

**Q&A Session from the 2011 Coding Update for Speech-Language Pathologists
Dee Adams Nikjeh and Nancy B. Swigert
Date: Wednesday, December 08, 2010**

Please note that all Current Procedural Terminology (CPT) codes are © American Medical Association.

Q1: If we are evaluating a patient who just suffered an acute CVA and they are in the hospital, should we still bill late effects of CVA, aphasia (or whichever specific code reflects their symptoms)?

A1: No. Coding using 438 late effects tends to be provider-setting dependent. For acute-care providers it is probably best to use the 784.3 aphasia diagnosis. For skilled nursing facilities and other settings use code 438.11 (aphasia) is recommended. Speech-language pathologists should realize that late effects (438.11) means any time after the onset of the causal condition although acute care settings tend to prefer 784.3.

Q2: Why does the dysarthria code 784.51 exclude CVA? What code would you use for dysarthria secondary to CVA?

A2: The exclusion that you mention gives the answer: use 438.13 dysarthria due to late effects of cerebrovascular accident. Remember that late effects can actually be early effects (so to speak).

Q3: What about this confusion of a child with receptive language disorder/delay and expressive language disorder/delay? What about oral-motor weakness where a child needs oral-motor exercises? Help with coding?

A3: Not sure if this fully answers this question or not

A child with a receptive/expressive language disorder could be coded under the 315 series if there is no associated medical condition (i.e., a developmental problem), or under the 784 series if there is a documented, organic condition such as cerebral palsy. These codes are described in detail below. There is no separate CPT procedural or ICD-9 diagnostic code for the oral-motor component of speech production impairment. Oral-motor impairment is considered a component part of the speech-language problem.

This info was found on the ASHA site:

An SLP or audiologist may select the most appropriate diagnostic code from those provided here. A section of the ICD-9-CM manual in the Mental Disorders chapter is called "neurotic disorders, personality disorders, and other nonpsychotic mental disorders (300-316)." It may seem like a strange place to find the diagnostic code you need, but this is where it might be located.

ICD-9-CM 315.3 is for developmental speech or language disorders and requires a fifth digit code for reporting. That is, if one uses 315.3 it will be rejected because a more specific diagnosis is required. ICD-9-CM 315.31 is for an expressive language disorder and includes developmental aphasia and word deafness. It excludes acquired aphasia (784.3) and elective mutism (309.83, 313.0, and 313.23).

The next diagnostic code is 315.32 for mixed receptive-expressive language disorder. The revised text of the 2008 ICD-9-CM indicates that this code should be used for central auditory processing disorder, but it excludes an acquired central auditory processing disorder (388.45), a new code.

The third diagnostic code for consideration is 315.34, speech and language developmental delay due to hearing loss. This is a new code as of Oct. 1, 2007, and should be helpful in ensuring that health plans understand that the cause of the speech and language developmental delay is clearly related to a hearing loss.

The last code in the developmental speech or language section is 315.39, other. This general diagnosis includes developmental articulation disorders, dyslalia, and phonological disorders. It excludes lisping and lalling (307.9), and stammering and stuttering (307.0).

One other code of interest is found in the symptoms section of the "Symptoms, Signs and Ill-defined Conditions" chapter. The diagnoses in 785.4, "Lack of expected normal physiological development," all require the fifth digit for an appropriate diagnosis. The third diagnosis code in this category, 783.42, is specifically identified as a pediatric code (age 0–17) that includes late talker and late walker. One might need to consider 783.42 if the developmental codes are inappropriate.

Q4: If you have a patient that comes in with speech disturbance due to TIA, can you use late effects of CVA?

A4: Yes

Q5: If you have a head/neck cancer patient coming for speech and swallowing therapy, which dx code should be primary?

A5: Whichever one you're going to spend more time treating or is more complex.

Q6: in the private practice setting, when is the best time to transition to coding using the ICD-10-CM codes?

A6: Mainly billing Medicaid and insurance companies.

