

Keys to Coding and Documentation for Reimbursement

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Agenda for the afternoon

- MIPPA: what it means for you
- Medicare Regulations – getting started
- Other payers: Medicaid and private
- Diagnostic Coding System
- Procedural Coding System
- Billing how-to
- Coding clinic

MIPPA

- Passage of MIPPA
 - Medicare Improvements for Patients and Providers Act
- Independent provider status for SLPs
- Began to bill Medicare for services July 1, 2009

What else did MIPPA do?

- Had a major impact on how our billing codes will be valued
 - More on that later

What are the specific regulations re: private practice?

- Released October 30, 2008 as part of MPFS
- Mirror PP PT and OT
 - Don't allow use of assistants

Regulations for SLP PP

- SLP can provide services as one of:
 - An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated slp practice
 - An employee of a physician group
 - An employee of a group that is not a professional corporation

Regulations for SLP

- Services may be offered in:
 - The SLP's private office space, provided that the space is owned, rented, or leased by and used exclusively for the practice
 - The patient's home, not including any institution that is a hospital, a critical access hospital, or a skilled nursing facility. A private office space is not required if the SLP sees patients only in their homes.

What do YOU have to do to become a provider for Medicare

- 1. Obtain an NPI number**
2. Learn about the enrollment
 - Basic steps to enrollment
 - Understanding the form (CMS 855)

What's an NPI and why do I need one?

- A number to uniquely identify a health care provider in standard transactions (e.g. with third party payer)
- HIPAA requires covered entities to use them
 - E.g. health plans, health care clearing houses, health care providers who transmit any health information electronically

Obtaining an NPI – National Provider Identifier

- Web-based application process
 - <https://nppes.cms.hhs.gov/NPPES/Welcome.do>
- Paper NPI Application/Update Form
 - 1-800-465-3203
 - Email: customerservice@npienumerator.com
 - NPI Encounter
 - P.O. Box 6059
 - Fargo, ND 58108-6059

NPI – what will you need to know

- Taxonomy code for SLP: 235Z00000X
- Provider Type: 23

NPI and HIPAA

- Health Insurance Portability & Accountability Act (1996)
 - Designed to protect health insurance coverage for workers and their families when they change or lose jobs
 - Requirements of HIPAA apply to the storage and/or electronic transmission of patient related information
 - Intended to ensure patient confidentiality for all health care related information

HIPAA

- Covers all individually identifiable health care information in any form, electronic or non-electronic, that is held or transmitted by a covered entity
- An entity that collects, stores, or transmits data electronically, orally, in writing or through any form of communication, including fax, is covered under the HIPAA privacy rule

HIPAA Security Breach Requirements

- Beginning September 23, 2009
- Covered Entity (CE) must provide notice to affected individuals following the discovery of a breach of unsecured PHI.
 - Unsecured means PHI that is not rendered unusable, unreadable or indecipherable
- Written notice without “unreasonable delay” and no later than 60 days after discovery of the breach

HIPAA and coding

- More later about diagnosis coding and HIPAA

MEDICARE

- Part A coverage - inpatient, home health and hospice
- Hospital and nursing home Part A benefits limited to 90 and 100 days per spell of illness, with co-insurance
- Part B for out-patient services
- Part B can apply to inpatient settings when Part A benefits exhausted

Does everyone have A & B?

- No
- Part A is “free” (no premium)
- Part B requires a monthly premium (\$96.40)
- Medicaid programs usually pay the Part B premium automatically
- Make sure the person you are seeing has PART B

Medicare – who decides what

- Congress controls the Social Security Act, which describes the Medicare law.
- Centers for Medicare & Medicaid Services (CMS), interprets the laws in the Code of Federal Regulation and Medicare Manuals.
- Contractors interpret the manuals in Local Coverage Determinations.

Medicare Benefit Policy Manual – Therapy Policies

Part B Outpatient

CR 3648

Chapter 15 Sections 220 and 230

VISIT This Site

These slides are a summary and not the official CMS manual. Official and current CMS manuals are found at: www.cms.hhs.gov/manuals

QUESTIONS? www.cms.hhs.gov/medlearn/therapy

Contact:

- the contractor who pays Medicare bills or,
- if you do not bill, the Regional Office in your area.

“Physicians” for Therapy Services

PHYSICIANS

- Doctor of Medicine, Osteopathy, Podiatry
- Optometry only for low vision

NOT PHYSICIANS

- Chiropractor (except for demo)
- Dentists

“Provider” of Therapy Services

- Providers include facilities such as OP hospital, Rehab. Agencies, SNF for Part B, CORFs, HHAs Hospice, Clinics, OP Rehab Facilities, Public Health Agencies with agreements for therapy. Providers have agreements that preclude charging patients for covered services.
- A PROVIDER IS NOT A PERSON

“Supplier” of Therapy Services

- **Individual practitioners such as:**
 - **Physicians**
 - **Nonphysician Practitioners (PA, NP, CNS)**
 - **PTs and OTs in Private Practice**
 - **SLPs in Private Practice**

“Assess” or “Evaluate”

- **Evaluation – for new diagnosis or setting, payable, comprehensive, using professional skills, objective and subjective measures to determine condition and plan toward goals.**
- **Assessment – daily, not payable, brief, objective or subjective, requires professional judgment on progress toward goals.**

Re-evaluate

- **Re-eval – periodically payable for > or < in condition during treatment or at discharge, using professional skills to continue or modify goals or treatment.** Current Procedural Terminology does not define a reevaluation code for speech-language pathology; use the evaluation code.

220.1 Conditions

- **Services are or were needed**
- **A plan has been established**
- **Furnished under the care of a physician/NPP**
- **Furnished on an outpatient basis.**

All conditions are met when a physician/NPP certifies the outpatient plan of care.

220.1.1. Orders Recommended but Not Required for Payment

- **This does NOT mean direct access. When a patient presents without an order, a plan may be established and treatment begun with the expectation that there is a physician/NPP under whose care the patient will receive treatment, and who will certify the plan. Payment will be denied if the plan is not approved.**

220.1.2 Plans of Care

- **Must be established (written- dictated) by:**
 - **Physician/NPP (after coordination with therapists) Note: In CORF, only a physician may establish the plan.**
 - **Therapists who will provide the services**
- **Must be signed, with date and professional's identification (MA, CCC-SLP)**

Plan before treatment

- The plan must be established **before** treatment begins.
- **May be written on the same day as evaluation and initial treatment**
- Treatment before writing is only allowed by the qualified professional who evaluates and develops the plan, and must be established by COB of the next day.

Contents of Plan

- **The plan of care shall contain, at minimum, the following**
- **Diagnoses;**
- **Long term treatment goals; and**
- **Type, amount, duration and frequency of therapy services**
- **Signature, date and professional identity of the person who established the plan.**

Certification Issues (cont.)

- An order or referral is not required for outpatient therapy services. Payment may be denied for lack of a certified plan.
- You have 30 days from the initial evaluation to obtain a certification of the plan.
- Certification is approval of the plan - a dated signature by a physician/NPP is required.

Plan Issues

- The therapist who will provide the services is supposed to write the plan
- If the patient receives an evaluation only, the evaluation serves as the plan of care if it includes:
 - Diagnosis (or in states where SLPs cannot diagnose, description of condition from which MD can make the diagnosis)

Plan Issues

- The SLP plan must be independent of PT/ OT- but not necessarily on separate paper
- The duration may be any length, but the certification may not exceed 90 days.

