

Reimbursement Issues for 2009

Health Care Economics: It's Not Just Coding , It's Your Livelihood
0186

ASHA Health Care Economics Committee

November 20, 2008

Chicago, IL

Health Care Economics Committee (HCEC)

- Assisting Governmental Relations and Public Policy Board and cluster staff in determining current economic issues and developing goals for ensuring equitable coverage and reimbursement
- Developing recommendations for coding (procedural and diagnostic) and relative values
- Anticipating further socioeconomic needs of the professions and the consumers

Health Care Economics Committee (HCEC) 2008

- **SLP Members**

- Nancy Swigert, Chair
 - *Ciao!*
- Becky Cornett
- Bernard Henri
- Wayne Holland, CPT Advisor
- Dee Adams Nikjeh

- DeAnne Owre, VP for Governmental and Social Policies
 - *Thanks for your service*

- **Audiology Members**

- Tom Rees, Co-Chair
 - *Thanks for your service*
- Neil Shepard
- Bob Fifer, RUC Advisor
- Stuart Trembath
- Bob Woods

- Steve White, Ex Officio

- **Joining us in 2009:**
 - Gretchen Bebb (SLP)
 - Richard Hogan (AUD)
 - Tom Hallahan (VP)

Agenda

- Recognition of Our Collaborators During the Year
- Health Care Trends
- Good News: Professional Work Component
- Introduction to the Process of Coding and Valuation
 - Special Guest: Todd Klemp, American Medical Association
- 2009 Medicare Fee Schedule
- ICD-9-CM Codes
 - Q & A on ICD-9 Codes
- CPT Codes
 - Q & A on CPT Codes
- Evaluation & Management (E & M) Codes
- CMS Highlights
- General Q & A

HCEC collaborates with many other organizations, e.g.,

Speech-Language Pathology

- American Cleft Palate-Craniofacial Association
- Association of VA SLPs
- United States Society for Augmentative & Alternative Communication

Audiology

- Academy of Rehabilitative Audiology
- American Academy of Audiology
- American Academy of Otolaryngology-Head & Neck Surgery
- Association of VA Audiologists
- Military Audiology Association

Audiology / SLP

- Academy of Federal Audiologists & SLPs
- American Academy of Private Practice in SLP & Audiology
- Directors of Speech & Hearing Programs in State Health and Welfare Agencies
- Special Interest Divisions

Health Care Mega Trends

Bernard Henri

Health care “Mega-Trends” Affecting Our Services

- Healthcare Challenges (per Price Waterhouse Coopers; www.pwc.com)
 - Consumerism
 - Charity care and the uninsured
 - Medicare
 - Rising costs of healthcare

“Mega-Trends”

- Digital health and patient-centric care
- Quality and pay-for-performance
- Sarbanes-Oxley and transparency
- Workforce

Chronic Disease Management

- Stroke; diabetes; hypertension; neurological conditions
 - Incenting healthy life styles habits: smoking cessation; healthy diets; exercise to decrease HC costs
 - Hearing loss: though not a disease
 - “Boomer wave” = 76,000,000 hitting the beach (tennis courts and golf courses!)

Transparency in Health Care

- “the hospital curtain is being pulled aside”
 - A definition: ...allowing others to see the truth, without trying to hide or shade the meaning, or altering the facts to put things in a better light (Oliver, R. W. 2004. *What is Transparency?* McGraw Hill.)
 - Ample data on healthcare: Pricing; physician fees; U.S News Hospital ratings, etc.

Transparency in Health Care

- Hospital pricing
- Physician fees
- Amount of charity care provided by hsps
- Non-profit hospital community benefit activities
- Publicly-reported quality indicators:
“core measures”

Transparency in Health Care

- Mortality data
- Patient perspectives on care/patient satisfaction data
- Diagnoses present-on-admission (POA) to a hospital
- Facility fees for hospital-based clinics or outpatient departments.

Transparency in Health Care

- See Cornett, B.S. article, *Transparency in Health Care: Through a Glass, Dimly*. Jr. of Health Care Compliance. Aspen Publishers, 2007.

Transparency in Health Care

- Increasing emphasis on consumer/patient health care literacy (See Rao, P. R. *Health Literacy: The Cornerstone of Patient Safety*. The ASHA Leader, May 8, 2007.)
- Requires a more sophisticated/informed health care consumer

Evidence-Based Practice and Clinical-Translational Research

- ASHA National Outcome Measurement System (NOMS) and other outcome measure approaches
- Insurers requiring evidence based practice; no “experimental care”

Compliance

- Quality and safety issues for SLP
- Value-base purchasing of health care services
- Electronic health records (EHR)
 - Creates myriad compliance problems: how will information be protected

Compliance

- Growing costs of compliance
 - Increasing laws, rules and regulations
 - Organizational accreditations
 - Licensing of practitioners
 - Certification by HICs and contractors
 - Multiple reports, site visits and audits

Payer-Related Challenges

- Almost all of US now covered by some form of managed care
 - Credentialing SLPs and audiologists to provide services to a plan's beneficiaries is taking up to a year
 - Continuous erosion of approved number of annual visits (48 to 30 to 20)
 - “It's the school's responsibility”

Payer-Related Challenges

- More restricted application of “medical necessity” to “illness or injury related”
- Poor oversight of HMOs by state Depts of Insurance: “take it or leave it”
- Reimbursements well below cost of delivering services, in most cases
- Inconsistent payment of approved codes

In the Workplace...

- Productivity increases in all settings, whether billable hours or number of patient/clients/children in caseload
- Altered work weeks:
 - Longer work days, e.g., 8 am to 7 pm
 - Working on weekends
 - Better fill-in coverage of vacations, sick and CE days

Critical Importance of Constant Advocacy and Education of:

- Legislators: term limits
- Bureaucrats: rules & regulations
- School administrators: implementation
- General public: changing HC environment
- Patients and clients: re: responsibilities & rights.

