care Finance Administration or HCFA (the former name of CMS). This notice applied to the states in HCFA Region IV (Alabama, Georgia, Kentucky, Mississippi, South Carolina and Tennessee). See Appendix B for the complete language in this notice.

Without clear and complete guidance from CMS, states and localities outside of Region IV can establish their own standards for “…under the direction of …,” resulting in the lack of any supervision requirements or vague, nonspecific requirements. The result is a high degree of variability in the standards.

**Medical Necessity**

Medicaid guidance indicates that services provided to children must be medically necessary. This standard is verified “by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.” (U.S. DHHS, 2004; 44 CFR Section 440.120 (c ) (i)). Through the state plan process, each state establishes whether this referral must be made by physicians or whether it may be made by speech-
language pathologists licensed under state law. The state’s standard will be dependent, in part, upon whether that state’s laws enable a speech-language pathologist to practice without a physician’s signature.

**Medical and Educational Requirements in Personnel Qualifications**

One of the challenges of applying the Medicaid qualification and supervision requirements to the public education environment is the difference between qualifications and standards for medical providers versus educational providers. Medicaid is a medical model that applies nationwide. In contrast, education standards are the purview of each state. These standards vary from state to state and historically have not been based on ASHA certification. In the past, when the bachelor’s level was the highest degree in the field, that degree was the educational standard. Gradually, master’s degrees became more prevalent and served as the standard for ASHA certification and state licensure, but educational standards did not keep pace. States began to change their requirements following reauthorization of IDEA in 1986, when that Act required states to assure that personnel providing special education services meet the highest qualification standards set in the state. Since many states had the masters’ degree (with or without ASHA certification) as the highest standard in the profession, the IDEA requirements moved state education agencies to amend their teacher credentialing standards to be comparable.

Currently, in 36 states, individuals entering a public school system must have at least a master’s degree to work as a speech-language pathologist. However, even in those states, there are individuals who were “grandfathered,” continuing to be employed as a result of entering the school system when only a bachelor’s degree was required. Further, there are states that provide emergency credentials for persons to provide services to
students with speech-language impairments. The emergency credentials generally include
requirements for meeting the qualification standards. However, depending upon the
state’s requirements, persons without background in the field may receive emergency
credentials.

As states’ Medicaid offices worked to establish state equivalency standards to
meet the federal speech-language pathology qualification standards, they had to address
the varying standards between state licensure and state education credentials. As a result,
there are vast differences nationwide in the credentials of persons recognized as qualified
to provide reimbursable services and those who can provide services only “under the
direction of” qualified personnel.

Table 1 reflects the variations in qualifications for supervisor and supervisee that
may be recognized by various state Medicaid policies. As state terminology for speech-
language clinicians and paraprofessionals will vary greatly, it is important to look at
specific states’ qualification standards, rather than the position title, to determine the
qualifications of the specific person.

**Challenges**

The varying qualification requirements for supervisor and supervisee can create
challenges in the relationships among staff and in the system. Although the relationship
between the supervisor and the supervisee will vary by situation, ASHA members have
reported the following challenging scenarios:

- A recent graduate with master’s degree is asked to supervise a 25-year veteran with a
  bachelor’s degree who holds state education credentials.
Table 1. Qualifications of Supervisor and Supervisee Who May Be Recognized by Various State Medicaid State Plans

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<tbody>
<tr>
<td>ASHA CCC SLP</td>
<td>Masters</td>
<td>YES</td>
<td>completed</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Masters SLP – state licensed</td>
<td>Masters</td>
<td>NO</td>
<td>N/A</td>
<td>YES</td>
<td>N/A</td>
</tr>
<tr>
<td>Masters SLP – state ed credential</td>
<td>Masters</td>
<td>NO</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
</tr>
<tr>
<td>Masters SLP – CF</td>
<td>Masters</td>
<td>NO</td>
<td>In process</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Masters SLP</td>
<td>Masters</td>
<td>NO</td>
<td>In process</td>
<td>N/A</td>
<td>YES</td>
</tr>
<tr>
<td>Masters speech-language pathologist</td>
<td>Masters</td>
<td>NO</td>
<td>N/A</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Masters speech-language pathologist</td>
<td>Masters</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Bachelors SL Clinician–grandfathered in education</td>
<td>Bachelors</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Bachelors SL Clinician–state education standard</td>
<td>Bachelors</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Bachelors SL Clinician–emergency credential</td>
<td>Bachelors</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>Emergency</td>
</tr>
<tr>
<td>Bachelors – education professional–emergency credential</td>
<td>None</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>Emergency</td>
</tr>
<tr>
<td>Masters’ student intern</td>
<td>Bachelors</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Bachelors’ student intern</td>
<td>None</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>ASHA SLPA</td>
<td>None or Associate</td>
<td>NO</td>
<td>N/A</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>None</td>
<td>NO</td>
<td>N/A</td>
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Colleagues with different credentials have worked as equals for 5 years. When the school district decides to claim Medicaid reimbursement, the relationship changes as one staff member is now required to supervise a colleague or peer.

A speech-language pathologist is required to review and sign paperwork of a less credentialed colleague without observing the actual delivery of service.

A speech-language pathologist supervises several persons who are not qualified under Medicaid, in addition to carrying a full-time assignment and caseload.

The supervising speech-language pathologist sees issues of concern. Yet with no evaluation authority (the principal conducts the personnel evaluation), he or she has limited ability to elicit a change in the supervisee’s behavior.

**Recommended Personnel Qualification Standards**

In order to assure quality services to students with speech-language impairments, ASHA recommends that certain minimum qualification standards be met for both the supervisor and the supervisee. The recommended minimum qualifications for supervisors are an ASHA Certificate of Clinical Competence (CCC) and a contract with the employer of the supervised speech-language pathologist(s). In addition, the following standards are preferred for the supervisor:

- active interest in supervision
- training in supervision
- two or more years of experience after receiving CCC
- willingness to serve in this role.
ASHA recommends that, at a minimum, supervisees either hold a full state education credential in speech-language disorders or be a student intern who is participating in an ASHA accredited program and receiving supervision in accordance with the supervision requirements of the program. This standard excludes persons with emergency credentials from a state department of education (regardless of whether they have a degree in speech-language pathology) and paraprofessionals.

These standards are reflected in Table 2. The sections of the table that are shaded reflect those persons with qualifications who are recommended for either the supervisor or supervisee.