Modifier to indicate provider

- CMS requires the the –GN modifier be added to every code that is rendered under a SLP or dysphagia plan of treatment
 - -GO = OT
 - -GP = PT

Who Changes the Plan

- **The physician/NPP**
- **The therapist if he/she established the plan,**
- **The therapist, may change a plan established by the physician/NPP with approval**
- **A registered nurse if dictated by the physician/NPP or therapist.**

Changes in Plan

- The plan **SHOULD** be modified for significant changes in condition - those that change long term goals.

Not Changes in Plan

- Alterations that do not change long term goals.
- Procedures (supraglottic swallow) and use of equipment (computerized language training) are not goals and may be modified without a change in plan.
- **Insignificant changes include:**
 - decrease in frequency and duration due to illness,
 - modifications of short-term goals to adjust for improvements
 - deletions of achieved goals, or specific interventions

Documentation: Certification of Plan of Care

- Prior to 2008, recertification of the plan of care was required every 30 days.
- **The plan of care must be recertified at least once every 90 calendar days – mandated by new regulations.**
- Therapists are encouraged to develop plans of care appropriate to the patient's needs.

220.1.3 Certification

- **Certification is a physician's/NPPs approval of a plan of care. It indicates the care was provided under the care of a physician for a patient who needs/needed therapy services.**
- **Approval must include physician/NPPs signature and a date.**

Payment Depends on Certification

- **Unless there is reason to believe the plan was not certified appropriately, or it is not timely, no further evidence that the patient was under the care of a physician/NPP and that the patient needed the care is required.**

Format of Certification

- **No specified format**
 - SLPs don't have to use CMS 700 (page 67)
 - Example of one that has worked for us (page 69)
- **Recommended: signature (dated) on the plan or on a record referring to the plan**
- **Other forms:**
 - Physician/NPP signed note,
 - Order that references approval of plan with evidence plan was sent to physician/NPP

**SPEECH-LANGUAGE PATHOLOGY
TREATMENT PLAN /CERTIFICATION/RECERTIFICATION**

| | |
|---|---|
| Patient Name: | |
| Patient #: | |
| Medical Diagnosis/ICD-9: | |
| Problem areas to be addressed: | |
| Date treatment initiated: | |
| Estimated amount, frequency and duration of treatment: | |
| Reasonable expectation to meet treatment goals: | |
| Date of report: | At discharge, total # treatment units: |

Progress on goals
A = Achieved; I = Improved; N/C = No Change

Long Term Goal Functional Goal(s):

| Date established | Speech therapy for these short term goals in functional/measurable terms | Progress/Date |
|------------------|--|---------------|
| | | |

Speech-language Pathologist Signature _____ Date _____

Outpatient Certification

1. The Speech-Language Pathology services are, or were, furnished while the patient was under a physician's care.
2. A plan for furnishing such services is, or was, established by the SLP and periodically reviewed by a physician.
3. The Speech-Language Pathology services are, or were, reasonable and necessary for the treatment of the patient.

Referring Physician Signature _____ Date _____

CC: _____ M.D.

Date sent: _____

Keeping track

- Calendar tracking form included in your handout
 - Track length of the certification period

Timing for Certification of Plan

- **Forward the plan immediately so the physician/NPP can certify the plan as soon as possible -- at least within 30 days/1 month of the first therapy encounter.**
- **Certification may be timely if a verbal order is recorded timely and followed within 14 days by a signature.**

Re-certification

- **If therapy continues after one interval, the plan should be signed before or during each interval by the physician/NPP responsible for care at that time (unless the plan is delayed).**

220.1.3 VISIT to Physician?

- **If a physician/NPP requires a visit, the physician/NPP may refuse to certify a plan unless the patient makes a visit.**
- **Medicare does not require a visit unless the National Coverage Determination requires it (for electrical stimulation and electromagnetic therapy for wounds.)**

More about Medicare

- LCDs
- HMOs
- Contracting with facilities
- Incident to compared to private practice
- MACs and RACs

Local Coverage Determinations LCDs

- Policy documents written by the MAC
- May specify what is or is not covered
- Often contain list of “covered” ICD codes

LCDs

- Since mid-2003, CMS has relinquished detailed coverage policies to each local intermediary and carrier.
- There are no national Medicare medical review guidelines for SLP services.
- Must refer to Local Coverage Determinations (LCDs) for your coverage policies

Medicare and HMOs

- Must provide benefits and services comparable to Medicare A and B benefits
- Beneficiaries can join or change plans during an annual election period
- Appeal of denials may often expand coverage - use outcomes studies when you can
- May offer extra benefits to attract enrollees

As a private practitioner, you might contract to serve a facility or agency

- SLPs should know the PPS-associated patient assessment instruments in applicable settings, because payments are tied to resource used based on assessments:
- HHA – OASIS
- SNF – Long-term Care Resident Assessment, including MDS, & RAP

“Incident to physicians’ services”

- The only condition under which a non-physician’s services may be billed on a physician’s billing form
 - practitioner must be employee of physician
 - physician must be on the premises when services rendered

Medicare Administrative Contractor : MACS

- These are insurance companies contracted by Medicare program to process claims
- CMS Medicare Intermediary-Carrier Directory (link from ASHA)

Medicare Administrative Contractors (MACs)

- 15 MACs replaced over 50 intermediaries and carriers
- Will need to carefully review the LCD of the MAC
 - May or may not be like the LCD with which you're currently familiar

Medicare Administrative Contractors, (cont.)

- Noridian Administrative Services (NAS): Jurisdiction 6
IL, MN, WI
- National Government Services (NGS) Jurisdiction 8
IN, MI
- Cahaba Government Benefit Administrators (Cahaba
GBA) Jurisdiction 10 AL, GA, TN
- Palmetto Gov't Benefits Admin (Palmetto GBA)
Jurisdiction 11 NC, SC, VA, WVA
- Highmark Medicare Services (HMS) Jurisdiction 15
KY OH



Recovery Audit Contractors- RACs

- Demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program.
- The Recovery Audit Contractor (RAC) demonstration program was designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers and suppliers and, therefore, protect the Medicare Trust Fund.

RACs

- Demonstration programs finished in 2009
 - CA, FL, NY
- Full contracts for RACs in all 50 states 2010
- Best prevention is documentation that shows medical necessity and dates that actual procedures performed

Feedback from RACs

National Medicare Recovery Audit Contractor Summit March 2009

- RACs will focus on:
 - Payments made for services that don't meet Medicare medical necessity requirements
 - Payments made for services that were incorrectly coded
 - Services highlighted by the OIG and GAO
 - Known high-risk DRGs

Feedback from RACs

National Medicare Recovery Audit Contractor Summit March 2009

- RACs have coders related to each specialty
- They will data-mine, looking for *coding errors*

Feedback from Health Care Providers

National Medicare Recovery Audit Contractor Summit March 2009

- Critical to success with RAC audits:
 - Conduct proactive assessments
 - Review your documentation extensively
 - Educate your staff
 - Prepare adequately for appeals
 - Appeal everything, if you are prepared
 - Use data mining to improve outcomes
 - Use RAC tracking software to manage audits and appeals
 - Spreadsheets, share drives and email will fail in long run

Feedback from Health Care Providers

National Medicare Recovery Audit Contractor Summit March 2009

- Meeting deadlines is a MUST
 - If you miss a record request or appeal deadline by only one day, RAC will recoup disputed revenues and cash flow will be impacted immediately
- During demo period, success rates with appeals consistently low (less than 10% average) in first 2 levels of appeal
 - At 3rd level, success rates improved significantly

What about other payers?

Private Insurance

Medicaid

Third party payers are taking control via strategies

- Utilization review
- Preauthorization
- Practice guidelines
- Outcomes measurements
- Efficacy studies
- Payment methods with different levels of risk
(e.g. capitation)



Services may be covered only when....