When the U.S. accepts the ICD-10-CM system and that will be October 1, 2013. Until then, Medicaid and insurance companies won't be ready to process these codes. Watch the ASHA Leader for updates. More info on ICD 10 can be found: <http://www.asha.org/Practice/reimbursement/coding/ICD-10/>

Q7: Can we use ICD-10-CM codes now? If so, should we also use ICD-9-CM codes with them?

A7: No, don't use ICD-10-CM codes until the U.S. accepts them. Once the switch is made to ICD-10-CM, the ICD-9-CM will no longer be used. Information on ICD 10 can be found: <http://www.asha.org/Practice/reimbursement/coding/ICD-10/>

Q8: It was suggested to use developmental codes (315 codes) for children with Down's Syndrome. How is using a developmental code appropriate?

A8: You could use "organic" codes from the 784 series for patients with speech-language impairments due to Down Syndrome because that condition is an organic, medical condition. You may have to defend your coding. The health plan may have exclusion for conditions present at birth, such as Down Syndrome, but you are accurately coding your services using the 784 series.

Q9: Can you discuss which codes you would use for primary and secondary codes for treating feeding disturbances in children diagnosed with failure to thrive or weight gain disturbances?

A9: Use the code for the problem you're treating: For example, 787.21 for oral dysphagia and then the medical diagnosis for failure to thrive 783.41. You might also consider using 783.3 Feeding difficulties and mismanagement

Feeding problem (elderly) (infant)

Excludes: feeding disturbance or problems:

 in newborn (779.3)

 of nonorganic origin (307.50-307.59)

Q10: I keep trying to get insurance to cover and they do not for 784.5 and not for 315.39 or 32

I think this one needs a broader discussion of how to choose codes, have we done a Bottom Line on that?

A10: First, 784.5 was changed to 784.51 (dysarthria) and 784.59 (other speech disturbance). Use the 784 series of codes for speech-language impairments of an organic nature, such as cerebral palsy. A child with dysarthric speech due to cerebral palsy would be coded as 784.51. If no known organic condition is present for a 5-year old with significant speech-production problems, you may be limited to using a 315 code. Look in the medical record for any neurological issues that might qualify for describing the speech production problem as organic.

Q11: If one wishes to become certified in coding is it better to start learning ICD-10-CM now or go back and learn ICD-9-CM and get certified then learn ICD-10-CM and get certified again.

A11: This is a decision that has to be made individually. You can visit the AAPC site (link: <http://www.aapc.com>) for more information.

Q12: My manager looked up the new cognitive codes in the state of Indiana to see if these were covered for speech therapy or cognitive tx charge and he states that the new ICD-9-CM codes were not covered. Are the new cognitive codes acceptable in all states?

A12: The new codes must be used in all states consistent with the Health Insurance Portability and Accountability Act (HIPAA). However, each insurance company and employer determines what diagnoses are covered.

ASHA expects to have clarification on use of the new cognitive codes in early 2011, working with CDC's National Center for Health Statistics ICD-9 Committee and AHA's Coding Clinic.

Q13: What documentation is necessary (in a private practice) to list Autism/Downs Syndrome/Cerebral Palsy as secondary ICD-9-CM in a new client? Doctor's report? Prior speech-language progress report?

A13: I think it's helpful if you have this medical diagnosis on some physician documentation. More information on related medical diagnoses is found in the FAQ: While SLPs are part of evaluation teams for children referred for possible autism, the diagnosis of Asperger's Syndrome or autism is not within the scope of practice of speech-language pathology. The speech-language pathologist diagnoses and treats the speech/language disorder(s) resulting from these medical conditions.

Physicians, psychiatrists, psychologists typically use the ICD-9 diagnostic code 299.0 to report infantile/childhood autism. The diagnostic code 299.8, under the same psychosis section, is "other pervasive developmental disorders: Asperger's disorder" and is used for Asperger's Syndrome.

The following fifth-digit subclassification is for use with category 299:

- 0 (current or active state)
- 1 (residual state)

Thus, code Apserger's as 299.80.

