THE 7TH ANNUAL
VOICE AND VOICE
DISORDERS:
REIMBURSEMENT UPDATE

ASHA Member Advisory Group
Edie Hapner, Ph.D.

ASHA VP Elect for Planning

Member: Reimbursement Committee of SIG 3 since 2006

Voice Clinician, Faculty Emory University, Instructor University of Georgia
Barbara Jacobson, Ph.D.

Chair, Member Advisory Group

Associate Director, Medical SLP, Author of VHI, Vanderbilt University faculty
Dee Nikjeh, Ph.D.

Co-Chair: ASHA’S Healthcare Economics Committee

Author: Perspectives on Voice and Voice Disorders Dollars and Sense Column

Member SIG 3 Reimbursement Committee and MAG since 2006

Voice Clinician, Consultant, Researcher
Mary Sandage, Ph.D.

SIG 3 Steering Committee Coordinator 2007–2009

Reimbursement Committee, MAG since 2006

Voice Clinician, Assistant Professor, Auburn University
Sandra Schwartz

SIG 3 Reimbursement Committee, MAG since 2006

Voice Clinician, Duquesne University – Adjunct Instructor, KayPENTAX Inc. – Clinical Consultant
Lisa Satterfield, M.S., CCC–A

ASHA: Director, Health Care Regulatory Advocacy

ASHA Liaison to CMS (G-codes, PQRS, Manual Medical Review, MAC/RAC audits)
Mark Kander

ASHA: Director, Health Care Regulatory Analysis

ASHA Staff for Member Advisory Group

Authored many articles on Medicare and Coding/Reimbursement
Disclosures

Financial: Satterfield/Kander are ASHA staff

Non-financial: Hapner, Jacobson, Nikjeh, Sandage, Schwartz – Members of ASHA Member Advisory Group
Hapner – VP-Elect for Planning
Nikjeh – Co-Chair HCEC
Schwartz – Consultant to KayPENTAX
Satterfield/Kander – Participate in meetings with CMS, MedPAC, and other federal agencies related to health care policies.
Role of the Member Advisory Group

- The MAG provides 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
  - MAG members monitor listserves for recurring B & R themes and to realign approaches to billing/reimbursement

- Provide input to the Health Care Regulatory Analysis/Advocacy group as needed.
MAC reimbursement & Jimmo vs Sebelius decision

Lisa Satterfield, ASHA Director of Health Care Regulatory Advocacy
Mark Kander, ASHA Director of Health Care Regulatory Analysis
Supervision and Videostroboscopy

- National direction:
  - 31579 was removed from supervision requirement in July, 2011
  - MAC transitions are resulting in retirements and/or updates to several LCDs
MAC Transitions – Ongoing

Consolidated A/B MAC Jurisdictions
| Palmetto L31603 Jurisdiction 11/M | “Professional guidelines recommend that the service be provided in a team setting with a physician/NPP who provides supervision of the examination and interpretation of medical conditions revealed in it” has been removed |
| Noridian L33741 (B) L33744 (A) Jurisdiction E | The Speech–Language Pathologist performs clinical and instrumental assessments and analyzes and integrates the diagnostic information to determine candidacy for intervention as well as appropriate compensations and rehabilitative therapy techniques. |
| NGS L27404 Jurisdiction K and 6 | This procedure may be used for assessing voice production and vocal function. It may be performed by qualified speech–language pathologists. |
| CGS L31899 Jurisdiction 15 | This procedure may be used for assessing voice production and vocal function. It may be performed by qualified speech–language pathologists under **direct physician supervision**. |
State Licensure Limitations – Endoscopy

Not necessarily videostroboscopy (endoscopy used in general terms includes FEES)
Supervision level not always specified

Examples:

<table>
<thead>
<tr>
<th>State</th>
<th>Supervision Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Flexible endoscope must be authorized and supervised by physician</td>
</tr>
<tr>
<td>Illinois</td>
<td>Physician must be available; CPR certification of SLP must be current</td>
</tr>
<tr>
<td>Indiana</td>
<td>Requires general supervision</td>
</tr>
<tr>
<td>Michigan</td>
<td>“In collaboration with” physician</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Physician must be on the premises</td>
</tr>
</tbody>
</table>
Questions?