2009 CPT

Robert Fifer

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 procedures. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services.”

2009 CPT Revisions

Introduction to Special Otorhinolaryngologic Services no longer includes:

“All services include medical diagnostic evaluation. Technical procedures (which may or may not be performed by the physician personally) are often part of the service but should not be mistaken to constitute the service itself.”

2009 CPT Revisions

- The phrase, “With Observation and Evaluation by Physician” no longer precedes the Vestibular Function Tests Without Electrical Recording codes (92531 – 92534)
- The phrase, “and Medical Diagnostic Evaluation” no longer precedes the Vestibular Function Tests With Electrical Recording codes (92541 – 92548). The reference to “PENG” is also deleted
- The phrase, “With Medical Diagnostic Evaluation” no longer precedes the Audiologic Function Tests (92551 – 92596)

2009 CPT Addition

A new procedure code in the Other Procedures section of Neurology/Neurology and Neuromuscular Procedures:

- **95992 Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day
(Do not report 95992 in conjunction with 92531, 92532)**

Evaluation & Management Codes

Robert Woods

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 of 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 a new patient involving history-taking, examination, and “straight forward” 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.”**

Professional Work Component

Nancy Swigert

Finally! Professional Work for SLPs

- **Passage of MIPPA**
- **Independent provider status for SLPs**
- **Will be able to bill Medicare for services July 1, 2009**
 - **Special session on this Saturday, noon – 1:00 PM, in S105B/C, McCormick South**
 - **CMS and the AMA RUC have agreed we can now survey SLP codes for ‘work’**
 - **Please be ready for the surveys**

Audiology and Work

- **Audiology has now revised most procedures so that their values are in the professional component rather than the technical component – thank you Bob, Stu, and other HCEC audiologists**
- **2008 saw work component RVUs accepted for**
 - **92620 Central auditory function eval; initial 60 min**
 - **+92621 ...; each additional 15 minutes**
 - **92625 Tinnitus assessment**
 - **92626 AR eval; first hour**
 - **+92627 ...; each additional 15 minutes**
 - **92640 Diagnostic analysis auditory brainstem implant, per hour**

Professional Component (“*Work*”)

- **Major element of reimbursement**
- **Core element of resource-based relative value system (RBRVS)**
- **Permits scaling of relative value units (RVUs) based on skill, effort, risk, and time**
- **Some AUD and SLP codes have work by virtue of “physician supervision”**

Professional Component (“Work”)

- **Neither AUD nor SLP specifically authorized work relative value units (RVUs) in statute**
- **Previous payment for most AUD codes and some SLP codes via Non-Physician Work Pool**
 - **Considered practice expense and included some indirect costs plus malpractice RVUs**

Professional Component (“Work”)

- **Timing is good to be recognized for ‘work’ because:**
 - Non-physician work pool being abolished
 - New formula for calculation of practice expense relative value units (RVUs)
 - Possibility / probability of reduction in reimbursement
- **However, any SLP codes surveyed for work will not appear on fee schedule with revised values until 2010 at earliest**

Proposed 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

Proposed Timeline for Presenting SLP Procedures for Review (2009)

CPT Code	Descriptor	Physician 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

Be Prepared for Upcoming Work Surveys

- 92610
- 92611
- 92526
- 92597
- Online survey using RVS Online (sent out early December)
- To sign up to receive surveys, go to <http://www.asha.org/about/legislation-advocacy/slpresponseform.htm>

Audiology & Speech-Language Pathology RBRVS & RUC Process

Todd Klemp, American Medical Association



The RBRVS and the AMA/ Specialty Society RVS Update Committee (RUC) Process

2008





Todd Klemp, MA, MBA, MSC
RBRVS Data and Methodology Manager
Physician Payment Policy and Systems