Q14: A child is dysfluent when excited and has general forward tongue carriage. Her /s/ and /z/ sounds are distorted resulting in a frontal lisp. Should I use 315.35 as a primary code and what code is used for the articulation problem?

A14: The articulation impairment would be coded as 315.39 (developmental articulation disorder).

Q15: At the 2009 ASHA Annual Convention, after attending a similar course, it was my understanding that for the dx the medical code would be primary and then speech for secondary, and then vice versa for treatment (so speech code primary and medical code secondary)

A15: From <http://www.asha.org/Publications/leader/2008/080923/bl080923>: A "primary diagnosis" is the disorder being treated (i.e., the disorder for which a bill is submitted). Local Medicare policies may specify diagnoses allowed as secondary (i.e., disorders that are a cause of the condition being treated). For example, a polyp of the larynx (478.4, must be assigned by a physician) is a cause or secondary diagnosis for "other voice disorder" (784.49).

Q16: Why are speech CPT codes untimed when occupational and physical therapies are timed?

A16: This information was found the on the ASHA Reimbursement site:

Historically, the physical medicine and rehabilitation procedure codes were assigned time units of 15 minutes while the codes for speech-language pathology were not.

Because of the way codes are developed and established, it is difficult to revise descriptors.

There are two 15-minute treatment codes available to speech-language pathologists under Medicare - CPT 97532, Development of cognitive skills, each 15 minutes; and 97533, Sensory integrative techniques, each 15 minutes. Moreover, there are timed evaluation codes that speech-language pathologists can use – one for aphasia testing; per hour (96105), one for speech-generating device evaluation; first hour (92607), auditory rehabilitation evaluation; first hour (92626), and developmental testing; per hour (96111). There are additional relevant codes for 92607 (92608 – additional 30 minutes) and for 92626 (92627 – additional 15 minutes).

Note that Medicare assigns 97532 a total value of 0.66 which converts to a national fee of \$25.01. CPT 97533 has a total value of 0.70 and a national fee of \$26.53.

These are in contrast to 92507 which has a total value of 1.67 and a national fee of \$63.29.

Q17: Can you discuss how our billing differs from occupational and physical therapy (i.e. billing in units versus time)? Can we bill more if we see the client for more than an hour?

A17: Historically, the physical medicine and rehabilitation procedure codes were assigned time units of 15 minutes while the codes for speech-language pathology were not.

Because of the way codes are developed and established, it is difficult to revise descriptors.

There are two 15-minute treatment codes available to speech-language pathologists under Medicare - CPT 97532, Development of cognitive skills, each 15 minutes; and 97533, Sensory integrative techniques, each 15 minutes. Note that Medicare assigns 97532 a total value of 0.66 which converts to a national fee of \$25.01.

CPT 97533 has a total value of 0.70 and a national fee of \$26.53. These are in contrast to 92507 which have a total value of 1.67 and a national fee of \$63.29.

Since SLP codes are untimed, you bill only one code regardless of the amount of time you spend with the client if billing Medicare. Some private insurance companies and some state Medicaid agencies do negotiate different rates for different lengths of time. Be sure and check with the payer in question.

Q18: can we use CPT codes for therapeutic procedures (occupational and physical therapy typically use these), such as 97150, 97530 and 97535?

A18: CMS staff advises that physical medicine codes (97000 series) are not appropriate for SLP or dysphagia services, except for 97532 and 97533.

Two Medicare payers allow limited exceptions in Local Coverage Determinations beyond 97532 and 97533.

CMS has not released a formal policy statement on this issue.

Q19: please define non-speech generating device (non-SGD) and give specific examples.

A19: A non-SGD is an augmentative and assistive device that does not produce a speech. Something as simple as an alphabet board or a basic communication board with pictures would be considered a non-SGD. Some low-tech AAC devices are also non-SGDs.

Q20: Does there have to be a normed level/test to use an attention diagnosis like in the poll question?

A20: The code does not specify that normative testing must be completed.

Q21: What type of codes do you use when doing parent education (i.e., working directly with a parent versus the child)?