**Supervision**

The speech-language pathologist who supervises personnel providing services to Medicaid eligible students is ethically and legally bound to assure that these students receive appropriate and high quality speech-language services. This standard of care can only be assured when the supervisor directly observes the services provided, regularly reviews relevant paperwork, and confers with the supervisee. Supervisors must have explicit knowledge of the nature of services provided, should be able to suggest needed program modifications to the IEP team, and should facilitate development of supervisee clinical skills when needed.
Table 2. Recommended Qualifications of Supervisor and Supervisee

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<td>Masters SLP – state licensed</td>
<td>NO</td>
<td>Masters</td>
<td>NO</td>
<td>N/A</td>
<td>YES</td>
<td>N/A</td>
</tr>
<tr>
<td>Masters SLP – state ed credential</td>
<td>NO</td>
<td>Masters</td>
<td>NO</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
</tr>
<tr>
<td>Masters SLP – CF</td>
<td>NO</td>
<td>Masters</td>
<td>NO</td>
<td>In process</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| SUPERVISEE | Masters SLP | YES | Masters | NO | In process | N/A | YES |
| Masters speech-language pathologist | YES | Masters | NO | N/A | YES | YES |
| Masters speech-language pathologist | YES | Masters | NO | N/A | NO | YES |
| Bachelors SL Clinician – grandfathered in education | YES | Bachelors | NO | N/A | NO | YES |
| Bachelors SL Clinician – state education standard | YES | Bachelors | NO | N/A | NO | YES |
| Bachelors SL Clinician - Emergency Credential | NO | Bachelors | NO | N/A | NO | Emergency |
| Bachelors education professional - Emergency Credential | NO | None | NO | N/A | NO | Emergency |
| Masters’ student intern | YES, if in ASHA program and supervised according to CAA standards | Bachelors | NO | N/A | NO | NO |
| Bachelors’ student intern | None | NO | N/A | NO | NO |
| ASHA SLPA | YES, if supervised according to ASHA guidelines | None/Associate | NO | N/A | NO | NO |
| Paraprofessionals | NO | None | NO | N/A | NO | NO |
The following supervision recommendations apply only for speech-language services received by Medicaid-eligible students “under the direction of” the qualified provider. Supervision guidelines for clinical fellows, student interns, and speech-language pathology assistants have been clearly defined in other documents (see Appendix C for Summary Table of Minimum Supervision Requirements) and may be above and beyond the guidelines described in this document. For those supervisees, those guidelines must also be followed, although a supervisor may meet components of those requirements while observing services for Medicaid-eligible students.

**Supervisor Definition**

As described previously, qualified providers supervising speech-language services to Medicaid-eligible students--

- should be speech-language pathologists holding a Certificate of Clinical Competence in Speech-Language Pathology from ASHA
- should have at least 2 years of experience following ASHA certification
- should have an active interest in supervision
- should have training in the supervisory process
- must be willing to serve in this role.

Supervision is a complex and multilayered task requiring knowledge and/or skills in clinical work, interpersonal relationships, regulatory issues, clinical writing and documentation, and clinical teaching. For supervising Medicaid-eligible students in the schools, knowledge of educational curriculum, district or state student assessment procedures, and classroom management are also needed. The above recommendations for supervisors were developed to assure that supervising clinicians possess the needed
experience, information, motivation, and interest to assume this role. In addition, these
tasks require considerable expenditure of time, effort, and skill on the part of the
supervisor. As a result, supervision responsibilities should be factored into workload
formulas to support the supervisor adequately to meet these demands.

Supervision Tasks

The multifaceted roles of supervisors are discussed in *Clinical Supervision in Speech-Language Pathology and Audiology* (ASHA, 1985), which identifies 13 tasks integral to the supervisory process. These tasks are restated in this document to assure
that supervisors, supervisees, and administrators recognize the breadth of responsibilities assumed when serving in this role.

1.0 Task: Establishing and maintaining an effective working relationship with the
supervisee.

2.0 Task: Assisting the supervisee in developing clinical goals and objectives.

3.0 Task: Assisting the supervisee in developing and refining assessment skills.

4.0 Task: Assisting the supervisee in developing and refining management skills.

5.0 Task: Demonstrating for and participating with the supervisee in the clinical
process.

6.0 Task: Assisting the supervisee in observing and analyzing assessment and
treatment sessions.

7.0 Task: Assisting the supervisee in development and maintenance of clinical and
supervisory records.

8.0 Task: Interacting with the supervisee in planning, executing and analyzing
supervisory conferences.
9.0 Task: Assisting the supervisee in evaluation of clinical performance.

10.0 Task: Assisting the supervisee in developing skills of verbal reporting, writing and editing.

11.0 Task: Sharing information regarding ethical, legal, regulatory and reimbursement aspects of the profession.

12.0 Task: Modeling and facilitating professional conduct.

13.0 Task: Demonstrating research skills in the clinical or supervisory process.

These tasks clearly identify that supervision includes clinical teaching. The skills of the clinician providing speech-language service will affect the quality of that service. Supervisee development is often discussed on a continuum model (Anderson, 1988; McCrea & Brasseur, 2003) with beginning supervisees needing explicit evaluation/feedback. Supervisors provide less direct instruction as the supervisee becomes more independent. Supervisors must adjust their supervisory interactions to meet the needs of each individual supervisee. Supervisors may facilitate growth of a supervisee’s skills by demonstration and modeling, questioning, providing feedback, joint problem solving, or acting more as a consultant with skilled supervisees. Quality services for students will only be assured when supervisees are competent clinicians and paraprofessionals. Potential supervisors, supervisees and their administrators must accept that the skills of the supervisee will be analyzed and that goals for improvement will be established when needed. Supervisors should involve the supervisee in setting goals and assure that the established goals are specific and appropriate (Dowling, 2001).
Supervisory Relationship

As identified in this document, the range of professionals who fall under the “non-qualified provider” determination is broad and will vary from state-to-state (see Table 1). This presents a special challenge to the supervisor, who potentially is charged with supervising more experienced paraprofessionals, graduate student interns, or. While the supervisor does assume ultimate responsibility for the services provided, both supervisor and supervisee should collaborate to provide quality speech-language services to students in the schools.

Supervision Recommendations

The nature, frequency, and length of supervision must be adequate to assure that quality speech-language services are provided. The following recommendations are considered to be minimum levels of observation, contact, and review needed to accomplish this goal. These recommendations build upon the language from the CMS Final Rule of Medicaid Audiology Qualification. The levels of direct and indirect supervision should be increased when client complexity, supervisee preparation, experience, and/or performance indicate the need for more guidance. Supervisory interactions should be maintained at an adequate level to allow the supervisor to determine whether the quality of services offered is appropriate. Graduate student supervisees or speech-language pathology assistants may require more demonstration or specific direction from the supervisor, while more experienced clinicians may benefit from a mentorship model.
Direct Supervision

At least once a month, the certified speech-language pathologist will directly observe each Medicaid-eligible student receiving speech-language services. The observation may be on-site or through real-time distance video technology. The length of the observation is not prescribed but should be of adequate time to assure that the students are “receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.” [add med guidance]

Indirect Supervision

At the beginning of each school year, the supervisor will review the IEP for each Medicaid-eligible student and determine that the speech-language service plan is appropriate. At least once a month, the supervisor will confer with the supervisee about each Medicaid-eligible student. The conference may be live, by phone, or by e-mail, and should include --

- discussion of direct observations
- review of records
- review of goals and progress made.