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

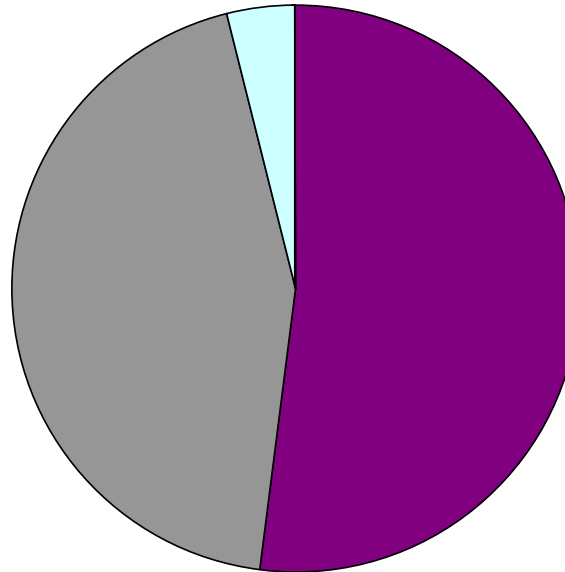
Components of the RBRVS

Percent of Total Relative Values

**Professional
Liability
Insurance, 4%**

**Practice
Expense, 44%**

**Physician
Work, 52%**



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 2009 = \$36.0666*

CPT 1993 - 2009

AMA Relative Value Update

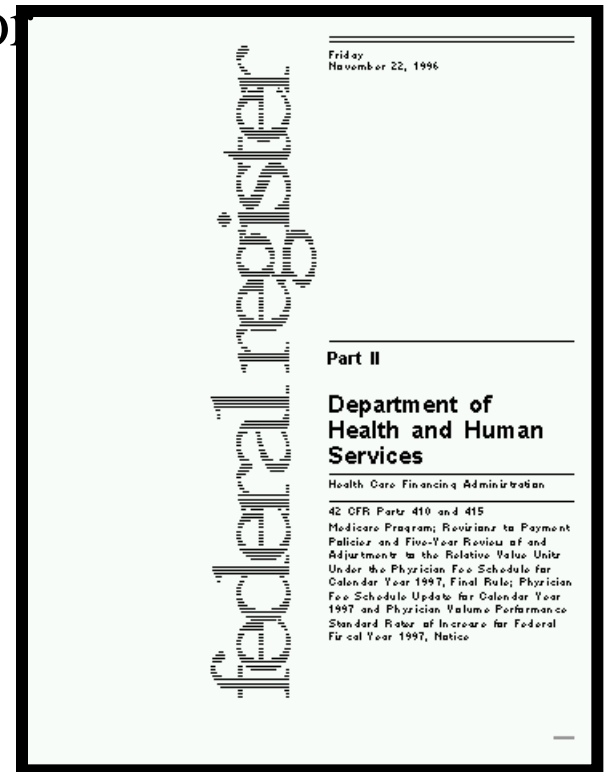
Committee (RUC) Recommendations

- Over 3,600 RUC recommendations for new and revised codes
- Over 300 RUC recommendations for carrier priced or non-covered services
- 1,118 RUC recommendations during the First Five-Year Review
- 870 RUC recommendations during the Second Five-Year Review
- 751 RUC recommendations during Third Five-Year Review



Relative Value Update Committee (RUC) Recommendations

- CMS/Carrier Medical Director review
- Implementation of “interim” values by Medicare carriers with 60-day Comment period
- CMS’s acceptance rate has increased to more than 90% annually.
 - For 2009 Physician Work and Practice Expense RUC recommendations 97% accepted



RUC Composition

American Medical Association

CPT Editorial Panel

American Osteopathic Association

Practice Expense Review Committee

Health Care Professionals Advisory Committee

Anesthesiology

Internal Medicine

Pediatric Surgery*

Cardiology

Neurology

Pediatrics

Dermatology

Neurosurgery

Plastic Surgery

Emergency Medicine

Obstetrics/Gynecology

Psychiatry

Family Medicine

Ophthalmology

Radiology

Gastroenterology*

Orthopaedic Surgery

Thoracic Surgery

General Surgery

Otolaryngology

Urology

Infectious Disease*

Pathology

* *indicates rotating seat*





RUC Cycle and Methodology

- RUC's cycle for developing recommendations is closely coordinated with both CPT's schedule for annual code revisions and CMS's schedule for annual updates in the Medicare Payment Schedule
- CPT meets three times a year to consider coding changes for the next year's edition
- CMS publishes the annual update to the Medicare RVS in the *Federal Register* every year
- These codes and relative values go into effect annually on January 1

RUC Cycle

CPT Editorial
Panel

Level of Interest

Medicare
Payment
Schedule

Survey

CMS

Specialty RVS
Committee

The RUC





RUC Cycle

- Cannot publish RVU recommendations until CMS publishes *Federal Register*
- CMS publishes the annual update to the Medicare RBRVS in the *Federal Register* every year (November 1)
- These codes and relative values go into effect annually on January 1

RUC Advisory Committee

- One physician representative is appointed from each of the 109 specialty societies seated in the AMA House of Delegates
- Advisory Committee members assist in the development of RVUs and present their specialties' recommendations to the RUC
- Each member comments on recommendations made by other specialties
- Advisory Committee members are supported by an internal specialty RVS committee

Health Care Professionals Advisory Committee (HCPAC) Composition

Audiologists

Physical Therapists

Chiropractors

Physician Assistants

Dieticians

Podiatrists

Nurses

Psychologists

Occupational Therapists

Social Workers

Optometrists

Speech Pathologists



HCPAC

- Purpose: To allow for the participation of limited license practitioners and allied health professionals in the RUC process
- The professionals represented on the HCPAC use CPT to report the services they provide independently to Medicare patients, and they are paid for these services based on the RBRVS physician payment schedule
- The HCPAC recommendations are sent directly to CMS

RUC Practice Expense Activities

- The RUC submits recommendations to CMS on practice expense inputs for new and revised codes
- The Practice Expense Advisory Committee (PEAC), (1999-2004) was responsible for reviewing all existing practice expense data
- The PEAC reviewed and made recommendations on almost 7,000 CPT codes from a variety of specialties
- The RUC Practice Expense Subcommittee continues to review and make recommendations on direct practice expense data for each CPT Code (clinical labor, medical supplies and equipment)



RUC Subcommittees and Workgroups

- *Administrative Subcommittee* – primarily charged with the maintenance of the RUC’s procedural issues
- *Extant Data Workgroup* – reviewing potential sources of physician time data
- *Five-Year Review Identification Workgroup* – oversees the process of the Five-Year Review of the RBRVS and identification of potentially misvalued services
- *Multi-Specialty Points of Comparison (MPC) Workgroup* – charged with maintaining the list of codes, which is used to compare relativity of codes under review to existing relative values



RUC Subcommittees and Workgroups

- *Practice Expense Subcommittee* – reviews direct practice expenses (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of practice expense relative values
- *Professional Liability Insurance (PLI) Workgroup* – reviews and suggests refinements to Medicare’s PLI relative value methodology
- *Research Subcommittee* – primarily charged with development and refinement of RUC methodology



Medicare's Payment System for Physician Services

Since the introduction of RBRVS, changes have included:

- Annual updates for new or revised CPT[®] codes
- Three Five-Year Reviews of work values – 1997, 2002 & 2007
- Resource-Based Practice Expense RVUs – 1999
- Resource-Based PLI RVUs – 2000

The RBRVS Five-Year Review

- Omnibus Budget Reconciliation Act of 1990 requires CMS to review all relative values at least every five-years and make any needed adjustments
- Five-Year Review results implemented on January 1, 1997 and every five years thereafter



First Five-Year Review of the RBRVS

- Corrected anomalies in work values for codes
Example: Gynecologic procedures to equate urology procedures
- Improvements to Evaluation and Management work relative values
- Updated RBRVS to reflect increased work for certain procedures since the inception of RBRVS