A21: There really isn't a code for parent education. If the child is present, and you're demonstrating techniques and having the parent learn these techniques, I typically charge the treatment code.

Q22: So, does that mean that in a rehabilitation setting, we could bill and see someone on the same day for speech therapy and physical therapy?

A22: Yes. See the CCI edits on ASHA's Website: See http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm .

Q23: When exactly would you use the laryngeal function testing? What is the definition of this?

A23: CPT 92520 is for aerodynamic testing and acoustic testing.

Q24: When treating a child who has cochlear implants or hearing aids and treatment consists of ling sounds checks, listening skills, speech and language therapy, and cognitive milestones, what CPT codes should you use? 92507, 92630, 97532 &/or 97533

A24: SLP treatment and listening skills would be captured under 92507 and 92630 (auditory rehabilitation). You might be able to use 97532 for “cognitive-communication” treatment. You would have to check the payer’s site to see if 97533 (sensory integration) is covered when provided by a speech-language pathologist.

Q25: We cannot see a patient for speech treatment on the same day that they are having a Modified Barium Swallow Study (MBSS) with another provider. Is there a modifier/edit we can use to be able to still treat a patient on the same day they get MBSS?

A25: There is no CCI edit for the 92507/92611 pair. Thus, no modifier is required under Medicare to bill for both procedures on the same day. Please note private health plans often selectively adopt Medicare coverage policies.

Q26: Is there someone at ASHA that we can contact about which codes to use in different circumstances?

A26: Yes, send your questions to: reimbursement@asha.org or call the ASHA Action Center and ask them to transfer you to a member of the Health Care Economics and Advocacy Team. There is also a lot of coding information on the ASHA Web site at www.asha.org/practice/reimbursement.

Q27: Can procedure code 92507 be used by a speech-language pathologist in conjunction with 97532 on the same day?

A27: Speech-language pathologists can bill Medicare for 97532 (cognitive skills development) this procedure, but not on the same day as 92507. Medicare CCI edits appear to allow 92507 and 97532 but this applies to situations when another discipline provides the cognitive therapy (e.g. occupational therapists). The prohibition for a speech-language pathologist providing both procedures is identified in Chapter 11, Section H.3 of the *National Correct Coding Initiative Policy Manual*.

Q28: Can 92507 and 92526 be billed both on the same day?

A28: Yes - apply modifier -59. For more information on edits, see: http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm .

Q29: Our Skilled Nursing Unit is requesting speech/language evaluations for all patients newly admitted to the unit, regardless of reason for admission. Would the evaluation code (92506) be reimbursed if there's no diagnosis to support an evaluation?

A29: Mark and Steve- Not a SNF expert, but took a shot: In general, any payer, including Medicare, expects services to be medically necessary. If the patient is not presenting any communication and/or swallowing problems, then it doesn't seem that an evaluation is necessary. It seems, instead, that a screening is indicated to determine if there are possible problems, and screenings are not reimbursable.

Q30: What is the expected time of treatment (30min vs. 60 min) for 92526? Can we bill more than once a day with modifiers; and which modifiers?

A30: There is no published minimum treatment time in the Medicare program for untimed codes although the fee for 92526 is derived from relative value units based on surveyed average face-to-face time of 45 minutes.

Medically Unlikely Edits (MUEs), applicable to Medicare (and Medicaid as of October 1, 2010), list a single visit as the limit for most untimed SLP codes, including 92526. See www.cms.hhs.gov/National/Correct/CodInitED/08_MUE.asp for MUEs, some facilities have had success in attaching the modifier -76 (Repeat procedure by same practitioner) to the second instance of the code. The same CPT code (with modifier) should be reported on a separate line of the claim.

Q31: How do we get an insurance company to increase reimbursement for 92507 or other service codes, now that we have really been paid low? How do we get "them" (and who to go to) to look at our reimbursement? In GA, we really get paid pretty low.

A31: You should work with your State Advocate for Reimbursement. See http://www.asha.org/practice/reimbursement/private-plans/reimbursement_network.htm to learn about the STAR Network and who is your state STAR. ASHA also has resources on this subject, including a recent ASHA Leader article: <http://www.asha.org/Publications/leader/2009/091124/BottomLine091124.htm>.