At least once a month, the supervisor will review relevant paperwork for each Medicaid-eligible student to determine that the services provided are consistent with those prescribed in the IEP. Paperwork review should include --

- session notes
- attendance records
- progress reports (when applicable)
• updated assessment results (when applicable).

**Documentation**

Records of supervisory contacts should be maintained and include--

• date of supervisor’s review and approval of speech-language component of the IEP

• date of monthly observation for each Medicaid-eligible student

• log of indirect supervision contacts (e.g. paperwork reviewed)

• date, agenda, and action plan for monthly conference with supervisee.

**Time Allocation for Supervision**

Appropriate time needs to be allocated within both the supervisor’s and the supervisee’s workloads to address the requirements for both direct and indirect supervision. The time allocation will vary based on the individual circumstances. The number of individuals one supervisor can supervise will also vary, dependent upon the individual needs involved. The supervisee’s and supervisor’s credentials, skills, experience, workload, and travel distance should be considered when allocating time.

The time necessary for direct supervision can be calculated based on the number of Medicaid-eligible students and how they are individually scheduled. It is important to determine if the state Medicaid office has a timeframe and, if so, to adhere to it. In addition, it is wise to observe supervisees in each environment or service delivery model (e.g., individual versus group therapy, direct therapy versus classroom intervention). In order to provide appropriate direct supervision, the supervisor must have flexibility within his or her schedule to vary the time for the observations to occur on a monthly basis.
In addition to time for direct supervision, time must also be allocated for indirect supervisory tasks. The supervisor’s review of record documentation will not require time from the supervisee. However, time should be allocated in both schedules for conferences and demonstrations or modeling.

In summary, the function of supervision should be considered part of the workload for both the supervisor and the supervisee. Supervision of persons for Medicaid billing cannot be added to an existing workload without some adjustment of duties or caseload. The amount of supervision necessary should be individually assessed, allocated, and reviewed periodically, making adjustments as needed.

**Legal and Ethical Issues**

Although Medicaid presents an opportunity for school districts to generate revenue for speech-language pathology services provided to Medicaid-eligible school children, participation in the Medicaid reimbursement process imposes additional responsibilities and liability on the recipient school system. As a direct result thereof, the individual Medicaid-qualified service provider incurs additional responsibility and liability related to the provision of professional services in the schools which seek Medicaid reimbursement. Moreover, the legal and ethical liability increases for the speech-language pathologist who agrees to supervise another individual’s work with students for the purposes of Medicaid reimbursement.

It is incumbent on a school district to follow the Medicaid rules when seeking reimbursement. Failure to do so can result in the district’s liability with respect to the state Medicaid agency. This may include reimbursing Medicaid and/or paying penalties
for fraudulent billing. A district bears the risk of having to return Medicaid funds generated erroneously regardless of whether the inappropriate implementation was intentional or inadvertent.

Likewise, the supervising speech-language pathologist risks individual liability within the Medicaid reimbursement program. It is ill-advised to presume that the speech-language pathologist is protected from all liability by virtue of employee status in a school district. The doctrine of *respondeat superior* (i.e., “My employer is responsible for, and bears all liability for, my wrongful actions committed within the scope of my employment”; Garner, 1999) may be applicable in some situations involving an employee’s conduct but should not be assumed to be or interpreted as blanket insulation from all liability in all situations.

As one example, billing for time not spent with a client or for nonreimbursable activities is fraud. It would be naïve to believe that an employer would support an employee’s, alleged fraud, much less accept responsibility for it. Consider the possibility for erroneous billing to occur within the supervisory relationship. It is imperative that a supervising speech-language pathologist provide adequate supervision to ensure that appropriate billing practices are being followed. Remember that the qualified Medicaid provider is the professional who bears all legal responsibility for the supervisee under his or her direction.

A mindful supervisor may encounter a situation where a student has received appropriate speech-language services according to special education rules and regulations. However, the documentation for Medicaid reimbursement for these services is either incomplete or nonexistent. Therefore, the supervising speech-language pathologist must exercise the option, or, depending upon the school system, take
affirmative steps to disapprove those services for Medicaid reimbursement purposes.

Similarly, if no reasonable benefit is expected to occur as a result of continuing therapeutic services, the supervising speech-language pathologist is obligated to refer the student for a re-evaluation or to request the appropriate mandated meeting to make a change in the service.

Further, additional legal and ethical issues are raised for supervising speech-language pathologists who “sign off” on a student’s potentially reimbursable services without having contact with the student and observing some of the intervention. Depending on each individual state plan, this practice may be challenged as a demonstration of negligence in providing professional services. Here again, the speech-language pathologist would be ill-advised to feel protected by an employer for such conduct that reasonable people would view as unprofessional and that may very well carry common legal ramifications.

Take the former example one step further. Consider the situation in which the supervising speech-language pathologist does, in fact, observe the provision of services by a supervisee but deems those services to be inappropriate. Clearly the supervisor is obligated to disapprove the services for Medicaid reimbursement and should not “sign off” on them. That may eliminate a potential legal issue. However, this situation begs the following question: What are the ethical issues which confront the supervising speech-language pathologist? Should the supervisor provide additional mentoring and modeling to the supervisee to ensure appropriate and competent services? Does the supervisor’s responsibility change if the supervisee is a Clinical Fellow as opposed to an assistant? Does the responsibility change if the supervisee is a peer of many years but one who lacks the necessary credentials to work independently as a qualified Medicaid provider?
Notwithstanding the numerous permutations of supervisors and supervisees as well as the inherent relationships that may exist, the supervisor’s responsibility and liability remain constant. Services assigned to the supervisee must be appropriate and competently provided by the supervisee.

At a minimum, the previous examples caution against ethical negligence of supervisory obligations. Principle I of the ASHA Code of Ethics (ASHA, 2003) requires that “[i]ndividuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally…” Specifically, Rule E. requires that “[i]ndividuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, students, or any nonprofessionals over whom they have supervisory responsibility. An individual may delegate support services to assistants, technicians, support personnel, students, or any other persons only if those services are adequately supervised by an individual who holds the appropriate Certificate of Clinical Competence.” Rule G. requires that “[i]ndividuals shall evaluate the effectiveness of services rendered …and shall provide services…only when benefit can be reasonably expected.” Rule I. states that “[i]ndividuals shall not provide clinical services solely by correspondence.” Clearly it would be difficult to satisfy these ethical rules if the supervising speech-language pathologist has never seen the student nor taken an active role in the student’s treatment.

Continuing on, Principle of Ethics II states that “[i]ndividuals shall honor their responsibility to achieve and maintain the highest level of professional competence.” Embodied in this Principle is Rule D., which states that “[i]ndividuals shall delegate the provision of clinical services only to…(2) persons in the education or certification
process who are appropriately supervised by an individual who holds the appropriate Certificate of Clinical Competence; or (3) assistants, technicians, or support personnel who are adequately supervised by an individual who holds the appropriate Certificate of Clinical Competence.”

