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ASSOCIATION

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February 2, 2015

Representative Mitch Greenlick
Chair, House Committee on Health Care
900 Court St. NE, H-493
Salem, OR 97301

RE: H.B. 2796

Dear Representative Greenlick:

On behalf of the Oregon Speech-Language-Hearing Association's members, I am writing to address a concern with the recent proposed legislation, H.B. 2796, which we believe unnecessarily licenses music therapists.

The Oregon Speech-Language-Hearing Association (OSHA) is the state professional association for more than 2300 actively licensed Speech-Language Pathologists, Audiologists and Speech-Language Pathology Assistants, as well as students enrolled in the three graduate level programs in Oregon universities. The Board of OSHA met on 1/31/15 and as a governing body, agreed that passage of this bill and the potential for licensing of Music Therapists (MTs) will not be in the best interest of persons with communication disorders who need the services of highly qualified professionals to provide them with the services that will make meaningful and lasting change in their ability to communicate in a variety of life contexts.

Please refer to the letter you will have received from Eileen Crowe, of the American Speech-Language and Hearing Association (ASHA) for a description of the training of SLPs and the contrast to that of MTs. She also provides a contrast in the Scopes of Practice, therefore, those elements will not be repeated here. Additionally, find enclosed the OSHA position statement regarding Universal Licensure, as covered in Senate Bill 287 and referred to the Senate Education Committee.

As the Committee is well aware, the resources available to meet the needs of persons with developmental and disabling medical conditions are limited. The Oregon Health Plan currently allows for a combined benefit of 30 visits for medically necessary services (see Guideline Note 6 of the 2015 Prioritized List of Health Services)[i]. The defined medically necessary services include Physical, Occupational, Speech, Cardiac and Vascular Therapy. An additional 30 visits may be authorized if the individual is making objective and measureable progress with the authorized plan of treatment, which is overseen by a Physician and authorized by the Managed Care Organization administering the benefits. These guidelines were recommended by the Health Evidence Review Committee in their 8/14/14 meeting, and implemented with the October, 2014 Prioritized List of Health Services. As identified in the materials presented at that meeting concerning the existing Rehabilitation Guidelines[ii],
"Issues:

1) The current guideline with different visit numbers based on age without medical justification is not allowed under the ACA
2) At the May, 2014 meeting, the VBBS adopted a modified guideline without any visit limits
3) Medical Director feedback indicates that some type of numerical limits are strongly desired. The modified guideline shown in the recommendations section has been reviewed by the Medical Directors and they have no objections or comments.
4) HERC staff are concerned about lack of coverage for neurologic injuries, which may take longer to rehab and may vary on when rehab can begin."

With many conditions, particularly those that involve complex neurologic systems, all three primary rehabilitation disciplines are involved and these limited resources are quickly exhausted before the plan of care can be completed and/or the individual receives maximum benefit from the prescribed therapy program. To introduce another professional entity into this grouping will further dilute these benefits, particularly when all three of the highly trained professionals incorporate elements of music therapy into their treatment modalities when, in their professional training and judgment, the individual would benefit from the approach. By contrast, Music Therapists are trained only in these specific modalities. As acknowledged in the Scope of Practice of Music Therapists[iii]

"**Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.

**Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition."

If the ultimate intent of licensing of Music Therapists is to allow for billing of services to medical health plans, including the Oregon Health Plan, we strongly discourage the Committee from passing this bill. As guided by the American Music Therapy[iv], "Insurance companies' case managers have the control to approve or disapprove a certain service or CPT® code. It is essential for music therapists to effectively communicate with clients' case managers when seeking reimbursement." The document goes on to list potential Current Procedural Technology (CPT) codes that are potentially billable by Music Therapists, including codes for evaluation (e.g., 96105 – Assessment of Aphasia, 96110 – Developmental Testing, 92506 – Speech Evaluation). Per the language of HB2796, Section 1.H (b), "Music Therapy" does not include the diagnosis of physical, mental or communication disorders. When a Speech-Language Pathologist evaluates a patient for communication disorders resulting from a medical illness, accident, injury, or a condition that contributes to a developmental delay, they are using the above codes to describe the service performed to diagnose the communication disorder they will be treating on referral from a Physician.

OSHA does not take the position that Music Therapy serves no value to the individuals. However, we are very concerned about preserving the integrity of the licensing process for the highly trained professionals who are currently identified as qualified medical service providers under the Oregon Health Plan, the Affordable Care Act, the Centers for Medicare and Medicaid Services, and all health insurance plans.