- Mark Kander
- Mkander@asha.org
Medicare “Improvement Standard”

- Center for Medicare Advocacy: Medicare is denying skilled services due to the beneficiary’s inability to improve or restore function, despite the need to prevent or slow deterioration
- CMS: A beneficiary’s lack of restoration potential cannot, in itself, serve as the basis for denying coverage
Settlement (January 24, 2013), where CMS agreed to:

- Clarify policy and update program manuals
- Disseminate materials and educate stakeholders on policy of skilled services
- Random claims review to identify problems
- By January 23, 2014, Medicare policy manuals must be revised

CMS did not admit fault
Jimmo Application

- Med A, Med B, and Med C (Medicare Advantage)
- Not limited to particular conditions or diseases
- Home health, skilled nursing, and outpatient therapy facilities

- Does NOT change number of days covered (does not add to 100 days of Part A stay)
Settlement Agreement standards apply retroactive to January 18, 2011

Individuals, not providers, will be able to request a re-review of their denied claims

Claims must have been submitted to Medicare, denied, and appeals expired

Waiting for more instruction – it was thought that requests for re-review must occur before end of the year – but CMS has not updated
Providers must ensure documentation reflects skilled care
- Use terminology and reflects the clinician’s technical knowledge
- Indicate rationale
- Report objective data
- Specify feedback to patient
- Explain decision making
- Elaborate and evaluate patient or caregiver training
Example:

- Short-term goal: Pt. will communicate in phrase level utterances x 10 with appropriate vocal quality, pitch, and loudness to indicate wants/needs.

- Unskilled treatment note
  - Pt. tolerated speaking valve for 30 minutes.

  *There is no clear connection between the daily note and the short-term goal.*

- Skilled treatment note
  - Speaking valve was placed to help facilitate verbal communication. Pt. repeated 10 phrases without visible signs or symptoms of respiratory distress for 30 minutes. Pt.'s SPO\(_2\) level maintained at 99%-100% during the entire session.
Find out more

- Register for *ASHA’s Headlines* to receive email updates when CMS acts
  - blank e-mail with the words "subscribe to Headlines" in the subject line to emailsupport@asha.org
- [www.asha.org/Practice/reimbursement/medicare/Documentation-of-Skilled-Versus-Unskilled-Care-for-Medicare-Beneficiaries/](www.asha.org/Practice/reimbursement/medicare/Documentation-of-Skilled-Versus-Unskilled-Care-for-Medicare-Beneficiaries/)
- Lisa Satterfield: Lsatterfield@asha.org
New SLP CPT Evaluation Codes
2014 Medicare Update
International Classification of Diseases–10th Edition

Dee Adams Nikjeh, Ph.D.
ASHA Health Care Economics Committee
A Reminder……

  - Procedural codes (CPT) describe what we **DO** with the patient or client

- **International Classification of Diseases and Disorders, 10th Edition**
  - ICD codes describe the **REASON** for the visit
Current Procedural Terminology

“... a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers....”

- CPT codes are 5-digit numbers assigned to every procedure and service a medical practitioner may provide
  - Medical
  - Surgical
  - Diagnostic
- Used to determine amount of reimbursement received by provider
- Ensure uniformity of communication
- Developed, maintained, and copyrighted by the American Medical Association (AMA)
- Updated annually – usually announced Nov 1
Relative Value Unit (RVU)

- Every CPT procedure or service has a *resource-based relative value*
- Payments for services are determined by the *resource costs* needed to provide them
- All procedures are ranked on this same scale
- Standardized physician payment schedule
Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

- MIPPA – Effective July 1, 2009
- Granted SLPs *independent billing* to Medicare
- Changed our status with CMS to a *Medicare Provider*
- Recognized SLPs as *professionals* rather than technical assistants
- Allowed for the “relative value” of SLP CPT (procedure) codes to be re-valued to include a professional work component
- SLP clinical time was taken out of practice expense
Three Components of Relative Value Unit

- *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**
How Does a CPT Code Get a Dollar Value?