Rule E. requires that “[i]ndividuals shall not require or permit their professional staff to provide services…that exceed the staff member’s competence, level of education, training, and experience.” (Emphasis added.) It is clear that a supervisor – even for reimbursement purposes – cannot satisfactorily maintain these ethical principles if he or she has never seen the student nor provided adequate supervision.

Principle of Ethics III, Rule D. has implications for both the supervisory process and for Medicaid reimbursement issues as well. Rule D. states that “[i]ndividuals shall not misrepresent diagnostic information, research, services rendered, or products dispensed; neither shall they engage in any scheme to defraud in connection with obtaining payment or reimbursement for such services or products.”

Similarly, Principle of Ethics IV requires that “[i]ndividuals shall honor their responsibilities to the professions…Individuals shall uphold the dignity of the professions…and accept the professions’ self-imposed standards.” Demonstrating this Principle are 1) Rule B, which states that “[i]ndividuals shall not engage in dishonesty, fraud, deceit, misrepresentation, sexual harassment, or any other form of conduct that adversely reflects on the professions or on the individual’s fitness to serve professionally”; and 2) Rule G., which mandates that “[i]ndividuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.” (Emphasis added.)
Conclusion

The speech-language pathologist, whether or not engaged in a supervisory relationship, must keep in mind that participation in the Medicaid reimbursement program places him or her in a fiduciary position; i.e., the speech-language pathologist is entrusted by the government to provide quality services and/or supervision of services and to bill appropriately for those services in accordance with Medicaid regulations. The difficulty in determining acceptable supervisory practices for purposes of Medicaid reimbursement is compounded by the lack of guidance from CMS and by the variability across states’ Medicaid plans as well as the plethora of state licensure laws, state education agency credentials, and professional policy documents. Therefore, it behooves the practitioner to be fully informed of the various federal, state, and local regulations affecting his or her professional practice as well as the ethical proscriptions involved. When there may be a potential conflict in varying regulations, the best rule of thumb is to err on the side of caution and follow the higher standard.

References


A. Medicaid Requirements

1. Background

Medicaid is the Federally assisted State program authorized under title XIX of the Social Security Act (the Act). Medicaid is responsible for payment of a substantial number of school-based speech, hearing, and language services provided by, or under the direction of, qualified providers defined at § 440.110(c). Under Medicaid, States are permitted the flexibility to provide audiology services under a variety of benefits. The majority of States offering audiology services do so under their home health programs. Medicaid-eligible children with disabilities under the Individuals with Disability Education Act (IDEA) (Pub. L. 105–17, enacted on June 4, 1997), Medicaid is responsible for payment of a substantial number of school-based speech, hearing, and language services provided by, or under the direction of, qualified providers defined at § 440.110(c). Under Medicaid, States are permitted the flexibility to provide audiology services under a variety of benefits. The majority of States offering audiology services do so under their home health benefit defined at § 440.70, or under optional benefits such as the therapies benefit defined at § 440.110, the rehabilitation benefit defined at § 440.130(d), or the clinic benefit defined at § 440.90. However, regardless of the benefit used to provide audiology services, the specific provider requirements at § 440.110(c) must be adhered to. Current Medicaid rules governing audiology services also permit States the flexibility to provide audiology services by, or under the direction of, a qualified audiologist.

2. Requirements for speech pathologists and audiologists to meet the academic and clinical experience requirements for a Certificate of Clinical Competence (CCC–A) granted by ASHA. In accordance with section 146 of the Social Security Amendments of 1994, Medicare revised its statutory requirements for speech pathologists and audiologists, removing the requirement for ASHA certification and placing primary reliance for determining provider qualifications on State licensure.

3. In summary, section 1861(l)(3)(B) of the Act currently governing Medicare audiology services, defines an audiologist as an individual with a master’s or doctoral degree who is licensed by the State or who meets specific academic and clinical requirements if providing services in a State that does not license audiologists. Unlike the Medicaid program, Medicare does not permit audiology services to be provided under the direction of a qualified audiologist.

4. Creating Consistency With the Medicare Program

As noted in our April 2, 2003, proposed rule (68 FR 15974), the revision of the Medicare requirements in 1994 prompted letters from audiology professionals and interested congressional members urging us to create consistency in the Medicaid and Medicare programs’ definition of a qualified audiologist by adopting the Medicare definition of qualified audiologist to recognize the role of State
licensure in defining a Medicaid qualified audiologist. Proponents recommending the change stated that

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the Medicaid definition had not changed in over 20 years and predated the national trend toward greater reliance on State determinations of professional qualifications through licensure. Our April 2, 2003, proposed rule noted that our initial responses to letters urging consistency expressed reluctance to change the Medicaid requirements due to the potential of adversely affecting quality and access to care as well as State flexibility. In addition, we noted our concern about adversely impacting services provided to children receiving school-based audiologist services under IDEA since school providers are often exempt from State licensure laws.

As we discussed, continued requests to reconcile the differing definitions prompted us to consider options for changing the Medicaid regulations in a manner that would not compromise State flexibility and quality of care. As we stated in our April 2, 2003, proposed rule, the revised requirements are a result of meetings and interviews with parties most likely to be affected by such a change.

As in the April 2, 2003, proposed rule, we again noted that this rule addresses the qualifications of audiologists as defined under § 440.110(c). The requirements under § 440.110(c)(2) addressing qualified speech-language pathologists (SLPs) remain as defined in existing regulations.

II. Provisions of the Proposed Regulations

On April 2, 2003, we published a proposed rule in the Federal Register that specified our intent to reconcile the existing Medicaid regulations governing audiologists to adopt the Medicare standards to recognize State licensure as a qualifying provider standard. Unlike Medicare’s standards, however, we proposed to apply the “default” standards to States that license, as well as to those States that do not license audiologists or that have specific licensure exemptions. Thus, all audiologists are required to have met specific academic and clinical standards, regardless of whether they practice in a State that has a licensure program, no licensure program, or that exempts certain audiologists from licensure. As we indicated in the April 2, 2003, proposed rule, the revised requirements also serve to recognize the autonomy of the professions of audiologist and speech-language pathologist by adding a new paragraph (3) § 440.110 to separately define a qualified audiologist. We also stated that the revised audiology requirements increased State flexibility in determining who is qualified to provide Medicaid audiologist services. We noted that our research of national audiology usage and review of currently approved Medicare State Plans also led us to conclude that most, if not all, qualified audiologists currently enrolled in the Medicaid program will continue to be qualified as a result of the continued flexibility in this rule. We commented on our expectation that States will continue to provide audiology services using the flexibility already granted under the Medicaid program to provide audiology services using individuals meeting State provider qualifications and working within State practice acts “under the direction of” a qualified Medicaid audiologist.

Additionally, we noted that conforming the Medicare and Medicaid provider requirements serve to eliminate the confusion providers may experience in complying with Federal rules and help to reduce or eliminate conflict where audiologists provide services to both the Medicaid and Medicare populations. We also pointed out that the revised standards eliminate inconsistencies in Medicaid provider standards and eliminate the need for equivalency rulings, which were administratively burdensome and timeconsuming for States to obtain.

