Reimbursement 2009
An Update in Reimbursement Issues for the Voice Clinician

Presented by the
Division 3 Reimbursement Committee
to the
American Speech Language Hearing Association Annual Convention

New Orleans, LA
A Trip Down Memory Lane
The History of the Division 3
Reimbursement Committee

Mary Sandage
Chair, Division 3 Steering Committee
Division 3 Reimbursement Committee

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The Problem

• Reimbursement for voice assessment and treatment can be difficult to navigate
  – Annual changes in health insurance coverage language pertaining to reimbursement for voice assessment and rehabilitation.
  – Procedures, such as endoscopic laryngeal assessment, require use of particular billing codes that are not generally used by speech language pathologists in general practice.
The Goal

• Division 3 made a commitment in 2006 to:
  – Educate affiliates on billing, coding, and reimbursement for the treatment of voice disorders
  – Communicate changes in Medicare reimbursement to affiliates in a timely manner
  – Develop training tools for documentation and coding
The Solution to Date

• 2006 Survey
• Annual ASHA presentations
  – Accessible to affiliates via the affiliate-only web forum
• Dollars and Sense Column in Perspectives 2008-present to address affiliates questions
• Monitoring listserv for dissemination of correct information
Plans for the Future

• Integrate additional affiliates into the committee and expand scope of committee
  a. Medicaid
  b. Private insurance
  c. University clinics
  d. NSSLHA
• Barbara Jacobsen will join committee 2010
• Develop web based learning tools
• Develop presentations for state meetings, etc
An Update on *All Things New* with Medicare Reimbursement 2009

Mark Kander
Ex-Officio Division 3 Reimbursement Committee
Medicare Overview

• Age 65+ (inpatient coverage – Part A)
• All ages, if with severe disabilities
• Almost all patients pay approx $100/month for Part B (covers individual practitioners)
• State Medicaid programs pay the monthly Part B premium for Medicare coverage
• The co-pay is 20% of the published Medicare fee and you must collect the co-pay
Private Practitioner cannot bill IF

The patient is admitted to a...

– Hospital
– Skilled nursing facility
– Home Health Agency 60-day episode
– hospice
Medicare Advantage Plans (MAP)

—Contracts with CMS to provide Medicare-covered services.
—Like an HMO, CMS pays the MAP a monthly fee per patient for all services.
—The MAP enrolls patients by offering services beyond the Medicare scope of coverage and other enticements.
—MAPs are not established in all urban areas.
Medicare Advantage Plans, contd.

- The MAP contracts with a limited number of SLPs (and other practitioners) in its geographic area
- Medicare private practice status may or may not be required by the MAP
- Your payment amount per session is subject to negotiation between you and the MAP
- Nationwide, MAPs serve 5 to 10% of all Medicare beneficiaries.
Annual Therapy Cap

• $1860, combined with physical therapy services
• The Exceptions Process has, for the most part, eliminated the cap because:
  • When you add the "KX" modifier to the CPT procedure code, it is certification that your documentation shows medically necessity
  • The exceptions process has been re-authorized by Congress each of the past 3 years while an alternative to the cap is being developed
Your link to Medicare Transactions

- Medicare Carriers or Medicare Administrative Contractors (MACs)
  - They process your enrollment application
  - They process and pay your claims
- All carriers will transition to MACs by 2011

Find carrier/MAC for your state:

http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf
Enrollment Applications

- [http://www.cms.hhs.gov/medicareprovidersupenroll](http://www.cms.hhs.gov/medicareprovidersupenroll)
- **Click left side of page: “Internet-Based PECOS"**
  PECOS: **Provider Enrollment, Chain and Ownership System**
- **PECOS is the preferred method for completing the enrollment application for individuals**
  - - *online & interactive* - -
Enrollment Application 855i

- As an employee or contractor in a group practice;
- If the practice is under your name or “Doing business as;” or
- You are the sole owner of a professional corporation, professional association, or limited liability company

- If other SLPs work for you, also complete Form 855B
Participating vs. “Nonparticipating”

- **Form CMS-460 “Participating Physician or Supplier Agreement”** (optional)
  - You agree to accept payment directly from Medicare instead of the patient (except for the patient’s 20% copayment)
Bypass Medicare?

