



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Medical Review Guidelines for Speech-Language Pathology Services

The medical review guidelines found here were refined from Medicare original guidelines to assist practitioners and third party payers in defining the scope of coverage for speech-language pathology services. They are based on former national medical review guidelines established for the Medicare program and are similar to current Local Coverage Determinations (LCDs) developed by Medicare carriers and fiscal intermediaries. At times, private health plans adopt coverage policies based on Medicare standards. The attached document represents an enhancement of former national guidelines by DynCorp (now known as AdvanceMed), contracted by the Centers for Medicare and Medicaid Services (CMS), and, subsequently, the ASHA Health Care Economics Committee.

Medicare carriers process claims from practitioners (e.g., private practice physicians, physician groups, private practice audiologists, and private practice physical therapists). Fiscal intermediaries process claims from institutions (e.g., hospitals, skilled nursing facilities, rehabilitation agencies). Not all carriers and fiscal intermediaries have developed LCDs for speech-language pathology or dysphagia services.

To view LCDs for your geographic area, go to:

<http://www.cms.hhs.gov/contacts/med/search.asp>

- Select “Local Coverage”
- Deselect “Articles”
- Select “Final Policies Only”
- Select “Geographic area” OR “Contractor”
 - (Contractor is the specific intermediary or carrier)
- Select “Keyword”
- Select “Title”
 - (Keyword in title would be speech, dysphagia, or swallowing)

For further information, please contact Mark Kander, Director of Health Care Regulatory Analysis, 800-498-2071, ext. 4139 or via email: mkander@asha.org.

Model Local Coverage Determination

Speech-Language Pathology Services

ASHA substantive revisions are indicated by

- **Underlined text**
- **Strike-throughs**

The revisions are followed by ASHA's rationale for the change.

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Contractor Name

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LCD Title

Medical Review of Part B Speech-Language Pathology Services

AMA CPT Copyright Statement

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CMS National Coverage Policy

The basis of the CMS national coverage and payment policy for Medicare Part B speech-language pathology services referenced in this policy is located in the following documents.

Statutory Authority: *Social Security Act: Title XVIII (the Act)*:

Section 1831 establishes the Part B program as a voluntary insurance program to provide medical insurance benefits. This is financed from premiums paid by enrollees together with funds appropriated by the Federal Government.

Section 1832 establishes the scope of benefits provided under the Medicare Part B supplementary medical insurance (SMI) program.

Section 1833 establishes the payment of benefits for Part B services. This includes outpatient speech-language pathology services furnished by institutional providers that bill intermediaries [*Sec. 1833(a)(8)*].

Section 1834 establishes special payment rules for particular items and services under Part B to institutional providers of outpatient speech-language pathology. These settings include rehabilitation agency and comprehensive outpatient rehabilitation facility (CORF) providers [*Sec. 1834(k)*].

Section 1835 establishes conditions for payment of claims to institutional providers of outpatient speech-language pathology service, including certification and plan of treatment requirements [*Sec. 1835(a)*].

Section 1861 of the Act establishes definitions of services, institutions, etc. that include references to outpatient speech-language pathology services (1)(1). The term "speech-language pathology services" means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) as would otherwise be covered if furnished by a physician.

3) In this subsection:

- (A) The term "qualified speech-language pathologist" means an individual with a masters or doctoral degree in speech-language pathology who--
 - (i) is qualified as a speech-language pathologist by the State in which the individual furnishes such services, or
 - (ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

Section 1862 establishes statutory exclusions from coverage and Medicare as a secondary payer provisions.

Section 1862 (a)(1)(A)

SEC. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services-- (1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862 (a)(7) This section excludes routine physical examinations.

Section 1833 (e)

No payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

CMS Regulatory Authority: Code of Federal Regulations (42CFR)

Part 409 includes the definition of ‘reasonable and necessary’ therapy services.

Part 410 describes the benefits under Medicare Part B, including outpatient therapy services.

Part 411 describes those specific services excluded from Medicare or that are subject to limitations on payment. Several services listed fall within the scope of practice of physical therapists.

Part 414 describes the provisions of payment of Part B services under a fee schedule.

Part 415 describes services furnished by physicians in providers, supervising physicians in teaching settings, and residents in certain settings.

Part 420 describes specific Medicare Program Integrity requirements to prevent fraud and abuse.

Part 421 identifies the activities required of the intermediaries and carriers that process Medicare claims.

Part 424 describes the conditions for Medicare payment, including those governing Part B outpatient speech-language pathology services.

Part 484 includes the personnel qualification requirements for a speech-language pathologist under Medicare.

Part 485 describes the number of speech-language pathology qualified personnel and speech-language pathology programs offered by an institution.

Part 498 describes appeal procedures for determinations that affect participation in the Medicare program.

Part 489 includes the definition of a ‘provider’ under Medicare.

CMS National Coverage Determinations (NCDs):

Coverage Issues Manual (CMS Pub. 6)

The Coverage Issues Manual sets forth whether specific medical items, services, treatment procedures or technologies can be paid for under Medicare. National Coverage Decisions (NCDs) have been issued on the items addressed in this manual. All decisions that items, services, etc. are not covered are based on §1862 (a)(1) of the Social Security Act (the "not reasonable and necessary" exclusion) unless otherwise

specifically noted. Where another statutory authority for denial is indicated, that is the sole authority for denial. Where an item, service, etc. is stated to be covered, but such coverage is explicitly limited to specified indications or specified circumstances, all limitations on coverage of the items or services because they do not meet those specified indications or circumstances are based on §1862 (a)(1) of the Act. Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in this Manual, the Intermediary Manual, or the Carriers Manual, it is up to the Medicare carrier or intermediary to make the coverage decision. This decision is made in consultation with its medical staff, and with the Centers for Medicare and Medicaid (CMS), when appropriate, based on the law, regulations, rulings and general program instructions.