- provided by M.D.
- medically necessary
- due to accident or illness
- not educational in nature
- not provided by schools
- provided at accredited facility
- provided by licensed practitioner

Specific limits to managed care:

- Limited access to services
- Limited number of authorized visits
- Limited scope of covered services

MEDICAID - Title XIX of SSA

- Serves low-income families
- States determine eligibility levels
- Comprehensive services required to children

Medicaid scope of services

- IP and OP hospital services required
- Nursing facility services required
 - Rehab services required
- Intermediate care facilities for MR
- Augmentative communication devices

CHIPS –Children’s Health Insurance Programs

- Provides coverage to children from families who previously did not qualify for Medicaid
- The “working poor”
- May or may not cover therapy services

Medicaid: EPSDT

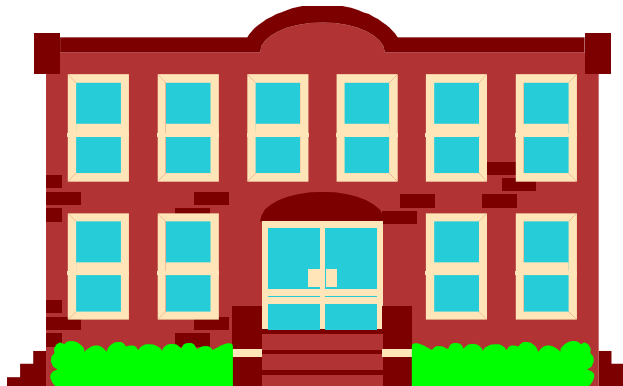
- Early, Periodic Screening, Diagnosis and Treatment
- \$\$ within Medicaid to cover therapy services
- Any Medicaid provider has access to EPSDT
- No stringent “homebound” requirements

Medicaid and the schools

- U.S. Department of Education (Jan. 1993) indicated that IDEA (Part B)
 - neither prescribes nor restricts the responsibility of health insurance companies to pay for health care services
 - prohibits public agencies from requiring parents to use insurance proceeds where they would incur a financial loss

Rehab services billing in schools

- Under the direction of certified SLPs, PTs, and OTs



Let's switch gears to coding

- Two coding systems:
 - Diagnostic
 - ICD-9 CM
 - Procedural
 - CPT

International Classification of Diseases – 9th Edition - Clinical Modification (ICD-9-CM)

International Classification of Diseases – 9th Edition - Clinical Modification (ICD-9-CM)

- Official classification system used in U.S. to assign diagnostic codes to diseases and disorders based primarily on body system
- Under auspices of U.S. Dept of Health & Human Services
→ regulated by a governmental agency
- Government evaluates utilization patterns and appropriateness of health care costs
- Developed approximately 30 years ago
- Contains more than 15,000 codes

International Classification of Diseases – 9th Edition - Clinical Modification (ICD-9-CM)

- *ICD-9-CM* published in 3 volumes
 - Vol. 1 (Tabular List) – Diseases and injuries (001-999)
 - Vol. 2 (Alphabetic Index) – diseases, conditions, and diagnostic terms
 - Vol. 3 Procedures (hospital inpatient procedures only)
- Diagnosis/disease coding primarily by body system
- 3-, 4-, and 5-digit codes indicating levels of specificity

International Classification of Diseases (ICD-9-CM) – *Principles of Coding*

- General rule - code to highest degree of *medical certainty*
 - Carry code to 5th digit when possible (e.g. 389.18 Sensori-neural hearing loss of combined types)
 - Use most specific code possible

ICD-9

- Avoid NOS (not otherwise specified) and NEC (not elsewhere classified)
 - NOS infers that condition was *not adequately described* by the provider
 - NEC infers that *no appropriate code* was found in the tabular list based on information provided

International Classification of Diseases (ICD-9-CM) — *Principles of Coding*

- Primary Diagnosis
 - Condition *chiefly responsible* for visit
 - Disease, condition, problem, symptom, injury, or reason for encounter
 - If multiple problems exist, select most resource intensive diagnosis and list others as secondary
- Secondary diagnoses
 - Co-existing conditions, symptoms, or reasons
OR
 - Symptoms found *after study*

Dysphagia diagnoses

- **Primary**
- **787.20 Dysphagia, unspecified**
- **787.21 Oral Phase**
 - Impaired structure/physiology of palate, tongue, lips, cheeks
- **787.22 Oropharyngeal Phase**
 - Impaired structure/physiology of tongue base and pharyngeal walls
- **787.23 Pharyngeal Phase**
 - Impaired structure/physiology of pharynx and larynx
- **787.24 Pharyngoesophageal Phase**
 - Impaired structure/physiology of upper esophageal sphincter
- **787.29 Other dysphagia**

- **Some FIs requiring a secondary diagnosis**
 - Consult the list in the LCD

New ICD-9 codes October '09

784.4 Voice & Resonance Disorders

- 784.40 Voice & resonance disorder, unspecified (revised)
- 784.41 Aphonia, Loss of voice
- 784.42 Dysphonia (new code) Hoarseness
- 784.43 Hypernasality (new code)
- 784.44 Hyponasality (new code)
- 784.49 Other voice and resonance disorders (revised)

The 784.5 series expanded:

- 784.5 Other speech disturbance

Excludes: speech disorder due to late effect of CVA
(438.10-438.19)

- Added 784.51 Dysarthria (new code)

(Excludes: dysarthria due to late effect CVA (438.13))

- 784.59 Other speech disturbance (new code)

- Dysphasia, Slurred speech, speech disturbance NOS

ICD-9 Diagnostic Coding

- If results of diagnostic testing are NORMAL, code signs or symptoms to report the reason for test/procedure and explain normal result in report

International Classification of Diseases (ICD-9-CM) – *Principles of Coding*

- Non-physicians (SLPs and AUDs) may code signs, symptoms, or ill-defined conditions
- *Disease codes should match procedure codes*

What Were We Thinking?!?

- Examples of ICD codes billed with speech-language treatment procedure:
 - 216 episodes - “stress incontinence male”
 - 202 episodes - “traumatic amputation of legs”
 - 164 episodes - “malignant neoplasm of prostate”
 - “Diverticulitis of colon”
 - “Breast cancer”
 - “Sprains and strains of ankle and foot”
 - “Constipation”

International Classification of Diseases (ICD-9-CM) – *Principles of Coding*

DO NOT...

- ...code conditions previously treated that *no longer exist*
- ...code “*probable,*” “*suspected,*” “*questionable,*” or “*rule out*” diagnoses
- ...choose a code *just to get reimbursed* or for your patient’s convenience...**FRAUD**

V Codes

- Supplementary Classification of Factors Influencing Health Status and Contact with Health Services
 - Person not currently sick encounters health services for some specific purpose
 - Circumstance or problem is present which influences person's health status but is not in itself a current illness or injury

Proposed Changes from ASHA to ICD-9 Delineate Resonance from Phonation

Chapter 16 Signs, Symptoms & Ill Defined Conditions

- 784.4 Voice disturbances
 - 784.40 Voice disturbance, unspecified
 - 784.41 Aphonia, loss of voice
 - 784.49 Other – change in voice, dysphonia, hoarseness, hypernasality, hyponasality

Chapter 16 Signs, Symptoms & Ill Defined Conditions

- 784.4 Voice **and resonance** disorders
 - 784.40 Voice **disorder**, unspecified
 - 784.41 **Voice disorder**, aphonia - loss of voice
 - 784.42 Voice disorder, dysphonia – hoarseness, breathiness**
 - 784.43 Resonance disorders – hypernasality**
 - 784.44 Resonance disorders – hyponasality**
 - 784.49 Other – change in voice

Changes May Be Coming...

