THE 6TH ANNUAL
VOICE AND VOICE
DISORDERS:
REIMBURSEMENT UPDATE

ASHA Member Advisory Group
Members of the Advisory Group

Edie Hapner, Ph.D.

Coordinator: SIG 3

Member: Reimbursement Committee of SIG 3 since 2006

Voice Clinician, Faculty Emory University, Instructor University of Georgia
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Chair, Member Advisory Group

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Awarded PhD in Kinesiology, Auburn University, 2012

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ASHA Staff for Member Advisory Group

Authored *many* articles on Medicare and Coding/Reimbursement
Disclosures

All: No relevant financial disclosures
Non-financial – Hapner, Jacobson, Nikjeh, Sandage, Schwartz – Members of ASHA Member Advisory Group
Hapner – Coordinator of Special Interest Group 3; Jacobson – Member, Steering Committee SIG 3; Nikjeh – Co-Chair HCEC; Schwartz – Consultant to KayPENTAX
Kander – Director of Health Care Regulatory Analysis, ASHA
HISTORY

- **2006** Committee established
- **2006** Affiliates Survey #1
- **2007** ASHA Convention Reimbursement Workshop
- **2008** Affiliates Survey #2
- **March 2008** *Perspectives* issue
- *Dollars $$ Sense:* Ongoing column in each *Perspectives* issue since **2008**
- **2008** ASHA Convention Reimbursement Workshop
- **2009** ASHA Convention Reimbursement Workshop
- **March 2010** *Perspectives* issue
- **2010** ASHA Convention Reimbursement Workshop
- Monitoring VOICESERVE for Karnell and ASHA Community SIG listserve
- Advising ASHA staff on issues as they arise (e.g. CMS/31579/92511 ruling)
- Conversion to a Member Advisory Group (MAG) in 2012 due to SIG restructuring
Why A Member Advisory Group?

- SIG 3 has only 2 subcommittees under SIG restructuring
- Continuing need to provide current, accurate, and timely responses to ASHA members’ inquiries about:
  - Coding
  - Billing practices
  - Responses to insurance denials
  - Changes in CMS policy and interpretation by MACs
- Members use SIG 3 community and VOICESERVE as resource for answers about billing and reimbursement
International Classification of Diseases, 9th Revision (ICD-9)
### 2013 Medicare Fee Schedule

**How some SLP codes are impacted by the conversion factor (25.0008):**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2012 Rate</th>
<th>2013 Rate (with 26.5% cut, no Congressional intervention)</th>
<th>2013 Rate (estimated, with Congressional intervention)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31579</td>
<td>Diagnostic laryngoscopy with stroboscopy</td>
<td>$218.18</td>
<td>$160.01</td>
<td>$217.84</td>
</tr>
<tr>
<td>92506</td>
<td>Speech, lang., aud. process evaluation</td>
<td>$165.42</td>
<td>$159.51</td>
<td>$217.16</td>
</tr>
<tr>
<td>92507</td>
<td>Speech, lang., aud. process treatment</td>
<td>$74.88</td>
<td>$52.25</td>
<td>$71.14</td>
</tr>
<tr>
<td>92508</td>
<td>Speech/hearing treatment, group</td>
<td>$22.46</td>
<td>$15.25</td>
<td>$20.76</td>
</tr>
<tr>
<td>92511</td>
<td>Nasopharyngoscopy</td>
<td>$144.66</td>
<td>$105.50</td>
<td>$143.64</td>
</tr>
<tr>
<td>92512</td>
<td>Nasal function studies</td>
<td>$61.95</td>
<td>$46.25</td>
<td>$62.97</td>
</tr>
<tr>
<td>92520</td>
<td>Laryngeal function studies</td>
<td>$70.46</td>
<td>$55.00</td>
<td>$74.88</td>
</tr>
<tr>
<td>92526</td>
<td>Swallowing treatment</td>
<td>$83.05</td>
<td>$56.75</td>
<td>$77.27</td>
</tr>
<tr>
<td>92597</td>
<td>Voice prosthetic evaluation</td>
<td>$83.05</td>
<td>$50.75</td>
<td>$69.10</td>
</tr>
<tr>
<td>92605</td>
<td>Evaluation for non-speech generating device, first hour</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>92618</td>
<td>Evaluation for non-SGD, each +30 min</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
ASHA’s analysis of the 2013 Medicare Fee Schedule for Speech-Language Pathologists is available on ASHA’s Billing & Reimbursement Website at:

www.asha.org/practice/reimbursement/medicare

Check back for updates on Congressional action and fee schedule rates
Requires CMS by January 1, 2013 to implement a claims-based data collection strategy to collect data on “patient function during the course of therapy services in order to better understand patient condition and outcomes”.