The following list identifies the CMS National Coverage Determinations (NCDs) that may be directly related to services, equipment, and/or supplies associated with speech-language pathology services. This list is not all inclusive.

35-72	<u>Electrotherapy for Treatment of Facial Nerve Paralysis (Bell's Palsy)</u>
35-89	<u>Speech Pathology Services for the Treatment of Dysphagia</u>
35-67	<u>Melodic Intonation Therapy</u>
65-16	<u>Tracheostomy Speaking Valve</u>
60-23	<u>Speech Generating Devices</u>
65-5	<u>Electronic Speech Aids</u>
80-1	<u>Institutional and Home Care Patient Education Programs</u>

Examples of codes for speech generating devices and electronic speech aids that a speech-language pathologist can recommend are listed in the Coverage Issues Manual.

DME/Prosthetic Devices

E2500-Speech-generating device, digitized speech, using prerecorded messages, less than or equal to 8 minutes recording time

E2502- Speech-generating device, digitized speech, using prerecorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time

E2504- Speech-generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time

E2506- Speech-generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time

E2508-Speech-generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device

E2510-Speech-generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access

E2511-Speech-generating software program, for personal computer or personal digital assistant

L8500 - Artificial larynx, any type

L8501 - Tracheostomy speaking valve

CMS Program Manuals

CMS Manuals established for distinct provider settings have been phased out. See the Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230 at http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp for therapy services.

Recent CMS Transmittals

Program Memorandum AB-01-56

AB-01-68

AB-01-135 **RATIONALE FOR ADDING THIS PROGRAM MEMORANDUM:** It mentions speech-language pathology services acceptable in medical review of services for patients with dementia.

Primary Geographic Jurisdiction

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LCD Description

This Local Coverage Determination describes the services that may be furnished under the Medicare Part B benefit by or under the supervision of speech-language pathologists. Speech-language pathology services are those services necessary for the diagnosis and treatment of speech-language disorders that result in

communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. This policy applies to all services speech-language pathologists furnish regardless of whether they are employees of or subcontractors to institutions (e.g. hospitals, skilled nursing facilities), or whether they are providing the services incident to a physician's services in a doctor's practice. This policy includes reference to medical equipment/supplies that may be related to the speech/language pathology plan of treatment. This policy does not address dysphagia (swallowing) services rendered by speech-language pathologists.

Indication and Limitations of Coverage and/or Medical Necessity

Definition of Speech-Language Pathology Services

General - Speech-language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. They must relate directly and specifically to a written treatment regimen established by the physician after any needed consultation with the qualified speech-language pathologist the speech-language pathologist or physician. **RATIONALE FOR DELETIONS & ADDITIONS: The speech-language pathologist or physician may establish the plan of treatment per 42 CFR 410.61(b).**

Reasonable and Necessary - Speech-language pathology services must be reasonable and necessary for the treatment of the individual's illness or injury. To be considered reasonable and necessary, the following conditions must be met:

- The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;
- The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech-language pathologist;
- There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment by the physician of the patient's restoration potential after any needed consultation with the qualified speech-language pathologist; or, the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. (The affiliated contractor should consult with local speech-language pathologists, the state Speech-Language-Hearing Association and /or American Speech-Language-Hearing Association in the development of any utilization guidelines.)

Restorative Therapy - If an individual's expected restoration potential would be insignificant in relation to the extent and duration of speech-language pathology services required to achieve such potential, the services would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness or injury it is determined that the expectations will not materialize, the services will no longer constitute covered speech language pathology services, as they would no longer be reasonable and necessary for the treatment of the patient's conditions and would be excluded from coverage under Section 1862 (a)(1)(A).

Maintenance Program - After the initial evaluation of the extent of the disorder or illness, if the restoration potential is judged insignificant or, after a reasonable period of trial, the patient's response to treatment is judged insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified speech-language pathologist may be required if the treatment aim of the physician is to be achieved; e.g., a multiple sclerosis patient may require the services of a speech-language pathologist to establish a maintenance program designed to fit the

patient's level of function. In such a situation, the initial evaluation of the patient's needs, the designing by the qualified speech-language pathologist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient and the treatment objectives of the physician, the instruction of the patient and supportive personnel (e.g., aides or nursing personnel, or family members where speech-language pathology is being furnished on an outpatient basis) in carrying out the program, and such infrequent reevaluations as may be required, would constitute covered speech-language pathology. After the maintenance program has been established and instructions have been given for carrying out the program, the services of the speech-language pathologist would no longer be covered, as they would no longer be considered reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under **Section 1862 (a)(1)(A)**.

If a patient has been under a restorative speech-language pathology program, the speech-language pathologist should regularly reevaluate the condition and adjust the treatment program. Consequently, during the course of treatment the speech-language pathologist should determine when the patient's restorative potential will be achieved and, by the time the restorative program has been completed, should have designed the maintenance program required and instructed the patient, supportive personnel, and/or family members in the carrying out of the program. A separate charge for the establishment of the maintenance program under these circumstances would not be recognized. Moreover, where a maintenance program is not established until after the restorative speech-language pathology program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under **Section 1862 (a)(1)(A)**, since the maintenance program should have been established during the active course of treatment.