ICD-10-CM

- **U.S. Dept of Health & Human Services proposed October 1, 2011, as the compliance date for ICD-10-CM and ICD-10-PCS code sets for all covered entities.**
- **Rest of industrialized nations except Italy has been using ICD-10 past 10 years (U.S. only using for mortality statistics)**
- **ICD-10 code sets contain more than 150,000 codes and provides increased granularity**
- **Can accommodate many new diagnoses and procedures**

ICD-10-CM

However...

- **Met with opposition by different medical & health care groups**
- **Cost is “burdensome” to providers**
- **Time consuming to change over & will take “valuable time” from pts**
- **Asking to wait until after HIPAA upgrades are done (5 or 6 years)**

New implementation date



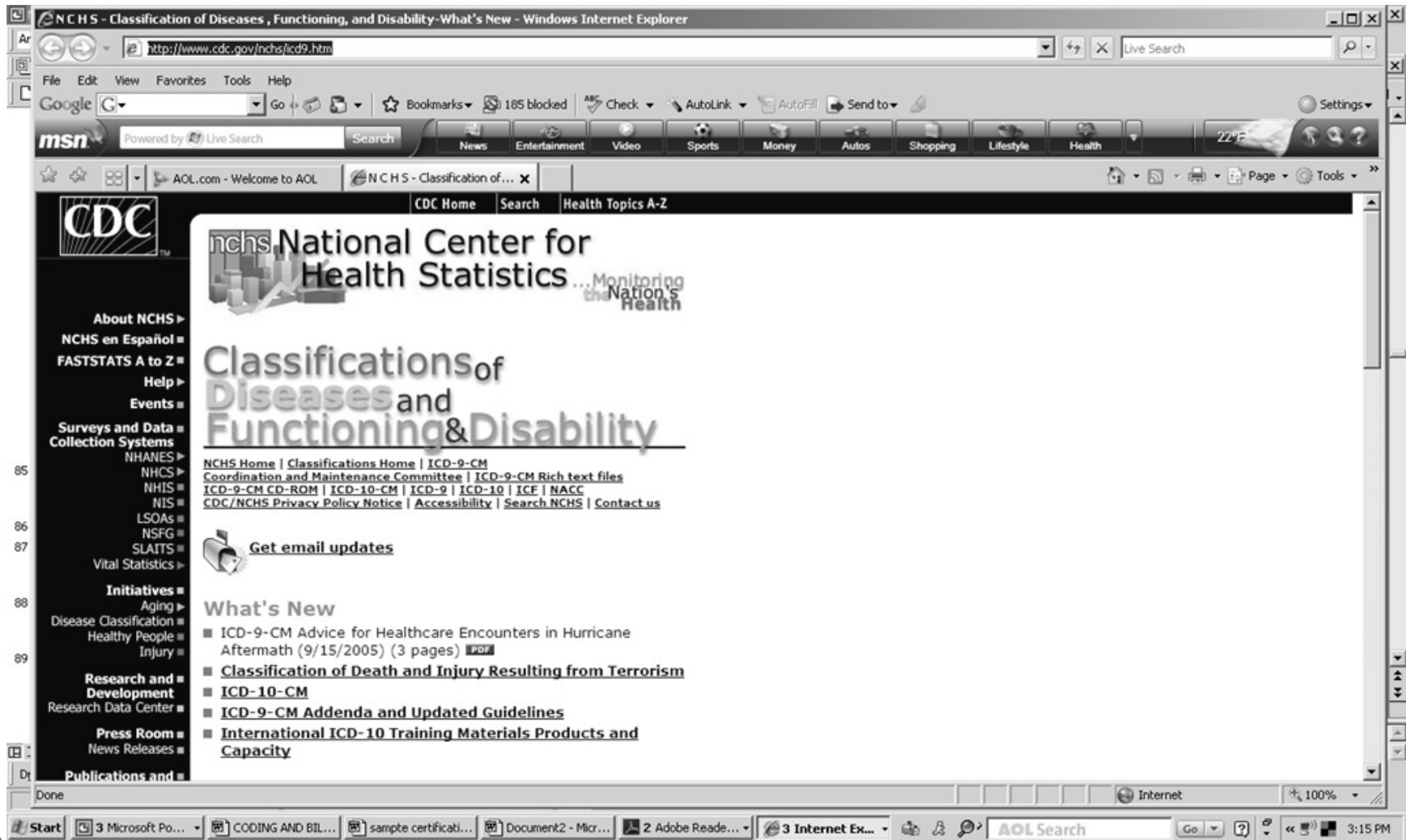
- The implementation date has been delayed to:
- October 1, 2013

ICD-10-CM – will incorporate changes made to ICD-9

- **R1310 Dysphagia, unspecified**
- **R1311 ..., oral phase**
- **R1312 ..., oropharyngeal phase**
- **R1313 ..., pharyngeal phase**
- **R1314 ..., pharyngoesophageal phase**
- **R1319 Other dysphagia**
- **In ICD-9-CM: 787.20 – 787.29**

ICD home page:

www.cdc.gov/nchs/icd9.htm



Is there any other guidance on which ICD codes to use?

- The LCDs often contain a list of “acceptable” diagnostic codes
- Remember, the diagnostic code and the procedure code have to make sense together

From diagnostic coding to procedure coding

- Diagnostic codes describe the reason you saw the patient
- Procedure codes describe what you did for the patient

2009 CPT

Current Procedural Terminology, Fourth Edition

“...a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services.”



The CPT/RUC Process

Who is responsible?

- American Medical Association (AMA) CPT Editorial Panel
- CPT Advisory Committee
- Health Care Professionals Advisory Committee (HCPAC)
 - limited license practitioners and qualified health care professionals
- AMA Department of Coding & Nomenclature

CPT/RUC Process

What's needed to begin? Asha starts the process

- Code Description
- Clinical Vignette
- Applicable diagnosis or diagnoses
- Rationale
- Supportive research documentation
- Related code deletions

The CPT/RUC Process

Relative Value Update Committee (RUC)

- So you get a code approved – then what?
- Then the code has to be valued

- RUC*
- RBRVS*
- PERC*

Who/what is the RUC?

- Part of the AMA CPT/RUC process
- RUC = Relative Value Update Committee

Medicare RBRVS

- Medicare implemented the Resource-Based Relative Value Scale (RBRVS) on January 1, 1992
- Standardized physician payment schedule where payments for services are determined by the resource costs needed to provide them
- Most public and private payers utilize the Medicare RBRVS

Medicare RBRVS

- The cost of providing each service is divided into three components
 1. Physician Work
 2. Practice Expense
 3. Professional Liability Insurance

Physician Work

- Determined by:
 - The time it takes to perform the service
 - The technical skill and physical effort
 - The required mental effort and judgment
 - Stress due to the potential risk to the patient