H.R. 3630—Middle Class Tax Relief and Job Creation Act (Feb 17, 2012)
Claims–Based Outcomes Reporting for Therapy Services

- Jan 1, 2013 – Claims–based data collection strategy for reporting *patient condition* and *outcomes*
  - Mandated by Congress
  - 6–month testing period
  - July 1, 2013 – claims that do not comply will be returned

- CMS adopted 7 ASHA NOMS Functional Communication Measures (FCMs)

- Use non–payable G–codes and 7–point severity modifier
  - Admission
  - Every 10th treatment day
  - Discharge from treatment plan
7 Functional Communication Measures adopted by CMS for Data Collection

- Swallowing
- Motor–Speech
- Spoken Language Comprehension
- Spoken Language Expression
- Attention
- Memory
- Voice
- Other SLP Functional Limitation
Voice Example – G-codes

- **G9171**
  - Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals

- **G9172**
  - Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy

- **G9173**
  - Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation
## 7-point Severity/Complexity Scale

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Impairment Limitation Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>0 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CI</td>
<td>At least 1% but less than 20% impaired, limited or restricted</td>
</tr>
<tr>
<td>CJ</td>
<td>At least 20% but less than 40% impaired, limited or restricted</td>
</tr>
<tr>
<td>CK</td>
<td>At least 40% but less than 60% impaired, limited or restricted</td>
</tr>
<tr>
<td>CL</td>
<td>At least 60% but less than 80% impaired, limited or restricted</td>
</tr>
<tr>
<td>CM</td>
<td>At least 80% but less than 100% impaired, limited or restricted</td>
</tr>
<tr>
<td>CN</td>
<td>100% impaired, limited or restricted</td>
</tr>
</tbody>
</table>
Medicare Therapy Cap

- Final rule released on Nov 1 states that exceptions process for therapy cap will expire on Dec 31, 2012
- Congressional action needed to continue
- $1900 anticipated 2013 cap for combined SLP/PT services
- ASHA expects Congress to extend the exceptions process and manual medical review
- Hospital outpatient departments will continue to fall under the fee cap
- Updates will be posted on the ASHA Website: [www.asha.org/practice/reimbursement/ExceptionProcess.htm](http://www.asha.org/practice/reimbursement/ExceptionProcess.htm)
CPT and ICD Coding News for SLPs

SLP Code Changes in 2013
New SLP Evaluation CPT Proposals
ICD–10 – It’s Coming
2013 – REVISED CPT Codes

- **92613 (revised)** Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; *interpretation and report only*
- **92615 (revised)** Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; *interpretation and report only*
- **92617 (revised)** Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; *interpretation and report only*
CCI Edit
CPT 97532 and CPT 92526

- CPT 97532 (Cognitive Skills Development, 15-mins) and CPT 92526 (Dysphagia Tx) may now be billed together on the same day
  - Only when cognitive treatment is truly distinct and separate from swallowing treatment
  - Distinct plans of care for each disorder
  - Add modifier –59 to CPT 97532 when billing together on same day

- For more information, see:
Videostroboscopy Supervision

- Not many MACs so far address LVS in their LCDs because it is not a therapy code; HOWEVER...

- National Government Services (NGS)
  - “may be performed by qualified SLPs”
  - Covers CT, NY

- Palmetto
  - quotes supervision requirements from Benefit Policy Manual dysphagia section and specifies direct supervision
  - Covers CA, NV, NC, SC VA, WV
Development of 4 New SLP Evaluation Procedure Codes

To replace CPT 92506 hopefully in 2014
Proposed New SLP Evaluation Codes

- Evaluation of speech fluency (e.g., stuttering, cluttering)
- Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) \textit{with} evaluation of language comprehension and expression (e.g., receptive and expressive language)
- Behavioral and qualitative analysis of voice and resonance
Impact of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

- MIPPA – Effective July 1, 2009
  - 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
Relative Value of Procedure Code is Based on Three Components

- **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 of support personnel
  - Supplies
  - Equipment
  - Overhead

- **Professional Liability/Insurance Costs**
## SLP Codes Revalued for Work
### Before (2009) and After (2013)