Would it be advisable to add reference to the SERCU modules?

Q32: In addition to 92520 and 31579 what other codes need a GN modifier?

A32: Any code billed to Medicare by an SLP needs to have a GN modifier attached to indicate the service was performed by an SLP.

The only exception would be a code not on the "Therapy" or 'Sometimes Therapy" list (e.g. videostroboscopy).

Q33: Is there an appropriate code for a motor speech disorder--meaning a client who has a diagnosis of apraxia--the primary diagnosis would be to treat this motor speech disorder, which to me is different than treating an articulation disorder.

A33: 438.81 Apraxia, if related to a CVA: If not, use code 784.69 (other symbolic dysfunction; apraxia). The oral-motor problem is a component of the speech production disorder.

Q34: If seeing a mentally retarded adult for assessment of communication skills (no new dx codes) but has poor communication skills, would I use a developmental speech/language disorder code even though they are an adult?

A34: If the communication impairment is one that has been present since birth rather than due to an acute event (e.g. a stroke) then the developmental codes seem appropriate.

Q35: could you use a HCPCS to indicate use of electrodes as a supply?

A35: Most payers consider electrodes to be an integral part of the payment established for the particular procedure. The HCPCS for electrodes is A4556.

Q36: You change prosthesis on a TEP patient. Then, one week later, under the same script, pt. returns with leaking prosthesis and another new one is placed. Do you charge another 92597 or 92507?

A36: If you remove the old prosthesis, resize and insert another prosthesis, that seems like a re-evaluation. Thus I would code 92597

Q37: Hello! When will the 2011 Medicare rates be in effect? Do those start on 1/1/2011? Will these affect Medicaid and other private payer rates shortly after they are in effect, or does it take a while to effect other payers reimbursement rates?

A37: The 2011 Medicare Physician Fee Schedule went into effect January 1, 2011. Other payers like Medicaid and private health plans will announce their rates individually. The rates for each payer must be checked individually.

For more information on the Medicare Physician Fee Schedule, go to ASHA's Web site at www.asha.org/practice/reimbursement/medicare/feeschedule

Q38: How does one get a contact person at an insurance company to help us when they say they do not have an extension or a way to get back to that person?

A38: You should work with your state's STAR network member and your state association. The insurance commissioner's office will have a contact name or number for you or will serve as an intermediary, and may be interested in knowing about the health plan's uncooperative nature.

I recommend sending a copy of any letter that is sent to the insurer to the state insurance commissioner as well. Here is the link to the map of state insurance commissioners:

http://www.naic.org/state_web_map.htm

Q39: 96105 Assessment of Aphasia w/interpretation and report per hour - is there a limit to number of hours?

A39: No but the time should be reasonable.

Q40: if you are working with a child for speech and they sensory integrative techniques to enhance sensory processing and promote adaptive response (communication) can 97533 be coded as a CPT code with the 92506 code

A40: It would depend on the payer. Currently, there is not a lot of evidence for SLPs using sensory integrative techniques. However, CMS recognizes that SLPs may bill for that code. Work with your payer.

Q41: Can these codes be combined and billed on the same date...96105 (assessment of aphasia), 96125 (standardized cognitive performance testing), 92506 (speech and language evaluation)?

A41: There is no edit preventing that the billing of these three codes on the same date. Information on edits can be found at the following site:

http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm

However, you would need to make sure that the total time spent with the client matched the amount of time billed in the two timed codes and that there was additional time with the client to be reflected for the 92506 code.

Q42: Is there a specific procedural code if you are using PROMPT that is more specific than 92507

A42: No. 92507 is an umbrella code that includes most techniques used in speech therapy

Q43: the 787.21 code is used for swallowing in the oral phase is this also the code you use when you are working on feeding not self-feeding but feeding specific to oral motor skills)

A43: Yes, because you are treating an oral phase disorder.

