Speaker Disclosures

- **Financial**
  - No relevant financial relationships exist

- **Non-Financial**
  - Health Care Economics Committee (American Speech-Language-Hearing Association)
  - Receive no compensation as members
Health Care Economics Committee Purpose

- Assist Government Relations and Public Policy Board (GRPP) and cluster staff in determining current economic issues and develop goals for ensuring equitable coverage and reimbursement
- Develop recommendations for coding (procedural and diagnostic) and relative values of procedural codes
- Anticipate further socioeconomic needs of the professions and the consumers
2013 Health Care Economics Committee (HCEC)

**SLP Members**
- Dee Adams Nikjeh, Co-Chair, alternate RUC Advisor
- Wayne Holland, CPT Advisor
- Gretchen Bebb
- Carmen Vega-Barachowitz
- Tim Weise
- Theresa Rodgers, VP for Government Relations & Public Policy

**Audiology Members**
- Stuart Trembath, Chair, alternate CPT Advisor
- Bob Fifer, RUC Advisor
- Faith Akin
- Bob Burkard
- Leisha Eiten
- Tim Nanof, Ex Officio, Director, Health Care Policy & Advocacy
Agenda

- Introduction
- Overview of Payer Sources
- Overview of CPT & ICD Coding Systems
- Coding Rules & Tools
- Coding & Documentation Scenarios
- G-code & Severity Modifiers
- Questions & Answers
- Wrap Up
Payer Sources
Medicare

- Federally funded program
- Beneficiaries are
  - Age 65+
  - Under 65 with certain disabilities
  - Suffer from permanent kidney failure
Medicare

- Part A (Hospital)
  - Paid under a prospective payment system (per-stay)
    - Hospital stays
    - Skilled nursing facility care when daily skilled services are needed
    - Home health care
    - Hospice care
Medicare

- Part B (Outpatient)
  - Paid under the Medicare Physician Fee Schedule.
    - Private practice SLP services
    - Physician services
    - Outpatient hospital services
    - Rehabilitation agency services and comprehensive outpatient rehabilitation facility services
    - When Part A funds have been exhausted
    - Some Durable Medical Equipment (e.g., Speech-generating devices)

See also: [www.asha.org/practice/reimbursement/medicare/](http://www.asha.org/practice/reimbursement/medicare/)
Who is a Qualified Medicare Provider?

- Qualified SLPs may treat Medicare beneficiaries only if they are enrolled as a Medicare provider.
- Meets one of these requirements:
  - The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the ASHA; or
  - Meets educational requirements for certification and is in the process of accumulating the supervised experience required for certification.
- Clinical Fellows are not licensed in AL, CT, HI, MA, NV, NY, ND, PA, TN, & UT
  - Request written acceptance from the carrier/MAC.
SLP Student Supervision

- Only services of the SLP can be billed and paid under Part B
- Services of student are not reimbursed even if provided under “line-of-sight” supervision by the qualified practitioner
- Student considered extension of the qualified practitioner
- This does **NOT** apply to non-Medicare settings unless specified
Medicaid

- The country’s largest single health program
- Jointly funded by the state and federal governments
- Managed by the states
  - If you know one Medicaid program, you know one Medicaid program
- Beneficiaries are families/individuals with low income or certain disabilities
Medicaid - Federal Role

- Establishes broad guidelines, minimum standards, and qualifications
- Oversight of the State Medicaid plans
- Processes plan amendments and waiver requests
- Ensures program integrity
Medicaid - State Role

- Administers the program
- Determines eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets payment rates
Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

- Although audiology and speech-language pathology are optional under Medicaid, under EPSDT, States must provide services to children under 21.

- Medically necessary services must be provided to individuals under 21, even if the service isn’t available to the rest of the State’s population.
ACA – Essential Health Benefits to be Covered by Exchanges and Medicaid Programs

10 categories of covered service areas

<table>
<thead>
<tr>
<th>Ambulatory patient services</th>
<th>Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td><strong>Rehabilitative and habilitative services and devices</strong></td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Laboratory services</td>
</tr>
<tr>
<td>Maternity and newborn care</td>
<td>Preventive and wellness services and chronic disease management</td>
</tr>
<tr>
<td>Mental health and substance use disorder services</td>
<td>Pediatric services, including oral and vision care</td>
</tr>
</tbody>
</table>
Medical Necessity

- **Reasonable**: appropriate amount, frequency, and duration of treatment in accordance with accepted standards of practice.
- **Necessary**: appropriate treatment for the patient’s diagnosis and condition.
- **Specific**: targeted to particular treatment goals.
- **Effective**: expected to yield improvement within a reasonable time.
- **Skilled**: requiring the knowledge, skills, and judgment of a speech-language pathologist, that is, complex and sophisticated.
# Medicaid Coverage: State Comparison