We appreciate your consideration of this matter.

Sincerely,

Kathy de Domingo, MS, CCC-SLP, FACMPE

Kathy de Domingo, MS, CCC-SLP, FACMPE
Legislative Chair
Oregon Speech-Language and Hearing Association

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[i] Prioritized List of Health Services, 1/1/15, Practice Guidelines, page GN-2
[ii] Oregon Health Evidence Review Commission, HERC Meeting Materials, August 14, 2014, page 110
[iii] "Scope of Music Therapy Practice, 2015", American Music Therapy Association, Certification Board for Music Therapists
[iv] "CPT Codes", American Music Therapy Association, 2007, page 1

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

January 30, 2015

Representative Mitch Greenlick
Chair, House Committee on Health Care
900 Court St. NE, H-493
Salem, OR 97301

RE: H.B. 2796

Dear Representative Greenlick:

On behalf of the American Speech-Language-Hearing Association's members, I am writing to address a concern with the recent proposed legislation, H.B. 2796, which we believe unnecessarily licenses music therapists.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for more than 173,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Over 1,700 members reside in Oregon.

**Speech-Language Pathologists: Professionals Trained to Assess and Treat Communication Disorders**

Speech-language pathologists (SLPs) are uniquely educated and trained to assess and treat speech, language, hearing, swallowing, balance, and cognitive communication disorders in children and adults. These services help children acquire language and enable individuals to recover essential skills to communicate about their health and safety, to safely swallow adequate nutrition, and to have sufficient attention, memory, and organizational skills to function in their environment.

SLPs complete a comprehensive education program that meets rigorous standards of practice based on objective methodology which includes the following:

- A master's or doctoral degree with **75 semester credit hours in a course of study addressing the knowledge and skills pertinent to the field of speech-language pathology, as determined, validated, and systematically updated using a skills validation process.**
- A minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology, with the supervision provided by individuals holding the ASHA Certificate of Clinical Competence (CCC).
- A passing score, determined by a cut score analysis, on a national examination administered and validated by the Educational Testing Service.
- Completion of a supervised Clinical Fellowship to meet the requirements of the Certificate of Clinical Competence, the recognized standard in the field.
- State licensure (SLPs are regulated in all 50 states and the District of Columbia).
- Completion of 30 hours of professional development activities every 3 years.

**Music Therapists: Broad Scope of Practice**

Music therapists (MT) are certified through the Certification Board for Music Therapy (CBMT), which broadly defines music therapy and states that MTs can assess sensory, physical, and cognitive and communication abilities. While H.B. 2796 states that MTs cannot diagnosis communication disorders, MTs certified by the CBMT are required to abide by their broad scope of practice that is identified in their Board Certified Domains, which allows for assessment of communication disorders. We believe that a profession's scope of practice is limited to specific competencies acquired through education, training, and practical experience. Unlike SLPs, MTs are not subject to the same rigorous qualification standards and do not acquire the skills necessary to assess and treat communication disorders in their prescribed program of study and subsequent clinical training. However, SLPs are uniquely qualified and trained to evaluate and treat communication disorders.

Of the music therapy licensure bills that have been proposed, only four states have adopted legislative language to regulate MTs through licensure. The Washington state sunrise review below is an illustrative example of state objections to music therapy licensure.

**Washington State Sunrise Review**

In December 2012, the Washington State Department of Health completed its sunrise report on the proposed regulation of MTs. Washington MTs had indicated that the regulation of their profession was necessary to protect the public from misuse of terms and techniques; ensure competent practice; protect access to music therapy services by encouraging payment by third-party payers; recognize music therapy as a valid, research-based health care service; validate the profession in state, national, and international work settings; establish credentialing; and provide a method of addressing consumer complaints and ethics violations.

The Department found that the regulations of MTs do not meet the sunrise criteria based on the following:

- The applicant had not identified a clear and easily recognizable threat to public health and safety from the unregulated practice of music therapy.
- The proposal did not articulate the public need for regulation or that regulation would ensure initial and continuing professional ability above the current requirements for nationally certified music therapists.
- The applicant did not demonstrate that the public cannot be effectively protected by other means in a more cost-beneficial manner.
- The proposal would place a heavy financial burden on the small pool of potential music therapy practitioners to cover the state's costs of regulating the profession.
- The proposal contains flaws that would prohibit the use of music-based therapy by other practitioners as well as Native American and other traditional healers who may use music to aid the sick, injured, or dying.