Q44: if you spend thirty minutes with 2 patients in a group, would each patient be considered as getting 30 minutes of therapy or 15? (e.g., towards their three hour therapy requirement)

A44: The three-hour rule applies to inpatient rehabilitation facilities. There is no current restriction on group treatment; 30 minutes can be counted for each patient.

For Part A SNF patients, 30 minutes also applies to each patient with group treatment allowed up to 25% of each week's treatment per discipline.

Q45: HELP! What is the BEST way to bill for a child who is 6 or 7 with an artic error of /r/, /r/ blends, and vocalic /r/ along with oral-motor weaknesses? The insurance company is giving family and this SLP a hard time. I would welcome ALL suggestions and codes.

A45: There is no best way, just choosing accurate codes. The most appropriate diagnostic code seems to be:

315.39 Other
Developmental articulation disorder
Dyslalia
Phonological disorder

If the insurance company does not cover these types of problems without a related medical diagnosis, changing the codes will not help

Q46: how do we learn more about EPSDT?

A46: This information was found on the ASHA site: As part of the comprehensive developmental history, speech-language pathology and audiology services are included for 1) the identification of children with speech or language impairments, 2) diagnosis and appraisal of specific speech or language impairments, 3) referral for medical or other professional attention necessary for rehabilitation of speech or language impairment, 4) provision of speech and language services, and 5) counseling and guidance of parents, children, and teachers. Additionally, EPSDT requires that any devices such as hearing aids and augmentative and alternative communication devices be covered when medically necessary. Federal Medicaid EPSDT specifically states that, at a minimum, the program include "diagnosis and treatment for

defects of hearing, including hearing aids." Although ESPDT services are required to be provided, ASHA has learned that states have used the waiver program to exempt provision of all but core medical services.

http://www.asha.org/practice/reimbursement/medicaid/medicaid_faqs.htm

Q47: we are trying to prepare for CMS proposed rule for hospital based outpatient program for multi-discipline services for physical therapy on the same day - what will be the impact on reimbursement?

A47: I would advise doing an audit of the last 6 months to a year to see how often the rehab services are billing the same code on the same day (this won't happen much with SLP compared to physical therapy and occupational therapy, because we don't use the physical medicine codes). It will happen more between physical therapy and occupational therapy.

Q48: Do you all think SLPs in private practice ought to go to EMRs (electronic medical records) even though that will decrease or eliminate the personal care that we give.

A48: Each SLP in private practice needs to decide the best way to document services. You must consider the location (are all services rendered in one location? Do the SLPs travel to other sites?), types of clients seen, expectations of your payer sources, ease of use, accuracy, etc. Using an EMR should not change the "personal care" you provide. Regardless of whether you write a progress note by hand, type it in a Word document, or use an EMR, you will likely spend about the same amount of time in documentation (perhaps less with an EMR).

Q49: How should we code "Dysphagia" group? Highmark has one approach, which appears to be contrary to the CMS direction. Highmark says code each individual in the group with their portion of the total time, and code it under the dysphagia treatment code.

A49: We cannot find Highmark's "approach" described above in their dysphagia LCD or other directives. It is not advisable to adopt a coding practice solely on the verbal instructions of a payer employee.

Because there is no specific code, we recommend that you check with the payer to see how they want you to code it. If billing Medicare, you actually have two options that you can present to your contractor:

- **Use 92508:** Precedent from WPS Medicare Local Coverage Determination - http://wpsmedicare.com/j5macparta/policy/active/local/_files/l26565_physmed015.pdf
- **Use 97150 Therapeutic procedures, group:** Precedent from NGS Local Coverage Determination – http://wpsmedicare.com/j5macparta/policy/active/local/_files/l26565_physmed015.pdf (97150 is actually included in the Medicare Benefit Policy Manual (section 15/230.A) as a code that SLPs can use)

Q50: Can you legally provide a service for someone self-pay in a hospital outpatient setting (who maybe had only 10 visits through their insurance or maybe no SLP coverage), and charge what you get reimbursed from Medicare?