Second Five-Year Review of the RBRVS

- Unprecedented opportunity to improve the accuracy of the physician work component
- The RUC submitted recommendations on 870 individual CPT codes to CMS
- On November 1, 2001, CMS published a Final Rule in the Federal Register with refined work relative value units. CMS accepted 98% of the RUC's recommendations. The relative value changes were implemented on January 1, 2002

Third Five-Year Review of the RBRVS *Evaluation and Management Services*

- 27 specialties presented a consensus comment letter to CMS stating that the work of E/M services had changed significantly since the first Five-Year Review in 1995
- The societies concluded that 35 E/M services were not appropriately valued because:
 - the intensity, complexity, and duration of entire medical care service had increased in the past ten years;
 - the work per unit of time for E/M services is less than the work per unit of time for almost any other service
- CMS accepted 100% of the RUC's recommendations for E/M services
- The RUC submitted formal recommendations for 751 identified codes to CMS in October 2005, February 2006, March 2007 and May 2007

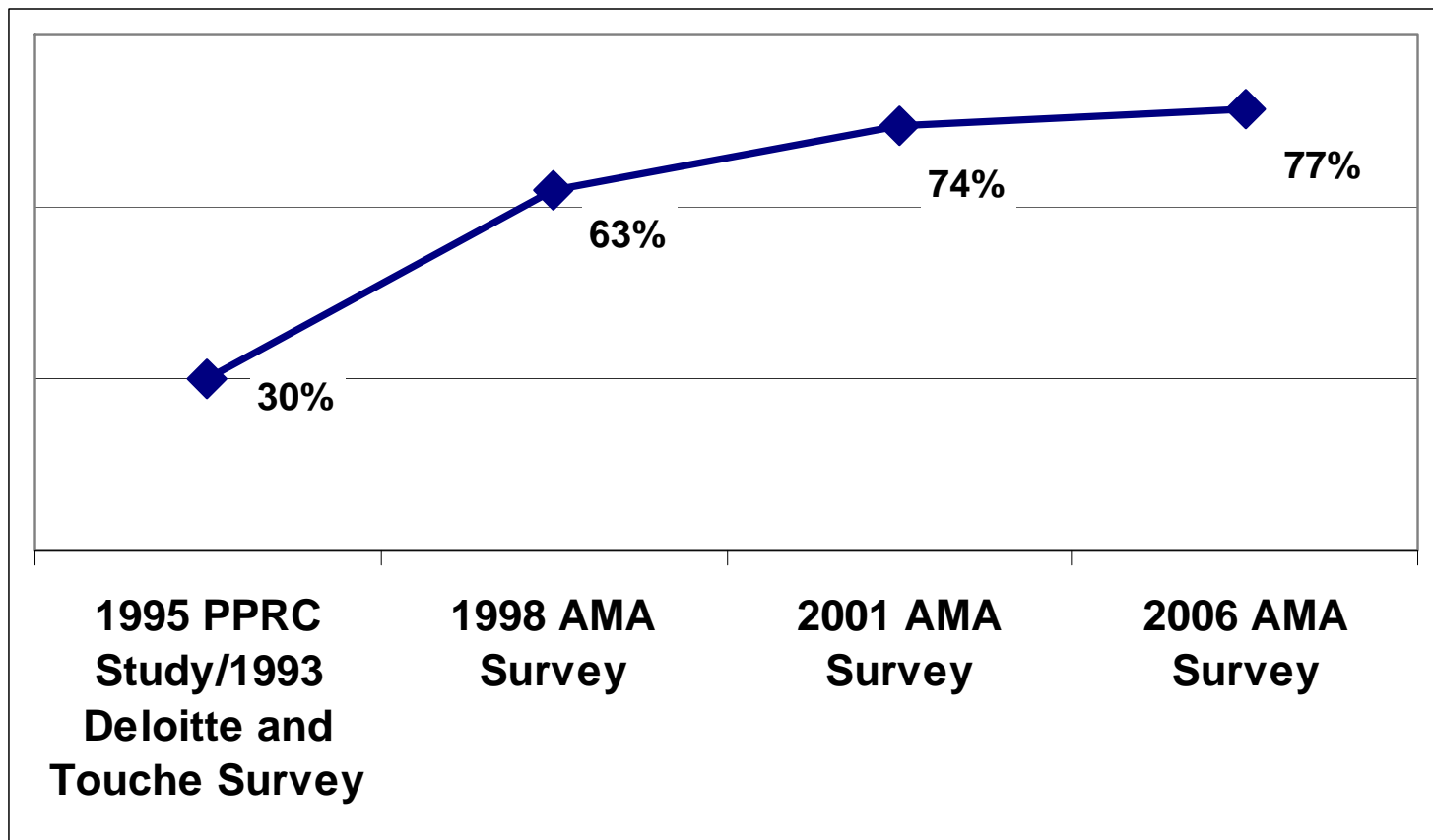
Why is the Medicare RBRVS Important?

- Many health plans use the Medicare RBRVS as a basis for their payment system
- According to the AMA Non-Medicare Use of the RBRVS 2006 Survey 77% of respondents indicated they currently use the RBRVS