Practice Expense

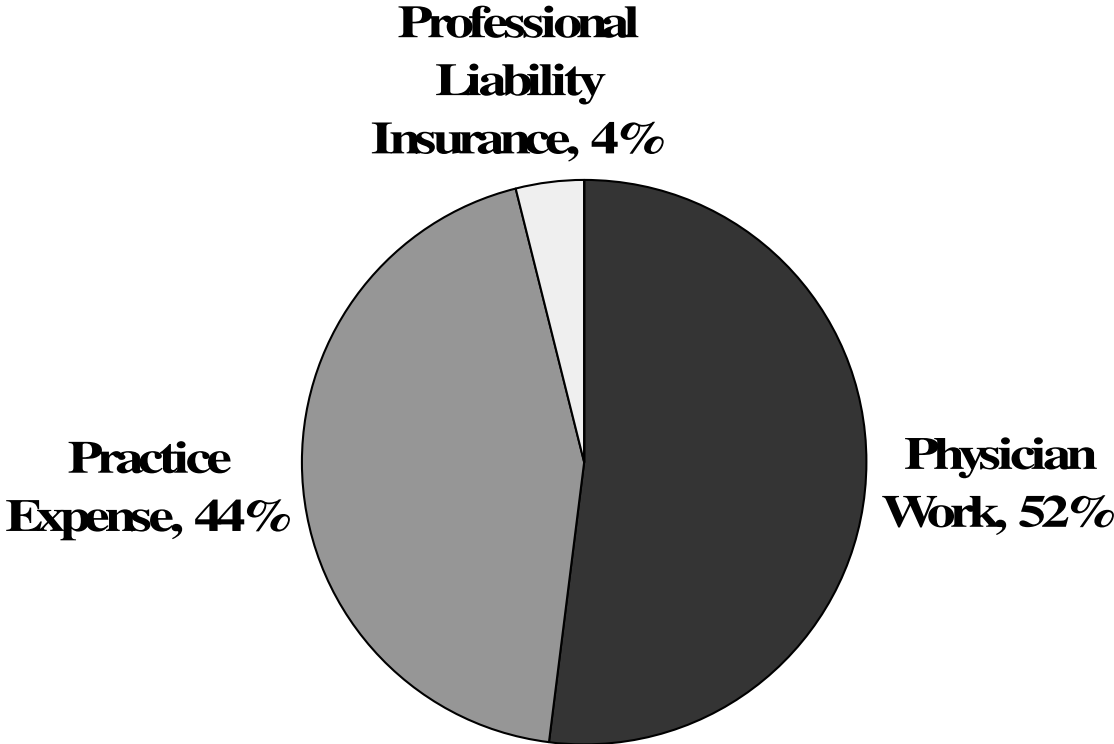
- Direct Practice Expense Inputs (*RUC Reviewed*)
 - Clinical Labor – Non Physician Staff Time (RN, LPN, MA, Trained Technicians)
 - Medical Supplies Typically Used to Perform Procedure
 - Medical Equipment (Exam Table, Suction Machine, Defibrillator, Treadmill, etc.)
- Indirect Practice Expense (*CMS determined through national survey data*)
 - Overhead Costs, Administrative Staff Salaries, and other Expenses

Professional Liability Insurance

- In 2000, CMS implemented the resource-based professional liability insurance (PLI) relative value units
- Based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the states, the District of Columbia, and Puerto Rico

Components of the RBRVS

Percent of Total Relative Values



Medicare RBRVS

- Payments are calculated by multiplying the combined costs of a services by a conversion factor (a monetary amount that is determined by the Centers for Medicare and Medicaid Services)
- Payments are also adjusted for geographical differences in resource costs (geographic practice cost index (GPCI))

Calculating Medicare Payment

- The formula for calculating payment schedule amounts entails computing the geographically adjusted relative value components components, adding them up and multiplying by the conversion factor to get a dollar figure
- The general formula for calculating Medicare payment amounts for calendar year 2009 is expressed as:
 - **Total RVU =**
 - [(work RVU x work GPCI)
 - + (practice expense RVU x practice expense GPCI)
 - + (malpractice RVU x malpractice GPCI)
 - **Total RVU x Conversion Factor* = Medicare Payment**

* *The Conversion Factor for CY 2010 = \$36.0666*

| CPT/HCPCS | Mod | Description | Physician Work RVUs | Non-Facility Practice Expense RVUs | Malpractice RVUs | Non-Facility Total RVUs | Fee |
|--------------------|-----|---|---------------------|------------------------------------|------------------|-------------------------|-----|
| 92507 | | Speech, lang., aud. process treatment | 0.52 | 1.16 | 0.02 | 1.70 | \$ |
| 92508 | | Speech/hearing treatment, group | 0.26 | 0.54 | 0.01 | 0.81 | \$ |
| 92511 | | Nasopharyngoscopy | 0.84 | 3.14 | 0.03 | 4.01 | \$ |
| 92512 | | Nasal function studies | 0.55 | 1.02 | 0.02 | 1.59 | \$ |
| 92520 ⁹ | | Laryngeal function studies | 0.75 | 0.84 | 0.03 | 1.62 | \$ |
| 92526 | | Swallowing treatment | 0.55 | 1.60 | 0.02 | 2.17 | \$ |
| 92597 | | Voice prosthetic evaluation | 0.86 | 1.89 | 0.03 | 2.78 | \$ |
| 92605 | | Evaluation for non-speech generating device | 0.00 | 0.00 | 0.00 | 0.00 | |
| 92606 | | Non-speech generating device services | 0.00 | 0.00 | 0.00 | 0.00 | |
| 92607 | | Evaluation for | 0.00 | 4.17 | 0.05 | 4.17 | \$ |

| | | | | | | |
|--------------------|--|---|------|------|------|------|
| | | device | | | | |
| 92606 | | Non-speech generating device services | 0.00 | 0.00 | 0.00 | 0.00 |
| 92607 | | Evaluation for speech-generating device; first hour. (If less than 1 hr, use -52 modifier.) | 0.00 | 4.12 | 0.05 | 4.17 |
| 92608 | | Evaluation for speech-generating device; additional 30 minutes | 0.00 | 0.76 | 0.05 | 0.81 |
| 92609 | | Speech-generating device services | 0.00 | 2.18 | 0.04 | 2.22 |
| 92610 | | Evaluate swallowing function | 0.00 | 2.08 | 0.08 | 2.16 |
| 92611 | | Motion fluoroscopy/swallow | 0.00 | 2.27 | 0.08 | 2.35 |
| 92612 ⁹ | | Endoscopy swallow test (FEES) | 1.27 | 2.89 | 0.04 | 4.20 |
| 92613 | | Physician interpretation (FEES) | 0.71 | 0.29 | 0.05 | 1.05 |
| 92614 ⁹ | | Laryngoscopic sensory test | 1.27 | 2.43 | 0.04 | 3.74 |
| 92615 | | Physician | 0.63 | 0.26 | 0.05 | 0.94 |

Once the RUC or RUC HCPAC approves the code, then what

CMS

- **Value of Code Ranked**
- **Reimbursement Assigned**

And then.....

New CPT Book

New Medicare Fee Schedule



What did MIPPA do to SLP code values?

- CMS and AMA RUC agreed that SLP codes could now be valued for professional work

Timeline for Presenting SLP Procedures for Review (2008-2009)

| CPT Code | Descriptor | Physician Work | RUC Meeting Date to Present |
|-----------------|--|-----------------------|------------------------------------|
| 92610 | Evaluation of oral and pharyngeal swallowing function | No | Jan/Feb 2009 |
| 92611 | Motion fluoroscopic evaluation of swallowing function by cine or video recording | No | Jan/Feb 2009 |
| 92526 | Treatment of swallowing dysfunction and/or oral function for feeding | Yes | Jan/Feb 2009 |
| 92597 | Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech | Yes | Jan/Feb 2009 |

Timeline for Presenting SLP Procedures for Review (2009)

| CPT Code | Descriptor | MD work? | RUC Meeting Date to Present |
|----------|--|----------|-----------------------------|
| 92605 | Evaluation for prescription for non-speech generating AAC devices | No | Oct 2009 |
| 92606 | Therapeutic services for use of non-speech generating devices, including programming and modification | No | Oct 2009 |
| 92607 | Evaluation for prescription of speech-generating AAC device, first hour | No | Oct 2009 |
| 92608 | Evaluation [92607], each additional 30 minutes | No | Oct 2009 |
| 92609 | Therapeutic services for use of speech-generating device, including programming and modification | No | Oct 2009 |
| 96105 | Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour | No | Oct 2009 |

Proposed Timeline for Presenting SLP Procedures for Review (2010)

| CPT Code | Descriptor | Physician Work | RUC Meeting Date to Present |
|----------|--|----------------|-----------------------------|
| 92506 | Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status | Yes | Feb 2010 |
| 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual | Yes | Feb 2010 |
| 92508 | Group, two or more individuals | Yes | Feb 2010 |

Timed and untimed CPT codes

- Most codes used by SLPs are not timed
- Do not treat these codes as if they are timed
 - Don't bill 92507 X 2 because you were with the patient an hour

There are a few timed codes

- A few assessment codes are per hour, including interpretation and report
- 15 minute codes – minimum face-to-face treatment:
 - 1 unit = 8 to <23 minutes
 - 2 units = 23 to < 38 minutes
 - 3 units = 38 to < 53 minutes
 - 4 units = 53 to < 68 minutes
 - 5 units = 68 to < 83 minutes
 - 6 units = 83 to < 98 minutes
- These are reflected in yellow on subsequent slides

What are commonly used CPT codes?