- Relative Value Units (RVUs) are assigned thru a rigorous procedure developed by the AMA
- Recommendations for a relative value for a procedure sent to Centers for Medicare and Medicaid (CMS)
  - Accepted, rejected, or adjusted
  - Ranked
- RVUs $\times$ Monetary Conversion Factor (CF) =
- Medicare Payment per Procedure
  - Establishes the Medicare Physician Fee Schedule
  - Payment adjusted for geographic location
- Final 2013 CF = $34.0376
- 2014 CF = approx 24% decrease, unknown at this time
Familiar Voice Procedure Codes

- CPT 31579 Laryngeal Videostroboscopy
- CPT 92507 Treatment
- CPT 92511 Nasopharyngoscopy
- CPT 92520 Laryngeal function study
- CPT 92524 Evaluation of voice and resonance
- CPT 92597 Evaluation for use/fitting of TEP
Table 2. National Medicare Part B Rates for Speech-Language Pathology Services

Speech-language pathology services are paid at non-facility rates, regardless of setting. All claims should be accompanied by the -GN modifier to indicate services provided by an SLP.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>National Fee Final 2013 Rates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>31579</td>
<td>Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy</td>
<td>$217.84</td>
<td>This procedure may require physician supervision based on MACs’ (Medicare Administrative Contractors) local coverage policies or state practice acts.</td>
</tr>
<tr>
<td>92506</td>
<td>Evaluation of speech, language, voice, communication, and/or auditory processing</td>
<td>$217.16</td>
<td></td>
</tr>
<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</td>
<td>$71.14</td>
<td></td>
</tr>
<tr>
<td>92508</td>
<td>group, 2 or more individuals</td>
<td>$20.76</td>
<td></td>
</tr>
<tr>
<td>92511</td>
<td>Nasopharyngoscopy with endoscope (separate procedure)</td>
<td>$143.64</td>
<td>This procedure may require physician supervision based on MACs’ local coverage policies or state practice acts.</td>
</tr>
<tr>
<td>92512</td>
<td>Nasal function studies (e.g., rhinomanometry)</td>
<td>$62.97</td>
<td></td>
</tr>
<tr>
<td>92520</td>
<td>Laryngeal function studies (e.g., aerodynamic testing and acoustic testing)</td>
<td>$74.88</td>
<td></td>
</tr>
<tr>
<td>92526</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding</td>
<td>$77.27</td>
<td></td>
</tr>
<tr>
<td>92597</td>
<td>Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech</td>
<td>$69.10</td>
<td></td>
</tr>
<tr>
<td>92605</td>
<td>Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</td>
<td>$0.00</td>
<td>CMS will not pay for this code and instructs SLPs to use 92506 for non-SGD evaluation (Federal Register, December 31, 2002, p. 80010).</td>
</tr>
<tr>
<td>92618</td>
<td>each additional 30 minutes (List separately in addition to code for primary procedure)</td>
<td>$0.00</td>
<td>This is an add-on code for 92605. CMS will not pay for this code and instructs SLPs to use 92506 for a non-SGD evaluation.</td>
</tr>
</tbody>
</table>
Coding Clarification

Edits and Modifiers
Two types of similar edit systems depending on setting

- National Correct Coding Initiative (CCI) – any Part B services not rendered in a hospital
- Outpatient Code Editor (OCE) – outpatient hospital services

Automated edit systems used by CMS to control specific CPT code pairs that can be reported on the same day for the same patient

- CCI is updated quarterly and OCE follows one quarter later
- Since late 2010, CCI also applies to Medicaid per federal law
Coding Clarifications–Edits