Finally, because the authority to provide services under direction remains unchanged, the preamble of the April 2, 2003, proposed rule included our guidance on providing audiology services “under the direction of.” We included the guidance in response to requests for our interpretation of acceptable standards of practice when providing services under the direction of a qualified audiologist.

III. Analysis of and Responses to Public Comments

We received 107 timely letters containing over 1,323 public comments in response to the April 2, 2003,
always available.

Response: As proposed, the revised Medicaid standards incorporate recognition of State licensure in defining a qualified Medicaid audiologist. As we stated in the proposed rule, we believe recognition of State licensure will afford States increased flexibility in determining who is qualified to provide Medicaid audiological services, thereby increasing the provider pool of “qualified” individuals.

Comment: Two commenters expressed support of the proposal to recognize State licensure, but stated that if private certification is mentioned in our rules, the American Board of Audiology certification must be included.

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Response: While we appreciate the intention behind this suggestion, we do not plan to specifically cite the American Board of Audiology certification as a qualifying standard since the primary purpose in revising the Medicaid audiology standards is to recognize the role of State licensure.

Continued reference and reliance on the ASHA CCC–A in the final rule serves to continue our recognition of individuals currently qualified and enrolled in the Medicaid program by virtue of their ASHA certification. In addition, retention of ASHA certification as a provider standard helps ensure that those individuals who are dually certified as speech-language pathologists and audiologists do not face additional compliance burdens by having to comply with two different standards within the Medicaid program itself.

Comment: Twenty-seven respondents stated they supported the generic definition of an audiologist in instances where State licensure does not exist or where there are special provider exemptions. One commenter felt the proposed standardized definition would enhance access to services by virtue of removing any confusion regarding the qualifications of the individual(s) where State licensure does not exist or apply, particularly since a State license should determine ability to practice—not membership in a political lobbying group. A few commenters who expressed support of the generic definition also stated that the generic definition helped resolve concerns around licensure exemptions of school-based audiology providers.

Response: We agree that the generic definition of an audiologist is very important for States, and in those circumstances, where licensure does not exist or apply. As we noted previously, the proposed “generic standards” serve to provide additional consumer protections by ensuring that Medicaid audiological services continue to be provided by, or under the direction of, professionally recognized individuals who have completed academic and clinical training programs consisting of demonstrated high quality industry standards.

Comment: Two respondents expressed overall support of the revised standards but strongly encouraged us to recognize State licensure as the sole national standard for defining qualified audiologists.

Response: We do not believe recognition of State licensure as the sole national standard for defining qualified audiologists is in the best interests of the Medicaid population. As stated in the April 2, 2003, proposed rule, because many States either choose not to license audiologists or exempt audiologists practicing in specific settings from licensure, we believe it imperative that we also incorporate quality standards defining qualified audiologists that guarantee Medicaid-eligible individuals receive services from recognized, qualified professionals in their field.

Comment: One respondent supported the April 2, 2003, proposed rule but expressed concern that the requirement of 350 clock-hours of supervised clinical practicum creates a more restrictive environment than current State licensure requirements. The respondent stated “this restriction would reduce the number of audiologists available to the Medicaid population and increase the provider registration burden to the local program to verify training hours rather than simply verifying licensure.”

Response: As stated in the April 2, 2003, proposed rule, we believe the inclusion of minimum standards relating to the provision of Medicaid audiology services serves to address concerns about quality of care in instances where State licensing does not apply. In addition, the proposed Medicaid standards are consistent with the Medicare program standards, helping to further create consistency between the two programs.

We note, however, that we are unclear as to this comment since States currently are required to meet the existing Medicaid requirements at § 440.110(c), which require that an individual be ASHA-certified or working toward certification. Since ASHA certification requires a minimum of 375 clock-hours of clinical practicum, we do not believe the proposed requirement of 350 clinical clock-hours is more restrictive. In addition, we believe States continue to enjoy the additional flexibility afforded them under the Medicaid program since the proposed standards retain the provision permitting audiology services to be provided under the direction of a qualified audiologist.

We also should point out that as a usual and customary business activity, the Medicaid program requires States to ensure that enrolled Medicaid providers meet all qualification requirements set forth in Federal and State law. Providers of Medicaid services must be in compliance with any relevant Federal and provider requirements at the time services are furnished to appropriately claim and receive Medicaid reimbursement.

ASHA Certification

Comment: Twenty-three respondents expressed support for the April 2, 2003, proposed rule and retention of the CCC–A. The respondents stated they are pleased that we recognize the need to retain the CCC–A as the professional industry standard that ensures quality services continue to be provided to Medicaid beneficiaries. Many specifically stated concern that removal of the CCC–A would present a special problem for Medicaid services furnished in the school setting, especially where a teacher’s certificate is used in lieu of State licensure. Four additional commenters felt that continued reliance on the ASHA CCC–A retains compliance for dually certified individuals and ensures reciprocity.

Seventeen commenters supported retaining ASHA certification, specifically because they believe State licensure alone is not a sufficient tool
establish competency. They stated that because not all States license audiologists and because not all States have universal licensure, reliance on State licensure results in audiology services being provided by lesser or unqualified individuals. Two commenters stated that we should retain the current rule and reliance on ASHA. They believe that the CCC–A should continue to be the primary credentialing authority so as not to weaken the quality of the workforce and quality of care. Response: Our proposed definition of a qualified audiologist continues recognition of the CCC–A as a standard for determining qualifications to provide Medicaid audiology services. As we noted, the existing requirements at § 440.110(c)(2), which rely on ASHA certification or its equivalent to define a Medicaid speech-language pathologist, remain unchanged. Therefore, retention of the CCC–A serves to maintain consistency in provider standards within the Medicaid program, as well as limit the administrative burden to States and to individuals who are dually certified. In addition, as we stated above, we believe the standards requiring specific academic achievements and clinical training proposed in this rule serve as added protection to ensure services are provided by professionally recognized and qualified audiologists. Comment: We received nine comments in support of the proposed rule but objecting to mandating commenters expressing opposition to the April 2, 2003, proposed rule overall. In summary, seventy-three commenters wrote in strong support of the rule and urged us to finalize. Forty-five of these same commenters stated they believe the April 2, 2003, proposed rule would improve access to Medicaid audiology services. Sixty-three stated they supported recognition of State licensure, twenty-seven thought the generic standard, but more importantly because it recognizes industry quality standard, not only because it ensures continuity and reciprocity for those providers who are dually certified and/or currently enrolled in the Medicaid program by virtue of certification. Thus, ASHA certification is no longer mandated, but is retained as one method by which individuals qualify to provide, or continue to provide, Medicaid audiology services. Support April 2, 2003, Proposed Rule Comment: We received a considerable number of comments in support of the April 2, 2003, proposed rule overall. In summary, seventy-three commenters wrote in strong support of the rule and urged us to finalize. Forty-five of these same commenters stated they believe the April 2, 2003, proposed rule would improve access to Medicaid audiology services. Sixty-three stated they supported recognition of State licensure, twenty-seven thought the generic definition of an audiologist very important in States and instances where licensure does not exist or apply, and fifty-two said they thought it important that we reconcile the Medicare and Medicaid rules defining a qualified audiologist.

