



## **Model Medical Review Guidelines for Dysphagia Services**

The medical review guidelines found here were refined from Medicare original guidelines to assist practitioners and third party payers in defining the scope of coverage for dysphagia services. They are based on former national medical review guidelines established for the Medicare program and are similar to current Local Coverage Determinations (LCDs) developed by Medicare carriers and fiscal intermediaries. At times, private health plans adopt coverage policies based on Medicare standards. The attached document represents an enhancement of former national guidelines by DynCorp (now known as AdvanceMed), contracted by the Centers for Medicare and Medicaid Services (CMS), and, subsequently, the ASHA Health Care Economics Committee.

Medicare carriers process claims from practitioners (e.g., private practice physicians, physician groups, private practice audiologists, and private practice physical therapists). Fiscal intermediaries process claims from institutions (e.g., hospitals, skilled nursing facilities, rehabilitation agencies). Not all carriers and fiscal intermediaries have developed LCDs for speech-language pathology or dysphagia services.

To view LCDs for your geographic area, go to:

<http://www.cms.hhs.gov/contacts/med/search.asp>

- Select “Local Coverage”
- Deselect “Articles”
- Select “Final Policies Only”
- Select “Geographic area” OR “Contractor”
  - (Contractor is the specific intermediary or carrier)
- Select “Keyword”
- Select “Title”
  - (Keyword in title would be speech, dysphagia, or swallowing)

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## Model Local Coverage Determination Dysphagia Services

ASHA substantive revisions are indicated by

- Underlined text
- Strike-throughs

The revisions are followed by ASHA's rationale for the change.

### Contractor's Policy Number

Contractor Entry

### Contractor Name

Contractor Entry

### Contractor Number

Contractor Entry

### Contractor Type

Contractor Entry

### LCD Title

Medical Review of Dysphagia Services – Part B

### AMA CPT Copyright Statement

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### CMS National Coverage Policy

#### Statutory Authority

[Social Security Act: Title XVIII](#) (the Act): Sections Affecting the Part B Benefit

#### [Title XVIII of the Social Security Act, Section 1862 \(a\)\(1\)\(A\)](#)

SEC. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services-- (1)(A) which, except for items and services described in a succeeding subparagraph, are not **reasonable and necessary** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

[Title XVIII of the Social Security Act, Section 1862 \(a\)\(7\)](#) This section excludes routine physical examinations.

[Title XVIII of the Social Security Act, Section 1833 \(e\)](#)

No payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

### **CMS Regulatory Authority**

#### **[Code of Federal Regulations \(42CFR\): Specific Regulations Affecting Part B Speech-Language Pathology Benefit](#)**

[Part 409](#) includes the definition of ‘reasonable and necessary’ therapy services that applies to both Part A and Part B services.

[Part 410](#) describes the benefits to be paid for under Medicare Part B.

[Part 411](#) describes those specific services excluded from Medicare or that are subject to limitations on payment.

[Part 414](#) describes the provisions of payment of Part B services, under a fee schedule.

[Part 415](#) describes services furnished by physicians in providers, supervising physicians in teaching settings, and residents in certain settings.

[Part 420](#) describes specific Medicare Program Integrity requirements to prevent fraud and abuse.

[Part 421](#) identifies the activities required of the intermediaries and carriers that process Medicare claims.

[Part 424](#) describes the conditions for Medicare payment, including those governing Part B outpatient physical therapy services.

[Part 484](#) describes any therapy services offered by the HHA directly or under arrangement given by a qualified therapist in accordance with the plan of care.

[Part 485](#) describes adequate number of speech language pathology qualified personnel and adequate program of speech language pathology offered by an organization.

[Part 498](#) describes appeal procedures for determinations that affect participation in the Medicare program.