Provider Qualification Requirements

Medicare Part B pays for outpatient speech-language pathology services if they are furnished to a beneficiary by a provider that bills fiscal intermediaries [including hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), clinics, rehabilitation agencies, public health agencies, comprehensive outpatient rehabilitation facilities (CORFs), hospices, critical access hospital (CAHs), community mental health centers (CMHCs); or others under arrangements with, and under the supervision of the provider]. Speech-language pathology services may also be rendered incident to a physician's services. Medicare Part B pays for these physician services which are billed to Medicare carriers.

Practitioner Qualification Requirements

A qualified speech-language pathologist (SLP) is an individual who:

- Is licensed, if applicable, as an SLP by the state in which they are practicing; and,
- Is eligible for a certificate of clinical competence in speech-language pathology granted by the American Speech-Language Hearing Association, or, meets the educational requirements for certification and is in the process of accumulating the supervised clinical experience required for certification. *[42CFR484.4]*.

The qualified SLP has a master's or doctoral degree. In addition, the SLP possesses a Certificate of Clinical Competence (CCC-SLP); or, has met all the educational requirements leading to a Certificate of Clinical Competence, and is in their clinical fellowship (CF-SLP).

Supervision Requirements

Currently, the Medicare requirements governing the supervision of Part B speech-language pathology services vary depending on the type of provider or physician/supplier billing for the services. The following summarizes these variations.

Incident-to a Physician's Services

Medicare law, §1862(a)(20) provides an exemption from licensing requirements for Part B speech-language pathology services provided as an incident-to a physician's professional services. According to the Carriers Manual Section 2050.1, coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct ~~personal~~ physician supervision. This applies to services of auxiliary personnel employed by the physician and working under his/her supervision, including speech-language pathologists. Thus, where a physician employs auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service. Under this definition, the speech-language pathologist, or any other employee of a physician or physician group practice would require the direct ~~personal~~ supervision of the physician for coverage under Medicare Part B. Additionally, regulation 42 CFR 410.27 provides a definition of this required supervision level as follows, "Direct supervision" means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

RATIONALE FOR DELETION OF "PERSONAL:" The above paragraph discusses "direct supervision" as defined in 42 CFR 410.27(b), not "direct personal supervision." CMS elsewhere defines the term "personal supervision" which could be wrongly applied to the misnomer, "direct personal supervision."

Aides/Assistants

Services furnished by unlicensed aides/assistants under the direction of speech-language pathologists are not covered under Part B, as they do not meet the 'licensing and other standards' required in §1861(p) of the Act.

Students

According to ~~Program Memorandum AB 01-56~~, Services performed by a student are not reimbursed under Medicare Part B. Medicare pays for services of physicians and practitioners authorized by statute. Students do not meet the definition of practitioners listed in §1861 of the Act. However, § 15304 of the Carriers Manual a recent letter (11/2001) to the American Speech-Language Hearing Association from CMS clarifies that there are certain conditions under which services are billable: Please see Appendix A

- The qualified practitioner is in the room for the entire session
- The practitioner is not engaged in treating another patient or doing other tasks at the same time
- The practitioner directs the service, making the skilled judgment, and is responsible for the assessment and treatment

RATIONALE FOR REVISIONS: The 11/2001 letter to ASHA has been manualized.

Referral Requirements

Medicare Part B pays for outpatient speech-language pathology services if they are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine [42CFR410.60]. Physician assistants, nurse practitioners, and clinical nurse specialists may refer to a speech-language pathologist for Part B services under [42CFR410.74], [42CFR410.75], and [42CFR410.76] respectively. Medicare Part B does not pay for diagnostic or therapeutic services furnished or ordered by a chiropractor [42CFR410.22(b)(2)].

Outpatient must be under the care of a physician

Medicare coverage guidelines require that speech-language pathology services be furnished to an individual who is under the care of a physician. The necessity for physician visits and the frequency is determined entirely by the physician. This physician may be the patient's private physician, a physician on the staff of the provider, a physician associated with an institution which is the patient's residence, or a physician associated with a medical facility in which the patient is an inpatient. Intermediary Manual Section 3148.2 and Carrier Manual Section 2206.2.

Plan of Treatment Requirements

Establishment of the plan of treatment

The services must relate directly and specifically to a written treatment regimen established by the speech-language pathologist, or by the physician (or nurse practitioner, clinical nurse specialist, or physician assistant under the general supervision of a physician), after any needed consultation with the qualified Speech-Language Pathologist (SLP).

Medicare Part B pays for outpatient speech-language pathology services if they are furnished under a written plan of treatment that meets the following requirements. (1) The plan is established before treatment is begun by one of the following: a physician, a speech-language pathologist who furnishes the speech-language pathology services, a nurse practitioner, a clinical nurse specialist, or a physician assistant.

(2) The plan describes the type, frequency of visits, and estimated duration of the speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated functional goals.

Changes in the plan of treatment

The speech-language pathologist who furnishes the speech-language pathology services or the physician (or nurse practitioner, clinical nurse specialist, or physician assistant), after any needed consultation with the SLP, ~~a registered professional nurse or staff physician~~, makes any changes in the plan in writing. These changes may also be made in accordance with oral orders from the physician or speech-language pathologist who furnishes the services, a nurse practitioner, a clinical nurse specialist, or a physician assistant, registered professional nurse, or staff physician. These changes are also incorporated into the plan immediately [42CFR410.61].

RATIONALE FOR ADDING “after any needed consultation with the SLP:” This phrase is used above, immediately after “Establishment of the plan of treatment.”