<table>
<thead>
<tr>
<th>Location</th>
<th>Covered</th>
<th>Prior Approval</th>
<th>Limitation</th>
<th>Reimbursement</th>
<th>Population</th>
<th>Amount (2010 data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>Yes</td>
<td>Services other than to continue therapy provided in the previous 30 days on inpatient basis</td>
<td></td>
<td>FFS</td>
<td>Categorically and medically needy (CN &amp; MN)</td>
<td>13.35 per unit</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Yes</td>
<td></td>
<td>35 visits/year</td>
<td>FFS</td>
<td>CN &amp; MN</td>
<td>73.29</td>
</tr>
<tr>
<td>California</td>
<td>Yes</td>
<td>Services after initial 6-mo eval</td>
<td>Limited to pregnant or institutionalized adults, MD order required</td>
<td>FFS</td>
<td>CN &amp; MN</td>
<td>25.47</td>
</tr>
<tr>
<td>Kansas</td>
<td>Yes</td>
<td></td>
<td>Limit to SP for post-trauma or illness only, MD order and rehab potential required, specific limits regarding audiological testing and eval</td>
<td>FFS</td>
<td>CN &amp; MN</td>
<td>47.49</td>
</tr>
</tbody>
</table>
Hear from the Medicaid Committee

**Medicaid Lunchtime Presentation**
Location: Exhibit Hall Learning Lab 1
Time: 12:30 pm – 1:30 pm
Medicaid Resources

- www.asha.org/practice/reimbursement/medicaid/
- www.asha.org/practice/health-care-reform/
- Advisory Board—Medicaid expansion
  www.advisory.com/Daily-Briefing/
- Kaiser Family Foundation
  www.kff.org/healthreform/upload/8332.pdf
- State health facts—www.statehealthfacts.org
- Robert Wood Johnson Foundation
  www.rwjf.org/en.html
Medicaid Resources


- EPSDT: [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html](www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html)

- State Profiles: [www.medicaid.gov/](www.medicaid.gov/)

Medicaid Resources


- State Refor(u)m: [www.statereforum.org](http://www.statereforum.org)
  An online network for health plan reform and implementation
Private Health Insurance

- Offered by commercial insurance companies (e.g., Blue Cross Blue Shield, Aetna)
- Coverage can vary widely
- Exclusions can include:
  - Speech disorders that are developmental
  - Disorders that are not acquired
  - Habilitative services

See also: [www.asha.org/practice/reimbursement/private-plans/overview/](http://www.asha.org/practice/reimbursement/private-plans/overview/)
Overview of CPT & ICD

International Classification of Diseases (ICD)
Two Health Care Coding Systems

- **Procedural Codes** – Describe what we **DO** with the client/patient
  - Current Procedural Terminology a.k.a. CPT codes

- **Diagnostic Codes** – Describe the **REASON** we are evaluating or treating the client/patient
  - International Classification of Diseases, 9th Revision, Clinical Modification a.k.a. ICD-9 codes
Purpose of Coding Systems

- Provides common language among providers, third party payers, and benefits administrators
- Standardizes descriptions of procedures, names of diagnoses, and names of items/supplies
- Provides data for government to evaluate utilization patterns and appropriateness of health care costs
International Classification of Diseases (ICD)

Coding the Diagnosis
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
Examples of ICD-9-CM

- **315.31** Expressive language disorder
- **315.35** Childhood onset fluency disorder
- **787.21** Dysphagia, oral phase
- **784.43** Hypernasality
- **784.69** Other symbolic dysfunction
Changes are Coming...ICD-10-CM
ICD-10 Begins October 1, 2014
Will you be ready?

- **October 1, 2014** implementation date
- ICD-10 includes
  - ICD-10-CM diagnosis codes for all settings
  - ICD-10-PCS procedure codes for hospital inpatients
- ICD-10-CM diagnostic code set contains more than 68,000 codes
- Combined with ICD-10-PCS, there are about 150,000 total codes
- See: [www.asha.org/Practice/reimbursement/coding/ICD-10/](http://www.asha.org/Practice/reimbursement/coding/ICD-10/)
Examples of ICD-10-CM

- F80.1 Expressive language disorder
- F80.81 Childhood onset fluency disorder
- I69.320 Aphasia following cerebral infarction
- R13.11 Dysphagia, oral phase
- R48.8 Other symbolic dysfunctions
- R49.0 Dysphonia
- R49.21 Hypernasality
ASHA Resources