• If your patient, of his/her own free will, requests that you do not submit a claim
• Your fee cannot exceed that of the Medicare Fee Schedule:

  http://www.asha.org/practice/reimbursement/medicare/feeschedule.htm
CPT Modifiers

- “GN” must be entered after the CPT code, item 24.d of the claim form
- GN is for Medicare only. Indicates service rendered by an SLP
- GO = occupational therapy
- GP = physical therapy
- “59” = Distinct Service (CCI Edits)
- 22 & 52 mods: usually not Medicare accept
Videostroboscopy & Medicare

- Not a “therapy procedure”
- Billable in physician office or hospital clinic
- Physician must be in the office suite and immediately available
- 31579 cannot be split into PC + TC
- NPI # on CPT line of the claim form is the physician’s (or nurse practitioner or physician assistant)
Medicare & Speech-Language Pathologists in Private Practice

Countdown to Implementation

Introduction

On July 16, 2008 the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was passed, which included a provision that will allow speech-language pathologists in private practice to directly bill the Medicare program effective **July 1, 2009**. The provision is currently going through the regulatory phase at the Centers for Medicare and Medicaid Services (CMS).

This site contains the information and updates you will need to prepare your practice for billing Medicare as you countdown to **July 1, 2009**.

- Enrollment Process
- Billing & Coding
- Documentation
- Your Questions Answered

**Upcoming Educational Opportunities**

- 2009 Medicare Fee Schedule
- Includes SLP Private Practice Regulations (11/17/08)
- Stay updated! Sign up for e-mail alerts by sending a blank e-mail with the word "subscribe" in the subject line to medi-slp-priv-prac-request@lists.asha.org

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CMS Website

Medicare Benefit Policy Manual:

• 220.1 Physician Certification
• 220.2 Reasonable & Necessary Services
• 220.3 Documentation Requirements for Therapy
• 230.3 SLP Scope of Coverage

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Dee Adams Nikjeh, PhD
Division 3 Reimbursement Committee
Health Care Economics Committee Co-Chair

- Numeric classification system of diseases and disorders
- Developed approximately 30 years ago
- 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
- Contains more than 15,000 codes
International Classification of Diseases (ICD-9-CM) – Principles of Coding

- Code to **highest** degree of *medical certainty* & *specificity*
  - Codes are arranged by categories
  - There are levels within each category
  - Carry code to 5th digit when possible

- 784.4  Voice and Resonance Disorder
- 784.42  Dysphonia, Hoarseness
International Classification of Diseases (ICD-9-CM) – *Principles of Coding*

- 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**
  - *Reason* for your procedure
  - Disease, condition, problem, symptom, injury, or reason *chiefly responsible* for visit

- **Secondary diagnoses**
  - Co-existing conditions, symptoms, or reasons
  - Symptoms found *after study*
• If results of diagnostic testing are **NORMAL**
  – code signs or symptoms to report the reason for test/procedure
  – explain normal result in report
International Classification of Diseases (ICD-9-CM) – *Principles of Coding*

- *Disease codes should match procedure codes*

- Non-physicians (SLPs and AUDs) may code signs, symptoms, or ill-defined conditions
New ICD-9-CM Codes
Effective October 1, 2009

• 784-series Symptoms Involving Head and Neck
  – 784.4 (revised) Voice disturbance and resonance disorders
  – 784.40 (revised) Voice disturbance and resonance disorder, unspecified
  – 784.42 (new) Dysphonia, hoarseness
  – 784.43 (new) Hypernasality
  – 784.44 (new) Hyponasality
  – 784.49 (revised) Other voice and resonance disorders
New ICD-9-CM Codes
Effective October 1, 2009

- 784.5-Other speech disturbances, Excludes speech disorders due to late effect of cerebrovascular accident (438.10-438.19)
  - 784.51 (new code) Dysarthria, Excludes dysarthria due to late effect of cerebrovascular accident (438.13)
  - 784.59 (new code) Other speech disturbance
    Dysphasia
    Slurred Speech
    Speech Disturbance NOS
New ICD-9-CM Codes
Effective October 1, 2009

• 438 Late effects of cerebrovascular disease
  – 438.13 (new code) Dysarthria
  – 438.14 (new code) Fluency disorder
  Stuttering
Looking Forward to ICD-10-CM

• U.S. Dept of Health & Human Services has set October 1, 2013 as compliance date for implementation

• All industrialized nations except for U.S. and Italy now use ICD-10-CM

• ICD-10 contains
  – More than 150,000 codes
  – Diagnosis codes for all settings
  – Procedure codes for hospital inpatients
Current Procedural Terminology a.k.a. CPT Codes

• 5-digit classification codes that describe *medical services and procedures*
  – Most frequently used SLP procedure codes
    • 92506   Evaluation of speech, language, voice, communication, and/or auditory processing
    • 92507   Treatment of speech, language, voice, communication, and/or auditory processing

• Publication of the American Medical Association (AMA)
• Updated annually
• Over 8,000 CPT codes

- Provide uniform language to report medical procedures and services for reimbursement
- Describe and define procedures for medical, surgical, and diagnostic services
- Provide utilization info to AMA and Centers for Medicare and Medicaid (CMS)
  - Reimbursement
  - Resource allocation
  - Documentation of services
  - Productivity and staffing
  - Cost analysis
  - Provider profiles
  - Health research and trends

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ICD-9-CM codes versus CPT codes
What are the differences?