- Let's look at procedure codes commonly used by SLP
- Notes I'm sharing are included in Medicare CPT Coding Rules (page 70)

Swallowing Function

CPT codes

- **92526** Treatment of swallowing dysfunction and/or oral function for feeding
- **92610** Evaluation of swallowing function
- **92611** Motion fluoroscopic evaluation of swallowing function
- **92612** Flexible fiberoptic endoscopic evaluation of swallowing
- **92616** Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing

Speech & language evaluation

CPT codes

- **92506** Evaluation of speech, language, voice, communication, and/or auditory processing *
- **92626** Evaluation of auditory rehabilitation status, 1st hour
 - **92627** each additional 15 minutes
- **96105** Assessment of aphasia with interpretation and report, per hour *
- **92597** Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech *

Speech & language evaluation

CPT codes

- **96110** Developmental testing; limited, w/ interpretation and report
- **96111** Extended, with interpretation and report, per hour
- **96125** Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report *

Voice & Resonance

CPT codes

- These must be billed by a hospital or physician-directed setting because they are not on list of therapy codes *
- **92520** Laryngeal function studies
- **92511** Nasopharyngoscopy w/ endoscope
- 92512 Nasal Function studies
- **31575** Laryngoscopy; flexible fiberoptic; diagnostic _
- **31579** Laryngoscopy; flexible or rigid fiberoptic, with stroboscopy

CMS “therapy codes”

- Found in Medicare Claims Processing Manual
- Chapter 5
- Section 20.B
- List of codes considered therapy codes

Speech & language treatment CPT Codes

- **92507** Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual *
- **92508** group, two or more individuals *

Speech Path has to use 92507 instead of:

- **92630** Auditory rehabilitation; pre-lingual hearing loss
- **92633** Auditory rehabilitation; post-lingual hearing loss

Group Therapy



- Services provided simultaneously to two or more individuals by a practitioner
 - Individuals can be, but need not be performing the same activity
- Therapist must be in constant attendance, but one-on-one patient contact not required

Group Therapy

- Became a hot topic when CMS released in May 2002 Transmittal 1753, clarification of group therapy in the Medicare Carriers Manual
- Stated can't bill for individual therapy (and get a higher rate) for sessions in which therapists treat more than one patient

Group or Concurrent Therapy?

- CMS has stated you can't bill for individual therapy (and get a higher rate) for sessions in which therapists treat more than one patient
- Group therapy for Part A – limits group treatment to 25% of any patient's treatment per week/per discipline
- Maximum 4 patients per group

Group Therapy

- Services provided simultaneously to two or more individuals by a practitioner
- Same services provided to everyone
- Patients perform same or similar activities
- Therapist must be in constant attendance, but one-on-one patient contact not required

Concurrent Therapy

- New regulations and payment revisions for SNFs October 1, 2010
- Concurrent therapy minutes defined as:
“treating multiple patients at the same time while the patients are performing different activities.”

Concurrent Therapy: Old Rules

- Allowed concurrent therapy in SNFs with no restrictions on number of patients treated simultaneously or total number of minutes of treatment time recorded for each patient

Concurrent Therapy: New Rules Fall 2010

- Limit to two patients at a time
- Total number of minutes for the session must be allocated between the patients
 - number for each patient cannot be greater than the total time spent with the patient

Augmentative and Alternative Communication CPT Codes

- **92597** Evaluation for use/fitting of voice prosthetic device to supplement oral speech *
- **92605** Evaluation for prescription of non–speech generating augmentative and alternative communication device *
- **92606** Therapeutic service(s) for the use of non–speech generating augmentative and alternative communication device, including programming and modification *
- **92607** Evaluation for prescription for speech–generating augmentative and alternative communication device; face–to–face with the patient; evaluation, first hour
- **92608** Evaluation for speech device; each additional 30 minutes
- **92609** Therapeutic services for the use of speech–generating device, including programming and modification

Physical Medicine (97000)

CPT codes

- **97532** Development of cognitive skills to improve attention, memory, problem solving, direct one-on-one patient contact by the provider; each 15 minutes
- **97533** Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands; each 15 minutes

Physical Medicine Codes

- CMS has made it clear that SLPs are NOT to use the PM codes
 - 97110 Therapeutic procedure
 - 97112 Neuromuscular reeducation
 - 97530 Therapeutic Activity
 - 97535 Self care

Limitations to Use of Physical Medicine Codes (97000)

- CMS staff says the codes were developed for PT/OT services based on the vignettes.
Exceptions: 97532 & 97533
- CMS has described the speech-language and swallowing therapy codes as “umbrella” codes for any treatment under the plan of care.

Physical Medicine Codes (cont.)

- The Highmark intermediary has physical medicine codes (in addition to 97532/97533) in its speech-language LCD, effective October 2007.
- Highmark is the only intermediary that includes physical medicine codes for speech-language pathology services.

Physical medicine codes (cont.)

Highmark, contd.

- **97110** – Therapeutic exercises to develop strength/endurance, range of motion and flexibility, each 15 minutes
- **97530** - Dynamic activities to improve functional performance, each 15 minutes
- **97535** – Self-care/home management training, each 15 minutes

Evaluation and Management (E/M) Codes

- E/M codes are used to report evaluation and management services provided as:
 - Office visits
 - Hospital visits
 - Consultations
 - Home services
 - Case management services

Evaluation and Management (E/M) Codes

- E/M codes are classified into new versus established patients
- Further classified into levels relating to
 - skill, effort, time, and responsibility, using designations such as “expanded”, “detailed”, and “comprehensive” that require varying levels of medical decision making (low, moderate, or high complexity).
- Most are “face to face” encounters

Evaluation and Management (E/M) Codes

Q. Can ASHA members use E/M codes?

A. Possibly.

- **AMA CPT Code Book refers to E/M codes as physician services**
- **However, the code book states “Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified healthcare professional.”**

Evaluation and Management (E/M) Codes

Q. Are any speech-language pathologists or audiologists successfully reporting services using E/M codes?

A. Yes. It is important to report all services rendered. However, you need to communicate with the managed care organization and check to see if the E/M codes can be used. *Get approval in writing.*

Examples of E/M Codes

- **99202:** Used with 92506 (Speech-Language Evaluation) or Audiological Evaluation
 - Office visit for new patient involving history-taking, examination, and “straightforward” medical decision making, and lasting 20 minutes face to face with patient and/or family
 - Also includes counseling and/or coordination of care with other providers or agencies, consistent with the nature of the problem(s) and the patient’s and/or family’s needs
- Some use 99203 which reflects medical decision making of low complexity with 30 minutes face to face

More E/M Examples

- **99358**

Used with 92506 (Speech-Language Evaluation) or Audiological Evaluation

- Prolonged evaluation and management service without direct (face-to-face) patient contact
- Includes review of extensive records and tests, communication with other professionals, and/or the patient/family; first hour

- **99359 for each additional 30 minutes**

More E/M Examples

- **99211: Used with 92507 (Speech Treatment)**
 - For the evaluation and management of an established patient, that may not require the presence of a physician
 - Usually the presenting problem(s) are minimal
 - Typically 5 minutes are spent performing or supervising these services

E/M Summary

- Purchase current AMA CPT Code Book
- Study CPT codes (check ASHA reimbursement site)
- Check with your health plan to obtain written approval for use of codes
- Be sure your documentation supports all activities and procedures performed: “If it isn’t written, it didn’t happen.”