RATIONALE FOR RELOCATION OF “a registered professional nurse or staff physician:” As stated in 42CFR 410.61, these practitioners have a role only in transcribing oral orders, not in the initiation of changes in the plan of treatment.

The physician may change a plan of treatment established by the speech-language pathologist. The speech-language pathologist may not alter a plan of treatment established by a physician.

Review of the plan of treatment

The physician reviews the plan as often as the individual's condition requires, but at least every 30 days. (See exception for CORF services in a following section.) Each review is dated and signed by the physician who performs it [42CFR410.60] and [42CFR410.61]. Physician assistants, nurse practitioners, and clinical nurse specialists may review a speech-language pathologist plan of treatment for Part B services in accordance with [42CFR410.74], [42CFR410.75], and [42CFR410.76] respectively.

Certification Requirements

Purpose of certification

According to [42CFR424], The physician has a major role in determining utilization of health services furnished by providers. Among these responsibilities, the physician decides upon admissions, orders tests, drugs, and treatments, and determines the length of inpatient stay. Accordingly, section 1835(a)(2)(c) of the Act establishes as a condition for Medicare payment that a physician certify the necessity of the services and, in some instances, re-certify the continued need for those services.

General certification procedures

The provider must obtain the required certification and re-certification statements. This includes keeping the statements on file for verification by the intermediary or carrier, if necessary. In addition, the provider must certify on the appropriate billing form that the statements have been obtained and are on file. No specific procedures or forms are required for obtaining the certification and re-certification statements. The provider may adopt any method that permits verification, therefore, the certification and re-certification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. There must be a separate signed statement for each certification or re-certification. Certification statements for speech-language pathology services require certain specific information. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found [42CFR424.11].

Specific certification requirements for Part B Speech-Language Pathology services

Medicare Part B pays for medical and other health services furnished by providers only if a physician certifies that: (1) the individual needs, or needed, speech-language pathology services; (2) the services were furnished while the individual was under the care of a physician, nurse practitioner, clinical nurse specialist, or physician assistant; and, (3) the services were furnished under a plan of treatment that meets the requirements of [42CFR410.61]. (The content requirements differ for services furnished in a CORF – see section below.) The certification statement must be obtained at the time the plan of treatment is established, or as soon thereafter as possible. If a physician, nurse practitioner, clinical nurse specialist, or physician assistant establishes the plan of treatment, that physician or non-physician practitioner must sign the certification. If the plan of treatment is established by a speech-language pathologist, the certification must be signed by a physician or by a nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case [42CFR424.24].

Re-certification Requirements

Re-certification statements are required at least every 30 days and must be signed by the physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan of treatment. (See exception for CORF services below.) The re-certification statement must indicate the continuing need for speech-language pathology services and an estimate of how much longer the services will be needed. The physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan of treatment must sign re-certifications.

Certification and Re-certification Requirement Exception for Part B Services Billed by CORFs

Medicare Part B pays for CORF services only if a physician certifies, and the facility physician re-certifies, the following as appropriate: (1) the individual needs, or needed, skilled speech-language pathology services; (2) the services are furnished while the individual is under the care of a physician; and, (3) a written plan of treatment has been established and is reviewed periodically by the physician.

Re-certification is required at least every 60 days, based upon review by a facility physician who, when appropriate, consults with the professional personnel who furnish the services. The recertification must include the following content: (1) the plan is being followed; (2) the patient is making progress in attaining

the rehabilitation goals; and, (3) the treatment is not having any harmful effect on the patient
[42CFR424.27].

Excluded (non-covered) Services by Statute

Under the provisions of Section 1862 of the Social Security Act, no payment can be made under Part A or Part B for the services determined to be not reasonable and necessary. In addition, Medicare will not pay for services that it has no legal obligation to pay for or provide, that are otherwise paid for by a governmental entity, are not provided within United States, or are resulting from war. Additional services not paid for by Medicare are those considered to be for personal comfort, routine services and appliances, certain foot care services and supportive devices for feet, custodial care, and cosmetic surgery. Charges by immediate relatives or members of household, dental services, services paid or expected to be paid under workers' compensation, and non-physician services provided to a hospital inpatient, which were not provided directly or arranged for by the hospital, are also excluded from coverage.

Excluded (non-covered) Services by Regulation

Regulatory exclusions identified in [42CFR410.60] indicate that no service is included as an outpatient speech-language pathology service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient. Those speech-language pathology services that are considered covered in inpatient settings are described in [42CFR409.32] discussed below.

Covered Services by Regulation

Reasonable and Necessary Skilled Services

According to the inpatient regulations [42CFR409.32], the following criteria establish whether a service is medically necessary as defined by the need for skilled services. To be considered a skilled speech-language pathology service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, a speech-language pathologist, physician, or qualified personnel. A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non-skilled (such as those listed in 42CFR409.33(d)) may be considered skilled because it must be performed or supervised by skilled rehabilitation personnel. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in 42CFR409.33.

Types of Skilled Speech-Language Pathology Services

Types of Services — Speech-language pathology services can be grouped into two main categories: services concerned with diagnosis or evaluation, and therapeutic services.

Diagnostic and Evaluation Services -- Unless excluded by section 1862(a)(7) of the law, these services are covered if they are reasonable and necessary. The speech –language pathologist employs a variety of formal and informal speech and language assessment tests to ascertain the type, causal factor(s), and severity of the speech and language disorders. Reevaluation of patients for whom speech and language services were previously contraindicated would be covered only if the patient exhibited a significant change in medical condition. However, monthly reevaluations, e.g., a Western Aphasia Battery, for a patient undergoing a restorative speech-language pathology program, are to be considered a part of the treatment session and could not be covered as a separate evaluation for billing purposes.