### **CMS National Coverage Determinations (NCD)**

#### **[Pub. 6 Coverage Issues Manual](#)**

##### [35 - Medical Procedures](#)

##### [35-89 Speech Pathology Services for the Treatment of Dysphagia](#)

### **CMS Program Manuals**

- [Section 544.3 Medicare Skilled Nursing Manual](#)
  - [10- Special Instructions for Billing Dysphagia](#)
- [Section 450 Medicare Hospital Manual](#)
  - [10- Special Instructions for Billing Dysphagia](#)

- [Section 391.0 Medicare Intermediary Manual](#)
  - [10- Special Instructions for Billing Dysphagia](#)
- [Section 453 Medicare Home Health Manual](#)
  - N/A
- [Chapter 6 Medicare Program Integrity Manual](#)
  - [10- Special Instructions for Billing Dysphagia \[Rescinded by CMS, June 2003\]](#)
- [Section 504 Medicare Outpatient Physical Therapy Comprehensive Outpatient Rehabilitation Facility and Community Mental Health Center Manual](#)
  - 504 - [Special Instructions for Billing Dysphagia \[Rescinded by CMS, June 2003\]](#)

### **Primary Geographic Jurisdiction**

Contractor Entry

### **Secondary Geographic Jurisdiction**

Contractor Entry

### **CMS Region**

Contractor Entry

### **CMS Consortium**

Contractor Entry

### **Original Policy Effective Date**

Contractor Entry

### **Original Policy Ending Date**

Contractor Entry

### **Revision Effective Date**

Contractor Entry

### **Revision Ending Date**

Contractor Entry

### **LCD Description**

Dysphagia is a swallowing disorder that may be due to various neurological and/or structural impairments. It may be the result of head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies. Dysphagia most often reflects problems involving the oral cavity, pharynx, esophagus, or gastroesophageal junction. Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia, and death.

### **Indications and Limitations of Coverage and/or Medical Necessity**

#### **Dysphagia Services Authorization for Evaluation and Treatment**

If dysphagia is suspected or if the patient is at risk for aspiration, the physician writes an order for a dysphagia evaluation consulting with the qualified therapist, if needed. The physician may order dysphagia services based on medical documentation, clinical judgment and/or physical examination. The physician may also order an instrumental swallowing study in which the speech-language pathologist might collaborate with the physician.

Documentation within the medical record must include at least one of the following conditions:

- History of aspiration or high risk for aspiration;
- Nasal regurgitation, choking, or frequent coughing during swallowing;
- Wet gurgling voice quality after swallowing, or delayed or slow swallow reflex;
- Presence of oral motor disorders such as drooling, oral food retention, or leakage of food or liquids placed into the mouth;
- Impaired salivary gland performance and/or presence of local structural lesions in the oral cavity or pharynx;
- In-coordination, sensation loss, postural difficulties or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the oral cavity and/or to bite, chew, suck, shape and/or squeeze the food bolus into the upper esophagus while protecting the airway;
- Post-surgical reaction affecting ability to adequately use oropharyngeal structures for swallowing;
- Documented weight loss and/or malnutrition of undetermined etiology that would require an evaluation to rule out dysphagia;
- The presence of a tracheostomy, NG- or G-tube; reduced or inadequate laryngeal elevation, labial closure, airway management problems, velopharyngeal closure, laryngeal closure, or pharyngeal peristalsis; or cricopharyngeal dysfunction.
- Existence of other conditions affecting the structural or functional integrity of the pharyngeal area.

### **Dysphagia Clinical Evaluation**

A speech-language pathologist (SLP) usually performs the clinical evaluation. The evaluation typically includes a bedside assessment of oral-motor functioning and signs and symptoms of pharyngeal dysphagia. An OT or PT who is qualified may perform the clinical evaluation. Depending upon the patient's history and condition, the clinical evaluation usually precedes any instrumental evaluation. The qualified therapist's clinical assessment must document history, appropriate diagnosis, current eating status, and clinical observations that may include:

#### **Clinical Observations**

- History, including any prior dysphagia and treatment for that dysphagia, pneumonia, unexplained weight loss, respiratory status, and any medical conditions that might cause or contribute to the dysphagia;
- Onset and duration of current swallowing problems;
- Current method of nutrition and nutrition status compared to prior status;
- Behavioral characteristics such as level of alertness, cooperation, motivation;
- Cognition and communication skills;
- Any problems with appropriate positioning of patient;
- Oral motor structure, sensation and function;
- Laryngeal function;
- Signs of oral dysphagia, such as pocketing food, drooling, oral residue, poor dentition;
- Signs of pharyngeal dysphagia such as coughing and choking, wet gurgly vocal quality, multiple swallows, difficulty initiating swallow, reduced laryngeal elevation;
- Any changes in patient's symptoms as a result of rehabilitative and/or compensatory strategies, if indicated;
- Diagnosis which describes phase(s) of swallow affected; and/or
- Recommendations for future assessment or treatment/intervention.

The clinical evaluation is used to determine the necessity for further medical testing or instrumental assessment. It also provides valuable information for treatment planning, particularly for oral phase disorders.

### **Dysphagia Instrumental Assessment**

An instrumental evaluation (e.g. Modified Barium Swallow Study, Flexible Fiberoptic Endoscopic Evaluation of Swallowing , Flexible Fiberoptic Endoscopic Evaluation of Swallowing with Laryngeal Sensory Testing, and Modified Barium Swallow with Manofluorograph) is indicated for patients with suspected, or who are at high risk for, pharyngeal dysphagia . Oral stage dysphagia treatment may continue prior to the instrumental assessment. The final analysis and interpretation of an instrumental assessment should include a definitive diagnosis, identification of the swallowing phase(s) affected, and a recommended treatment plan, including compensatory swallowing techniques and/or postures and food and/or fluid texture modification. Analysis by an individual discipline may be submitted as a separate line item charge. An instrumental assessment is not indicated if findings from the clinical evaluation fail to support a suspicion of dysphagia; or, when findings from the clinical evaluation suggest dysphagia but include either of the following: (1) the patient is unable to cooperate or participate in an instrumental evaluation; or (2) the instrumental examination would not change the clinical management of the patient. Absence of instrumental evaluation does not preclude the patient from receiving dysphagia treatment.

Definition of the above instrumental assessments is as follows:

- Motion fluoroscopic evaluation of swallowing by cine or video recording , also known as the modified barium swallow (MBS) is a videofluoroscopic, radiographic test that differs from the traditional barium swallow procedure. The MBS incorporates a set of modifications in consistency, bolus size, texture, patient positioning, and radiographic focus to facilitate optimum visualization of the oral-pharyngeal-laryngeal structures and their function during swallowing. The effects of compensatory maneuvers and diet modification on aspiration prevention and/or bolus transport during swallowing are able to be studied radiographically to determine a safe diet and to maximize efficiency of the swallow.
- Motion luoroscopic evaluation of swallowing function by cine or video with Manofluorograph simultaneously records oropharyngeal pressure changes; anatomic biomechanical and physiological swallow events and bolus transit onto videotape. Pressure changes associated with each swallow are displayed simultaneously in analog form as negative or positive pressure waves. The relationship among the forces created by the opposition and the contractions of the tongue, pharynx, larynx, esophagus, and bolus are able to be studied.
- Endoscopic evaluation of swallowing by cine or video recording (also called Flexible Fiberoptic Endoscopic Evaluation of Swallowing (FEES) utilizes the fiberoptic nasopharyngolaryngoscope to evaluate the pharyngeal swallow. Detailed information regarding swallowing function and related functions of structures within the upper aerodigestive tract are obtained. Therapeutic maneuvers are attempted during this examination to determine a safe diet and to maximize the efficiency of the swallow.
- Flexible Fiberoptic Endoscopic Evaluation, of Swallowing with Sensory Testing (FEESST) is the performance of a FEES with the incorporation of laryngeal sensory testing. The sensory evaluation is completed by delivering pulses of air at sequential pressures to elicit the laryngeal adductor reflex. A sensory threshold is thus established.