ICD-10 website includes:
1. ICD-9 to ICD-10 Mapping Tool
2. ICD-9 to ICD-10 Mapping Spreadsheets
3. ICD-10-CM Code Lists

All resources developed by ASHA are free and tailored specifically for audiologists and SLPs.

www.asha.org/Practice/reimbursement/coding/ICD-10/
ICD-9 to ICD-10 Mapping Tool
www.asha.org/icdmapping.aspx

Search for ICD-9 to ICD-10 Mappings
A Tool for Audiologists and SLPs

The ICD-9 to ICD-10 mapping tool below allows audiologists and speech-language pathologists to compare ICD-9 to ICD-10 codes for conditions they treat. Please read more about this tool for important information, including how it works and how to interpret the results.

ASHA’s ICD-10 website contains more information about the ICD-10 system, including ICD-10 code lists for audiologists and SLPs.

Enter ICD-9 Code: 315.39
Type one ICD-9 code at a time, to the highest level of specificity possible.
Enter ICD-9 Code: 315.39

Type one ICD-9 code at a time, to the highest level of specificity possible.

ICD-9 Code: 315.39
Description: Other (developmental speech or language disorder)
Developmental articulation disorder

ICD-9 code 315.39 maps to

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F80.0</td>
<td>Phonological disorder</td>
</tr>
<tr>
<td></td>
<td>- Functional speech articulation disorder</td>
</tr>
<tr>
<td></td>
<td>- Speech articulation developmental disorder</td>
</tr>
</tbody>
</table>

Excludes1: speech articulation impairment due to aphasia NOS (R47.01), speech articulation impairment due to apraxia (R48.2)

Excludes2: speech articulation impairment due to hearing loss (F80.4), speech articulation impairment due to intellectual disabilities (F70-F79), speech articulation impairment with expressive language developmental disorder (F80.1), speech articulation impairment with mixed receptive expressive language developmental disorder (F80.2)

F80.89     Other developmental disorders of speech and language
F80.9      Developmental disorder of speech and language, unspecified
More on ICD-10-CM…

ICD-10 Is Coming! Are You Ready?
Session #1101
Room: S105A
Time: 3:00 pm – 4:00 pm TODAY! (Thursday)
Presenters:
- Janet McCarty, ASHA Private Health Plans Advisor
- Neela Swanson, ASHA Director, Health Care Coding Policy
From Diagnostic Coding (ICD) to Procedure Coding (CPT)

- Diagnostic codes describe the reason you see the patient
- Procedure codes describe what you do for the patient

Coding the Procedure
CPT (Procedure) Codes

- Owned and copyrighted by the American Medical Association – first published in 1966
- Designed for use by physicians and surgeons
- Other health care professionals’ use of coding system not considered until early 1990s
- Codes are now available for audiologists, speech-language pathologists, psychologists, physical and occupational therapists, and others
- Updated annually
CPT Codes

- Each code is designated by 5 digits.
- Represent every procedure and service a medical practitioner may provide.
  - Medical
  - Surgical
  - Diagnostic
- CPT codes are used for billing, data analysis of individual procedures, and insurance coverage decisions.
- Improves uniformity of communication.
- Approximately 8,000 codes.
AMA Criteria for New Procedure Code

- Represent unique procedure that is not covered by other established codes
- Represent procedure widely used within U.S.
- Not investigational
- Have substantial peer reviewed literature to support procedure in journals published in U.S.
Examples of Common SLP CPT Codes

- 92507  Treatment of speech, language, voice, communication, and/or auditory processing
- 92526  Treatment of swallowing dysfunction and/or oral function for feeding
- 92610  Evaluation of oral & pharyngeal swallowing function

Full list of SLP codes:  
www.asha.org/uploadedFiles/ModelSuperbillSLP.pdf
CPT Process...How a Code Becomes a Code

ASHA:
- Complete Request Form
- Collect Data/Surveys
- Write Vignettes
- Collaborate-Related Orgs

AMA CPT Editorial Panel
- Defend
- Negotiate
- Rationalize

CPT HCPAC Advisors

RUC HCPAC Advisors

RUC-Relative Value Update Committee
- Assigns a Relative Value
- Defend Professional Work Skills
- Practice Expense (Subcommittee)
- Professional Liability/Insurance

Approximately 2 Years

CPT Codebook
& Medicare Fee Schedule

CMS (Medicare)
- Value of Code Ranked
- Reimbursement Assigned
Resource-Based Relative Value Scale (RBRVS)