Some procedures considered to be “mutually exclusive” and may not be billed together for the same patient on the same day

Examples for SLP

- 92607 (Speech–generating device evaluation) & 92597 (Voice prosthetic evaluation)
- 92507 (Speech, lang tx) & 97532 (Cog tx)

SLP CCI Edits can be found at
www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm
Medically Unlikely Edits (MUEs)

- Subset of the CCI edits, also for Medicare Part B and Medicaid claims
- An MUE is the maximum number of times that a CPT code can be reported on the same day for the same patient
- Example: CPT 92507 may only be billed one time per day in office or hospital OP settings
- For a complete list of SLP–related MUEs, see: [www.asha.org/Practice/reimbursement/coding/Medically-Unlikely-Edits-SLP/](http://www.asha.org/Practice/reimbursement/coding/Medically-Unlikely-Edits-SLP/)
Coding Clarification – Modifiers
Special Circumstances

- **-59** Indicates Distinct and Separate Procedural Service
  - Only modifier used with NCCI edits
  - For two procedures not ordinarily performed on the same day by the same practitioner, but which, under certain circumstances, may be appropriate to perform and therefore code on the same day (e.g., different site or organ system)

- **Examples**
  - CPT 31579 (Laryngeal videostroboscopy) & 92520 (Laryngeal function study)
  - CPT 92611 (MBS) & 92610 (Clinical Swallow Eval)
  - CPT 92526 (Dysphagia tx) & 97532 (Cog tx)
  - CPT 92508 (Group tx) & 92507 (Indiv tx)
Other Types of Modifiers

- Service Provider
  - **GN**: Speech-language pathologist
  - **GO**: Occupational therapist
  - **GP**: Physical therapist
- Severity Level Modifiers
  - G-codes for functional claims reporting
Examples of Modifiers Sometimes used by SLPs

- “–52” indicates an abbreviated procedure
- “–22” indicates a much longer than usual procedure
- “–76” indicates a repeat procedure by the same provider on the same date of service
## CCI Edit Page for SLP Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Can be used on same date?</th>
<th>If so, what modifier?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MD office</td>
<td>Other settings</td>
</tr>
<tr>
<td>92506</td>
<td>92507</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92508 (SLP group)</td>
<td>92507</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92526</td>
<td>92520</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92526</td>
<td>97532 Cog Tx 15min</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92610</td>
<td>92611 (MBS)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92612 (FEES)</td>
<td>31575, 92511, 92520, 92614</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm
New SLP Evaluation Procedures

CPT 92521
CPT 92522
CPT 92523
CPT 92524
2014 – 4 New SLP Evaluation CPT Codes Will Replace CPT 92506

- 92521 – Evaluation of speech fluency (e.g., stuttering, cluttering)
- 92522 – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- 92523 – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) *with* evaluation of language comprehension and expression (e.g., receptive and expressive language)
- 92524 – Behavioral and qualitative analysis of voice and resonance
Billing Codes Together?

- Sometimes it is appropriate for more than one disorder to be evaluated on the same day.
- The *CPT Handbook* does not include language to restrict ability to bill these codes together.
- Documentation should clearly reflect a complete and distinct evaluation for each disorder.
- Evaluation codes should not be billed for brief assessments that could be considered screenings.
  - Let’s Talk.
- Time for identification of other disorders is already built into the value of each code.
- Inappropriate use of multiple evaluations on same day will result in restrictions through the National Correct Coding Initiative (CCI) edits.
- While no restrictions appear in the *CPT Handbook*, the 2014 quarterly CCI edits have not yet been published.
A 38 year–old female diagnosed with bilateral vocal cord nodules was referred for an evaluation of functional voice use and resonance to facilitate the design of a voice therapy/behavioral treatment plan. The patient complains of progressive hoarseness, inadequate projection, altered resonance, vocal fatigue, and tightness and pain in her throat which compromises her ability to communicate effectively.
Pre-Service Procedure Description