While the CBMT Domains assert that MTs can assess and treat individuals with a wide range of disorders, we believe that SLPs are the only professionals who can appropriately assess and plan treatment for individuals with communication disorders. Therefore, we urge you reject the proposal to license MTs.

Thank you for the opportunity to submit comments. Should you have any questions or need further information, please contact Eileen Crowe, ASHA's director of state association relations, at ecrowe@asha.org or by phone at 301-296-5667; or Janet Deppe, ASHA's director of state advocacy, at jdeppe@asha.org or by phone at 301-296-5668.

Sincerely,

Judith L. Page

Judith Page, PhD, CCC-SLP
2015 ASHA President

cc: Representative Julie Parrish
Members of the House Committee on Health Care

**GUIDELINE NOTE 5, OBESITY**

*Line 325*

Medical treatment of obesity is limited to accepted intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss. Maintenance visits are covered no more than monthly after this intensive counseling period. Pharmacological treatments are not intended to be included as services on this line.

**GUIDELINE NOTE 6, REHABILITATIVE THERAPIES**

*Lines 34,50,61,72,75,76,78,85,95,96,135,136,140,154,157,164,182,187,188,199,200,204,205,211,258,260,275,290,292,297,305, 306,315,322,345,349,351,358,359,362,374,380,381,391,410,412,420,422,427,435,447,459,468,471,472,484,492,504,515,533, 545,560,577,579,588,597,616*

A total of 30 visits per year of rehabilitative therapy (physical, occupational and speech therapy, and cardiac and vascular rehabilitation) are included on these lines when medically appropriate. Additional visits, not to exceed 30 visits per year, may be authorized in exceptional circumstances, such as in cases of rapid growth/development.

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included on these lines when the following criteria are met:

1. therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide the therapy,
2. there is objective, measurable documentation of clinically significant progress toward the therapy plan of care goals and objectives,
3. the therapy plan of care requires the skills of a medical provider, and
4. the client and/or caregiver cannot be taught to carry out the therapy regimen independently.

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.

Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.

**GUIDELINE NOTE 7, ERYTHROPOIESIS-STIMULATING AGENT (ESA) GUIDELINE**

*Lines 12,63,97,99,116-120,130,137,139,161,162,165,167,183,195,203,204,212,214,218,219,221,233,238,241,242,262-266,274, 279,291-293,299,300,319-321,333,401,402,424,439,533,600*

A) Indicated for anemia (Hgb < 10gm/dl or Hct < 30%) induced by cancer chemotherapy given within the previous 8 weeks or in the setting of myelodysplasia.
   1) Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, ESAs should be discontinued once the hemoglobin level reaches 10, unless a lower hemoglobin level is sufficient to avoid the need for red blood cell (RBC) transfusion.

B) Indicated for anemia (Hgb < 10gm/dl or HCT < 30%) associated with HIV/AIDS.
   1) An endogenous erythropoietin level < 500 IU/L is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200 mg/week.
   2) Reassessment should be made after 8 weeks. If no response, treatment should be discontinued. If response is demonstrated, the lowest ESA dose sufficient to reduce the need for RBC transfusions should be used, and the Hgb should not exceed 11gm/dl.

C) Indicated for anemia (Hgb < 10 gm/dl or HCT <30%) associated with chronic renal failure, with or without dialysis.
   1) Reassessment should be made after 12 weeks. If no response, treatment should be discontinued. If response is demonstrated, the lowest ESA dose sufficient to reduce the need for RBC transfusions should be used, and the Hgb should not exceed 11gm/dl. In those not on dialysis, the Hgb level should not exceed 10gm/dl.

**GUIDELINE NOTE 8, BARIATRIC SURGERY**

*Lines 30,594*

Bariatric surgery for is included under the following criteria:

A) Age ≥ 18
B) The patient has
   1) a BMI ≥ 35 with co-morbid type II diabetes for inclusion on Line 30 TYPE II DIABETES MELLITUS; OR.
   2) BMI >=35 with at least one significant co-morbidity other than type II diabetes (e.g., obstructive sleep apnea, hyperlipidemia, hypertension) or BMI >= 40 without a significant co-morbidity for inclusion on Line 594
C) No prior history of Roux-en-Y gastric bypass or laparoscopic adjustable gastric banding, unless they resulted in failure due to complications of the original surgery.
D) Participate in the following four evaluations and meet criteria as described.
   1) Psychosocial evaluation: (Conducted by a licensed mental health professional)
      a) Evaluation to assess potential compliance with post-operative requirements.