- Implemented by CMS January 1, 1992
- Relative value units (RVUs) for each CPT code
- Assigned by AMA/Specialty Society Relative Value Scale Update Committee (RUC)
- Establishes standardized payment schedule
- Payments determined by resource costs needed to provide them
Relative Value Units (RVUs) of Procedure Codes

- 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
## 2014 Medicare Fee Schedule

Based on 2014 Proposed Rule (not final)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2013 Rate</th>
<th>2014 Rate (with estimated 24.4% cut, no Congressional intervention)</th>
<th>2014 Rate (estimated, with Congressional intervention)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31579</td>
<td>Diagnostic laryngoscopy with stroboscopy</td>
<td>$217.75</td>
<td>$158.71</td>
<td>$206.18</td>
</tr>
<tr>
<td>92507</td>
<td>Speech, lang., aud. process treatment</td>
<td>$71.11</td>
<td>$54.21</td>
<td>$70.43</td>
</tr>
<tr>
<td>92508</td>
<td>Speech/hearing treatment, group</td>
<td>$20.75</td>
<td>$15.45</td>
<td>$20.07</td>
</tr>
<tr>
<td>92511</td>
<td>Nasopharyngoscopy</td>
<td>$143.58</td>
<td>$97.43</td>
<td>$126.57</td>
</tr>
<tr>
<td>92512</td>
<td>Nasal function studies</td>
<td>$62.94</td>
<td>$45.05</td>
<td>$58.52</td>
</tr>
<tr>
<td>92520</td>
<td>Laryngeal function studies</td>
<td>$74.85</td>
<td>$54.74</td>
<td>$71.11</td>
</tr>
<tr>
<td>92526</td>
<td>Swallowing treatment</td>
<td>$77.23</td>
<td>$58.67</td>
<td>$76.21</td>
</tr>
<tr>
<td>92597</td>
<td>Voice prosthetic evaluation</td>
<td>$69.07</td>
<td>$52.38</td>
<td>$68.05</td>
</tr>
</tbody>
</table>
Four New SLP Evaluation Codes in 2014

- **CPT 92506**, Evaluation of speech, language, voice, communication, and/or auditory processing
- **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
More on the new codes...

...in our second session:

**2014 & Beyond: Health Care Coding & Reimbursement for SLPs**
Session #1607
Room: W470B
Time: 8:00 a.m. – 10:00 a.m. (Saturday)
Coding Rules & Tools

Basic guidelines for CPT & ICD coding
ICD-9-CM Coding Rules & Tools
The basic principles
A Word About ICD-10-CM

We will be discussing basic ICD-9-CM coding principles.

These same principles also apply to ICD-10-CM.
Principle #1
Code to the highest degree of medical certainty or specificity

- ICD-9-CM codes are 3-, 4-, and 5-digit codes
- Number of digits indicates level of code specificity
- Codes are arranged by categories
- There are levels within each category
- Carry code to 5th digit when possible
  - 787.20 Dysphagia, unspecified
  - 787.22 Oral pharyngeal dysphagia
Another Example of Coding Specificity

- 784 Symptoms involving head and neck
  - 784.4 Voice and Resonance disorders
    - 784.40 Voice and resonance disorder, unspecified
    - 784.41 Aphonia
    - 784.42 Dysphonia
    - 784.43 Hyponasality
    - 784.44 Hyponasality
    - 784.49 Other voice and resonance disorders
Principle #2
Avoid NOS and NEC Codes

- NOS, not otherwise specified, infers that condition was not adequately described by the provider.
- NEC, not elsewhere classified, infers that no appropriate code was found in the tabular list based on information provided.
- Example - 478.7 Other diseases of larynx, not elsewhere classified
  - 478.70 Unspecified disease of larynx
  - 478.74 Stenosis of larynx
  - 478.75 Laryngeal spasm
Principle #3
Understanding Primary and Secondary Diagnoses

- **Primary Diagnosis**
  - Condition *chiefly responsible* for visit
  - Disease, condition, problem, symptom, injury, or *reason* for encounter
  - If multiple problems exist, select most resource intensive diagnosis and list others as secondary

- **Secondary diagnoses**
  - Co-existing conditions, symptoms, or reasons
  - OR
  - Symptoms found *after study*
Example of Primary & Secondary Diagnoses

Your patient presents to you, the SLP, with hoarseness due to a benign vocal cord lesion.

