AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Knowledge and Skills in Business Practices Needed by Speech-Language Pathologists in Health Care Settings

Ad Hoc Committee on Business Practices for Speech-Language Pathologists in Health Care Settings

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About This Document

This policy statement was developed by the Ad Hoc Committee on Business Practices for Speech-Language Pathologists in Health Care Settings, whose members include Lee Ann C. Golper (chair), Evie Hagerman, Pete Johnson, Ann W. Kummer, Patricia A. Rogers, John M. Torrens, Janet Brown (ex officio), and Alex Johnson, 2000–2002 vice president for professional practices in speech-language pathology. This document was approved by ASHA's Legislative Council (SLP/SLS 2-2002) at their November 2002 meeting.

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Introduction

This Knowledge and Skills document is an official statement of the American Speech-Language-Hearing Association (ASHA). The focus of this document is the need to understand the business practice mechanisms underlying service delivery in health care settings.

Speech-language pathology is a service profession to which principles of business must be applied for success in health care settings. For a business entity (profit or nonprofit) to be successful, good business practices are essential. Providing quality services that are consistent in type and amount with client need and professional and ethical standards is good business practice. It is important that revenues collected for services cover and exceed all expenses (e.g., salary, benefits, overhead). Clinicians must understand their individual responsibility for adhering to practice standards that financially support their organization. Each clinician's daily decisions (clinical and nonclinical) affect the financial viability of his or her organization.

This document describes a continuum of knowledge and skill development for health care providers that is acquired through graduate education, on-the-job training, and continuing professional education. A glossary is provided.

Role 1.0 Provide appropriate services that meet the business needs of the organization

Knowledge Required:

a. The organization's vision, mission, values, and strategic plan and how they are integrated into clinical practice
b. Funding sources for different health care organizations (e.g., large/small, for-profit/non-profit, grant/fee for service) and their impact on clinical services
c. The impact of utilization, productivity, and efficiency on the financial viability of the organization and department and their effect on the value associated with the clinical services and on the job security
d. The importance of cost containment in health care settings
e. The importance of being flexible and creative to reconcile service delivery methods with payment realities (e.g., creating home programs, referring to community groups to extend services, using telepractice when transportation costs are problematic, etc.)

Skills Required:

a. Develop and manage an efficient schedule and workflow

b. Balance billable and nonbillable activities, given the organization's requirements
c. Identify and use available resources efficiently

Role 2.0 Ensure compliance and professional practice

Knowledge Required:

a. Voluntary accreditation organizations (e.g., Joint Commission on Accreditation of Health Care Organizations, CARF, Council on Accreditation of Professional Services) and mandatory state certification (e.g., Board of Health) when required
b. Facility/corporate policies and procedures
c. The ASHA Code of Ethics, Scope of Practice, Preferred Practice Patterns, and professional "best practices" (e.g., knowledge of policy documents and evidence-based practice)
d. How to access pertinent state and federal legislation (e.g., HIPAA, etc.) governing business practices through licensure boards and state associations and agencies
e. What constitutes fraud and abuse
f. How to report violations to the appropriate body
g. The similarities and differences between ASHA certification and state licensure and their respective roles
h. The purpose and requirements of voluntary professional recognition or certifications (e.g., ASHA Specialty Recognition, ANCDS Board certification, etc.)
i. Legislation affecting privacy and exchange of electronic information (i.e., HIPAA)

Skills Required:

a. Apply knowledge of standards during preparation for and participation in voluntary or mandatory accreditation or certification surveys
b. Access appropriate facility/corporate policies and procedures as needed
c. Comply with ASHA Code of Ethics, Scope of Practice, and other pertinent practice policy documents; state licensure requirements; and other applicable state and federal laws
d. Comply with legislation involving privacy and exchange of electronic information (i.e., HIPAA)

Role 3.0 Achieve quality outcomes and performance improvement

Knowledge Required:

a. Clinical outcome measurement tools and applications
b. Evidence-based practice and the differences between treatment efficacy, effectiveness, cost effectiveness, and efficiency
c. The importance of customer satisfaction
d. The importance of quality assurance and performance improvement

Skills Required:

a. Use and apply tools for clinical outcome measurements (e.g., National Outcomes Measurement System [NOMS]) and performance improvement

b. Apply evidence-based practices and principles in evaluating clinical techniques, products, and programs
c. Collect customer (e.g., consumer, payer, referral source) satisfaction data and use it to improve services
d. Participate in data collection for performance improvement and implement changes as directed