- Review available intake materials
  - Referral information
  - Medical records
  - Prior assessment and treatment records (e.g., previous voice/speech interventions)
  - Patient’s self-assessment of the impact of voice and/or resonance status on daily function (e.g., Voice Handicap Index, Voice-Related Quality of Life)
- Consultation with other professionals
- Select and prepare appropriate evaluation tools
Intra-Service Procedures

- Interview patient to review and clarify the information provided by the intake materials
- Obtain a complete case history relative to changes of voice, including:
  - Complaint/symptoms, onset, and development
  - Causal/contributory/perpetuating factors (e.g., health/medical, lifestyle, environmental)
- Determine patient/caregiver concerns and expectations
- Identify signs of abnormal oral function and craniofacial abnormalities (e.g., cleft lip or palate, occult submucous cleft, neurogenic velopharyngeal dysfunction)
- Perform a systematic auditory-perceptual evaluation of voice and resonance quality while having the patient produce a structured protocol comprised of voice and speech tasks that are designed to elicit salient features to differentiate voice and resonance disorders:
Intra–Service Procedures (cont.)

- Use standard scaling techniques to formally rate the resonance and vocal attributes of overall severity of dysphonia, roughness, breathiness, strain, pitch, and loudness
- Document/describe the presence of any additional vocal abnormalities (e.g., hard glottal attack, diplophonia, tremor, spasm, etc.)
- Document/describe the nature (e.g., hyper- or hyponasality) and severity of any abnormalities in resonance
- Assess upper body and extrinsic laryngeal muscle tension through observation and palpation
- Use voice and/or speech facilitating techniques to assess the potential effectiveness of intervention strategies
- Identify other deficits including speech sound production, language comprehension and expression, fluency, swallowing, and hearing
- Analyze and integrate pre–service and intra–service information to formulate findings and recommendations
- Document results
Post-Service Procedures

- Provide information to patient regarding preliminary conclusions, treatment recommendations, and prognosis
- Make referrals for additional assessments and/or treatments as appropriate
- Communicate final findings and recommendations to referral source(s)
Scenario 1: CPT Question

- I evaluate an adult with a voice disorder, using behavioral analysis and instrumental analysis. There is no resonance disorder.

- Do I code CPT 92524 with –52 modifier to indicate a shortened evaluation?
Scenario 1: CPT Answer

- No, –52 modifier is not required if only voice or only resonance is evaluated
- Recommend a statement of observation that one or the other is not impaired
- Code developed so that those who work with populations that may have multiple issues (e.g., cleft palate) have appropriate choices of procedure codes
- Complete documentation is key!
Scenario 2: CPT Question

- I do a voice evaluation and instrumental assessment.

- Which CPT codes do I use?
Code CPT 92524 for the behavioral and qualitative analysis of voice and resonance.

Code CPT 92520 for laryngeal function study (acoustic and aerodynamic assessment of voice)

No modifier is necessary
When I evaluate a child who has a cleft palate and speech and language problems, what procedures may I code?
Scenario 3: CPT Answer

- CPT 92523 Speech–sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
- CPT 92524 Behavioral and qualitative analysis of voice and resonance
I am evaluating a patient who has Parkinson’s disease. He has dysarthria and a voice impairment.

May I do two evaluation procedures and which procedures codes may I use?
Scenario 4: SLP CPT Answer

- Pending any NCCI edits that may come about, if your patient’s communication impairment warrants the evaluation of both dysarthria and voice, then YES do both and document completely including your recommendations for plan of care based on your two evaluations.
- CPT 92522 Speech–sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- CPT 92524 Qualitative and behavioral analysis of voice and resonance
I am evaluating an adult who has aphasia and dysarthria.

Which evaluation procedures and CPT codes may I use?
You may code CPT 96105 for the aphasia evaluation.
- This is a timed, per hour code
- 31 minutes is allowable for one hour
You may code CPT 92522 – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- Document each procedure with results, interpretation, recommendations, etc.
Scenario 5 Continued: Question

- What if that dysarthria has a phonatory component?