- You evaluate the hoarseness so your primary ICD-9-CM code is 784.42 to denote “dysphonia, hoarseness”.
- The hoarseness is due to a benign vocal cord lesion. The secondary code is 212.1 to denote “benign neoplasm of the larynx”.
Principle #4
Coding Normal Results

If results of diagnostic testing are **NORMAL**, code signs or symptoms to report the reason for test/procedure and explain normal result in report.
**Principle #5**

ICD-9 & CPT Code Should Agree

- Disease codes (ICD-9-CM) should appropriately correspond to the procedure codes (CPT) and vice versa.
- If SLP treatment is the procedure (CPT 92507), then the diagnosis code should reflect the reason for the speech treatment (e.g., childhood onset fluency disorder ICD-9 315.15).
- If this principle is not followed, your claim may be denied.
ICD-9-CM Coding Warnings

**DO NOT**...

...code conditions previously treated that no longer exist.

...code “probable,” “suspected,” “questionable,” or “rule out” diagnoses.

...misrepresent the service that was provided in order to receive reimbursement or for your patient’s convenience = **FRAUD**!
ICD-9-CM Resources

- ICD-9-CM Codes for SLPs:  
  [www.asha.org/practice/reimbursement/coding/icd9SLP.htm](http://www.asha.org/practice/reimbursement/coding/icd9SLP.htm)

- Guidelines for Coding & Reporting ICD-9-CM:  

- ICD Home Page:  

- Questions: e-mail [reimbursement@asha.org](mailto:reimbursement@asha.org)
CPT Coding Rules & Tools
How to use CPT codes
How Do We Use CPT Codes?
National Correct Coding Initiative (CCI) Edits

- Automated edit system that applies to all provider settings
- Controls which procedure codes may be paired and reported on the same day for the same patient
- Applies to Medicare Part B and Medicaid services, often adopted by other third party payers
- Updated quarterly by CMS
CCI Edits, cont’d

- Some procedures considered to be components of more comprehensive services or “mutually exclusive”

- Example: “mutually exclusive” code pairing for SLP
  - 92607 (Speech-generating device evaluation) and 92597 (Voice prosthetic evaluation)
  - 92507 (Speech, language treatment) and 97532 (Cognitive treatment)

- 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: CPT92507 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/
Modifiers

- Modifiers are two-digit numbers preceded by a hyphen that are added to CPT codes to describe unusual circumstances.

- Use of a modifier means that the protocol for the procedure did not change, but there was something unusual about the circumstances under which the procedure was performed.
Modifiers, cont’d

- May be used to bypass a CCI code edit
- Variety of modifiers exist for:
  - Unusual circumstances
  - Denoting Medicare therapy providers: GN (SLP)
  - Situations deemed necessary by CMS: **G-codes** and severity modifiers
- Documentation should reflect the unusual and extenuating circumstance as well as the rationale for use of a modifier
Examples of Modifiers Sometimes Used by SLPs

- "-52" indicates an abbreviated procedure

- "-59" indicates that two procedures are distinct and separate
  - CPT 92611 (MBS) & 92610 (Clinical Swallow Eval)
  - CPT 92526 (Dysphagia tx) & 97532 (Cog tx)
  - CPT 92508 (Group tx) & 92507 (Indiv tx)
  - CPT 31579 (Laryngeal videostroboscopy) & 92520 (Laryngeal function study)

- "-22" indicates a much longer than usual procedure

- "-76" indicates a repeat procedure by the same provider on the same date of service
How Do We Use CPT Codes?
Timed and Untimed CPT Codes

- Most codes used by SLPs are **untimed**
- SLPs have few timed codes; Increments **always** listed in descriptor
  - 96105 Assessment of aphasia with interpretation and report, **per hour**
  - 96125 Standardized cognitive performance testing, **per hour**
  - 97532, Development of cognitive skills, **each 15 mins**
How Do We Use CPT Codes?
Timed and Untimed CPT Codes

- Untimed codes (service-based) billed once per date of service, regardless of length of time spent on procedure
  - 92526 Treatment of swallowing dysfunction or oral function for feeding
  - 92507 Treatment of speech, language, voice, communication, and/or auditory processing

- [www.asha.org/practice/reimbursement/coding/timedcodes.htm](http://www.asha.org/practice/reimbursement/coding/timedcodes.htm)
How Do We Use CPT Codes?
Physical Medicine Codes (97000 series)

- Based on descriptors and vignettes of these codes, CMS officials advise that SLPs should **not** report
  - CPT 97110 Therapeutic exercises, each 15 mins
  - CPT 97112 Neuromuscular reeducation, each 15 mins
How Do We Use CPT Codes? Physical Medicine Codes (97000 series)

- There are exceptions to coverage*
  - Novitas includes 97110 (therapeutic exercises, each 15 mins), 97530 (therapeutic activities, each 15 mins), 97533 (sensory integrative techniques, each 15 mins), CPT 97535 (self-care/home management training, each 15 mins)