Therapeutic Services.--The following are examples of common medical disorders and resulting communication deficits which may necessitate active restorative therapy: This list should not be considered all inclusive.

- (i) Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;
- (ii) Neurological disease such as Parkinsonism or Multiple Sclerosis with dysarthria, dysphagia, inadequate respiratory volume/control, or voice disorder;

RATIONALE FOR ADDING “VOICE DISORDER” is found within the paragraph above headed “Reasonable and Necessary Skilled Services.” Skilled services may be needed to “prevent further deterioration or preserve current capabilities.”

- (iii) Laryngeal carcinoma requiring laryngectomy and resulting in aphonia. ~~may warrant therapy of the laryngectomized patient so that he/she can develop new communication skills through esophageal speech and/or use of the electrolarynx.~~

RATIONALE FOR DELETED SEGMENT: The examples in (i) and (ii) are limited to the medical disorder and resulting communication deficit. Item (iii) should follow the same pattern.

Examples of Unskilled Procedures-- These services do not require the skills of a SLP and are not covered by Medicare. Unskilled procedures may include but are not limited to:

- Non-diagnostic/non-therapeutic routine, repetitive and reinforced procedures, e.g., the practicing of word drills without skilled feedback.
- Procedures that are repetitive and/or reinforcing of previously learned material which the patient or family is instructed to repeat.
- Procedures that may be effectively carried out with the patient by any nonprofessional, e.g., family member or restorative nursing aide after instruction and training is completed.
- Supervision of the patient practicing the use of speech generating devices and non-speech generating devices.

Intermediaries/carriers must base decisions on the level of complexity of the services rendered by the speech-language pathologist, not what the patient is asked to do. For example, the patient may be asked to repeat a word and the speech-language pathologist analyzes the response and gives the patient feedback that the patient uses to modify the response. The speech-language pathologist may ask staff or family to repeat the activity as reinforcement. It is the speech-language pathologist's analysis that makes the activity skilled.

Group Therapy

Group therapy can be covered (if medically justified) if the following criteria are met:

- Group therapy services are rendered under an individualized plan of treatment, and are integral to the achievement of the patient's individualized goals;
- The skills of a speech-language pathologist are required to safely and/or effectively carry out the group services;
- The group consists of four or fewer group members;

- The group therapy satisfies all of the “reasonable and necessary criteria” listed under Indications and Limitations of Coverage and;
- Group therapy accounts for no more than 25% of the patient’s total time in therapy.

Generally, social or support groups such as stroke clubs or lost chord clubs are not reimbursable.

Speech Generating Devices

The Medicare program requires that a speech-language pathologist conduct a formal evaluation of a beneficiary’s cognitive and communication abilities before the patient can receive a speech-generating device (SGD). Complete requirements for the evaluation are found in the Regional DMERC Supplier Manuals. A speech-language pathologist also performs the therapeutic services related to the use of the SGD.

RATIONALE FOR ADDING THIS SECTION: The protocol for SGD evaluations was not yet established by the DMERCs when the DynCorp FTRP was developed.

Aural Rehabilitation

Speech reading may be considered medically necessary when it has been determined and documented by a qualified audiologist that the use of a hearing aid or other amplification alone would not sufficiently improve the patient’s understanding of speech; and where the beneficiary’s visual skills, cognition, and language comprehension are sufficiently intact that the patient could benefit from such services. Speech reading services generally would not be reasonable and necessary in lieu of appropriate amplification (which is not covered by Medicare). Routine screening for hearing acuity or evaluations aimed at the use of hearing aids is not considered a covered service. Therapy services and supplies directed toward the operation, use, maintenance or management of a hearing aid or other amplification device are excluded under **Section 1862** (a)(8) of the Social Security Act, which prohibits coverage of any expenses incurred for items or services where such expenses are for hearing aids or examinations therefore.

Audiology Testing

These services are not speech-language pathology services. However, hearing screening by the SLP may be included in the initial speech-language pathology evaluation, although not billable as a separate service.

Documentation Guidelines Supporting Medical Necessity Of Part B Speech-Language Pathology Service

CMS Pub. 83: Program Integrity Manual (Ch.6 Part 6).

General Documentation Guidelines Supporting Medical Necessity

Medical History

If a history of previous SLP treatment is not available, the provider may furnish a general summary regarding the patient’s past relevant medical history recorded during the initial assessment with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior treatment for the current condition, progress made, and treatment by the referring physician must be provided when available. The level of function prior to the current exacerbation or onset should be described.

The patient's medical history includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is necessary for patients who have transferred to a new provider for additional treatment. For chronic conditions, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate the start of skilled care at this time.

Speech-Language Pathology Evaluation

Intermediaries and carriers approve the initial assessment when it is reasonable and necessary for the speech-language pathologist to determine whether either restorative services or the establishment of a maintenance program will be appropriate for the patient's condition.

Reassessments are covered if the patient exhibits a demonstrable change in motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated SLP services. Periodic routine reevaluations (e.g., monthly, bimonthly) for a patient undergoing a SLP program are part of the treatment session and are not covered as separate evaluations. An initial assessment or reassessment that is determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the assessment determines that skilled services are not needed.