- Can I add to the aphasia evaluation and the speech–sound production evaluation a voice evaluation and maybe also an acoustic and aerodynamic assessment?
Scenario 5 Continued: Answer
International Classification of Diseases and Disorders

10th Edition
October 1, 2014
ICD codes describe the REASON (disease or disorder) we are providing a service
International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM)

- Numeric classification system of *diseases and disorders*
- Based primarily on body systems (e.g. circulatory, respiratory, nervous)
- Code or codes to describe the *problem* or *reason* for our procedure
- Issued by the U.S. Department of Health and Human Services
- Approximately 15,000 codes
ICD–10 begins October 1, 2014

- ICD–10 includes approx 160,000 codes
  - ICD–10–CM diagnosis codes for all settings
  - (> 68,000)
  - ICD–10–PCS procedure codes for hospital inpatients
- Greater specificity → 3–7 alphanumeric characters instead of 3–5 digits (ICD–9–CM)
- Code descriptor detailed, less room for error
- Accommodate current, complex, and future health care needs
ICD–9 to ICD–10
ASHA Mapping Tools

- Online Mapping Tools for ICD–9 to ICD–10 codes
  - Enter the ICD–9 code and a list of corresponding ICD–10 codes is generated
  - Mapping Spreadsheet to view related mappings in one list
- List specific to SLP or AuD ICD–10 codes
- Products are free and tailored for speech–language pathology and audiology
Voice ICD–10 Codes

- **R49  Voice and resonance disorders**
  - Excludes1: psychogenic voice and resonance disorders (F44.4)
- **R49.0  Dysphonia, Hoarseness**
- **R49.1  Aphonia, Loss of voice**
- **R49.2  Hypernasality and hyponasality**
  - R49.21  Hypernasality
  - R49.22  Hyponasality
- **R49.8  Other voice and resonance disorders**
- **R49.9  Unspecified voice and resonance disorder; Change in voice NOS, Resonance disorder NOS**
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J38.0</td>
<td>Paralysis of vocal cords and larynx</td>
</tr>
<tr>
<td></td>
<td>Laryngoplegia</td>
</tr>
<tr>
<td></td>
<td>Paralysis of glottis</td>
</tr>
<tr>
<td>J38.00</td>
<td>Paralysis of vocal cords and larynx, unspecified</td>
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<tr>
<td>J38.01</td>
<td>Paralysis of vocal cords and larynx, unilateral</td>
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<tr>
<td>J38.02</td>
<td>Paralysis of vocal cords and larynx, bilateral</td>
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<tr>
<td>J38.1</td>
<td>Polyp of vocal cord and larynx</td>
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<tr>
<td></td>
<td>Excludes 1: adenomatous polyps (D14.1)</td>
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<tr>
<td>J38.2</td>
<td>Nodules of vocal cords</td>
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<tr>
<td></td>
<td>Chorditis (fibrinous) (nodosa) (tuberosa)</td>
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<td>Singer's nodes</td>
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<td>Teacher's nodes</td>
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<td>J38.3</td>
<td>Other diseases of vocal cords</td>
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<td>Abscess of vocal cords</td>
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<td>Leukokeratosis of vocal cords</td>
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<td>Leukoplakia of vocal cords</td>
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<td>J38.4</td>
<td>Edema of larynx</td>
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<td>Edema (of) glottis, Subglottic edema, Supraglottic edema</td>
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<td>Excludes 1: acute obstructive laryngitis [croup] (J05.0) edematous laryngitis (J04.0)</td>
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<td>J38.5</td>
<td>Laryngeal spasm</td>
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<td>Laryngismus (stridulus)</td>
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<td>J38.6</td>
<td>Stenosis of larynx</td>
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<td>J38.7</td>
<td>Other diseases of larynx</td>
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<td>Perichondritis of larynx</td>
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<td>Ulcer of larynx</td>
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<tr>
<td>J39.3</td>
<td>Upper respiratory tract hypersensitivity reaction, site unspecified</td>
</tr>
<tr>
<td></td>
<td>Excludes: hypersensitivity reaction of upper respiratory tract, such as: extrinsic allergic alveolitis (J67.9), pneumoconiosis (J60-J67.9)</td>
</tr>
<tr>
<td>J39.8</td>
<td>Other specified diseases of upper respiratory tract</td>
</tr>
<tr>
<td>J39.9</td>
<td>Disease of upper respiratory tract, unspecified</td>
</tr>
</tbody>
</table>
ICD–10–CM Resources