HCPCS – “Hick-Picks”

- Health Care Common Procedure Coding System that complements CPT; maintained by CMS in the public domain.
- Codes are alphanumeric, beginning with letter followed by 4 digits.
- HCPCS Level I codes are procedural codes.
- Level II codes identify products, supplies, equipment, devices and services not included in CPT (e.g., DME, prosthetics, ambulance services).

HCPCS

- Examples of SLP/A codes included in HCPCS: speech generating devices, voice amplifiers, repair of AAC systems.
- CMS requires HCPCS codes on claims for covered supplies and devices.
- Access at:
www.cms.hhs.gov/medicare/hcpcs/

Coding Clarifications

- Correct Coding Initiative (CCI):
 - Mutually exclusive
 - Col 1& Col 2 (used to be called comprehensive/component)
- Coding Modifiers
- Sequential and Simultaneous Treatments

What about edits?

- CCI (Really NCCI)
- National Correct Coding Initiative
- Applies to any Part B services not rendered in a hospital
- Carriers implement CCI edits
- Intermediaries apply CCI edits to Part B services in institutions other than hospitals
- OCE
- This edit applies to hospital settings
- Almost always same as CCI (except for some services unrelated to rehab)
- Effective 3 months after CCI effective date

| | | Can be used on same date? Yes/No | | If so, what modifier? |
|-------|-------------------------------|----------------------------------|----------------|-----------------------|
| | | MD office | Other settings | |
| 92506 | 92507 | Y | Y | No modifier |
| 92508 | 92507 | Y | Y | -59 |
| 92526 | 92520 | Y | Y | -59 |
| 92526 | 97032 | N | N | N/A |
| | | | | |
| 92611 | 92610 | Y | Y | -59 |
| 92612 | 31575, 92511, 92520, 92614 | N | N | N/A |

Modifiers

- 59 Distinct Procedural Service-the only modifier used with edits

For two procedures not ordinarily performed on the same day by the same practitioner, but which, under certain circumstances, may be appropriate to perform and therefore code on the same day (e.g., different site or organ system...)

Other modifiers

- 76 Repeat Procedures by Same Practitioner

When a procedure or service is repeated by the same practitioner subsequent to the original procedure...

***22 – when procedure is longer than typical**

***52 – when procedure is shorter than usual**

Billing for your services

- Putting it all together How to get paid for your services

2010 Medicare Fee Schedule

- ASHA performs analysis of the MPFS each year

Review:

- **Medicare fees are based on the sum of the relative values—professional work, practice expenses and liability insurance multiplied by a dollar conversion factor (CF)**

Medicare Claims Processing Manual

- Chapter 26
- Everything you need to know about filing claims (and then some!)
- The information on following slides is taken from Chapter 26

Coinsurance

- Begins after annual deductible of \$100
- Like a co-pay
- Facility must bill coinsurance each billing and make reasonable effort to collect

Supplemental insurance

- Many Medicare beneficiaries carry supplemental insurance
- This may cover the coinsurance amounts

CMS-1500 form

- The basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers.
- It has also been adopted by the TRICARE Program and has received the approval of the American Medical Association (AMA) Council on Medical Services.
- Same form used by most private insurers

The CMS-1500 form

- It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc.
- To purchase them from the U.S. Government Printing Office, call (202) 512-1800.

The CMS-1500 form

- For instructions on how to fill out the form, see Chapter 26 of Medicare Claims Processing Manual

CMS-1500 tips

- Picky about how date information is entered – read carefully
- If the claim is incomplete, it will be returned, delaying your payment

CMS-1500 “Ordering physician”

- **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name.

CMS-1500 “Ordering physician”

- Doctor of medicine or osteopathy
- Doctor of dental surgery or dental medicine
- Doctor of podiatric medicine
- Doctor of optometry
- Chiropractor
- BUT for therapy services: medicine, osteopathy, podiatry
 - Optometry for low vision only

Submitting electronically

- Electronic claims are paid faster
- Can cut down on administrative burden
- See Chapter 26 of the Medicare Claims Processing Manual
- Must meet all required HIPAA standards
- CMS web page on Electronic Billing & EDI Transactions

Using billing software or service

- ASHA has compiled a list of software (page 95)
 - Documentation
 - Billing
- Companies that do nothing but complete billing for you

A few other considerations

- Students
- Two therapists (co-treatment)
- PQRI
- The therapy CAP
- Exceptions process

Student services Part B

- CMS clarified that existing policy does not allow Medicare Part B reimbursement for SLP, OT, PT services furnished by students without proper supervision
 - student can be in the room, but therapist has to be providing the service

Therapy Students

- Only services of the therapist can be billed and paid under Part B
- Services of student are not reimbursed even if provided under “line of sight” supervision by the therapist



Therapy Students

- However, presence of student in the room does not make the service un-billable
 - Qualified practitioner is present in room for entire session. Student participates in delivery of services when qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment

Therapy students

- Another example:
 - The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time

Therapy students

- Qualified practitioner is responsible for the services, and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's services, not for the student's services)

Two therapists at the same time?

- Two therapists working with the same patient, both therapists can't bill for the time spent with the patient
- Can't submit a claim for situations in which patients work on their own without a therapist's supervision

PQRI

- Under PQRI, Medicare providers are eligible to receive a bonus payment for submitting NQF approved quality measures.
- SLPs will be able to participate, but we don't have the details

PQRI & NOMS

- CMS currently recognizes the NOMS and the FCMs as an appropriate tool for documenting patient improvement related to the therapy cap exceptions process.

NOMS

- NOMS is a data collection system developed to illustrate the value of speech-language pathology services provided to adults with communication and swallowing disorders.
- The FCMs are a series of disorder-specific, seven-point rating scales designed to describe the change in an individual's functional communication and/or swallowing ability over time.
- The FCMs endorsed by NQF include writing, swallowing, spoken language expression, spoken language comprehension, reading, motor speech, memory, and attention.

NOMS

- Enroll in NOMS
 - Rmullen@asha.org
- National Center for Evidence Based Practice in Communication Disorders

Therapy Cap & Exceptions

- **Therapy caps are in effect.**
- Combined cap of \$1860 for PT & SLP
- Exceptions allow therapists to identify claims for medically necessary services that exceed caps by adding a KX modifier.

Therapy cap and exceptions

- Most therapy services don't reach the cap
- BUT – you should familiarize yourself with the exceptions process

Coding Clinic

Principles of Coding & Billing

- The first step to accurate coding and billing is appropriate service delivery (the right services, in the right setting, for the right amount of time to persons who can benefit in practical “functional” terms).
- The second step is accurate and complete documentation.

Diagnosis Coding

Outpatient treatment: List Diagnosis or problem for which patient is being treated (e.g., “late effects of CVA, aphasia – 438.11).