Role 4.0 Provide advocacy

Knowledge Required:

a. Consumer and professional advocacy resources (e.g., ASHA's Web site, consumer groups, other professional associations, public agencies)
b. Relevant issues, information, and data to use in advocacy (e.g., cost/benefit of services, outcomes)
c. How to influence the federal, state, and local legislative and regulatory process, as well as payers, consumers, and self-help groups

Skills Required:

a. Communicate the need for and benefit of services for individuals with speech-language and swallowing disorders
b. Engage in advocacy on a national, state, and/or local level on professional/consumer issues (e.g., advocating SLPs as the most qualified provider of services for speech-language and swallowing disorders)
c. Use data from multiple sources to advocate for clients, profession, and self

Role 5.0 Promote and market professional services

Knowledge Required:

a. The role of marketing and its importance to the profession
b. Marketing resources for the profession and how they would meet the needs and interests of different audiences (e.g., family members, health care professionals, payers, culturally and linguistically diverse groups)
c. The organization's marketing plan, its importance to the survival of the organization and profession, and the clinician's role
d. The organization's public relations program and its role in marketing (e.g., customer service, handling complaints)

Skills Required:

a. Identify opportunities and engage in activities to promote professional services with both internal (e.g., colleagues, other professionals) and external (e.g., referral sources, consumer groups) contacts
b. Select marketing resources that are appropriate to the audience
c. Deliver superior customer service consistent with the organization's mission and values
d. Resolve a complaint satisfactorily

Role 6.0 Use technology

Knowledge Required:

a. Personal computing hardware basics (e.g., processing speeds, memory, peripherals)
b. Personal computer software basics (e.g., operating systems, word processing, spreadsheets, databases, presentation, and communication applications)
c. Basic Internet functions (e.g., content searches, e-mail)

d. Basic network computing (e.g., file sharing, security, shared peripherals)
e. The basic issues surrounding the use of telepractice in the professions

Skills Required:

a. Identify/describe basic hardware components in a personal computing device
b. Use the functions of basic computing software and productivity software; search the Internet for relevant content; and send, receive, and file electronic mail
c. Identify/describe basic network computing concepts such as file sharing, security, and shared peripherals

Role 7.0 Obtain payment for services

Knowledge Required:

a. Different types of payers (e.g., Medicare, Medicaid, HMOs, PPOs, private health plans) and other private pay options and payment systems (e.g., Medicare Prospective Payment System, Medicare Fee Schedule)
b. The financial impact of patient placement along the continuum of care (e.g., acute, long term, home health, outpatient)
c. Payer-specific eligibility requirements (e.g., medical necessity, skilled versus unskilled services)
d. Payer-specific documentation requirements (e.g., plan of care, including measurable long- and short-term goals, prognostic statements)
e. Payer-specific documentation instruments (e.g., MDS, IRF PAI)
f. How to accurately record services and codes (e.g., CPT, ICD, HCPCS, DSM)
g. The relationship between procedural (CPT) and diagnostic (ICD) codes
h. What constitutes a billable service
i. The proper documentation procedures to reduce the probability of denials
j. The methods for appealing denials from third-party payers
k. The concept of medical necessity and how it is used for reimbursement by third-party payers
l. The importance of obtaining insurance and other required authorizations/reauthorizations in advance of the delivery of services
m. Eligibility and documentation requirements for obtaining equipment (e.g., Durable Medical Equipment [DME] and prosthetics)

Skills Required:

a. Work with case managers, third-party payers, clients, and families to establish the need for—as well as obtain authorization before—the delivery of services
b. Document services in a manner consistent with requirements (e.g., progress made, reasonable and necessary, medical necessity) of different types of payers
c. Code charges appropriately for services provided and documented to justify codes billed
d. Track the number of visits, amount of treatment time, and the authorization period so that services are not provided without authorization or an agreement from the patient/guardian to self-pay
e. Provide appropriate documentation to appeal a denial

Glossary

ANCDS: Academy of Neurologic Communication Disorders and Sciences. Group founded in 1983 that provides professional, clinical, educational, scientific, and charitable contributions to adults and children with neurologic communication disorders.