A50: We are assuming that this question pertains to a non-Medicare patient. If that is the case, then the hospital can charge their usual and customary fee.

Q51: If a refund is requested, what legal grounds do I have to spread out the re-payments?

A51: If this is from a private insurance company, this would depend on state insurance laws. You may want to consult with an attorney.

Q52: Can you please discuss medical necessity? I work with children with autism and see them 1-2 times a week for children. Medical necessity can be difficult at times to identify when you start really scrutinizing it.

A52: I don't know why she thinks her services aren't medically necessary for a child with autism. She should be able to show improvement with previous patients. ASHA has a resource on SLP and audiology services and medical necessity:

<http://www.asha.org/uploadedFiles/practice/reimbursement/mednecfinal3.pdf#search=%22medical%22>.

Q53: If I see a private pay patient, do I need to have a prescription or a signed plan of care? If not, what happens if the patient bills their private insurance company for reimbursement?

A53: It depends on the facility in which you work. If they require a prescription/order (most hospitals, for example, do require this) then you should obtain one.

If the facility does not require it, then you are under no obligation to get one. However, you might want to check to see if the insurance company requires one.

Q54: Cognitive tx 97532 charge - will Medicare cover this? Sometime this is covered, other times not when I charge this.

A54: Medicare covers 97532 when provided by a SLP and is medically necessary.

Q55: Can we as SLPs bill 97533, 97112 and 97535 if sufficiently trained?

A55: CMS advises that physical medicine codes (97000 series) are not appropriate for SLP or dysphagia services, except for 97532 and 97533.

Some Medicare carriers and intermediaries may allow exceptions in Local Coverage Determinations. Reference: ASHA meetings with CMS staff (2004).

CMS has not released a formal policy statement on this issue

Q56: Can I use modifier 59 when seeing physical therapy for 92507 and 97532 on the same day?

A56: Regarding 97532 (cognitive skills development), Medicare allows usage by speech-language pathologists, but not on the same day as 92507.

Q57: Will Medicaid or insurance cover a re-assessment charge 92506 for a child, let's say every 6 months? Or only if something significant medically has occurred?

A57: In general, payers expect a reevaluation to be done when there is a significant change (decline) or improvement which would be necessary in order to update the treatment plan

Q58: can 92609 be billed with 92507 or are they both umbrella codes so you would select the code that reimbursed the most and best described what you were doing

A58: They can be billed on the same date with modifier -59. For more information on CCI edits, see http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm

Q59: In private practice, if you have a client come in with a previous report diagnosing a covered code, but you don't see the same diagnosis for your client, how would you bill? For example, if a client comes in with a diagnosis of apraxia....

A59: I would only code what my evaluation supported.

Q60: What minimal data is needed as documentation for each inpatient procedure? Most disciplines document 2-3 times a week for daily visits on acute rehabilitation unit.

A60: Daily documentation would include listing the modalities addressed to justify the codes being used. Medicare does not provide detailed documentation rules for inpatient Part A services. You and a hospital

compliance officer may want to review the Medicare outpatient therapy documentation rules when determining inpatient requirements.

Q61: Do Health Spending Accounts or Flexible Spending Accounts reimburse for anything that private insurance does not in the area of speech services?

A61: HSAs and FSAs should be more liberal than private health plans. See <http://www.asha.org/uploadedFiles/public/coverage/HSABrochure.pdf#search=%22Health%22> for a document you can use with your patients who have HSAs. A 2006 *ASHA Leader* article can be found at <http://www.asha.org/Publications/leader/2006/060228/060228b>.

Q62: how do we show our clinical knowledge and document so that others (i.e., parent, nurse) can understand?

A62: A good place to start is <http://www.asha.org/slp/healthcare/documentation.htm>.

Q63: Slide 76 states group treatment for Part A is limited to 4 patients per group, what about Part B and SNF?

A63: For Part A, the only written limit is for SNFs: Maximum 4 patients and group treatment is no more than 25% per discipline per week. Each patient's time applies to their RUG.