The assessment establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals. The initial assessment must include objective baseline diagnostic testing (standardized or non-standardized), interpretation of test results, and clinical findings. If baseline testing cannot be accomplished for any reason, note this in the initial assessment or progress notes, along with the reason(s). Include a statement of the patient's expected rehabilitation potential.

Plan of Treatment

~~The plan of treatment must contain the following:~~

- ~~• The patient's diagnosis;~~
- ~~• Type services to be provided;~~
- ~~• Functional goals and estimated rehabilitation potential;~~
- ~~• Frequency of visits; and~~
- ~~• Estimated duration of treatment.~~

~~The plan of care must be established (reduced to writing) by either a qualified professional, or by the provider when it makes a written record of the oral orders before treatment is begun. When outpatient SLP services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days (60 days for CORF) that there is a continuing need for them. Intermediaries obtain the re-certification when reviewing the plan of treatment since the same interval of at least 30 days (60 days for CORF) is required for the review of the plans. Re-certification must be signed by the physician who reviewed the plan of treatment. Any changes established by the speech language pathologist must be in writing and signed by the speech language pathologist or by the attending physician. The physician may change a plan of treatment established by the speech language pathologist. The speech language pathologist may not alter a plan of treatment established by a physician.~~

RATIONALE FOR ABOVE DELETION: Information regarding plan of treatment and certification/recertification is redundant. (see pages 13-14)

Functional Goals

Functional goals must be written by the speech-language pathologist to reflect the level of communicative independence the patient is expected to achieve outside of the therapeutic environment. The functional goals reflect the final level the patient is expected to achieve, are realistic, and have a positive effect on the quality of the patient's everyday functions. Intermediaries and carriers assume that certain factors may change or influence the final level of achievement. If this occurs, the speech-language pathologist must document the factors that led to the change of the functional goal. Examples of functional communication goals in achieving optimum communication independence are the ability to:

- Communicate basic physical needs and emotional status;
- Communicate personal self-care needs; or
- Engage in social communicative interaction with immediate family or friends.

The term "communication" includes speech and language, as well as voice skills.

A functional goal may reflect a small, but meaningful change that enables the patient to function more independently in a reasonable amount of time. For some patients, it may be the ability to give a consistent "yes" and "no" response; for others, it may be the ability to demonstrate a competency in naming objects using auditory/verbal cues. Others may receptively and expressively use a basic spoken vocabulary and/or short phrases, and still others may regain conversational language skills.

Treatment Objectives

Treatment objectives are specific steps designed to reach a functional goal. When the patient achieves these objectives, the functional goal is met.

Frequency and Length of Visits

Frequency of visits is an estimate of how often the treatments are to be rendered (e.g., 3x week). Length of visits are typically 30, 45, or 60 minutes. Sometimes patients are seen for shorter periods several times a day (e.g., three 15 minute sessions, or a total of 45 minutes). Rarely, except during an assessment, are sessions longer than 60 minutes. If so, the provider must justify them, by noting, for example, that the patient is exceptionally alert, the number of appropriate activities needing skilled intervention is greater than average or special staff/family training is required. Post-operative intensive treatment is sometimes required (e.g., tracheoesophageal puncture) or post-onset of disorder (due to intensive family involvement).

Estimated Duration of Treatment

Estimated duration of treatment refers to the total estimated time over which the services are to be rendered, and may be expressed in days, weeks, or months.

Progress Reports

Intermediaries and carriers obtain progress reports or a treatment summary for the billing period including:

- The initial functional communication level of the patient at this provider setting;
- The present functional level of the patient and progress (or lack of progress) specific for this reporting period;

- The patient's expected rehabilitation potential; and
- Changes in the plan of treatment.

Where a valid expectation of improvement existed at the time services were initiated, or thereafter, the services are covered even though the expectation may not be realized. However, in such instances, intermediaries and carriers approve the services up to the time that no further significant practical improvement can be expected. Progress reports must document a continued expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

"Significant" means a generally measurable and substantial increase in the patient's present level of communication, independence, and competence compared to their levels when treatment was initiated. Intermediaries and carriers must not interpret the term "significant" so stringently that they may deny a claim because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's overall functional ability will occur. However, the speech-language pathologist and/or physician should document such lack of progress and explain the need for continued intervention.

Documentation includes a short narrative progress report and objective information in a clear, concise manner. This provides the reviewer with the status on progress in meeting the plan of treatment, along with any changes in the goals or the treatment plan. Medical reviewers request that new plans be forwarded with the original so that they can review the entire plan. However, the reviewer must have access to an overall treatment plan with final goals and enough objective information with each claim to determine progress toward meeting the goals.

Consistent reporting is important. For example, if the provider reports that the patient can produce an "m" 25 percent of the time, then reports 40, 60, 90 percent success, the intermediary may believe that treatment might be ending. However, if they have the final goal and the objectives, they can see the progress toward that goal and the steps needed to reach it. The speech-language pathologist might state that the final goal is "the ability to converse in a limited environment."

One underlying SLP goal might be to "reduce the apraxia sufficiently so the patient can initiate short intelligible phrases with a minimum of errors". Short-term goals may include the patient's ability to initiate easier phonemes before other, more difficult, phonemes. Therefore, the speech-language pathologist has a linguistically and neurologically sound basis for working on one phoneme production before initiating another.

The speech-language pathologist might work on a group of phonemes having a "feature" in common before working on another group. For example, working on all bilabials (since the patient can easily see the movement), might be desirable prior to sounds that are produced more intraorally.