- ASHA Website: www.asha.org/Practice/reimbursement/coding/ICD–10/
- National Center for Health Statistics Website: www.cdc.gov/nchs/icd/icd10cm.htm
- Centers for Medicare & Medicaid Services Website: www.cms.gov/ICD10/
Claims-Based Outcomes Reporting

Sandy Schwartz, MS
Edie Hapner, PhD
Who Needs to Use CBOR?

- Anyone providing therapy, including speech-language evaluation and treatment services, for Medicare Part B beneficiaries
When **WAS** the mandate?

- Implemented January 1, 2013, with a 6-month testing period. As of **July 1, 2013**, claims that do not comply with the data reporting requirements will be returned unpaid.
As part of reforming the Medicare payment for outpatient therapy services, *The Middle Class Tax Relief and Job Creation Act (MCTRJCA) of 2012* (Pub. L. 112–96) which mandates a claims–based data collection strategy for reporting patient status and outcomes.
How do I comply with CBOR?

- Include non-payable G-codes AND 7-point severity modifier at the time of the initial evaluation, the 10th visit, and at discharge.
Voice 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
What about the severity modifiers?

- ASHA’s NOMS were adopted by CMS for the speech–language pathology related Functional Communication Measures (FCMs). (http://www.asha.org/uploadedFiles/ASHA/NOMS/Adult-NOMS–FCMs.pdf)

- NOMS 7–point scale correlates directly with the CMS 7–point severity scale.
  - “SLPs are not required to use NOMS for purposes of reporting on the claim form; however, NOMS will assist with selection of appropriate G–code and severity modifiers”
NOMS accepted by CMS for reporting severity:

- Swallowing
- Motor Speech
- Spoken Language Comprehension
- Spoken Language Expression
- Attention
- Memory
- **Voice**
- Other SLP Functional Limitation
## Modifiers – Measurements of Severity

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>-CH</td>
<td>0 percent impaired, limited or restricted</td>
<td>7</td>
</tr>
<tr>
<td>-CI</td>
<td>At least 1% but less than 20% impaired, limited or restricted</td>
<td>6</td>
</tr>
<tr>
<td>-CJ</td>
<td>At least 20% but less than 40% impaired, limited or restricted</td>
<td>5</td>
</tr>
<tr>
<td>-CK</td>
<td>At least 40% but less than 60% impaired, limited or restricted</td>
<td>4</td>
</tr>
<tr>
<td>-CL</td>
<td>At least 60% but less than 80% impaired, limited or restricted</td>
<td>3</td>
</tr>
<tr>
<td>-CM</td>
<td>At least 80% but less than 100% impaired, limited or restricted</td>
<td>2</td>
</tr>
<tr>
<td>-CN</td>
<td>100% impaired, limited or restricted</td>
<td>1</td>
</tr>
</tbody>
</table>
At the time of the initial voice evaluation, reporting should include:

- current status: G9171
- projected goal: G9172
- modifiers on each
- The –GN modifier

Your billing might look like this:

92506–GN
G9171–GN –CK
G9172–GN –CI
The patient is seen for the initial evaluation only (92506 until Dec. 31, 2013). Either the patient is not interested or not appropriate for therapy OR they are going to another SLP.

- All 3 G-codes are reported for that visit and all modifiers are the same (ex. 92171–CJ; 92172–CJ; 92173–CJ)
Scenario

What if I am working on both voice and swallowing goals?