Authorization: Permission to provide a given service (evaluation or treatment) for a given condition, for a specified duration and frequency. Authorization is typically obtained from a patient's health plan through a case manager after the patient's insurance eligibility and benefits have been checked and found to cover speech-language pathology services.

CARF: The Rehabilitation Accreditation Commission. An independent, not-for-profit accrediting body promoting quality, value, and optimal outcomes of services through a consultative accreditation process.

Certification: A statement by a physician (or other designated health professional, depending on the type of facility), required by Medicare, that certifies that the service is medically necessary, that he/she concurs with the plan of treatment, and that the treatment is being provided under his/her supervision.

CMS: Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration or HCFA). The federal agency within the Department of Health and Human Services that administers Medicare and Medicaid programs.

Consumer/Customer: The entity affected by a provided service. May include the client/patient, payer, referral source, case manager, family, caregiver, and so forth.

Continuum of Care: Provision of services within an organization or across multiple organizations to meet an individual's ongoing or changing health care needs.

CPT Codes: Current Procedural Terminology codes. Codes maintained and copyrighted by the American Medical Association and used by providers and payers to provide uniform language for medical and surgical procedures. ASHA participates in the formal process for development of CPT codes that represent procedures rendered by SLPs or audiologists.

DME: Durable medical equipment. Permanent equipment for medical treatment (e.g., augmentative and alternative communication devices, wheelchairs, and oxygen tanks).

DSM: Diagnostic and Statistical Manual of Mental Disorders. The manual used by mental health workers as the diagnostic coding system for substance abuse and mental health disorders.

Effectiveness: How well a treatment works in real-life average conditions. Ideally, studies of a given treatment's effectiveness are made after the treatment is determined to be efficacious (i.e., beneficial in ideal, controlled conditions).

Efficacy: Probability that a defined treatment will benefit a specific population under ideal testing conditions, such as in randomized controlled trials (RCT).

Efficiency: Measurement of the cost per unit of outcome. Improving efficiencies implies producing effective outcomes with minimal expense, waste, or unnecessary effort.

Evidence-Based Practice: Use of the current best research findings and/or expert consensus opinions to make clinical decisions about patient care. Levels of evidence include Class I: randomized controlled clinical trials; Class II: evidence from at least one well-designed observational clinical study with concurrent controls; and Class III: evidence provided by expert opinion, case studies, and studies with historical controls.

Fraud and Abuse: Intentional deception or misrepresentation of services or patient needs that may result in an unauthorized benefit to the patient, clinician, or organization. Includes accepting kickbacks, waiving copayments, billing for services not rendered, or using a fraudulent diagnosis to obtain coverage.

HCPCS: Healthcare Common Procedure Coding System. Standardized coding system consisting of three levels. Level I codes consist of CPT codes as set forth by the American Medical Association. Level II codes are alphanumeric codes used to report medical services and supplies.

HIPAA: Health Insurance Portability and Accountability Act of 1996. The privacy rule and electronic data interchange provisions of HIPAA set forth regulations designed to protect the confidentiality of all health care-related information and to mandate the format of all electronically stored and transferred patient data.

HMO: Health Maintenance Organization. Managed care plan in which providers are reimbursed at a specified rate and enrollees are required to use participating providers (i.e., specific facilities, rehabilitation providers, dentists, physicians, etc.) Primary physicians serve as gatekeepers for referrals.

ICD: International Classification of Disease. Published by the World Health Organization. The manual consists of numeric codes assigned to written descriptions of a diagnosis, condition, or problem for the purpose of establishing standardized disease classifications. The codes are required documentation for Medicare B claims by physicians, as well as by many private payers. The version commonly used by health care providers is the ICD-9-CM (i.e., Ninth Revision, Clinical Modification).

IRF PAI: Inpatient Rehabilitation Facility Patient Assessment Instrument. Tool used to determine a patient's functional status in an inpatient rehabilitation facility as required by the Medicare Prospective Payment System.

JCAHO: Joint Commission on Accreditation of Healthcare Organizations. An independent, not-for-profit accreditation organization that develops standards to improve the safety and quality of patient care and accredits health care facilities (hospitals, home health agencies, long-term care facilities, ambulatory care, etc.).