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Response: The requirements finalized in this rule address our commitment to conform the Medicare and Medicaid programs through recognition of State licensure as a qualifying Medicaid standard. It does not change the scope of practice of professional audiology services. It also does not alter the current role of physicians in evaluating and determining an individual’s need for audiology services. Existing regulations at § 440.110(c) require that an individual be referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law before the receipt of audiology services. Therefore, physicians and other licensed practitioners practicing within the scope of State law continue to play an important role in ensuring that individuals receive appropriate medical evaluations and assessments to diagnose the need for audiology services. We agree with the comment that audiologists do not possess the training necessary to carry out the medical responsibilities of physicians and therefore should provide only those audiology services within the scope of practice governing their profession. Also in response to the above comments, we again point out that the Medicaid program permits speech-language and hearing services to be provided by physicians or under the supervision of physicians, under Medicaid’s physician services benefit in
Audiology services may be provided under this benefit as the qualifications of a physician can be construed as including those of providers of speech-language and hearing services as long as their services are provided "within the scope of practice of medicine or osteopathy as defined by State law or under the personal supervision of a qualified physician or other licensed practitioner of the healing arts before receipt of audiology services as defined under § 440.110(c). In addition, Medicaid regulations at § 440.50 permit physicians working within State practice acts to provide, or supervise the provision of, audiology services. In response to the comments opposing the April 2, 2003, proposed rule in favor of retaining the existing requirement for ASHA certification due to quality concerns, we believe our proposed standards, which include recognition of State licensure, combined with specific academic and clinical training standards and continued recognition of ASHA certification, continue our commitment to ensure a quality workforce and quality care.

Response: We received seven comments in opposition to the April 2, 2003, proposed rule because "it established a gatekeeper role and impedes access to hearing health care services by facilitating establishment of a gatekeeper system of care and inappropriately placing audiologists as gatekeepers to Medicaid hearing services." Response: See our detailed response to comments on physician involvement above. We do not believe the April 2, 2003, proposed rule inappropriately places audiologists as gatekeepers to Medicaid hearing services since § 440.110(c) continues to require a referral by a physician or other licensed practitioner of the healing arts before receipt of audiology services. Our proposed standards address reconciling the Medicare and Medicaid provider requirements through recognition of State licensure and do not authorize audiologists to prescribe hearing aids and related devices while providing instruction, rehabilitation, and counseling in the use and care of hearing aids and related devices.) Response: We do not agree that this final rule eliminates hearing aid specialists from participation in the Medicaid program. Further, this final rule will not affect the ability of hearing aid specialists to provide Medicaid-funded services. Currently, under Medicaid, it is possible for a hearing aid specialist to provide and receive Medicaid payment for services if he or she meets the provider requirements at § 440.110(c) and if the State offers those services under its Medicaid program. Individuals not meeting the specific requirements at § 440.110(c) may still be eligible to provide services "under the direction of" if so permitted within their State’s Medicaid plan. For example, if hearing services are being provided by individuals licensed in the State as physicians, or under the supervision of a physician as defined in the Medicaid’s physician services benefit at § 440.50, then providers must meet the provider qualifications applicable to those requirements. Providers must meet those qualifications because the qualifications of a physician can be construed as subsuming those of providers of speech-language and hearing services when they are provided as physician services.

Comment: Two respondents expressed concern that their organizations were not included in discussions and meetings before publication of the April 2, 2003, proposed rule. One "respects urges its inclusion whenever issues relating to hearing health are considered." The other "would like to request a meeting to discuss these issues, and any other speech, language, and hearing health care issues of interest to CMS." Response: It was not our intent to exclude any particular group or organization from participating in discussions and meetings before publication of the April 2, 2003, proposed rule. As we stated in the preamble, the intent of the contacts before publication was to gain an understanding of the implications change would have on Medicaid programs, providers, and beneficiaries. While we believe the information gained achieved that goal, we acknowledge and appreciate the comments’ interest in the Medicaid program and the formation of its rules and policies. As always, we wish to remain responsive to all concerns and welcome future opportunities to discuss issues of mutual interest.

Services Provided "Under the Direction of"

Comment: Fourteen respondents commented positively on the guidance regarding services provided "under the direction of" and the organization from participating in discussions and meetings before publication of the April 2, 2003, proposed rule. As we stated in the preamble, the intent of the contacts before publication was to gain an understanding of the implications change would have on Medicaid programs, providers, and beneficiaries. While we believe the information gained achieved that goal, we acknowledge and appreciate the comments’ interest in the Medicaid program and the formation of its rules and policies. As always, we wish to remain responsive to all concerns and welcome future opportunities to discuss issues of mutual interest.

Services Provided” if so permitted within their State’s Medicaid plan. For example, if hearing services are being provided by individuals licensed in the State as physicians, or under the supervision of a physician as defined in the Medicaid’s physician services benefit at § 440.50, then providers must meet the provider qualifications applicable to those requirements. Providers must meet those qualifications because the qualifications of a physician can be construed as subsuming those of providers of speech-language and hearing services when they are provided as physician services.

Comment: Two respondents expressed concern that their organizations were not included in discussions and meetings before publication of the April 2, 2003, proposed rule. One "respects urges its inclusion whenever issues relating to hearing health are considered." The other "would like to request a meeting to discuss these issues, and any other speech, language, and hearing health care issues of interest to CMS." Response: It was not our intent to exclude any particular group or organization from participating in discussions and meetings before publication of the April 2, 2003, proposed rule. As we stated in the preamble, the intent of the contacts before publication was to gain an understanding of the implications change would have on Medicaid programs, providers, and beneficiaries. While we believe the information gained achieved that goal, we acknowledge and appreciate the comments’ interest in the Medicaid program and the formation of its rules and policies. As always, we wish to remain responsive to all concerns and welcome future opportunities to discuss issues of mutual interest.
what constitutes an appropriate
supervisory ratio of Medicaid qualified
providers vs. ancillary support staff
consistent with State laws and practices.
They also believe we should set
appropriate ratios of direct contact/
supervisory time with the Medicaid
recipient for both assessment and
intervention. One commenter suggested
strengthening our policy to advise
audiologists in supervisory roles what
recourse options they have if asked to
supervise more ancillary support staff
than is ethically reasonable, and to
require States and school systems to
provide ancillary support staff with the
ability to reach the qualified audiologist
by means of personal contact,
telephone, pager, or other immediate
means.
Response: We appreciate the
commenters’ concerns and suggestions
on ways to strengthen the guidance for
providing services under direction. In
response to the suggestion that we
give providers’ ratios, we are not
establishing a ratio of providers to
ancillary staff because we believe this is
best done by States in a manner that
addresses the unique circumstances
within the State. In addition, we believe
placing specific requirements on States
may go beyond the authority of the
545 guidance contained in this document
and would require revisions to the
546 regulatory requirements at § 440.110(c).
547 We have, however, incorporated more
general language offering our guidance
with respect to staffing ratios by stating
that we expect contractual agreements
between providers to include:
548 requirements such as appropriate
supervisory ratios and information on
reporting instances of abuse of ethical
practices. In response to the suggestion
to require States and school systems to
provide contact information, we revised
the guidance to indicate our expectation
that individuals working under the
direction of a qualified audiologist be
given contact information to enable
them to directly contact the supervising
audiologist as needed during treatment.
We also would like to say that our
guidance in this area is evolving,
particularly as it relates to speechlanguage
and hearing services provided
to Medicaid-eligible children in schools.
We anticipate that we will continue to
update and provide guidance as
necessary to States and providers
through various means such as State
Medicaid Manual guidelines, letters to
State Medicaid Directors, and