- CMS covers these 97000 codes
  - CPT 97532 Cognitive skills development, each 15 mins
  - CPT 97533 Sensory integration, each 15 mins
Coding Scenarios
Scenario 1

- 5 year old patient with unintelligible speech referred for a speech/language evaluation. The evaluation takes 1 hour.
- How do you code the session?
  a) CPT 92506 Evaluation of speech, language, voice, communication, and/or auditory processing – 4x for each 15 minutes of the evaluation
  b) CPT 92506 – once for the entire session
Scenario 1

- The answer is: B – Most SLP codes are untimed. Timed codes will be indicated in the descriptor.
Scenario 2

- Patient seen for speech therapy
  - Articulation treatment
  - Oral-motor development
- How do you code the session?
  a) CPT 92507 Tx of speech, language, voice, communication, and/or auditory processing disorder & CPT 92526 Tx of swallowing dysfunction and/or oral function for feeding
  b) Only CPT 92507
  c) CPT 92507 & CPT 97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
Scenario 2

- The answer is... B
  - **Only CPT 92507** Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
  - Articulation treatment and oral-motor development are covered under 92507, a very comprehensive code. Using multiple codes in this situation would be considered “unbundling.”
  - With the exception of CPT 97532, SLPs should be careful about using the 97000 series of codes. Check with your payer.
How do we know we can’t use 97000 series CPT codes?

- CMS has provided guidance that the 97000 series codes were originally written for physical therapy. The vignettes are written to describe physical therapy.
- CMS has described the speech and swallowing therapy codes as “umbrella” codes.
How do we know we can’t use 97000 series CPT codes?

- Check with your MAC (Medicare Administrative Contractor) to see whether the particular 97000 code is covered in your region.
- Some third party payers other than Medicare might agree that other rehab professionals (e.g. SLP) can use the codes.
- You should determine this before billing the code.
- Even if the payer agrees to cover this code, it is likely that you would not bill this code and another code to describe the same session.
Scenario 3

- You see 3 patients for group swallowing therapy.

- How do you bill the session?
  a) CPT 92526 Tx of swallowing dysfunction and/or oral function for feeding – 3 times (once per patient)
  b) CPT 92508 Tx of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals – 3 times (once per patient)
  c) CPT 97150 Therapeutic procedure(s), group (2 or more individuals) – 3 times (once per patient)
Scenario 3

- The answer is...
  - **It depends!** There is no code for group dysphagia therapy. **You should contact your payer to determine which code to use.**
  - For Medicare, two contractors list CPT 92508 and one cites CPT 97150 for group dysphagia therapy. Check your local coverage determination. See: [www.asha.org/practice/reimbursement/medicare/group-treatment.htm](http://www.asha.org/practice/reimbursement/medicare/group-treatment.htm)
  - Most payers will not want to pay for CPT 92526 for each patient seen in the group setting. You could consider adding modifier -52 (reduced/shortened service).
Scenario 4

- Patient referred by ENT for a voice evaluation and laryngeal videostroboscopy
- Referring ICD-9-CM codes are:
  - 784.42 Dysphonia
  - 478.4 Nodules
Scenario 4

- Evaluation indicates normal vocal quality and no vocal lesions. What diagnostic code(s) can you include in your final report?
  a) 784.42 and 478.4 with an explanation and description of findings in the written report
  b) You do not need a code since you do not bill the patient/client when the findings are normal
Scenario 4

- The answer is... A
- You will use diagnostic codes 784.42 and 478.4 with an explanation and description of findings in the written report
Scenario 5

- Patient has impaired language and cognitive skills after traumatic brain injury.

- What is the ICD-9 (diagnosis) code?
  a) 784.69 Other (Other symbolic dysfunction, coded to 5th digit)
  b) 315.32 Mixed receptive-expressive language disorder
  c) 799.52 Cognitive communication deficit
Scenario 5

- The answer is...C
  - 799.52 Cognitive communication deficit
  - New codes in 799.5X Signs and symptoms involving cognition in 2011 for patients with TBI.
  - ASHA is currently verifying whether these codes could be used for cognitive deficits associated with other conditions.
  - Excludes cognitive deficits due to CVA
Scenario 6

- The same patient is seen for cognitive/language therapy due to the head injury.

How do you code the session?

a) CPT 92507 for language treatment & CPT 97532 for cognitive treatment
b) Only CPT 92507
c) Only CPT 97532
Scenario 6

- The answer is...
  - **Only CPT 92507**
    - OR
  - **Only CPT 97532**
  - SLPs may not bill 92507 & 97532 on the same day.
    - There is a CCI edit that allows these codes to be billed on the same day by using modifier -59, but only when the patient is seen by two different disciplines (e.g., PT bills 97532, SLP bills 92507)
Scenario 7

Child with diagnosis of autism (299.0) is referred for a speech-language evaluation. Assessment measurements indicate that the child has language deficit.