During these instrumental assessments, signs of esophageal disorders involving the lower two-thirds may be observed. Treatment of suspect esophageal disorders is outside the scope of this document, however, a referral to the appropriate physician should be made.

### **Dysphagia Treatment**

Individuals of all ages are treated on the basis of swallowing function assessment. At the conclusion of the assessment, the presence, severity, and pattern of dysphagia should be determined, and recommendations made in collaboration between the therapist and physician. Then appropriate therapeutic interventions,

dietary recommendations, and further evaluations can be implemented. An individualized care plan with clear goals must be developed which specifically addresses each problem identified in the assessment, which may include but is not limited to:

- Patient and care-giver training in feeding and swallowing techniques;
- Proper head and body positioning;
- Amount of intake per swallow;
- Appropriate and safest diet;
- Means of facilitating the swallow;
- Feeding techniques and need for self help eating/feeding devices;
- Food and fluid consistencies (texture and size);
- Facilitation of more normal tone or oral facilitation techniques;
- Oromotor and/or neuromuscular facilitation exercises to improve oromotor control;
- Training in laryngeal and vocal cord adduction exercises;
- Techniques to reduce shortness of breath or fatigue during duration of meal; and
- Oral sensitivity training.

As with all rehabilitation services, there must be a reasonable expectation that the patient will make material improvement within a reasonable period of time. The establishment of a functional maintenance program by a therapist may be an acceptable goal when further clinical improvement is unlikely.

Inefficient functioning of the esophagus during the esophageal phase of swallowing is a common problem in the geriatric patient. Swallowing disorders occurring only in the lower two thirds of the esophageal stage of the swallow have not generally been shown to be amenable to swallowing therapy techniques and may not be approved. An exception might be when discomfort from reflux results in food refusal. A therapeutic feeding program in conjunction with medical management may be indicated, and may constitute reasonable and necessary care. Positioning and other compensatory techniques to improve the peristalsis of food from the esophagus to the stomach may be beneficial.

### **Dysphagia Professional Services**

Speech-language pathologists, occupational therapists and physical therapists may be involved with dysphagia services to the extent that their training and scope of practice allows.

The modified barium swallow study is typically conducted and interpreted by the clinician in conjunction with the radiologist or other physician. Services can be performed individually or as a team with each member performing unique roles that do not duplicate services of others. Services may include, but are not limited to, the following example. This example should not be interpreted as the standard.

**EXAMPLE:** Speech-language pathologists, occupational therapists and physical therapists often work as a team to improve eating and swallowing skills. The SLP could address specific exercises to improve oromotor control, determining appropriate food consistency/form, assisting the patient with muscular movements necessary to close the buccal cavity or to shape food in the mouth in preparation for swallowing. The OT may be assisting with positioning, adaptive self-help devices, self-feeding techniques, or inhibiting abnormal oromotor and/or postural reflexes. The PT might be addressing a different role, such as increasing muscle strength, sitting balance or head control.

### **Nasogastric Tube, Gastrostomy Tube or J-Tube**

The presence of a nasogastric, gastrostomy, or jejunostomy tube does not preclude the need for treatment. These may be used in addition to oral feeding, for nutrition, hydration or medications, and on a long or short-term basis. Removal of a nasogastric, gastrostomy, or jejunostomy tube may be an appropriate treatment goal. **RATIONALE FOR ADDITION OF JEJUNOSTOMY: A J-tube is another common alternative to oral feeding.**

## **Professional Qualifications**

Swallowing rehabilitation is a highly specialized service. The professionals rendering care must have competencies and experience. Intermediaries and carriers should refer any suspected patterns of poor quality to the Regional Office.

## **Consultation**

Intermediaries and carriers are encouraged to seek consultation/advice from the American Speech-Language-Hearing Association, American Occupational Therapy Association, and American Physical Therapy Association, on competencies and practice guidelines as these claims may often require medical review by therapy or speech-language pathology consultants.