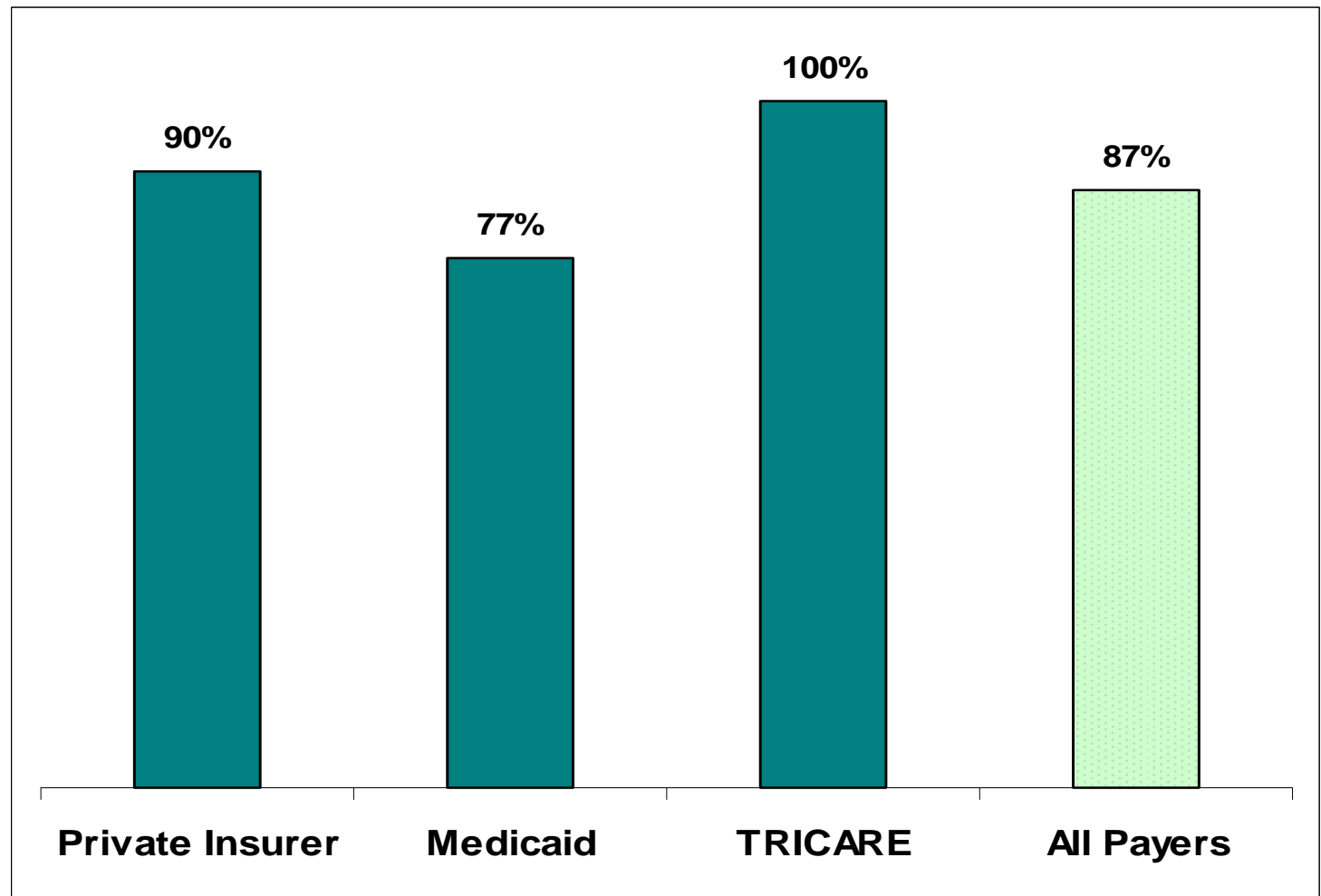
Non-Medicare Use of the Resource-Based Relative Value Scale (RBRVS) Survey

- National survey of public and private payers to assess the effect of this payment method in non-Medicare health markets
- AMA Department of Physician Payment Policy and Systems surveyed:
 - Private Health Plans
 - Medicaid Plans
 - Workers' Compensation
 - TRICARE
- Previously conducted surveys in 2001 and 1998

Utilization of Medicare RBRVS By Respondents



2006 Utilization of Medicare RBRVS by Payer Type by Enrollee





Utilization of Medicare RBRVS, All Payers: By Respondents

- 77% of respondents currently use the RBRVS
 - Of this group using the RBRVS: 93%= full implementation
 - 7% = in the process of implementation
- 8% are examining potential use of the RBRVS
- 85% of respondents are either using the RBRVS or were considering its use in 2006

RBRVS Summary

- The AMA RUC and Specialty Societies are heavily involved in all Medicare health policy regarding the RBRVS
- Increased recognition of physician involvement in refining and updating the RBRVS
- Favorable opinions of the RBRVS as a payment system continue:
 - Rational system
 - Easy to implement and update
 - Relativity is based on actual resources utilized
- The RBRVS continues to grow in importance all payor types as well as in physician productivity measures and compensation plans

Audiology and the Medicare RBRVS

- Audiologists are recognized by Medicare as independent practitioners who can independently bill for diagnostic audiologic tests.
 - Diagnostic tests have to be performed with a physician referral and there is no provision for direct payment to audiologists for therapeutic services.
 - “Incident-to” does not apply to diagnostic audiologic tests and audiologists do not require physician supervision.
- Beginning in 2009, audiologists will now be considered “eligible professionals” who may report data on quality measures and, if criteria are met, receive PQRI incentive payments, as required by MIPPA.
- SLPs are now recognized to bill as private practitioners



Audiology and the Medicare RBRVS

- Through 2007, an audiologists' work was captured in the practice expense component.
- In September 2006 ASHA requested that CMS agree to consider establishing physician work relative values for services provided by audiologists
- ASHA specifically requested that the professional work effort for audiologists providing these services be reflected in the work relative values rather than in the practice expense relative values

Audiology and the Medicare RBRVS

- In November 2006, CMS indicated that they would consider this possibility further
- CMS advised the RUC and HCPAC that if the committee recommends the use of work values for the audiology services, CMS will consider their recommendation
- ASHA, AAA and AAO-HNS surveyed 9 audiology codes and presented recommendations to the RUC in April 2007
- The RUC accepted the joint recommendations as presented

Audiology and the Medicare RBRVS

- In May 2007 the final RUC recommendations were sent to CMS
- Published in the November 2007 Final Rule
- Implemented in January 1, 2008
- Remaining 8 audiology codes scheduled to be reviewed at the October 2008 RUC meeting, values available for implementation January 1, 2010