<table>
<thead>
<tr>
<th>Code</th>
<th>Work RVUs</th>
<th>Practice Expense RVUs</th>
<th>Malpractice RVUs</th>
<th>Total RVUs</th>
<th>% Change in Total RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506 Speech–Language Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92507 Speech–language treatment</td>
<td>0.52</td>
<td>1.30</td>
<td>1.16</td>
<td>0.83</td>
<td>0.02</td>
</tr>
<tr>
<td>92508 Group speech–language treatment</td>
<td>0.26</td>
<td>0.33*</td>
<td>0.54</td>
<td>0.32</td>
<td>0.01</td>
</tr>
<tr>
<td>92526 Swallow treatment</td>
<td>0.55</td>
<td>1.34</td>
<td>1.60</td>
<td>1.03</td>
<td>0.02</td>
</tr>
<tr>
<td>92597 Voice prosthetic evaluation</td>
<td>0.86</td>
<td>1.26</td>
<td>1.89</td>
<td>1.11</td>
<td>0.03</td>
</tr>
<tr>
<td>92610 Swallow evaluation</td>
<td>0.00</td>
<td>1.30</td>
<td>2.08</td>
<td>1.25</td>
<td>0.08</td>
</tr>
<tr>
<td>92611 MBS</td>
<td>0.00</td>
<td>1.34</td>
<td>2.27</td>
<td>1.47</td>
<td>0.08</td>
</tr>
<tr>
<td>96105 Aphasia assessment</td>
<td>0.00</td>
<td>1.75</td>
<td>1.86</td>
<td>1.20</td>
<td>0.18</td>
</tr>
</tbody>
</table>
Relative Value Surveys for New Codes

- We need your help!
- To volunteer, go to http://www.asha.org/advocacy/slpcptcodeforum.htm
- A survey for the code(s) you chose will then be sent to you from asha.org@softekd.com
International Classification of Diseases and Disorders – 10th Revision
Coming October 2014
ICD–9 to ICD–10
ASHA Conversion Tool

- Online conversion tool for ICD–9 to ICD–10 codes
- List of ICD–10 codes, much like current ICD–9 list on ASHA website
- Both products will be free and tailored for speech–language pathology and audiology
- Will be made available in 2013

ASHA Web site: www.asha.org/Practice/reimbursement/coding/ICD–10/
ASHA’s Changing Landscape Summit Objectives

- Provide forum for knowledge transfer, open discussion, and deliberation about rapidly changing health care landscape;

- Discern specific implications of health care reform with regard to all aspects of the professions of speech-language pathology and audiology and the discipline of communication sciences and disorders;

- Identify a set of options and seek consensus recommendations for a strategic course of action to respond to challenges and opportunities posed by health care reform across the continuum of CSD;

- Determine ASHA’s role in proactively safeguarding the professions in light of the changing landscape in health care.
Changing Health Care Landscape

- SLPs will be paid for managing outcomes (value-based care and purchasing) not volume of visits or number of sessions or number of tests

- What will the patient do differently and/or better, to reduce burden of care and increase independence because he participated in SLP treatment?

- Use International Classification of Functioning, Disability, and Health (ICF) framework to determine levels of activity and participation

- Make your assessments and treatment context-sensitive
Changing Health Care Landscape

- How do SLP services:
  - Reduce costs and yet improve person’s activity and participation?
  - Decrease length of stay and improve quality of life?
  - Impact health care outcomes?
- SLPs need to be successful in showing value of services as rules change
- A move from “we want more visits” to “we can show you how the patient will function better”
Think……. **VALUE NOT VOLUME**

SLPs who provide service in the most efficient manner and obtain the best outcomes for the people they serve will thrive under this model!

Be a Catalyst for Change
Current Issues

Sandra A. Schwartz, MS, CCC–SLP
SLPs and Supervision for Endoscopy
In January 2011 – CMS changes level of supervision from “direct supervision” (in the office suite) to “personal supervision” (in the room) for codes

- 31579 – Laryngeal videostroboscopy
- 92511 – Nasopharyngoscopy

Members of ASHA and AAO-HNS met with CMS to dispute change in supervision stating:
- Long-standing use of endoscopic procedures safely by SLPs
- Various regional Medicare administrative contractors not requiring personal supervision for similar endoscopic procedures by SLPs.
- Inefficient use of physician’s time

October 1, 2011, all supervision levels removed

CMS acknowledges that “speech pathologists also perform these procedures to evaluate and treat a patient’s functional/use problems.”
What does “no level of supervision” mean?