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§ 440.110(c)(2) to remove the reference
to audiologists. Section 440.110(c)(1)
remains unchanged and continues to
require “a patient be referred by a
physician or other licensed practitioner
of the healing arts within the scope of
his or her practice under State law.”
549 to receive Medicaid audiology services.
550 In addition, although not part of the
551 standards affected by this final rule, we
552 are reiterating the guidance for
553 providing services “under the direction
of.” The guidance is intended as our
interpretation of appropriate practice
standards when providing audiology
services under direction set forth
§ 440.110(c)(1). In response to public
comments, we have made some
revisions to clarify and eliminate
confusion regarding an audiologist’s
scope of practice and to strengthen the
guidance to ensure quality services are
being provided in an appropriate and
professional manner (specific responses
to respondents’ comments are addressed
in section III).

Audiology services provided under
§ 440.110(c)(1) require that the “services
be provided by or under the direction
of an audiologist for which a patient is
553 referred by a physician or other licensed
practitioner of the healing arts within
the scope of his or her practice under
State law.”

We interpret the authority to provide
services “under the direction of” an
audiologist to mean that a federally
qualified audiologist who is directing
audiology services must supervise each
beneficiary’s care. To meet this
requirement, the qualified audiologist
must see the beneficiary at the
beginning of and periodically during
treatment, be familiar with the treatment
plan as recommended by the referring

physician or other licensed practitioner
of the healing arts practicing under State
law, have continued involvement in the
care provided, and review the need for
continued services throughout
treatment. The supervising audiologist
must assume professional responsibility
for the services provided under his or
her direction and monitor the need for
continued services. The concept of
professional responsibility implicitly
supports face-to-face contact by the
qualified audiologist at least at the
beginning of treatment and periodically
thereafter. Thus, audiologists must
spend as much time as necessary
directly supervising services to ensure
beneficiaries are receiving services in a
safe and efficient manner in accordance
with accepted standards of practice. To
ensure the availability of adequate
supervisory direction, supervising
audiologists must ensure that
individuals working under their
direction have contact information to
permit them direct contact with the
supervising audiologist as necessary
during the course of treatment.

In many cases, qualified audiologists
are employed by entities such as a
Medicaid agency, clinic, or school. In
such instances, the terms of the
audiologist’s employment must ensure
that the audiologist is adequately
supervising any individual providing
audiology services. In addition to the
supervisory requirements described
above, employment terms should
provide for supervisory ratios that are
reasonable and ethical and in keeping
with professional practice acts in order
to permit the supervising audiologist to
adequately fulfill his or her supervisory
obligations and ensure quality care.
In all cases, documentation must be
kept supporting the qualified
audiologist’s supervision of services and
ongoing involvement in the treatment
services. Because Medicaid law requires
that documentation be kept supporting
the provision and proper claiming of
services, appropriate documentation of
services provided by supervising
audiologists, as well as services
performed by individuals working
under the direction of a qualified
audiologist, are necessary. Absent
appropriate service documentation,
Medicaid payment for services may be
denied providers.

Where appropriate, audiology services
must adhere to all State requirements
and State practice acts governing the
provision of services under the direction
of a qualified audiologist. As with all Medicaid benefits that permit services furnished under direction, both Federal and State requirements must be met at all times. Services furnished for the Medicaid program to appropriately provide Federal financial participation for services furnished on behalf of Medicaid eligible individuals.

V. Collection of Information Requirements

This document does not impose any information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995. We have determined, however, that the regulations in section 1774 are not a major rule under Executive Order 12866, and that this rule is not a major rule under 121, specifies that a “major rule” is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises in domestic and export markets.

In addition, consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare and publish an initial regulatory flexibility analysis for proposed regulations unless we have determined that the regulations would not have a significant impact on a substantial number of small entities. For purposes of the RFA, we do not consider States or individuals to be small entities.

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The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million or less in any 1 year. We are unable to provide a specific dollar estimate of the economic impact this final regulation will have on State and local governments and participating providers. Because the flexibility permitted under Medicaid allows States to provide audiology under various Medicaid benefits, it is not possible to capture accurate expenditure data.

We have determined, however, that this rule is not a major rule under Executive Order 12866, and that this rule will not have a significant economic impact on a substantial number of small entities. We have made this determination because while we believe this rule will permit States to have more flexibility in determining who is qualified to provide audiology services, we do not anticipate any increase in States’ use of audiology services due to this regulation. Section

804(2) of title 5, United States Code (as added by section 251 of Pub. L. 104–121), specifies that a “major rule” is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises in domestic and export markets.

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utilization in some manner. In addition, many States limit the use of optional services such as audiology in favor of mandatory Medicaid benefits. States providing audiology services to children under the EPSDT program primarily do so as part of their school based services program under IDEA. Since all 50 States currently have a school-based services program in operation, we do not anticipate this rule to have any significant effect on audiology services provided to Medicaid children.

Additionally, recognizing that States currently use the flexibility permitted in the Medicaid law to provide audiology services “under the direction of” a qualified audiologist, we expect States will continue to do so by providing audiology services using individuals working under the supervision of qualified audiologists. Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts a State law, or otherwise has Federalism implications. We do not believe this rule in any way will impose substantial direct compliance costs on State and local governments or preempts or supersedes State or local law. This rule permits States to use State-licensed audiologists to provide Medicaid audiology services, thereby giving them increased flexibility in providing Medicaid audiology services. In addition, after researching the national audiology usage and reviewing States’ currently approved Medicaid State Plans, we anticipate that most, if not all, qualified audiologists currently enrolled in the Medicaid program will continue to be qualified as a result of the continued flexibility established in this rule. For this reason, we do not believe that the change in requirements for audiologists included in this rule will result in reduced access to services, or otherwise result in fewer audiology services available through the Medicaid program. We also anticipate that States will continue to provide audiology services by using the additional flexibility already granted under the Medicaid program to provide audiology services using individuals meeting State provider qualifications and working within State practice acts “under the direction of” a qualified Medicaid audiologist. We believe the additional flexibility set forth in this rule to recognize State licensure will serve to enhance States’ ability to provide services. We do not, however, anticipate this rule will have a significant effect on the actual provision of audiology services in State Medicaid programs, and, therefore, the rule does not have Federalism implications.