## **CPT/HCPCS Section & Benefit Category**

### *CPT/HCPCS Section*

- Surgery
- Radiology
- Medicine
- Physical Medicine and Rehabilitation
- Special Otorhinolaryngology

### *Benefit Category: Medicare Part B*

- **Medical and other health services except when furnished by or under arrangements with a provider of services –1832(a)(1):**
  - Services and supplies incident to a physician's professional services [1861(s)(2)(A)] {1833(a)(1)(N), 1848(a)(1) & 1848(j)(3)}
  - Physician assistant services and incident to [1861(s)(2)(K)] {1842(b)(12)}
  - Nurse practitioner services and incident to [1861(s)(2)(K)] {1842(b)(12)}
  - Clinical nurse specialist services and incident to [1861(s)(2)(K)] {1833(a)(1)(O), 1833(r), & 1848}
  - Other diagnostic tests [1861(s)(3)] {1833(a)(1)(N), 1848(a)(1), & 1848(j)(3)}
- **Medical and other health services only when furnished by or under arrangements with a provider of services –1832(a)(2)(B):**
  - Outpatient hospital services and supplies incident to a physician's services [1861(s)(2)(B)] {1833(a)(2)(B), 1833(a)(4), 1833(I), & 1886}
  - Outpatient speech-language pathology [1861(p)] {1833(a)(2)(B)}
  - Other diagnostic tests [1861(s)(3)] {1833(a)(2)(E) & 1833(n)}
- **Outpatient speech-language pathology 1832(a)(2)(c) [1861(p)] {1833(a)(2)(B)}**
- **CORF Services 1832(a)(2)(E) [1861(cc)] {1833(a)(3)}**
- **ASC facility services 1832(a)(2)(F) {1833(a)(4), 1833(I), & 1833(n)}**

## **Type of Bill Code**

Type of bill codes apply only to intermediary claims  
12x, 13x, 22x, 23x, 34x, 74x, 75x, 83x

## **Revenue Codes**

Revenue center codes apply only to intermediary claims  
044X, 043X, 042X

## **CPT/HCPCS Codes**



### **When Performed by a Therapist**

#### **[CMS IN 2003 REPLACED G-CODES WITH NEW CPT CODES 92610 – 92617]**

92610	Clinical evaluation of swallowing function. This service describes the clinical examination and evaluation of the patient, typically by a speech-language pathologist.
92611	Motion fluoroscopic evaluation of swallowing by cine or video recording
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (FEES)
92613	physician interpretation and report only
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing (FEESST)
92617	physician interpretation and report only
92526	Treatment of swallowing dysfunction and/or oral function for feeding

### **Not Otherwise Classified (NOC)**

#### **ICD-9 Codes that Support Medical Necessity**

One of the specific medical diagnoses listed on the claim is appropriate for the disorder or disease. See next section.

#### **Diagnoses that Support Medical Necessity**

146.0 – 146.9	Malignant neoplasms of oropharynx
148.0 – 148.9	Malignant neoplasms of hypopharynx
150.0 – 150.9	Malignant neoplasms of esophagus
235.6	Neoplasms of uncertain behavior of larynx
239.1	Neoplasms of unspecified nature, respiratory system
<u>318.2</u>	<u>Profound mental retardation</u>
<u>331.0</u>	<u>Alzheimer's disease</u>
<u>331.11</u>	<u>Pick's disease</u>
<u>331.2</u>	<u>Senile degeneration of brain</u>
<u>331.7</u>	<u>Cerebral degeneration of brain</u>
332.0	Paralysis agitans (Parkinson's disease)
332.1	Secondary Parkinsonism
333.0	Other degenerative diseases of the basal ganglia
<u>340</u>	<u>Multiple sclerosis</u>
333.2	Myoclonus
333.4	Huntington's chorea
333.5	Other choreas
333.6	Idiopathic torsion dystonia
333.82	Fragments of torsion dystonia, orofacial dyskinesia
333.89	Fragments of torsion dystonia, other
333.90 – 333.99	Other and unspecified extrapyramidal disease and abnormal movement disorders
<u>334.8</u>	<u>Ataxia telangiectasia [Louis-Bar syndrome]</u>
335.20	Amyotrophic lateral sclerosis
341.0 – 341.9	Other demyelinating diseases of central nervous system
342.0 – 342.9	Hemiplegia and hemiparesis
<u>343.0</u>	<u>Diplegic</u>
<u>352.1</u>	<u>Glossopharyngeal neuralgia</u>
<u>352.2</u>	<u>Other disorders of glossopharyngeal [9<sup>th</sup>] nerve</u>
<u>352.4</u>	<u>Disorders of accessory [11<sup>th</sup>] nerve</u>
<u>352.5</u>	<u>Disorders of hypoglossal [12<sup>th</sup>] nerve</u>