How do you code the diagnosis?

a) 784.69 Other symbolic dysfunction as primary diagnosis for language deficits and 299.0 as secondary diagnosis for autism disorder
b) 299.0 Autism disorder
c) 299.0 as primary diagnosis and 784.69 Other symbolic dysfunction as secondary diagnosis for language deficit
Scenario 7

- The answer is... A
- **784.69** as primary and **299.0** as secondary
  - According to the American Hospital Association (U.S. clearinghouse for the proper use of ICD-9):
    - the primary code should be the specific reason for the encounter (language disorder)
    - the underlying cause for the disorder, in this case autism, should be coded as the additional or secondary diagnosis.
  - Code the disorder you are treating as the primary.
Scenario 8

Question:
How many times per day can you provide and bill for 92507 (speech & language treatment), not as a unit but as a full treatment?
Scenario 8

Answer: The Medically Unlikely Edits (MUEs) specify once per day.

CMS developed the MUE program to reduce the paid claims error rate for Medicare claims.
Scenario 9

- Can you bill 97532 (cognitive treatment) and 92526 (swallowing treatment) together on the same day?
Scenario 9

- Yes, with a modifier -59 appended to 97532 to indicate separate and distinct procedures.
CPT Coding Resources

- CPT Codes for SLPs: [www.asha.org/practice/reimbursement/coding/default.htm](http://www.asha.org/practice/reimbursement/coding/default.htm)
- Questions: e-mail [reimbursement@asha.org](mailto:reimbursement@asha.org)
Medicare Coding Rules & Tools
Claims-Based Outcomes Reporting for Therapy Services

- Medicare Part B claims-based data collection strategy to collect data on patient “patient function during the course of therapy services in order to better understand patient condition and outcomes”
- Mandated by Congress
- Commonly referred to as “G-codes”
Claims-Based Outcomes Reporting for Therapy Services

- CMS adopted 7 of ASHA’s NOMS Functional Communication Measures (FCMs) for claims reporting
- Use non-payable G-codes and 7-point severity modifier
  - Admission
  - Every 10th treatment day
  - Discharge from treatment plan
# G-Codes for Swallowing Functional Limitation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G 8996</td>
<td>Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals</td>
</tr>
<tr>
<td>G 8997</td>
<td>Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy</td>
</tr>
<tr>
<td>G 8998</td>
<td>Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation</td>
</tr>
</tbody>
</table>
CMS adopted a 7-point severity scale to coincide with the NOMS scale:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Impairment Limitation Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>0% 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>
Functional Reporting Requirements

- For each reporting, there are at least two G-codes with severity modifiers
- Evaluation*
  - Current status
  - Projected Goal status
- Progress - on or before every 10th treatment day
  - Current status
  - Projected Goal status
- Discharge
  - Projected Goal status
  - Discharge status
Functional Reporting Requirements

- **Only one** condition/disorder/functional limitation at a time
  - New requirement: **All evaluations** must include G-code reporting
- Primary functional limitation chosen first
- After primary achieved and discharge reported, subsequent functional limitation reporting begins
- Therapy services for beneficiary **under more than one POC** (PT, OT, and/or SLP) will have more than one G-code set
New “G-code” Information

In late October, CMS changed its guidance on reporting multiple conditions on the same day!

- **Previously:** Do **NOT** report two functional limitations on the same day.

- **Now:** **All evaluations** should be **reported**, even on the same day as other ongoing G-code reporting for the primary functional limitation.

- **Note:** Although more than one evaluation may be reported on the same day, **ongoing reporting** is still only allowed for one functional limitation.

- For more information, see: [www.asha.org/Practice/reimbursement/medicare/Guidance-on-Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/](http://www.asha.org/Practice/reimbursement/medicare/Guidance-on-Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/)

- Questions? Contact Lisa Satterfield ([lsatterfield@asha.org](mailto:lsatterfield@asha.org))
G-code Scenario #1

- A patient is seen for a swallowing evaluation and is referred to a different facility for treatment.