# Rehabilitation Guideline

Question: What type of restrictions should be placed on physical and occupational therapies and other rehabilitative therapies?

Question source: HERC staff

Issues:

1) The current guideline with different visit numbers based on age without medical justification is not allowed under the ACA
2) At the May, 2014 meeting, the VBBS adopted a modified guideline without any visit limits
3) Medical Director feedback indicates that some type of numerical limits are strongly desired. The modified guideline shown in the recommendations section has been reviewed by the Medical Directors and they have no objections or comments.
4) HERC staff are concerned about lack of coverage for neurologic injuries, which may take longer to rehab and may vary on when rehab can begin

Current guideline:

**GUIDELINE NOTE 6, REHABILITATIVE THERAPIES**

*Lines 37,50-52,64,74-76,78,80,85,89,90,94,95,98-101, 108, 109, 115, 116, 122, 129, 139, 141-143,145,146,158,161,167,179,184-185,189, 190, 192, 194, 195, 201, 202, 208, 209,216,226,237,239,270,271,273,274,279,288,289,293,297,302,304,307-309, 318, 336,342,349, 350, 363, 367, 369,375,376,378, 382,384,385,387, 400,406, 407, 434, 441,443,448,455,467,478,489,493,507,516,535,549,562, 580, 597,619,638*

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation, are covered for diagnoses paired with the respective CPT codes, depending on medical appropriateness, for up to 3 months immediately following stabilization from an acute event.

Following the 3 month stabilization after an acute event, or, in the absence of an acute event, the following number of combined physical and occupational therapy visits are allowed per year, depending on medical appropriateness:

- Age < 8: 24
- Age 8-12: 12
- Age > 12: 2

And the following number of speech therapy visits are allowed per year, depending on medical appropriateness (with the exception of swallowing disorders, for which limits do not apply):

- Age < 8: 24

- Age 8-12: 12
- Age > 12: 2

Whenever there is a change in status, regardless of age, such as surgery, botox injection, rapid growth, an acute exacerbation or for evaluation/training for an assistive communication device, the following additional visits are allowed:

- 6 visits of speech therapy and/or
- 6 visits of physical or occupational therapy

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.



*Guideline adopted in May, 2014*

**GUIDELINE NOTE 6, REHABILITATIVE THERAPIES**

*Lines 37,50-52,64,74-76,78,80,85,89,90,94,95,98-101,108,109,115, 116,122, 129, 139,141-143,145,146,158,161,167,179,184,185,189,190,192,194, 195,201, 202, 208,209,216,226,237,239,270,271,273,274,279,288,289,293,297,302,304,307-309,318,336,342,349,350,363,367,369,375,376,378, 382,384,385,387,400, 406, 407,434,441,443,448,455,467,478,489,493,507,516,535,549,562,580,597,619,638*

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included on these lines when the following criteria are met:

1) therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy,
2) there is objective, measurable documentation of progress toward the therapy plan of care goals and objectives,
3) the therapy plan of care requires the skills of a therapist, and
4) the client and/or caregiver cannot be taught to carry out the therapy regimen independently.

# Rehabilitation Guideline

HERC staff recommendation:

1) Adopt the modified rehabilitation guideline as shown below
    a. Consider adding a clause excepting neurologic injuries from visit limits

**GUIDELINE NOTE 6, REHABILITATIVE THERAPIES**

*Lines 37,50-52,64,74-76,78,80,85,89,90,94,95,98-101, 108, 109, 115, 116, 122, 129, 139, 141-143,145,146,158,161,167,179,184,185,189, 190, 192, 194, 195, 201, 202, 208, 209,216,226,237,239,270,271,273,274,279,288,289,293,297,302,304,307-309, 318, 336,342,349, 350, 363, 367, 369, 375,376,378, 382,384,385,387, 400,406, 407, 434, 441,443,448,455,467,478,489,493,507,516,535,549,562,580, 597,619,638*

A total of 30 visits per year of rehabilitative therapy (physical, occupational and speech therapy, and cardiac and vascular rehabilitation) are included on these lines when medically appropriate. Additional visits, not to exceed 30 visits per year, may be authorized in exceptional circumstances, such as in cases of rapid growth/development. Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included on these lines when the following criteria are met:

1) therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide the therapy,
2) there is objective, measurable documentation of clinically significant progress toward the therapy plan of care goals and objectives,
3) the therapy plan of care requires the skills of a medical provider, and
4) the client and/or caregiver cannot be taught to carry out the therapy regimen independently.