• ICD-9-CM
  – International Classification of Diseases, 9th Revision, Clinical Modification
  – Code or codes to describe the problem(s) you are treating
  – Issued by the U.S. Dept. of Health and Human Services

• CPT
  – Current Procedural Terminology
  – Code or codes to describe what you did
  – Issued by the American Medical Association
Special Circumstances for CPT Coding

- National Correct Coding Initiative (NCCI)
  - a.k.a. CCI Edits
  - automated Medicare edit system established in 1996
  - updated quarterly
- Controls specific CPT code pairs that may be billed on the same day
- Determines which codes are inappropriate to be delivered to the same patient on the same day

www.asha.org/members/issues/reimbursement/coding/CCI_edits_SLP.htm

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Special Circumstances for CPT Coding

CODE MODIFIERS

- **-52** Indicates that session was unusually short
- **-22** Indicates that session was unusually long
- **-59** Indicates that procedure is distinct or independent from other services performed on same day

- Caution- overuse of modifiers will alert payer that incidence is not “unusual”
• **31579* (laryngeal videostroboscopy)**  
  — Paired with 92520 *using modifier -59

• There are **NO** edits preventing pairing of 92506 and 92520*

• There are **NO** edits preventing pairing of 92506 and 31579*

• There are **NO** edits preventing pairing of 92506 and 92507

• Documentation must show that procedures are **separate and distinct**
## 2010 Medicare Fee Schedule

### Speech-Language Pathology

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2009 Rate</th>
<th>2010 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506</td>
<td>Speech &amp; language evaluation</td>
<td>$147.15</td>
<td>$121.58*</td>
</tr>
<tr>
<td>92507</td>
<td>Speech &amp; language treatment</td>
<td>$61.31</td>
<td>$50.38*</td>
</tr>
<tr>
<td>92520</td>
<td>Laryngeal Function Study</td>
<td>$58.43</td>
<td>$48.29</td>
</tr>
<tr>
<td>31579</td>
<td>Diagnostic laryngoscopy with stroboscopy</td>
<td>$199.81</td>
<td>$160.49*</td>
</tr>
</tbody>
</table>
What’s new for SLPs related to CPT? Impact of MIPPA

- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
  - Granted SLPs direct billing access to Medicare
  - Changed our status with CMS to a Medicare Provider
  - Allowed for the “relative value” of SLP CPT (procedure) codes to be re-valued to include a professional work component
Medicare Physician Fee Schedule and Relative Code Value

What’s the relationship?

• Medicare Physician Fee Schedule per CPT code is based on this formula:
  • Relative Value x Monetary Conversion Factor
  • Adjusted for geographic location

• Relative Value – What’s this?
Relative Value – What’s This?

• Relative Value for each CPT code is assigned by the Relative Value Update Committee (RUC) of the AMA

• Relative Value of a code is based on 3 factors:
  – Professional Work
  – Practice Expense
  – Professional Liability
Professional Work
A Key Element of CPT Code Value

— Professional Work
  • Time it takes to perform the service
  • Technical skill and physical effort
  • Required mental effort and judgment
  • Stress due to the potential risk to the patient

— Practice Expense
  • Time
  • Supplies
  • Equipment
  • Overhead

— Professional Liability/Insurance Costs
What’s new for SLPs related to CPT?

Professional Work Component

• SLP codes are being re-valued over a two-year period to include a professional work component
• Codes re-valued for 2010 to include professional work component:
  – 92610  Clinical Swallow Evaluation
  – 92611  Modified Barium Swallow Study
  – 92526  Dysphagia Therapy
  – 92597  Eval for use or fitting or voice prosthetic device to supplement oral speech
# 2010 Medicare Fee Schedule