For Part B, the group treatment restrictions are contained in LCDs. Most include the 4 person limit; some include the 25% limit.

Q64: Is there a modifier for billing a re-evaluation for speech for Medicare/Medicaid?

A64: There is no CPT code for re-evaluation. You use the evaluation code that applies. There are no modifiers to indicate re-evaluation

Q65: Can you charge 92507 and 92609 on the same day?

A65: They can be billed on the same date with modifier -59. For more information on CCI edits, see http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm

Q66: What is the code for "Oral-Motor Weakness"?

A66: There is no ICD-9-CM code for oral motor weakness... and that makes sense since SLPs don't treat oral motor weakness. They treat the ensuing communication disorder (e.g. dysarthria) or swallowing disorder (e.g. oral dysphagia)

Q67: how would you bill co-treatment with SLP and another discipline (Physical Therapy or Occupational Therapy)

A67: An excellent Bottom Line article addressed this question:

<http://www.asha.org/Publications/leader/2009/090120/bl090120/>

Q68: So if I see a patient for 45 minutes can I charge 3 units 92526?

A68: No, 92526 is an untimed code. You code it one time each visit. For more information on timed vs. untimed codes, see <http://www.asha.org/practice/reimbursement/coding/timedcodes.htm>

Q69: Can 92526 and 92507 be billed the same day or do you select the code that bills higher and best describes the treatment or reason for the visit?

A69: Dysphagia treatment and speech-language treatment are two different and distinct procedures, and thus can be billed in the same session. The medical record should reflect a treatment plan for each disorder. If you are seeing the client for back to back sessions (each a reasonable length of time) you can use each code. If both are addressed, for example, in one half hour session, you will have to pick only one code. The procedure that is the more complex may weigh your decision in favor of that code.

Q70: Can we charge for a MBS 92611 and swallow tx on the same day 92610?

A70: Yes with modifier -59. For more info on edits, see

http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm

Q71: Since we are coding what we are treating, is our treatment code often going to be the same as our diagnostic code?

A71: Your diagnostic code (ICD-9) is assigned to describe what is wrong with the client/patient. There is no 'treatment code' vs. a 'diagnostic code'. There is just the code or codes that describe the problem you are treating.

Q72: We are adding in dysphagia tx codes, should we be asking the physician to add in other codes as well? For example, if treating for dysarthria are we adding that code in via a physicians order and are we using that code for diagnosis and treatment code?

A72: The physician's order should include the reasons for the evaluation and all the problems to be treated.

Q73: I have attended other conferences in the past and was told that 92506 and 92507 can be billed same day- is this still correct?

A73: Yes, they can be billed on the same date. This is an example of a pair of codes that is not listed in the CCI edits and, therefore, the billing of these two procedures on the same date is not restricted.

Q74: can 92610 and 92506 be billed same day if that is what was done during the evaluation?

A74: I don't see an edit preventing that. For more information on edits, see http://www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm

Q75: If a Medicare beneficiary is seen as an outpatient and is then admitted to a hospital for exacerbation of chronic obstructive pulmonary disease, then 3 weeks later returns as an outpatient, does this require a re-evaluation and 92506 charge?

A75: The answer depends on the payer. Under Medicare, if the patient's communication/swallowing skills have significantly changed, then yes. Medicare further states that a formal re-evaluation is covered only if documentation supports the need for further tests and measurements after the initial evaluation. Medicare acknowledges that 92506 can be used for a re-evaluation because there is no speech-language re-evaluation code.

Q76: What is the difference between the cognitive therapy code (97532) and speech language code (92507) from a description and reimbursement standpoint?

A76: We can give you the 2011 Medicare Physician Fee Schedule rates for the two codes. The national rate for CPT 92507 (treatment of speech, language, voice, communication, and/or auditory processing disorder; individual) is \$82.22 and the national rate for CPT 97532 (development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes) is \$25.14 per 15 minutes.

Q77: Can I see 2 peds physical therapy together for a total of 45 min but chart 22-23 minutes each, and charge them both an indiv. charge of 92507?

A77: No. You are providing group therapy.