- Report 92610 (swallow evaluation) with:
  - Current status
  - Projected goal
  - Discharge status
G-code Scenario #2

- A patient is evaluated for both swallowing and cognition. The clinician determines that swallowing will be the reported functional limitation.
G-Code Scenario #2, cont’d

- CMS now wants clinicians to report on all therapy evaluations
- On initial claim:
  - Report swallow evaluation (92610) with:
    - Current status
    - Projected goal
  - Report cognitive evaluation (96125) with:
    - Current status
    - Projected goal
    - Discharge status
G-code Scenario #2, cont’d

- Treatment for both swallowing and cognition begins
- On claim for visit #10:
  - Report cognitive treatment (97532) with:
    - No G-codes
  - Report swallowing treatment (92526) with:
    - Current status
    - Projected goal
- On claim at patient discharge:
  - Report cognitive treatment (97532) with:
    - No G-codes
  - Report swallowing treatment (92526) with:
    - Projected goal
    - Discharge status
G-code Scenario #3

- A patient is being seen for speech/language treatment and functional reporting is ongoing. The patient discontinues therapy without notifying the clinician.

- On the last date of service, report speech/language treatment with:
  - Current status
  - Projected goal
  - **Do not** submit discharge status
Resources

- Detailed information available at:
  www.asha.org/Practice/reimbursement/medicare/Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/
Questions?
Multiple Procedure Payment Reduction (MPPR)

- Reduces practice expense (PE) payment for second and subsequent procedures provided on the same day to the same patient for Medicare Part B services
- Expanded to therapy services in 2011
  - 50% decrease in PE fees for Part B services in all settings
- CMS is considering applying the MPPR to all diagnostic tests (including audiology), but not in 2014
- See: www.asha.org/Practice/reimbursement/medicare/Calculating-Medicare-Fee-Schedule-Rates/#MPPR
SLP Codes Affected by MPPR

- 92507 Speech-language tx, individual
  - 92508 Group, two or more individuals
- 92526 Swallow tx
- 92597 Voice prosthetic eval
- 92607 SGD AAC eval, first hour
- 92609 SGD therapy
- 96125 Standardized cognitive testing
- 92521 Speech fluency eval
- 92522 Speech sound production eval
- 92523 Speech sound production & language eval
- 92524 Behavioral & qualitative analysis of voice
# MPPR Scenario

A patient is seen on the same day for speech-language treatment (92507) and swallowing treatment (92526)

<table>
<thead>
<tr>
<th></th>
<th>92526</th>
<th>92507</th>
<th>Total Payment w/o MPPR</th>
<th>Total Payment w/ MPPR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong></td>
<td>$33.06</td>
<td>$32.07</td>
<td>$65.13</td>
<td>No Reduction = $65.13</td>
</tr>
<tr>
<td><strong>Practice Expense</strong></td>
<td>$25.41</td>
<td>$20.48</td>
<td>$45.89</td>
<td>$25.41 + (50% x $20.48) = $35.65</td>
</tr>
<tr>
<td><strong>Malpractice</strong></td>
<td>$1.73</td>
<td>$1.73</td>
<td>$3.46</td>
<td>No Reduction = $3.46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$60.20</td>
<td>$54.28</td>
<td>$114.48</td>
<td>$65.13 + $35.65 + $3.46 = $104.24</td>
</tr>
</tbody>
</table>
Medicare Resources

- Medicare Billing & Reimbursement for SLPs:
  [www.asha.org/practice/reimbursement/medicare/](http://www.asha.org/practice/reimbursement/medicare/)

- Questions: e-mail
  [reimbursement@asha.org](mailto:reimbursement@asha.org)
Wrap Up
Need more info?

- Neela Swanson, Director, Health Care Coding Policy
  - nswanson@asha.org

- Lisa Satterfield, Director, Health Care Regulatory Advocacy
  - lsatterfield@asha.org
Resources Developed by the HCEC

- **Speech-Language Pathology Medical Review Guidelines:**
  - [www.asha.org/Practice/reimbursement/SLP-medical-review-guidelines/](http://www.asha.org/Practice/reimbursement/SLP-medical-review-guidelines/)
  - Overview of the profession of speech-language pathology including qualifications, standard practices, descriptions of services, documentation of services, and treatment efficacy data

- **Coding, Reimbursement, & Advocacy Modules:**
  - [www.asha.org/Practice/reimbursement/modules/](http://www.asha.org/Practice/reimbursement/modules/)
  - Eight narrated modules provide an overview of important reimbursement and advocacy concepts
What’s Next in Session Two?

- 2014 Medicare Fee Schedule
- New SLP Evaluation Codes
- SLP Codes Valued for Professional Work: 2009-2013
- Professional Work vs Unskilled Care
  - Documentation of Functional Goals
- PQRS
- ICD-10
Next Session:

2014 & Beyond: Health Care Coding & Reimbursement for SLPs

- Session #1607
- Saturday, 8:00 am – 10:00 am
- Room W190B (Convention Center)

- See you there!
Questions?