- no distinction or requirement in the level of supervision assigned to a videostroboscopy or nasopharyngoscopy performed by an speech-language pathologist (SLP) in the current Medicare policy
- However, state licensure laws and/or local Medicare Administrative Contractor (MAC) supervision requirements may supersede Medicare's requirement.
- Obtaining information regarding your specific regulation
  - Call ASHA at 800–498–2071 (State Advocacy Team)
  - ASHA's state by state for contact information for your state's licensure board
There is no distinction made in the level of supervision required based on practice setting.

There is no difference between an SLP who is employed by a physician practice or works as an independent contractor.

SLP may be an independent practitioner and may bill 31579 to Medicare if enrolled as a provider.

31579 may be billed to Medicare as “incident to” a physician (under the physician’s provider #) which implies that the procedure was performed under the supervision of that physician.
SLPs providing endoscopic evaluation independent of a physician

- A referral or order is required for evaluation
- This referring physician does not need to be an ENT
- The order may also be provided by a nurse practitioner, physician assistant or clinical nurse specialist (if permitted under state law).
- Follow up should be provided by a physician as outlined in *ASHA's Preferred Practice Patterns for the Profession of Speech-Language Pathology* (Section 34: Voice Assessment) recommending: "All patients/clients with voice disorders are examined by a physician, preferably in a discipline appropriate to the presenting complaint."
There is no technical/professional split of the CPT code assigned for videostrobscopy:

- no separate code for review or "interpretation" of a videostrobscopy (unlike FEES/FEEST).
- The MD may be able to bill an office visit or hospital consult code if he/she is directly involved in the care of the patient.
Obtaining additional information regarding supervision for endoscopy

- list of FAQs developed by SID3: http://www.asha.org/Practice/reimbursement/medicare/Medicare-Supervision-Requirements-for-Videostroboscopy-and-Nasopharyngoscopy-Procedures/
- Dollars $$ Sense (Perspectives on Voice and Voice Disorders; November 2011 vol. 21 no. 3 85–88)
  
  http://div3perspectives.asha.org/content/21/3/85.full
Manual Medical Review Process for Therapy Claims
As part of the Middle Class Tax Relief and Job Creation Act of 2012 the Medicare Part B Outpatient Therapy Cap Exceptions Process was extended through December 31, 2012.

This exception process allows claims to be submitted over the $1880 combined outpatient PT/ST cap using the KX modifier.

This is allowable for services provided in private practices, Part B skilled nursing facilities, home health agencies and outpatient rehabilitation facilities.

As of 2012 therapy cap will also apply to therapy services furnished in hospital outpatient departments.
Starting Oct. 2012 providers are required to submit a **request** for an exception for therapy services above a $3700 cap (combined PT/ST) (an additional $3700 for OT only)

Phase-in dates were assigned (letter were sent to providers prior to Sept 1)
- Phase I Oct 1, 2012 to December 31, 2012
- Phase II Nov 1, 2012 to December 31, 2012
- Phase III Dec 1, 2012 to December 31, 2012

If you are unsure of your assigned phase, you are able to lookup by NPI at:

https://data.cms.gov/dataset/Therapy-Provider-Phase-Information/ucun-6i4t
no automatic exceptions based on diagnosis
requests for exceptions can be made in increments of 20 treatment days
local contractors (MAC) will have 10 business days (upon receipt of all necessary documentation from the provider) to review the request for exception.
if a decision is not received within 10 business days of a request which contains all the required documentation, the request will be automatically approved.
each MAC will have detailed instructions posted to their websites
How do I apply for an exception?

- Information on the exception process, instructions and pre-claim review request forms can be obtained on your local MAC website.
- ASHA has provided MAC contact information and links to provide resources for therapy claims.

http://www.asha.org/Practice/reimbursement/medicare/Medicare-Administrative-Contractor-Resources-for-Therapy-Claims/
Obtaining additional information:


- To contact CMS with questions: [therapycapreview@cms.hhs.gov](mailto:therapycapreview@cms.hhs.gov).
The mandate to be accountable

DOCUMENTING OUTCOMES

Edie R. Hapner, PhD
Disclosures

- No relevant financial disclosures

- Relevant non-financial:
  - Member of ASHA’s Member Advocacy Team
  - Coordinator of Special Interest Group 3 (through 12/31/2012)
The performance of the health care system varies considerably….. A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services—services for which the potential risk of harm outweighs the potential benefits.