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.

Possible additional wording:
Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.

**American Music Therapy Association**
**8455 Colesville Rd., Ste. 1000**
**Silver Spring, MD 20910**
**Tel. (301) 589-3300**
**Fax (301) 589-5175**
**www.musictherapy.org**

**Certification Board for Music Therapists**
**506 East Lancaster Avenue, Suite 102**
**Downingtown, PA 19335**
**800-765-CBMT (2268)**
**Fax (610) 269-9232**
**www.cbmt.org**

# Scope of Music Therapy Practice

**2015**

## Preamble

The scope of music therapy practice defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Such practice also is governed by requirements for continuing education, professional responsibility and accountability. This document is designed for music therapists, clients, families, health and education professionals and facilities, state and federal legislators and agency officials, private and public payers, and the general public.

Statement of Purpose

The purpose of this document is to define the scope of music therapy practice by:

1. Outlining the knowledge, skills, abilities, and experience for qualified clinicians to practice safely, effectively and ethically, applying established standards of clinical practice and performing functions without risk of harm to the public;
2. Defining the potential for harm by individuals without formalized music therapy training and credentials; and
3. Describing the education, clinical training, board certification, and continuing education requirements for music therapists.

## Definition of Music Therapy and Music Therapist

Music therapy is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. A music therapist is an individual who has completed the education and clinical training requirements established by the American Music Therapy Association (AMTA) and who holds current board certification from The Certification Board for Music Therapists (CBMT).

## Assumptions

The scope of music therapy practice is based on the values of non-maleficence, beneficence, ethical practice; professional integrity, respect, excellence; and diversity. The following assumptions are the foundation for this document:

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music

intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.

- **Evidence-Based Practice.** A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

**Music Therapy Practice**

*Music therapy* means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups. Music therapy treatment plans are individualized for each client. The goals, objectives, and potential strategies of the music therapy services are appropriate for the client and setting. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. Music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas. Standards of practice in music therapy include:

- Accepting referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conducting a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client;
- Developing an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the assessed needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
- Implementing an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluating the client's response to music therapy and the music therapy treatment plan, documenting change and progress, and suggesting modifications, as appropriate;
- Developing a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimizing any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborating with and educating the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilizing appropriate knowledge and skills to inform practice including use of research, reasoning, and problem solving skills to determine appropriate actions in the context of each specific clinical setting.

Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context of the interdisciplinary team, supporting the treatment goals and co-treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implementation consider diagnosis and history, are performed in a manner congruent with the client's level of functioning, and address client needs across multiple domains.

**Potential for Harm**

Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices. The music therapist implements ongoing evaluation of client responses and adapts the intervention accordingly to protect the client from negative outcomes.

Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients. These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. Music therapists, therefore, participate in continued education to remain competent, know their limitations in professional practice, and recognize when it is appropriate to seek assistance, advice, or consultation, or refer the client to another therapist or professional. In addition, music therapists practice safely and ethically as defined by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws. Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs. Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary. Individuals attempting to provide music therapy treatment interventions without formalized music therapy training and credentials may pose risks to clients.

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).
- Recognize the client populations and health conditions for which music experiences are contraindicated.
- Comply with safety protocols with regard to transport and physical support of clients.

**Definition of Governing Bodies**

AMTA's mission is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA strives to improve and advance the use of music, in both its breadth and quality, in clinical, educational, and community settings for the betterment of the public health and welfare. The Association serves as the primary organization for the advancement of education, clinical practice, research, and ethical standards in the music therapy profession.

AMTA is committed to:

- Promoting quality clinical treatment and ethical practices regarding the use of music to restore, maintain, and improve the health of all persons.
- Establishing and maintaining education and clinical training standards for persons seeking to be credentialed music therapists.
- Educating the public about music therapy.
- Supporting music therapy research.

The mission of the CBMT is to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice. CBMT is an independent, non-profit, certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer.