Marketing: Process by which individuals or groups obtain what they want or need by creating and exchanging products or services with others. Marketing involves the “5 Ps”: product (the commodity being offered), price, place (access to the product), promotion (ads, commercials, and other media), and position (how the

product compares to similar products). Marketing differs from sales. Marketing seeks to identify the customers' needs and then to satisfy those needs. Sales promote an existing product to satisfy the seller's needs.

MDS: Minimum Data Set. A screening and care planning tool used to determine the functional status of nursing home residents and required as part of the Medicare Prospective Payment System for Skilled Nursing Facilities.

Medicaid: Federal/state health insurance program that provides coverage for qualified low-income people. It is financed by a mix of state and federal funds and administered by each state within broad federal guidelines.

Medical Necessity: Regulation by Medicare and most third-party payers that services provided must be necessary for the diagnosis or treatment of a patient's medical condition and that the services meet the standards of good medical practice.

Medicare: Federally funded health insurance program for individuals age 65 and older, individuals with end-stage renal disease, and some severely disabled individuals under age 65. Part A covers hospital services, hospice care, home health services, and the first 90 days and 100 days, respectively, of inpatient hospital and skilled nursing facility care. Part B is a voluntary supplemental program that covers medical services, inpatient ancillary services after Part A services have been exhausted, and outpatient services other than home health and hospice care.

Medicare Physician Fee Schedule: Payment rates set and adjusted annually by CMS based on CPT codes in the HCPCS. Rates are set using a resource-based relative value system (RBRVS) that assigns a relative value to each CPT procedure.

Medicare Prospective Payment Systems: Prospective payment systems (PPSs) were mandated by the Balanced Budget Act of 1997 in order to contain Medicare's health care costs. The different systems include SNF PPS (Skilled Nursing Facilities), Prospective Payment System for Home Health Agencies, OPPS (Outpatient Prospective Payment System for hospitals), and IRF PPS (Inpatient Rehabilitation Facilities). Medicare established a PPS for inpatient hospital stays in 1982 called DRGs (Diagnosis-Related Groups).

Mission: Brief statement defining basic goals and the major tasks and activities of the organization and what the organization is about. For example, “provide quality patient-centered and family-centered services to communicatively impaired individuals.”

NOMS: National Outcomes Measurement System. ASHA's database for tracking patient outcomes using seven-point Functional Communication Measures and scored by certified professionals at client admission and discharge.

Outcome: The change in patient status as a result of specific treatment procedures.

Performance Improvement: The process by which an individual's or organization's functioning is studied and adapted to achieve desired outcomes.

PPO: Preferred Provider Organization. Managed care plan organized by insurers or providers that contracts with networks of providers who agree to provide health care services and receive payment according to a negotiated fee schedule. Enrollees have free choice of providers but have a financial incentive to use providers within the network.

Productivity: Ratio of outputs (number of visits, number of procedures, minutes of treatment, etc.) to inputs (time, effort, and costs to produce those services).

Qualified Provider: Requirement by payers that professional staff be licensed, certified, or registered as required by state law. It is ASHA's long-established position that only individuals who hold a Certificate of Clinical Competence in Speech-Language Pathology are qualified to provide, or supervise others who assist in the delivery of, speech-language pathology services.

Risk Management: Systematic approach to identifying and reducing the occurrence of factors that put the patient or the provider at some risk (legal risk, risk of injuries or harm, or increased costs).

Skilled Service: Service that is sufficiently complex in nature to require the knowledge and training of a professional.

Strategic Plan: Processes aimed at maximizing an organization's competitive advantages and its ability to meet its goals.

Telepractice: The application of technology to deliver health services at a distance. May involve training or education, assessment, and treatment.

Unskilled Service: Service not requiring professional-level knowledge and training; can be accomplished by someone without formal training. Routine or repetitive activities are generally considered unskilled services.

Utilization Review: Systematic approach for identifying the provision or occurrence of unnecessary costs per unit of service (e.g., ordering unnecessary procedures, drugs, materials, or supplies or requiring unnecessary personnel) without diminishing the quality of care.

Values: Statement describing the basic beliefs from which the organization or corporation operates (e.g., “We put patients first”).

Vision Statement: Description of the goals the organization seeks to achieve (e.g., “serve as a model and center of excellence in clinical service delivery”).

Workflow Analysis: An examination of the component elements within a given task and connections between elements required to complete the task (e.g., the key elements, steps, and processes required to schedule a patient for an appointment).

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