The speech-language pathologist may choose how to demonstrate progress. However, the method chosen, as well as the measures used, generally remain the same for the duration of treatment. The provider must interpret reports of test scores, or comparable measures and their relationship to functional goals in progress notes or reports. Diagnostic testing should be appropriate to the communication disorder.

While a patient is receiving SLP treatment, the speech-language pathologist reassesses the patient's condition and adjusts the treatment. However, if the method used to document progress is changed, the reasons must be documented, including how the new method relates to the previous method. If the speech-language pathologist reports a sub-test score for one month, then a score of a different sub-test the next month without demonstrating the sub-test's interrelationship, a reviewer is not able to judge the progress. The intermediary or carrier may return these claims for an explanation/interpretation. They may refer the claims to Level III MR if needed. If there is a change in the plan of treatment, it must be documented in

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Deliverable # 23 – Final Therapy Review Protocols
Speech-Language Pathology Protocol

accordance with [42CFR410.61]. Additionally, when a patient is continued from one billing period to another, the progress report(s) must reflect comparison between the patient's current functional status and that obtained during the previous billing and/or at the initial evaluation.

Level of Complexity of Treatment

Intermediaries and carriers must base decisions on the level of complexity of the services rendered by the speech-language pathologist, not what the patient is asked to do. For example, the patient may be asked to repeat a word and the speech-language pathologist analyzes the response and gives the patient feedback that the patient uses to modify the response. The speech-language pathologist may ask staff or family to repeat the activity as a reinforcement. It is the speech-language pathologist's analysis that makes the activity skilled.

Reporting on a New Episode or Change of Condition

Occasionally, a patient who is receiving, or has previously received SLP services, experiences a secondary or complicating new illness. The provider documents the significance of any change to the communication capabilities. This may be by pre-and post-episodic objective documentation, through nursing notes or by physician reports. If the patient is receiving treatment, it might have to be lengthened because of his change in condition. If the patient has completed treatment, a significant change in the communication status must be documented to warrant a new treatment plan.

Skilled Procedures:

The established plan of treatment and therapeutic modalities are expected to improve the patient's functional abilities. Skilled procedures may include but are not limited to:

- Design of a treatment program addressing the patient's disorder.
- Continued assessment and analysis during the implementation of the services at regular intervals.
- Establishment of compensatory skills for communication, e.g., attention and organization strategies or word finding strategies.
- Analysis related to actual progress toward goals.
- Establishment of treatment goals specific to communication dysfunction and designed to specifically address each problem identified in the initial assessment.
- Selection of a device for augmentation or for use as an alternative communication system and short term training on how to use the device or system. Ongoing supervision of the practice in using the device or system is considered to be an unskilled service and not covered.
- Patient and family training to augment restorative treatment or to establish a maintenance program. Education of staff and family should begin at the time of evaluation.
- Supervision of a patient using augmentative or alternative communication systems vocabulary or vocabulary in new context for purposes of modification of the system.

Documentation must be present to support the ability of the patient to benefit from instruction or demonstrate improved communication through environmental modifications. Absence of this documentation will result in a denial of services.

CPT/HCPCS Section & Benefit Category

CPT/HCPCS Section

- Surgery
- Medicine

- Physical Medicine and Rehabilitation
- Special OtoRhinolaryngology

Benefit Category: Medicare Part B

- **Medical and other health services except when furnished by or under arrangements with a provider of services –1832(a)(1):**
 1. Services and supplies incident to a physician's professional services [1861(s)(2)(A)] {1833(a)(1)(N), 1848(a)(1) & 1848(j)(3)}
 2. Physician assistant services and incident to [1861(s)(2)(K)] {1842(b)(12)}
 3. Nurse practitioner services and incident to [1861(s)(2)(K)] {1842(b)(12)}
 4. Clinical nurse specialist services and incident to [1861(s)(2)(K)] {1833(a)(1)(O), 1833(r), & 1848}
 5. Other diagnostic tests [1861(s)(3)] {1833(a)(1)(N), 1848(a)(1), & 1848(j)(3)}
- **Medical and other health services only when furnished by or under arrangements with a provider of services –1832(a)(2)(B):**
 1. Outpatient hospital services and supplies incident to a physician's services [1861(s)(2)(B)] {1833(a)(2)(B), 1833(a)(4), 1833(I), & 1886}
 2. Outpatient speech-language pathology [1861(p)] {1833(a)(2)(B)}
 3. Other diagnostic tests [1861(s)(3)] {1833(a)(2)(E) & 1833(n)}
- **Outpatient speech-language pathology 1832(a)(2)(c) [1861(p)] {1833(a)(2)(B)}**
- **CORF Services 1832(a)(2)(E) [1861(cc)] {1833(a)(3)}**
- **ASC facility services 1832(a)(2)(F) {1833(a)(4), 1833(I), & 1833(n)}**

Type of Bill Code

Type of bill codes apply only to intermediary claims
12x, 13x, 22x, 23x, 34x, 74x, 75x, 83x

Revenue Codes

Revenue center codes apply only to intermediary claims
044x = speech-language pathology services

CPT/HCPCS Codes

Note: Listing of HCPCS codes contained in this LCD does not assure coverage of the specific service. Current coverage and medical necessity criteria still apply. The list of codes below contains commonly utilized codes for outpatient rehabilitation services used by speech-language pathologists. Further detailed descriptions of the documentation requirements that would support payment of many of these codes are located in the *'Indication and Limitations of Coverage and/or Medical Necessity'* section of this LCD.