CBMT is committed to:

- Maintaining the highest possible standards, as established by the Institute for Credentialing Excellence (ICE) and NCCA, for its national certification and recertification programs.
- Maintaining standards for eligibility to sit for the National Examination: Candidates must have completed academic and clinical training requirements established by AMTA.
- Defining and assessing the body of knowledge that represents safe and competent practice in the profession of music therapy and issuing the credential of Music Therapist Board Certified (MT-BC) to individuals that demonstrate the required level of competence.
- Advocating for recognition of the MT-BC credential and for access to safe and competent practice.
- Maintaining certification and recertification requirements that reflect current practice in the profession of music therapy.
- Providing leadership in music therapy credentialing.

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

**Education and Clinical Training Requirements**

A qualified music therapist:

- Must have graduated with a bachelor's degree (or its equivalent) or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA); and
- Must have successfully completed a minimum of 1,200 hours of supervised clinical work through pre-internship training at the AMTA-approved degree program, and internship training through AMTA –approved National Roster or University Affiliated internship programs, or an equivalent.

Upon successful completion of the AMTA academic and clinical training requirements or its international equivalent, an individual is eligible to sit for the national board certification exam administered by the Certification Board for Music Therapists (CBMT).

**Board Certification Requirements**

The Music Therapist – Board Certified (MT-BC) credential is granted by the Certification Board for Music Therapists (CBMT) to music therapists who have demonstrated the knowledge, skills, and abilities for competence in the current practice of music therapy. The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT, an independent, nonprofit corporation fully accredited by the National Commission for Certifying Agencies (NCCA).

The board certified music therapist credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the American Music Therapy Association (or an international equivalent) and successful completion of an objective written examination demonstrating current competency in the profession of music therapy. The CBMT administers this examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

Once board certified, a music therapist must adhere to the CBMT Code of Professional Practice and recertify every five years through either a program of continuing education or re-examination.

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual. The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

The recertification program contributes to the professional development of the board certified music therapist through a program of continuing education, professional development, and professional service opportunities. All three recertification categories are reflective of the Practice Analysis Study and relevant to the knowledge, skills and abilities required of the board certified music therapist. Documentation guidelines in the three categories require applying learning outcomes to music therapy practice and relating them to the CBMT Board Certification Domains. Integrating and applying new knowledge with current practice, developing enhanced skills in delivery of services to clients, and enhancing a board certified music therapist's overall abilities are direct outcomes of the recertification program. To support CBMT's commitment of ensuring the competence of the

board certified music therapist and protecting the public, certification must be renewed every five years with the accrual of 100 recertification credits.

NCCA accreditation demonstrates that CBMT and its credentialing program undergo review to demonstrate compliance with certification standards set by an impartial, objective commission whose primary focus is competency assurance and protection of the consumer. The program provides valuable information for music therapists, employers, government agencies, payers, courts and professional organizations. By participating in the CBMT Recertification Program, board certified music therapists promote continuing competence and the safe and effective clinical practice of music therapy.

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**AMTA and CBMT created this document as a resource pertinent to the practice of music therapy. However, CBMT and AMTA are not offering legal advice, and this material is not a substitute for the services of an attorney in a particular jurisdiction. Both AMTA and CBMT encourage users of this reference who need legal advice on legal matters involving statutes to consult with a competent attorney. Music therapists may also check with their state governments for information on issues like licensure and for other relevant occupational regulation information. Additionally, since laws are subject to change, users of this guide should refer to state governments and case law for current or additional applicable materials.**

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## CPT® Codes

CPT® (Current Procedural Terminology) is a systematic listing and coding of procedures and services performed by physicians, therapists, or other healthcare professionals in clinical practice. This coding system was developed by the American Medical Association (AMA) and is utilized by the majority of insurance companies for reimbursement purposes. All music therapists should become familiar with CPT® codes. Coding information can be found in the *CPT® Standard/Professional Edition* manual, available for purchase through the American Medical Association by calling: 1-800-621-8335. 2008 edition prices range from $71.95 - $99.95. The manual is updated each year, making it very important to check for any changes in codes used on a regular basis. (Current Procedural Terminology (CPT®) 2007 Professional Edition, 2006).

Basically, a code is assigned for therapeutic procedures that accurately and specifically identify the exact service being performed. Each code is identified with a 5-digit number.