Medicare Payment

- Starting in 2007 the Practice Expense (PE) methodology was changed to a “bottom-up” approach for determining relative direct costs for each service
- Under the bottom-up method, direct costs are determined by adding the costs of the resources (clinical staff, equipment and supplies) typically required to provide the service
- New methodology to transition over 4 years (2007-2010)



Medicare Payment

- The switch from PE component to work component, and the PE methodology transition will decrease Medicare payment for Audiology services
- Non-Facility Payment decreases may range from -12% to -65%
- Facility Payment decreases may range from -19% to -65%
- *Estimates calculated using 2009 CF*

Impact of Transition from PE to Work

Example	Estimate if work remained in PE	Actual	Actual	Actual	Estimate*
CPT Code 92568	2010	2007	2008	2009	2010
Work RVU	0	0	0.29	0.29	0.29
PLI RVU	0.04	0.04	0.04	0.04	0.04
Non-Fac PE RVU	0.15	0.32	0.24	0.17	0.10
Facility PE RVU	N/A	N/A	0.24	0.17	0.10
Medicare Non-Facility Pymt.	\$7.20	\$13.64	\$20.57	\$18.03	\$15.51
Medicare Facility Pymt.	N/A	NA	\$20.57	\$15.51	\$15.51
Conversion Factor	\$37.8975		\$38.0870	\$36.0666	\$36.0666

**Assuming the same conversion factor as in 2009*



Impact of Transition from PE to Work

- *92568 Acoustic reflex testing; threshold* Example:
- Using the 2009 conversion factor by 2010 Medicare non-facility payment for 92568 may decrease approximately -14%
- Using the 2009 conversion factor, if work remained in the practice expense component, by 2010 Medicare non-facility payment for 92568 may have decreased by -65%



More Information

For additional information, please contact:

Department of Physician Payment Policy and Systems

515 N. State Street

Chicago, Illinois 60654

(312) 464-4736 Phone

(312) 464-5849 Fax

RUC.Staff@ama-assn.org

Todd.Klemp@ama-assn.org

www.ama-assn.org/go/rbrvs



2009 Medicare Physician Fee Schedule

Wayne Holland

Robert Fifer

Medicare Fee Schedule

- The fee for each code under Medicare is based on:
 - Established Relative Value
 - Professional work
 - Practice expense
 - Malpractice
 - Monetary Conversion Factor
 - Geographic Adjustment Factor

2009 Medicare Fee Schedule

(Federal Register, November 19, 2008)

- **2009 Conversion Factor = \$36.0666**
- **A reduction of \$2.0204 from the current conversion factor of \$38.0870**
- **A negative 5.3% update factor**
- **Negative adjustment due to budget neutrality requirement**
- **MIPPA averted a steeper across-the-board reduction**

Conversion Factor Impact

Set by CMS to reflect sustainable growth rate

1999	\$ 34.7315	2005	\$ 37.8975
2000	\$ 36.6137	2006	\$ 37.8975
2001	\$ 38.2581	2007	\$ 37.8975
2002	\$ 36.1992	2008	\$ 38.0870
2003	\$ 36.7856	2009	\$ 36.0666
2004	\$ 37.3374		

2009 Medicare Fee Schedule

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)**
- **The 2008 conversion factor is \$38.09**
- **The 2008 work relative values were reduced by 11.94 percent to maintain budget neutrality. This adjustment was necessitated to “pay for” a large increase in the evaluation and management codes (visits and consultations)**

2009 Medicare Fee Schedule

- **MIPPA directed CMS to**
 - 1. adjust the CF instead of the work values for budget neutrality purposes, and**
 - 2. provide for an inflationary update of 1.1 percent.**
- **The net effect of these two adjustments (about a 6.41 percent reduction for budget neutrality and the 1.1 percent inflationary update) results in a 2009 CF conversion factor of \$36.0666.**

2009 Medicare Fee Schedule

- **In general, specialties for which professional work represents the majority of the total relative values for their procedures benefit from this change while specialties for whom practice expenses represents most of the payment are disadvantaged**
- **The change for ASHA members is mixed as the following tables illustrate**

2009 Medicare Fee Schedule

Speech-Language Pathology

- How some SLP codes are impacted by the conversion factor (\$36.0666):

CPT Code	Description	2008 Rate	2009 Rate
92506	Speech & language evaluation	\$146.25	\$147.15
92507	Speech & language treatment	\$62.84	\$61.31
92610	Dysphagia clinical evaluation	\$100.93	\$77.90
92526	Dysphagia treatment	\$82.65	\$78.26

2009 Medicare Fee Schedule

Speech-Language Pathology

- RVU changes in SLP procedures of note are:
 - **CPT 92506** - Speech and Language Evaluation total RVU **increases** to 4.08 from 3.84, and payment **increases** to \$147.15 from \$146.25
 - **CPT 92507** - Speech and Language Treatment RVU has **modest increase** to 1.70 from 1.65, but payment will **decrease** to \$61.31 from \$62.85
 - **CPT 92610** – Dysphagia clinical evaluation RVU **decreases** to 2.16 from 2.65 and the rate **decreases** from \$100.93 to \$77.90
 - **CPT 92526** – Dysphagia treatment RVU remains 2.17 and the rate **decreases** from \$82.65 to \$78.26

2009 Medicare Fee Schedule

Audiology

- How some audiology codes are impacted by the conversion factor (\$36.0666):

CPT Code	Description	2008 Rate	2009 Rate
92557	Comprehensive audiometry	\$52.88	\$45.08
92569	Acoustic reflex decay	\$17.52	\$14.43
92620	Central auditory function (first hour)	\$60.94	\$85.98
92626	Evaluation of auditory rehabilitation status (first hour)	\$82.27	\$91.61