When Performed by a Speech-Language Pathologist

31505 Laryngoscopy, indirect; diagnostic (separate procedure)

31570 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic

31575 Laryngoscopy, flexible fiberoptic; diagnostic

31579 Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

90901 Biofeedback training by any modality

92506 - Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status

92507 - Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals

92508 group, two or more individuals

~~92510 Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming~~ **RATIONALE FOR DELETION: CMS ceased reimbursing for this code in 2003. New codes for audiologists only are recognized.**

92511 Nasopharyngoscopy with endoscope (separate procedure)

92512 Nasal function studies (eg, rhinomanometry)

92526 Treatment of swallowing dysfunction and/or oral function for feeding`

92551 Screening test, pure tone, air only

92597 - Evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communication device to support oral speech

~~92598 – Modification of voice prosthetic or augmentative/alternative communication device to supplement speech~~ **RATIONALE FOR DELETION: In 2003, CPT 92598 was deleted. CMS instructed users to use 92507 in its place (Federal Register, December 31, 2002, p. 80016).**

THE FOLLOWING CPT CODES (UNDERLINED) WERE ORIGINALLY LISTED AS G CODES:

92607 Evaluation for prescription for speech-generating augmentative and alternative communicate device; face-to-face wit the patient; evaluation, first hour

92608 each additional 30 minutes

92609 Therapeutic services for the use of speech-generating device, including programming and modification

96105 - Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

96110 - Developmental testing; limited, with interpretation and report

96111 - Developmental testing, extended, with interpretation and report, per hour

96115 - Neurobehavioral status exam with interpretation and reporting, per hour

97532 - Cognitive skills development to improve attention, memory, and problem solving. Treatments may include compensatory and rehabilitative training techniques and require direct, one-on-one contact by the provider with the patient; billable in 15-minute increments.

97533 – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes.

RATIONALE for addition: CPT 97533 is included in the SLP LCDs of at least five fiscal intermediaries, including AdminaStar Federal, Mutual of Omaha, TriSpan. These services are clearly within the scope of practice of speech-language pathologists.

Not Otherwise Classified (NOC)

ICD-9 Codes that Support Medical Necessity

One of the specific medical diagnoses listed on the claim is appropriate for the disorder or disease.

Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

Diagnoses that DO NOT Support Medical Necessity

Reasons for Denial

Statutory Exclusions

Medicare will not pay for services that are statutorily excluded in Section 1862(a) of the Act

- 1862(a)(2): The service is one for which the individual has no legal obligation to pay;
- 1862(a)(3): The service is payable by another governmental agency;
- 1862(a)(4): The service was provided outside the United States;
- 1862(a)(5): The service was required as a result of war;
- 1862(a)(6): The items furnished constitute personal comfort items;
- 1862(a)(7): The service represents a routine screening;
- 1862(a)(8): The items furnished constitute non-covered supportive devices for the feet;
- 1862(a)(9): The services rendered constitute custodial care;
- 1862(a)(10): The services constitute cosmetic surgery;
- 1862(a)(11): The service was rendered by an immediate relative or member of the same household;
- 1862(a)(12): The services rendered constitute non-covered dental services;
- 1862(a)(13): Determine whether services constitute treatment of flat foot, treatment of subluxations of the foot or routine foot care;
- 1862(a)(14) The service constitutes other than physician services; or
- 1862(c) of the Act to determine whether services constitute "less than effective drugs."

Medical Necessity Denial ANSI Codes

The following American National Standards Institute (ANSI) Claim Adjustment Reason Codes (OCI 17-007 R 02/2001) indicate to the provider the reason for claim or line denials for medical necessity.

- 11 – The diagnosis was inconsistent with the procedure.
- 49 – These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 – These are noncovered services because the payer does not deem them a “medical necessity”.
- 51 – These are noncovered services because this is a preexisting condition.
- 55 – Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer. <http://www.hcfa.gov/coverage/8d2.htm> [Replace with updated URL] Medicare Coverage Policy ~ Clinical Trials National Coverage Decision
- 56 – Claim/service denied because procedure/treatment has not been deemed “proven to be effective” by the payer.
- 57 – Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage, or this day’s supply.

Non-covered ICD-9 Code(s)

Non-covered Diagnosis

Coding Guidelines

CMS developed the Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

CCI edits are updated quarterly and are available through the US Government's National Technical Information Services (NTIS) at: 1-800-553-6847, or at the following website:
<http://www.ntis.gov/product/correct-coding.htm#Print>. <http://cms.hhs.gov/physicians/cciedits/default.asp>

The most recent CMS instructions related to coding of Part B speech-language pathology services are contained in Program Memorandum AB-01-68 '*Consolidation of Program Memorandums for Outpatient Rehabilitation Therapy Services*' at: <http://www.CMS.gov/pubforms/transmit/AB0168.pdf>

Documentation Requirements

See '*Indication and Limitations of Coverage and/or Medical Necessity*' section.

Utilization Guidelines

Contractor Entry

Other Comments

Contractor Entry

Sources of Information and Basis for Decision

Social Security Act
Code of Federal Regulations
CMS Program Manuals
CMS Program Memorandums and Transmittals
CMS website
Carrier and Intermediary Local Coverage Determinations (LCDs)
Therapy Review Program Workgroups
Interviews with intermediaries and carriers
Interviews with treating clinicians and providers
Therapy Review Program Literature Review Activities
Documentation submitted by provider associations

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which include representatives from (fill in appropriate specialty name).

Advisory Committee meeting date:

Start Date of Comment Period

Contractor Entry

Ending Date of Comment Period

Contractor Entry

Start Date of Notice Period

Contractor Entry

Revision History

Contractor Entry

Number Date Changes