http://www.healthcare.gov/law/resources/reports/quality03212011a.html#es
The Affordable Care Act 2010

- Value based accountable care
- Calls for
  - Value
  - Coordination of Care
  - Transparency
  - Outcome based healthcare
- Emphasizes efficiency and effectiveness
  - Collect data to document initial status and functional outcomes

http://www.asha.org/practice/
Health-Care-Reform/Patient-Protection-and-Affordable-Care-Act/
Efficacy - Effectiveness - Outcomes

- Frattali (1998) *Measuring Outcomes in Speech Language Pathology*

Treatment effectiveness: Whether treatment does or does not work
Treatment efficiency: Whether one treatment works better than another/whether all components are necessary in a treatment
Treatment effects: Which aspects of treatment differentially influence which behaviors

- Benninger (1997)

Benninger et al. (1997) draw a distinction between efficacy research and outcomes research. Treatment efficacy is the ability of an applied treatment to produce a predicted result. Treatment efficacy is what drives controlled clinical studies. Conceptually, it is distinct from outcomes research that measures the effectiveness of a specific treatment as it is applied to a typical circumstance. Outcomes studies seldom incorporate experimental research designs because their focus is on the influence of the applied treatment over numerous facets of the patient’s life that typically cannot be experimentally controlled. Benninger and his colleagues conclude:
Speech pathologists must have adequate data to demonstrate

- Functional outcomes from therapy
  - Functional change due to therapy
    - Use the ICF for guidance on goal writing that demonstrates functional change
  - NOMS to document change due to therapy
  - Positive patient experience—patient satisfaction
    - Press Ganey notes: A conservative 5% dissatisfaction rate among patients can cost a physician $150,000 in revenue (www.pressganey.com, accessed 11/12)
Health is: the complete physical, mental, and social functioning of a person and not merely the absence of disease (WHO, 2001)

Using the ICF in Voice Therapy

- Concept—Same disability can impact people differently

- Classification system
  - ICF contains two sections: Body Function/Structure and Contextual Factors
    - Body Functions chapter CONTAIN a section on voice and swallowing
    - Contextual chapter discusses communication as a whole

- Clinicians can use the ICF to design therapy that meets both the needs associated with the disability and how that disability affects that person specifically.

Treats, Travis: www.asha.org/ICF
National Outcome Measurement System—NOMS (NCEP, 1999)

- Functional Communication Measures
  - 15 communication disorders
  - Adult and children
  - Inpatient and outpatient care/schools
  - Seven point severity rating scales
  - Purpose is to describe the change in functional communication and swallowing over course of tx

- Register at: www.asha.org/NOMS
VOICE FCM

- **LEVEL 1**: Unable to use voice
- **LEVEL 2**: Not functional most of the time
- **LEVEL 3**: Functional but distracting
- **LEVEL 4**: Functional but sometimes distracting
- **LEVEL 5**: Occasionally normal
- **LEVEL 6**: Normal most of the time
- **LEVEL 7**: Demands not limited by voice
Voice Scenario

- Ms Smith is a 72 year old woman diagnosed by the multidisciplinary voice team (ENT and SLP) with presbylaryngeus marked by prominent vocal processes, small midline glottal gap, and mid-membranous scaring and presenting to the voice lab with voice quality consistent with presbyphonia.
- She reports that her voice limits her ability to communicate effectively especially in high noise, high demand situations.
- Findings indicated: CAPEV score or 68/100, Psub of 3 cm/H20, decrease in CPP, reduced volume (68 dB SPL in running speech) and increased Sfo 235Hz, VHI-44
Using the NOMS—5 extra minutes

- Assign level at first therapy session from Voice FCM—7 point scale
  - Ms Smith: Level 4
- Upload to ASHA NOMS website with other demographic data
- Do your therapy as usual
- At discharge—rerate using Voice FCM and
  - Tally number of sessions
  - Tally length of therapy
  - Tally change
Some examples of information
ASHA NOMS TREATMENT OUTCOMES IN OUTPATIENT SETTINGS

Table 25: Mean Treatment Time by Amount of FCM Progress (in hours)

<table>
<thead>
<tr>
<th>Progress</th>
<th>Percent</th>
<th>Mean Tx Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Progress</td>
<td>14.0%</td>
<td>2.8</td>
</tr>
<tr>
<td>Increase 1 Level</td>
<td>31.6%</td>
<td>3.5</td>
</tr>
<tr>
<td>Increase Multiple Levels</td>
<td>54.4%</td>
<td>4.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>3.9</td>
</tr>
</tbody>
</table>