B. Anticipated Effects

We anticipate this rule will give States increased flexibility in determining who is a Medicaid-qualified audiologist. We also anticipate that the quality care standards established in this rule will help ensure that Medicaid audiology services continue to be provided by, or under the direction of, highly qualified and trained individuals. Additionally, we believe conforming the Medicare and Medicaid provider requirements will help eliminate any confusion providers may experience in complying with Federal rules and help resolve or eliminate conflict where audiologists provide services to both the Medicaid and Medicare populations (such as in nursing facilities or through home health care agency providers).

Additionally, this final rule also serves to eliminate inconsistencies in Medicaid provider standards by no longer recognizing equivalency rulings. Under the current Medicaid rules, States can seek equivalency rulings from their State Attorney General in instances where they believe State licensure is equivalent to ASHA certification. Since this rule recognizes State licensure that meets Medicare-equivalent standards, equivalency rulings are no longer necessary or required. We believe States will look favorably on the elimination of equivalency rulings since they proved administratively burdensome and timeconsuming to obtain.
1. The authority citation for part 440 continues to read as follows:


2. In § 440.110, paragraph (c)(2) is revised, and a new paragraph (c)(3) is added to read as follows:

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(c) * * * * *

t 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.

(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.

2. 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 paragraph (c)(3)(ii)(A) or (c)(3)(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 clinical 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.

(D) Act as a P.T.A. 2163

completed a national examination in audiology approved by the Secretary. (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)


Dennis G. Smith,
Acting Administrator, Centers for Medicare & Medicaid Services.


Tommy G. Thompson,
Secretary.

Editorial Note: This document was received at the Office of the Federal Register on May 25, 2004.

[FR Doc. 04–12096 Filed 5–27–04; 8:45 am]
BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[WT Docket No. 99–217; FCC 04–41]

Promotion of Competitive Networks in Local Telecommunications Markets

AGENCY: Federal Communications Commission.

ACTION: Final rule, petition for reconsideration.

SUMMARY: In this document the Commission addresses four petitions seeking Reconsideration and/or Clarification of the Commission’s determination to extend to users of fixed-wireless telecommunications antennas the same OTARD (Over-the-Air-Reception Devices) protections previously available to customers of multi-channel video service.


FOR FURTHER INFORMATION CONTACT:

Cara Voth, Broadband Division, Wireless Telecommunications Bureau, at (202) 418–0025.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission’s Order on Reconsideration, (Order) released on March 24, 2004 (FCC 04–41). The full text of the Order is available for inspection and copying during normal business hours in the FCC Reference Center, Room CY–A257, 445 12th Street, SW., Washington, DC 20554. The complete text may also be purchased...
Appendix B

Date: August 2001
From: Ms. Pat Daley, CMS (HCFA) Reg IX SF 415/744-3592

HCFA PROGRAM ISSUANCE
Transmittal Notice
REGION IV

PROGRAM IDENTIFIER: MCD-22-95

TO: All Title XIX Agencies and Welfare Agencies in AL, GA, KY, MS, SC, TN

SUBJECT: Guidance Regarding the term "Under the Direction of "in Regard to Speech Pathology and Audiology Services

The purpose of this notice is to provide you with guidance on the term "under the direction of for the purposes of speech pathology services, especially when provided as school health and early intervention services furnished under the Individuals with Disabilities Education Act (IDEA).

Some states have developed programs that provides services to children under IDEA which permit "teachers of speech and hearing impaired" to provide services "under the direction of a speech pathologist" who is qualified to provide these services under the Medicaid regulations at 42 CFR 440.110(c).

The above regulation provides that services for individuals with speech, hearing, and language disorders be provided by or under the direction of a speech pathologist or audiologist, for which a patient is refereed by a physician. A speech pathologist or audiologist is defined as an individual who has a certificate of clinical competence from the American Speech and Hearing Association, the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certification.

The Health Care Financing Administration's interpretation of the term "under the direction of a speech pathologist" is that the speech pathologist is individually involved with patient under his or her direction and accepts ultimate responsibility for the actions of the personnel that he or she agrees to direct. We advise states that the speech pathologist must see the patient after treatment has begun. The speech pathologist would also need to assume the legal responsibility for the services provided. Therefore, it would be clearly in the pathologist's own interest to maintain close oversight of any services for which he or she agrees to assume direction.

If there are any questions, please contact one of the members on the non-institutional coverage team (Andriette Johnson at (404) 331-5888, Mal Williams at (404) 331-5889.)
Appendix C

Minimum Supervision Requirements for Medicaid Reimbursement of School-Based Speech-Language Services

**ASHA Requirements/Recommendations**

<table>
<thead>
<tr>
<th>Supervisee Level</th>
<th>Direct Supervision</th>
<th>Indirect Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student Clinicians</strong></td>
<td>No less than 25% of student's total contact with each client/patient and must take place periodically throughout the practicum</td>
<td>None specified</td>
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<tr>
<td><em>(ASHA (2000) SLP Standards and Implementation for CCC-SLP)</em></td>
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<tr>
<td><strong>Clinical Fellows</strong></td>
<td>At least 18 on-site observations (1 hour each) in 36 weeks of employment of at least 30 hours/week. Observations must be spread out throughout the 36 weeks with 6 per 3 month segment.</td>
<td>At least 18 monitoring activities to include conferences, record review, etc. Monitoring activities must be spread out throughout the 36 weeks with 6 per 3 month segment.</td>
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<tr>
<td><em>(ASHA (2000) SLP Standards and Implementation for CCC-SLP)</em></td>
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<tr>
<td><strong>Speech-Language Pathology Assistants</strong></td>
<td>During first 90 workdays, at least 20% of actual patient/client contact time to be scheduled so that all patient/clients seen by the assistant are directly supervised in a timely manner. After first 90 workdays, no less than 10% direct supervision weekly or 4 hours in a 40 hour work week.</td>
<td>During first 90 workdays, no less than 10% of actual patient/client contact time. After first 90 workdays, no less than 10% indirect supervision weekly or 4 hours in a 40 hour work week.</td>
</tr>
<tr>
<td><em>(ASHA (2004) Guidelines for the training, use and supervision of support personnel in speech-language pathology)</em></td>
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</tr>
<tr>
<td><strong>Clinician providing services to Medicaid eligible students “under the direction of” certified SLP</strong></td>
<td>Direct supervision at least once monthly for each Medicaid eligible student. The length of supervision contact is not prescribed but must be adequate to meaningfully determine that appropriate services are provided.</td>
<td>At least once monthly, supervisor and clinician will discuss progress, review program and relevant paperwork for each Medicaid eligible student.</td>
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</table>