*Speech-Language Pathology Codes Re-valued with Professional Work*

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2008 Rate</th>
<th>2009 Rate</th>
<th>2010 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>92610</td>
<td>Dysphagia clinical evaluation</td>
<td>$100.93</td>
<td>$77.90</td>
<td>$88.06*</td>
</tr>
<tr>
<td>92611</td>
<td>Modified Barium Swallow Study</td>
<td>$105.50</td>
<td>$84.76</td>
<td>94.59*</td>
</tr>
<tr>
<td>92526</td>
<td>Dysphagia treatment</td>
<td>$82.65</td>
<td>$78.26</td>
<td>78.12*</td>
</tr>
<tr>
<td>92597</td>
<td>Voice Prosthetic Evaluation</td>
<td>$100.07</td>
<td>$100.27</td>
<td>82.38**</td>
</tr>
</tbody>
</table>
Grand Rounds:
Testing your Knowledge and Skill in Reimbursement and Coding

Sandy Schwartz
Division 3 Reimbursement Committee
“If you're not confused, you're not paying attention”

Tom Peters

“Sometimes I'm confused by what I think is really obvious. But what I think is really obvious obviously isn't obvious...”

Michael Stipe
“I think I speak for all of us when I say what in God’s name are you talking about?”
Who should I ask??

• Use resources wisely and be cautious when taking advice from colleagues
• Caution when looking to the list-serv
• Rules/regulations vary based on a variety of factors such as geographic location, state licensure laws, 3rd party contracts and facility type
• When in doubt refer to ASHA for guidance!
CASE SCENARIOS
and
QUESTIONS
Scenario #1

• Hospital based SLP
• Performing outpatient videostroboscopy independent of MD
• Sends reports / videoprints to MD for approval and signature

QUESTION:
• Can I bill 31579 without an MD present?
• 31579 is billed “incident to the MD” and therefore requires an MD supervision / in the office suite
• However, in a hospital setting MD supervision is assumed by Medicare
  – “physician supervision requirement is generally assumed to be met where the services are performed on hospital premises”
  (section 6/20.4.1 of the Medicare Benefit Policy Manual)
• Contracts with other 3rd party payers may vary (check your contract with your billing dept)
Medicare billing

• I understand that SLPs can now bill Medicare directly... I assume that is true for stroboscopy also??

• No, 31579 is an MD code and can only be billed by or “incident to” the MD regardless of your Medicare provider status
Question

• Does the “incident to” MD have to be an ENT?

• No, however the physician billed “incident to” is considered to be the supervising MD.

• It is still advisable to have exams, still images, and/or reports reviewed by an ENT as SLPs are NOT diagnosing pathology.
Scenario #2

• The strobe equipment will be housed in the speech tx dept, not the ENT's office.

• If the ENT comes to our dept to perform the exam, are we still to write up a clinical interpretation of the strobe and given that scenerio bill for 92506, speech/lang/voice eval?

• Does the MD bill the strobe examination?
• The MD bills the strobe examination (31579) if he/she performs the exam.
• The collaborating SLP should bill 92506 and perform the behavioral assessment and write up the functional interpretation of the strobe exam
• If the SLP is performing the examination (if endoscopy allowed by state licensure) it gets billed through the hospital
Student supervision

• How much involvement can graduate students have in participating in stroboscopy exams with patients when billing 31579?

• *stroboscopy is billed "incident to the MD' and considered by Medicare to be a physician code (supervised by the MD) - not supervised by the SLP*
We are having difficulty getting reimbursed for acoustic/aerodynamic testing.... Are we billing correctly??

- 92520 - Acoustic and Aerodynamic testing, usually done as a part of a full voice evaluation (92506)
- 92520-52 - Acoustic testing only
- 92520-59 - Acoustic and Aerodynamic testing and a strobe on the same visit
- 92520-52-59 - Acoustic testing only with a strobe on the same visit

*Keep in mind that 92520 is still listed as an physician code and must therefore SLPs must bill "incident to" and perform under physician supervision*
Scenario #3

• If I perform a voice evaluation and spend time reviewing vocal hygiene and initiating therapy the same visit – can I bill both the 92506 for the eval and 92507 for therapy on the same day???

• There is no CCI preventing this on the same day however keep in mind that many insurances require pre-certification before initiating therapy.
Scenario #4

• Patients are often sent to our clinic with a script to evaluate both voice and swallowing

QUESTIONS:

• Can we perform and bill for these evaluations on the same day?
• Can we perform a videostroboscopy and FEES on the same day?
• Yes, there is no CCI edit preventing 92506 (voice evaluation) and 92610 (dysphagia evaluation) on the same day

• You cannot bill videostrobscopy (31579) and FEES (92612) on the same day
Q and A: Talking Points
what questions do I have??