2009 Medicare Fee Schedule

Audiology

- RVU changes in audiology procedures of note are:
 - **CPT 92557** – Comprehensive audiometry total RVU **decreases** to 1.25 from 1.39 and payment **decreases** to \$45.08 from \$52.88
 - **CPT 92569** – Acoustic reflex decay total RVU **decreases** to 0.40 from 0.46 and payment **decreases** to \$14.43 from \$17.52
 - **CPT 92620** – Central auditory function (1st hour) total RVU **increases** to 2.38 from 1.60 and payment **increases** to \$85.98 from \$60.94
 - **CPT 92626** – Auditory rehabilitation status (1st hour) to RVU **increases** to 2.54 from 2.16 and payment **increases** to \$91.61 from \$82.27

CMS Update

Steven White

Medicare and SLP Private Practice

- Medicare Improvement for Patients and Providers Act of 2008 (MIPPA 2008)
 - **allows private-practice speech-language pathologists to bill Medicare Part B starting July 1, 2009**
- **Final Medicare Physician Fee Schedule (MPFS) 2009**
 - **SLPs can enroll as Medicare providers on or after June 2, 2009**
 - **New regulations for participation in Medicare**
 - **Mirror physical therapy regulations, except no provision for assistants**

Medicare and SLP Private Practice

- **Regulations in MPFS**
 - **An SLP can provide services in one of the following practice types:**
 - **An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice**
 - **An employee of a physician group**
 - **An employee of a group that is not a professional corporation**

Medicare and SLP Private Practice

- **An SLP can provide services in the following locations:**
 - **The SLP's private office space. The space must be owned, rented, or leased by the practice 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.**

Short Term Alternatives for Therapy Services (STATS)

- **Computer Sciences Corporation (CSC) has 2 year contract to develop short term solutions to the therapy caps**
 - **Current caps exception process extends through December 2009**
 - **CMS has also contracted with RTI for a 5 year study to collect data for a long term solution to the therapy caps**

STATS

- **CSC's Statement of Work includes:**
 - **Update utilization data**
 - Includes developing quarterly data updates for CMS
 - **Develop alternative policies**
 - Includes identifying and analyzing existing measurement tools;
 - Developing practice guidelines; and
 - Shareholder activities

STATS

- **Shareholder activities include workgroups:**
 - **Clinical workgroup**
 - Activities include evaluating existing outpatient therapy payment policies
 - **Assessment instrument workgroup**
 - Activities include evaluating existing patient assessment instruments
 - **Policy workgroup**
 - Activities include evaluating existing payment policies

Physician Quality Reporting Initiative (PQRI)

- **Certain providers are eligible to receive a bonus payment when they report recognized quality measures to Medicare.**
 - **Audiologists and SLPs are eligible for 2% bonus in 2009 and 2010**
 - **CMS will announce quality measures for 2009 by November 15**

PQRI

- **ASHA strategies**
 - **Continue to stress use of NOMS for SLP**
 - **Meeting with audiology organizations in December to begin to develop measures**
 - **Provided comments to CMS in connection with the MPFS recommending that FCMS associated with NOMs should be used for SLP measures**

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

Dee Adams Nikjeh

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 Sensorineural hrg loss of combined types)
 - Use most specific code possible
- 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*
- 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**

In the meantime...

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

Current Presentation

*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

Proposed

*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

In the meantime...

Proposed Changes from ASHA to ICD-9 Fluency Disorders

Current Presentation

Chapter 5 Mental Disorders

307 Special symptoms or syndromes,
not elsewhere classified

307.0 Stammering and stuttering

Proposed

Chapter 5 Mental Disorders

307 Special symptoms or syndromes,
not elsewhere classified

307.0 **Psychogenic** stuttering

Chapter 7 Diseases of Circulatory System

438 Late effects of CVA

438.14 Fluency disorder

*Chapter 16 Signs, Symptoms, & Ill Defined
Conditions*

784 Symptoms involving head & neck

**784.52 Stuttering with onset in
childhood**

Changes May Be Coming...

ICD-10-CM

- U.S. Dept of Health & Human Services proposing 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)**

ICD-10-CM

- **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-10-CM

- **H903** Sensorineural hearing loss, bilateral
- **H9041** ..., unilateral, right ear, with unrestricted hearing on the contralateral side
- **H9042** ..., unilateral, left ear, with unrestricted hearing on the contralateral side
- **H905** Unspecified sensorineural hearing loss
- **ICD-9-CM: 389.1 series – 389.18** sensorineural hearing loss, bilateral

Just a sample...

ICD-10 for Vocal Pathology

- J38.0 **Paralysis** of vocal cords and larynx
 - Laryngoplegia
 - Paralysis of glottis
- J38.00 Paralysis of vocal cords and larynx, unspecified
- J38.01 Paralysis of vocal cords and larynx, unilateral
- J38.02 Paralysis of vocal cords and larynx, bilateral
- J38.1 **Polyp** of vocal cord and larynx
 - Excludes1: adenomatous polyps (D14.1)
- J38.2 **Nodules** of vocal cords
 - Chorditis (fibrinous)(nodosa)(tuberosa)
 - Singer's nodes
 - Teacher's nodes
- J38.3 Other diseases of vocal cords
 - **Abscess** of vocal cords
 - **Cellulitis** of vocal cords
 - **Granuloma** of vocal cords
 - **Leukokeratosis** of vocal cords
 - **Leukoplakia** of vocal cords
- J38.4 **Edema** of larynx
 - Edema (of) glottis
 - Subglottic edema
 - Supraglottic edema
- J38.6 **Stenosis** of larynx
- J38.7 Other diseases of larynx
 - Abscess of larynx
 - Cellulitis of larynx
 - Disease of larynx NOS
 - Necrosis of larynx
 - **Pachydermia** of larynx
 - Perichondritis of larynx
 - Ulcer of larynx

International Classification of Diseases 9th Revision-Clinical Modification

ICD home page:

www.cdc.gov/nchs/icd9.htm

A Little Practice

Some scenarios on using ICD-9-CM and CPT codes for SLP

Making coding choices – more than a diagnostic choice

- CPT
 - Current Procedural Terminology
 - Code or codes to describe what you did
- ICD-9-CM
 - International Classification of Diseases, 9th Revision, Clinical Modification
 - Code or codes to describe the problem(s) you are treating

How to Use the Dysphagia Codes

- 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
- What do you code?