- Response: The primary functional limitation should be chosen: Voice OR Swallow
  - After that primary treatment goal is achieved, a second functional measure limitation can be reported as a new G Code and Severity Modifier
  - You may not report multiple conditions at the same time or on the same date of service
The patient was seen for videostroboscopic assessment (31579) and voice evaluation (92506 until Dec. 31, 2013) sent by ENT with diagnosis of vocal fold polyp. The patient has no voice complaints on interview or on VHI–10 (score = 2).

- **Response:** Use –CH modifier for all 3
Since SLP’s are allowed to bill 92506 (evaluation code until Dec. 31, 2013) and 92610 (clinical swallow evaluation) and 92611 (videofluoroscopic swallow evaluation), how do I report non-payable G codes?

Response: Report G-codes for all 3 evals – the functional limitation that will be continued as the primary will only be coded with 2 codes (current/goal status)
Coding, Billing, & Reimbursement Scenarios

Barbara Jacobson, Ph.D.
Mary J. Sandage, Ph.D.
Question: “What G-codes should I use when I’m coding for a TEP change? Some people have recommended that I use the Swallowing G-code set since TEP change can be used to address aspiration. Others have suggested that I use the ASHA NOMS for Alaryngeal Speech.”
G–Codes

**Answer:** We can only use the 8 functional measures (Voice, Swallowing, Motor Speech, Spoken Language Comprehension, Spoken Language Expression, Memory, Attention, ‘Other’) selected by CMS even though we may have access to up to 16 FCMs (if you are using NOMS). As TEP fitting is primarily for voice rehabilitation, it is most appropriate to use the Functional Limitation for Voice set of G–code with appropriate severity modifiers. All 3 G–codes are reported (initial, goal, discharge) in this instance.
G–codes

Question: “How do I report G–codes for videostroboscopy (31579)?”
Answer: Billing for videostroboscopy does not require G-codes. CMS billing requirements do not mandate a GN (speech pathology) modifier so G-coding is not appropriate. We are only using G-codes for CPT codes that require a GN modifier on the bill.
Yet more G–codes

Question: “What G–code set should I use for patients with PVFM (paradoxical vocal fold motion) or cough? What Functional Communication Measure (FCM) should I use?”
Yet more G-codes

**Answer:** You should use the “Other” G-code set. There are no FCMs for PVFM or cough. While the FCMs have a nice 1:1 correspondence with the 7 severity codes, your severity ratings do not need to be restricted to FCMs. Our PT & OT colleagues are using a variety of scales. So, if you want to use another measure (e.g. Dyspnea Index or Leicester Cough Questionnaire) and scale the scores, you are able to do that. You must justify your severity designation in your documentation.
G–code clarification from CMS

Question: “How do I report an evaluation when it is for a different functional limitation (primary) than I am currently reporting?”
G–code clarification from CMS

Answer: If an evaluation is performed on the same date of service as an ongoing functional condition is reported, the claim should include codes and modifiers for both sets of functional conditions.

If two evaluations are billed, each evaluation should include a functional reporting. The condition that is not deemed to be the primary condition will be reported with all 3 G–codes and severity modifiers. If one of those evaluations will continue to be reported as the primary condition, that evaluation only has the current and predicted G–codes with modifiers.

Although more than one evaluation may now be reported for the same date of service, ongoing reporting is allowed for only one functional limitation (i.e., the primary functional limitation evaluated).
Billing for Lymphadema therapy

Question: “Can I bill for lymphadema services that I provide during a therapy session?”
Billing for Lymphadema therapy

Answer: You may be able to use 97140 which is a PT code. You will need to check that your patient’s insurance carrier will reimburse this code when SLPs provide the service. 97140 is a timed code (15 minutes). You may be able to bill with another SLP code such as 92526 (swallowing therapy) or 92507 (speech/voice therapy).
QUESTIONS?