NOMS Provides a Means to Track National Trends in SLP

- Amount of Treatment by Service Delivery Model
- Functional Communication Measures Treated
- Progress by FCM Level
- Average Length of Stay
- Primary Reason for Discharge
- Continued SLP Treatment Recommended at Discharge
- Patient Setting Subsequent to Discharge
- Average Number of Sessions Per Week
- Length of Typical Session
NOMS AND PQRS

- 8 FCM’s were approved by CMS for Physician Quality Reporting System (PQRS).
  - spoken language comprehension, spoken language expression, motor speech, writing, reading, attention, memory and swallowing.
- PQRS is a voluntary program at present
- SLP who treat stroke patients can voluntarily register to report outcomes and potentially receive incentives (ASHA, 2012)
Private practice setting
Treat adult stroke patients covered under Medicare Part B
Bill Medicare Physician Fee Schedule
National Provider Identifier (NPI)
Taxpayer Identification Number (TIN)
NOMS data on three or more quality measures for at least 80% of all eligible Medicare beneficiaries seen
Value-based purchasing" proposal, Medicare will withhold 1 percent of its payments to hospitals starting in October 2012, putting those funds into a pool to be distributed as bonuses to hospitals that score above average on several measures. Patient satisfaction scores would determine 30 percent of the bonuses, and clinical measures for basic quality

Weisman and Koch (1989) have indicated that satisfied clients are more likely to follow their practitioners' recommendations for treatment.

Health care professionals with access to data..... possess a powerful tool for advocacy and negotiation

http://www.asha.org/Members/research/NOMS/NOMSBenefitHC/
Which Path Will You Take? 
Start NOW
Coding, Billing, & Reimbursement Scenarios

Barbara Jacobson, Ph.D.
Mary J. Sandage, Ph.D.
Question: “A community ENT has asked me to come to his clinic and train his medical assistants to perform videostroboscopy (with a rigid scope). Does CMS reimbursement rules mandate the type of professional who can do LVES?”
Scope of Practice

- Answer: No
- The Benefit Policy Manual Sec 15/60.A allows auxiliary personnel (employees of physicians, including medical assistants) to provide videostroboscopic services if properly trained and the physician is immediately available in the office suite (i.e., incident to rule).
- They can also be supervised by PAs, NPs or clinical nurse specialists, if allowed by state law (this is usually the case).
Question: “Can my laryngectomee patient purchase and bring in his voice prosthesis for me to insert or do I have to purchase the device?”
Answer: No

As of October 1, 2010, reimbursement only to provider. This prevents purchase by patient if a professional must insert the device (HCPCS code – L8509)

CMS policy states:
“Dispensing a prosthetic device in this manner raises health and safety questions.”

(ASHA has also been working with CMS to increase current allowable cost to $100)
Irritable Larynx

Question: “Is there a specific way to code for reimbursement for evaluation and treatment of PVFM and chronic cough?”
Irritable Larynx

- Answer: Yes
- Using the most specific code available
  - Paradoxical Vocal Fold Motion/Vocal Cord Dysfunction
    - 478.75 laryngeal spasm
      - While not ideal, this is the same code as for Spasmodic Dysphonia
  - Chronic cough
    - 786.2 chronic cough
    - 478.6 Edema of larynx – if edema is present
- Hoarseness may not accompany PVFM or cough
SLP as Medicare Provider

Question: “As a Medicare provider, does this status extend to all settings where I work (e.g. different ENT offices)?”
SLP as Medicare Provider

- Depends
- Your Medicare provider number applies to all work environments & does not limit your ability to submit claims from more than one setting
- Your Medicare provider number allows you to bill in facilities where you have a “Medicare assignment account”
  - You may bill as an independent provider in some facilities and “incident to” in others
University training clinics may be an exception if the qualified practitioner does not provide 100% in room supervision for SLP students providing therapy.
Use caution when consulting SIG 3 community and VOICESERVE
  ◦ Reimbursement MAG regularly monitors

Reimbursement rules/regulations will vary based on a variety of factors such as geographic location, state licensure laws, 3rd party contracts and facility type

Resources:
reimbursement@asha.org
http://www.asha.org/Practice/reimbursement/modules/
QUESTIONS?