Diagnostic services only: first code Diagnosis, condition, problem, or other reason for encounter
List other Dx (e.g., chronic conditions), second.

Correct Diagnostic Coding

- If the results of Diagnostic testing are normal, code the signs or symptoms to report the reason for the test/procedure (see Sections 780-799 of the ICD manual), and explain the normal result in the practitioner's report.
- Use only current version of ICD manual; use **both** Alphabetic Index and Tabular List to code (Alpha *first*).

Correct Diagnostic Coding

- Also code signs/symptoms when a definitive Diagnosis has not been established. Do not report “rule-out” or suspected Diagnosis.
- Be sure to use the *ICD-9-CM Official Guidelines for Coding & Reporting* as a companion tool.

Procedure Coding

- Use the CPT code that specifically describes the service delivered. Do **not** choose a code that “will get paid” if that code does not represent the actual service.
- Not every code listed in the manual is covered or payable. Some codes carry certain restrictions (e.g. site; supervision; time; face-to-face with patient vs. documentation time).

Analyzing your code use

- Look at the codes you have been using
- Know the rate of reimbursement for each code
- If either of two codes adequately describes what you do.....

Billing Compliance

- Code and bill for services performed by eligible practitioners for eligible patients.
- Charge codes, procedure codes, service delivered, and documentation must be supported.
- No documentation = no billing.
- Inadequate/incomplete documentation may mean claims denials upon medical review.

Bedside eval normal, suspect pharyngeal

- Bedside/clinical evaluation completed and there are no signs/symptoms of oral or pharyngeal dysphagia
- However, patient's pulmonary status is compromised and has history of pneumonia
- You want to refer for instrumental study
- ICD:
- CPT:

Bedside reveals oral problems

- Bedside/clinical evaluation revealed significant oral dysphagia: pocketing, increased time for bolus prep but no signs of pharyngeal dysphagia
- ICD Code:
- CPT Code:

Results of MBS

- Videofluoroscopic evaluation reveals difficulty with preparation of the bolus, premature loss over back of tongue, some penetration into upper laryngeal vestibule and residue in pyriforms with risk of aspiration
- ICD Code:
- CPT Code:

Scenario: Voice therapy

- Patient seen for voice therapy
- Relaxation exercises for jaw, neck, shoulders
- Digital manipulation of the larynx
- Vocal function exercises performed
- Discussed with patient avoiding high noise situations when talking and encouraged her to problem solve such situations

What is the CPT code? The choices are:

- 97530 – Therapeutic activities, direct patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes
- 97532-Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training)
- 92507 – Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

Scenario: Speech evaluation and treatment same day

- SLP performs speech/language evaluation and treatment on the same date of service.
- CPT Code(s):
- No modifier needed
- Would need to have Plan of Care by next day

Scenario: Voice evaluation

- Patient seen for voice evaluation
- Clinical exam included detailed case history, interview re: typical voice use and contributing factors
- More specific measurements are obtained using instrumentation (not defined)
 - VisiPitch
 - Videostroboscopy
 - KayPentax CSL

What CPT codes do you use?

- _____ for the clinical part of the exam
- SLP in private practice can't bill:
 - _____ for the aerodynamic and acoustic testing obtained through instrumentation
 - Add modifier –59 to show distinct procedure
 - Add –52 if you performed only a single test

Scenario:

Laryngeal Videostroboscopy

- Patient is referred by ENT doc for a voice evaluation and laryngeal videostroboscopy
- Referring ICD-9-CM codes are:
 - 784.42 Dysphonia
 - 478.4 Nodules
- Your clinical evaluation indicates normal vocal quality

You do the voice evaluation

- Code _____ for Voice Evaluation
- Videostroboscopy cannot be billed by independent SLP

What diagnostic code(s) can you include in your final report? Your choices are:

- 784.42 and 478.4 with an explanation and description of findings in the written report
 - OR
- You do not need a code since you do not bill the patient/client when the findings are normal

Scenario: Pediatric Articulation Evaluation

- 6-year-old child referred for articulation eval
- Medical history is negative for any known neurological or congenital conditions related to the child's speech production
- Clinical evaluation suggests that child's oral-motor and articulation behaviors are indicative of apraxia

What diagnostic code (ICD) do you use?

Your choices are....

- 315.39 Other (Developmental speech or language disorder)
 - Developmental articulation disorder
 - Dyslalia
 - Phonological disorder
- 784.69 Apraxia

Co-Treatment

- 4-year-old with verbal apraxia and impaired sensory processing and fine motor control
- The child spends 60 minutes in a session with the OT and the SLP
- What should each professional bill?

Co-Treatment

- Each professional can only bill for the amount of time they spent with the child
 - 30 minutes OT
 - 30 minutes SLP
- NOT 60 minutes by each
- SLP tx code is not timed.... That complicates things!

Early dementia? Aphasia?

- Neurologist refers patient with signs/symptoms of word finding problems and memory loss
- Neurologist refers for evaluation to determine if patient is presenting with primary progressive aphasia vs. dementia

Evaluation

- You administer Boston Diagnostic Aphasia Examination and Boston Naming
 - Spend 50 minutes with patient and 20 minutes analyzing and writing results
- You also administer the Ross Information Processing Test and the Wechsler Memory Scale
 - Spend 90 minutes with patient and then 35 analyzing and writing report

CPT code(s) choices?

- 92506 Evaluation of speech, language...
- 96105 Assessment of Aphasia, per hour
- 96125 Standardized Cognitive Performance Testing, per hour

Treatment of dementia

- Your evaluation reveals this is likely early dementia and not an aphasia
- The neurologist asks you to treat
- You develop a plan of care for addressing memory and organization deficits and family teaching
- You plan to see the patient for hour long sessions 1x week
 - Last 15 minutes each session actively involving family in planning home routine modifications

Treatment of dementia

- Short term therapy may be appropriate
- Which CPT code:
 - 92507 Speech, language... treatment
 - 97532 Cognitive skills development, each 15 minutes
 - 97535 Self-care/home management training, each 15 minutes

Mobile MBS

- Area nursing care facilities complain about the distance and expense to send their patients to an area hospital for videofluoroscopic evaluations
- A radiologist colleague has purchased a mobile videofluoro unit and wants you to perform the studies
- Can you?
- What code will you use?

Mobile MBS services

- Medicare Benefit Policy Manual 15/230.3.D.4 states modified barium swallow studies can be performed with fixed or mobile equipment
- What CPT code is appropriate?
- How would you bill Medicare?

Mobile MBS

- _____ is the appropriate code
- Should be billed with radiology procedure 74230
- BUT..... consolidated billing at the SNF requires you to bill the SNF
 - You're not bound by the MPFS rate but can negotiate with the SNF

Lots of resources from ASHA for purchase and some for free!

- Medicare Handbook for Speech-Language Pathologists,
- Medicare Handbook for Audiologists
- Health Care Plan Coding & Claims Guide
- Appealing Health Plan Denials
- Negotiating Health Care Contracts and Calculating Fees
- Getting Your Services Covered: A Guide to Working With Insurance and Managed Care Plans
- NO CHARGE
- 2008 Medicare Fee Schedule for Speech-Language Pathologists
- 2008 Medicare Fee Schedule and Hospital Outpatient Prospective Payment System for Audiologists will be available online very soon.

Web site Resources

- ASHA's Billing & Reimbursement Web site
 - <http://www.asha.org/members/issues/reimbursement>
- Medicare Fee Schedule (CMS)
 - <http://www.cms.hhs.gov/physicians/mpfsapp/step0.asp>
- ICD-9-CM (NCHS)
 - <http://www.cdc.gov/nchs/icd9.htm>

http://www.cms.hhs.gov/MLNGenInfo/01_overview.asp