Correct coding – CPT / ICD-9 / HCPCS/ Modifiers
Collaboration – who bills what?
Facility specific questions
Physician orders / Rx for evaluation and treatment
Indications – reasonable and necessary
Initial evaluations / Re-evaluations
Certifications/Re-certifications
Progress reports
Plan of treatment
Denials / Appeals
Asking and ANSWERING the Tough Questions: 
**Reviewing the Listerv**

Edie R. Hapner, PhD  
Chair- Reimbursement Committee  
Division 3
Question #1

• If a TEP patient plays the trombone professionally or avocationally and has somehow figured out how to play the trombone while utilizing the TEP through hard work in therapy, can you bill therapy for the trombone just as the PT/OT would for therapy to violinist with RSI or some other orthopedic injury to return to his pre-morbid condition.
Answer

• As far as reimbursement goes, this would not be considered medically necessary and does not fall into the description of the therapy procedure code.

• Strategies to improve singing technique really do not fall into speech therapy either; however, we can sometimes justify b/c these same strategies may be used for "voice habilitation" and carry-over into singing...otherwise, not medically necessary and belong to the role of the singing teacher or vocal coach.

• If charts were audited (and this is an increasing possibility beginning in the southeast and mid northwest), I think payment may be recalled
Question #2

• I have been struggling with how to comply with the Medicare enrollment regulations in a university clinic where patients are seen by graduate student clinicians.
Answer

• The bottom line is that most university clinics can do what they did before—charge a fee for supervised services provided by students to Medicare patients and keep the billing outside the Medicare system.

• However, if want to bill Medicare
  – Additional paperwork will involve completion of one form for each patient, either a Medicare form (ABN) or one the clinic develops.
  – Students must have 100% supervision.
  – University clinics must comply with all other Medicare guidelines regarding billing SLP services

• More information: ASHA Leader article 10/13/2009
Question # 3

• What do we code the articulation disorder that is associated with VPI? If I have a child with VPI (for whatever reason – repaired cleft, submucous cleft, other), and the child develops abnormal articulation….typically we are doing articulation therapy. Therefore, I am treating an articulation disorder. What is the code??
Answer

• You're correct that ICD-9 315.39 does not seem appropriate for articulation disorders that are a manifestation of a medical condition such as cleft palate or VPI.

• As the SLP, you are treating the speech disorder not the medical condition, so your primary code represents the speech disorder and the secondary code represents the cleft palate (or whatever the condition).
MORE

• Oct 1, 2009 a new ICD-9 code became
• ICD-9 784.59 which represents "Other speech disturbance" and falls under the broader category of 784 which represents "Symptoms involving head and neck."
• Under the inclusion criteria for 784.59 is "speech disturbance not elsewhere specified."
• Most appropriate code to use for a speech disorder that is a manifestation of a medical condition (excluding CVA).
• if you are working on resonance issues, we now have 2 new codes for this: 784.43 and 784.44 (hyponasality and hypernasality).
Question #4

• TEP changes? 92597 or 92507?

• I code 92597, but if pt has TEP problem and ends up being repeat visitor w/in 2wk period, am never sure if I should be coding those visits as 92507?
Answer

• **92597** is the more appropriate code to use when evaluating for fitting and change of a TEP prosthesis.

• If a **new problem** occurs, this is documented and the **visit may be considered another “episode” of care.**

• If the prosthesis is removed and a new evaluation and fitting occurs, then **92597** is appropriate.

• However, if the patient requires **training** on use or care of the prosthesis, then perhaps **92507** is more appropriate.
Explanation of Fee Change

• Voice prosthetic device evaluation.
• CMS maintained that the initial fitting of the device is included with a code reported by the physician 31611 (construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis).
• Consequently, CMS reduced the professional component RVU from 1.48 to 1.26.
Last Question

• I'm not trying to "stir the pot" so to speak, but I'm not understanding why it is such a bad idea to discuss billing/CPT Codes to continue to develop our understanding as professionals of appropriate billing practices and address inconsistencies that exist. Is this not an avenue for continued learning and development??? I personally like the opportunity to ask these such questions to a diverse group of professionals and continue to be aware of how other individuals are billing
Answer (s)

- Billing/coding/and reimbursement is an ever changing entity that is region specific, third party payer specific, and often institution specific regarding what an SLP can and cannot do within the institutions policies.

- The reimbursement committee of DIV 3 has asked members to utilize a number of resources for billing/reimbursement questions rather than the listserv as we have noticed that often misinformation is given over the listserv in terms of coding for procedures.
Most importantly

• Utilizing the wrong code not only jeopardizes reimbursement but could at the extreme constitute fraudulent practices if pursued by the third party payer.

• Take advantage of your ASHA Resources

• Become informed
Thank you ALL for working so hard for your patients and your colleagues everyday.

We are always happy to hear from you and to learn from what works for you. We are all in this together.

Your Division 3 Reimbursement Committee

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