Dysphagia unspecified

How to Use the Dysphagia Codes

- Bedside/clinical evaluation revealed significant oral dysphagia: pocketing, increased time for bolus prep but no signs of pharyngeal dysphagia
- What do you code?

Oral dysphagia 787.21

How to Use the Dysphagia Codes

- 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
- What do you code?

Oropharyngeal dysphagia 787.22

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

The answer is...

92507

Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

How do we know we can't use 97000 series CPT codes

- CMS has provided guidance that the 97000 series codes were originally written for physical therapy. The vignettes are written to describe physical therapy.
- CMS has described the speech and swallowing therapy codes as “umbrella” codes

How do we know we can't use 97000 series CPT codes

- Some third party payers other than Medicare might agree that other rehab professionals (e.g. SLP) can use the codes.
- You should determine this before billing the code.
- Even if the payer agrees to cover this code, it is likely that you would not bill this code and another code to describe the same session.

Scenario: Speech evaluation and treatment same day

- SLP performs speech/language evaluation and treatment on the same date of service.
- What procedural code(s) would you use (CPT)?

The answer is...

- Code 92506 for evaluation
- Code 92507 for therapy
- No modifier needed
- What is a modifier?
 - Two digit code
 - -59 — distinct procedural service
 - -22 — unusual procedural services
 - -76 — repeat procedure

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?

The answer is...

- 92506 for the clinical part of the exam
- 92520 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: Pediatric Articulation Evaluation

- 6 yr 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?

The answer is...

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

Scenario:

Laryngeal Videostroboscopy

- Patient is referred by ENT doc for a voice evaluation and laryngeal videostroboscopy
- Referring ICD-9-CM codes are:
 - 784.49 Dysphonia
 - 478.4 Nodules
- Evaluation indicates normal vocal quality and no vocal lesions

What diagnostic code(s) can you include in your final report?

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

The answer is:

- 784.49 and 478.4 with an explanation and description of findings in the written report
- Code for what the patient was referred to evaluate

Scenarios on how to use audiology ICD and CPT codes

- Three-year-old presents with a history of at least 5 episodes of otitis media in the last 6 months. Most recently treated with antibiotics three weeks ago. There is a history of hearing loss in the family as the mother reports a significant hearing loss in her right ear. Her mother and grandmother both had hearing loss in one ear. No other significant history was obtained

- A speech reception threshold of 45 dB was obtained for the right ear. A speech reception threshold of 25 dB was obtained for the left ear.
 - CPT 92555
- Conditioned Play Audiometry was attempted but was unsuccessful.
 - NO CODE
- Visual reinforcement audiometry under phones indicated a moderate hearing loss for the right ear with a PTA of 50 dB and a mild hearing loss for the left ear with a PTA of 30 dB.
 - CPT 92579
- Bone conduction testing was not completed as the child tired of the task.
 - NO CODE

- Acoustic impedance testing resulted in a normally shaped and compliant tympanogram with a maximum pressure peak of -300 mm H₂O for the left ear. The tympanogram for the right ear was rounded in shape with reduced compliance and no discernable pressure peak.
 - CPT 92567
- Ipsilateral and Contralateral acoustic reflexes were not elicited at 110 dB, bilaterally.
 - CPT 92568
- ABR testing using tone pips revealed a moderate, mixed hearing loss for the right ear with masked bone conduction results indicating a 25 dB air/bone gap at 500 Hz and 15 dB at 4000 Hz. Left ear ABR testing indicated hearing sensitivity at 20 dBnHL for all frequencies tested.
 - CPT 92585

What is the diagnostic code (ICD) for this child?

- 389.21 Mixed hearing loss, unilateral
- 381.81 Eustachian tube dysfunction

Scenario:

3 year old referred for hearing evaluation due to language delay

- History of otitis media
- 20 word vocabulary
- Expresses himself via grunts and pointing
- VRA minimum response levels are 10 dB to 15 dB from 500 Hz through 6000 Hz
- SDT at 10 dB with good localization
- Normal tympanometry bilaterally

What diagnostic (ICD) codes do you use?

The answer is...

- 389.9 Hearing loss, unspecified
- 315.31 Developmental language disorder
 - Expressive language disorder
- V72.11 Other examination of ears or hearing

Scenario

36 year old female with balance disorder

- 3 week history of incapacitating vertigo
- Roaring tinnitus, full sensation, and fluctuating hearing in one ear
- Referring diagnosis: Meniere's disease
- Caloric ENG showed unilateral weakness
 - CPT 92543
- Spontaneous nystagmus observed
 - CPT 92541 – can't be reported on same date as the ENG CCI edit prohibits it
- Positional testing unremarkable
 - CPT 92542

What diagnostic code(s)?

- 386.01 Active Meniere's Disease, cochleovestibular
- 386.10 Peripheral vertigo, unspecified
- 386.11 Benign paroxysmal positional vertigo
- 386.19 Other (aural vertigo, otogenic vertigo)

Pediatric referral

- 8 y.o. male fell from tree and experienced skull fracture and loss of consciousness
- Stabilized with hospital course
- After d/c, experienced academic difficulties that were not present pre-trauma

Evaluation by audiologist

- Audiological evaluation revealed significant deficits for several degraded speech paradigm presentations
- Pitch pattern recognition test could not be performed or the gap detection test
- Total evaluation time including informing parents of results: 1:35

What procedure codes should be charged? What diagnostic code?

- CPT code: 92620
- CPT code: 92621 (2 units)
- ICD code: 388.45 Acquired auditory processing disorder

ICD Questions?
CPT Questions?

Other Questions?

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>