How do CPT® codes pertain to music therapy? Most case managers and insurance companies consider the CPT® codes manual the reference of choice. The insurance company will reimburse for the therapy or service rendered based on a dollar amount per code. In addition, this code number may designate a fifteen-minute block of time. If a therapist is performing a specific service for one hour, then that code number would be used and the dollar amount multiplied times four. In one therapy hour, a therapist may use two or three different codes, and each code may be assigned a different dollar amount.

Currently, there are insurance companies that are reimbursing for prescribed music therapy services once certain CPT® codes have been approved by a case manager, utilization review director, or an insurance adjuster. **Please remember**: Currently, in order to bill insurance companies for music therapy, CPT® codes must be **APPROVED** prior to rendering the service. Typically, due to managed care, many clients in the United States today are subject to case management. Insurance companies' case managers have the control to approve or disapprove a certain service or CPT® code. It is essential for music therapists to effectively communicate with clients' case managers when seeking reimbursement.

On the following pages you will find the CPT® codes, which music therapists have used to seek reimbursement for their services. The listed codes have been found to be the most effective codes currently available to describe a variety of music therapy treatment interventions. These codes are not discipline specific and are also used by related healthcare professionals (i.e., physical, occupational, speech, and recreational therapy). It is advised that clinicians do not submit bills using the same codes as another discipline for treatment on the same day as that would appear to be duplication of services. Even though the interventions are different, the procedure codes are broadly defined and could be interpreted by someone processing the claim to be repetition of service. It is extremely important to communicate with other therapists involved in the client's treatment so you can adhere to proper billing procedures.

| CODE # | TITLE | DESCRIPTION |
|---|---|---|
| 97110 | Therapeutic Procedure, one or more areas, each 15 minutes | Therapeutic exercises to develop strength and endurance, range of motion and flexibility |
| 97112 | Neuromuscular Re-education | Of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities |
| 97113 | Aquatic Therapy with Therapeutic Exercises | |
| 97116 | Gait Training | Includes stair climbing |
| 97150 | Therapeutic Procedure(s), Group (2 or more individuals)<br><br>(Report 97150 for each member of group) | Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist |
| 97530 | Therapeutic Activities (one-on-one), each 15 minutes | Direct patient contact by the provider (use of dynamic activities to improve functional performance) |
| 97535 | Self Care/Home Management Training, each 15 minutes | Activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment; direct one-on-one contact by provider |
| 97537 | Community/Work Reintegration Training, each 15 minutes | Shopping, transportation, money management, avocational activities and/or work environment/ modification analysis, work task analysis; use of assistive technology device/adaptive equipment, direct one-on-one contact by provider |
| 97542 | Wheelchair Management, each 15 minutes | Propulsion Training |

| CODE # | TITLE | DESCRIPTION |
|---|---|---|
| 97139 | Unlisted Therapeutic Procedure | Specify |
| 97532 | Development of Cognitive Skills (one-on-one), each 15 minutes | Improve attention, memory, problem solving, (includes compensatory training), direct patient contact by the provider |
| 97533 | Sensory Integrative Techniques (one-on-one), each 15 minutes | Enhance sensory processing and promote adaptive responses to environmental demands, direct patient contact by the provider |
| 97799 | Unlisted Physical Medicine-Rehabilitation Service or Procedure | |
| 96105 | Assessment of Aphasia (per hour) | Includes assessment of expressive and receptive speech and language function, language comprehension, speed production ability, reading, spelling, writing, (e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report |
| 96110 | Developmental Testing | Limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report |
| 96111 | Developmental Testing-Extended | Includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, with interpretation and report |
| 92506 | Evaluation of Speech | Evaluation of speech, language, voice, communication, and/or auditory processing |
| 92507 | Treatment of Speech; individual | Treatment of speech, language, voice, communication, and/or auditory processing disorder |

**Health and Behavior Assessment/Intervention**

Health and behavior assessment/intervention (96150-96155), are procedures used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The codes include health and behavior assessment as well as health and behavior intervention, of which the latter is reported in 15-minute increments of direct face-to-face contact with the individual, a group, or the family of the individual.

| CODE # | TITLE | DESCRIPTION |
|---|---|---|
| 96150 | Health and Behavior Assessment, each 15 minutes | Health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, face-to-face with the patient, initial assessment |
| 96151 | Re-assessment | |
| 96152 | Health and Behavior Intervention, each 15 minutes | Face-to-face, individual |
| 96153 | Group (2 or more patients) | |
| 96154 | Family (with the patient present) | |
| 96155 | Family (without the patient present) | |