358.9	<u>Myoneural disorders, unspecified</u>
436	Acute, but ill-defined, cerebrovascular disease
438.11	<del>Late effects of cerebrovascular disease, aphasia</del>
438.12	<del>Late effects of cerebrovascular disease, dysphasia</del>
438.82	Other late effects of cerebrovascular disease, dysphagia
438.83	Other late effects of CVA, facial weakness/facial droop
464.0	<del>Acute Laryngitis</del>
464.51	<u>Supraglottitis, unspecified, with obstruction</u>
478.30 – 478.34	Paralysis of vocal cords or larynx
478.5	<u>Other diseases of vocal cords</u>
478.6	Edema of larynx
507.0	Pneumonitis due to solids and liquids, due to inhalation of food
519.1	<u>Other diseases of trachea and bronchus, not elsewhere classified</u>
530.0	Achalasia and cardiospasm
530.3	Stricture and stenosis of esophagus
530.6	Diverticulum of esophagus, acquired
530.81	Esophageal reflux
530.85	<u>Barrett's esophagus</u>
748.3	<u>Other anomalies of larynx, trachea, and bronchus</u>
749.01 – 749.04	<u>Cleft palate</u>
749.10 – 749.14	<u>Cleft lip</u>
749.2	<u>Cleft palate with cleft lip</u>
750.0	<u>Tongue tie</u>
750.10 – 750.13, 16	<u>Other anomalies of tongue</u>
756.4	<u>Chondrodystrophy</u>
758.0	<u>Down's syndrome</u>
759.7	<u>Multiple congenital anomalies, so described</u>
770.7	<u>Chronic respiratory disease arising in the perinatal period</u>
780.3	<u>Persistent vegetative state</u>
783.3	Feeding difficulties and mismanagement in the elderly
783.4	<u>Lack of expected normal physiological development in childhood</u>
786.09	<u>Dyspnea and respiratory abnormalities, other</u>
786.2	Cough
787.2	Dysphagia
850.0 – 850.9	<u>Concussion</u>
851.1 – 851.9	<u>Cerebral laceration and contusion</u>
852.0 – 852.5	<u>Subarachnoid, subdural, and extradural hemorrhage following injury</u>
853.0 – 853.1	<u>Unspecified intracranial hemorrhage</u>
854.0 – 854.1	<u>Intracranial injury of other and unspecified nature</u>
933.1	Foreign body in larynx
934.0	Foreign body in trachea
934.1	Foreign body in main bronchus
V10.21	<u>Other respiratory and intrathoracic organs, Larynx</u>
V10.85	<u>Personal history of malignant neoplasm of other sites, Brain</u>
V41.6	Problems with swallowing and mastication
V43.8	<u>Organ or tissue replaced by other means, Other organ or tissue</u>
V44.0	<u>Tracheostomy</u>
V48.3	Mechanical and motor problems with neck and truck

**RATIONALE FOR ADDED DIAGNOSES: The added diagnosis codes represent anatomic anomalies, or respiratory or neurologic conditions that are frequently associated with dysphagia.**

**ICD-9 Codes that DO NOT Support Medical Necessity**

Claims that do not contain an ICD-9 code from the above list should be subject to medical review.

**Diagnoses that DO NOT Support Medical Necessity**

Claims that do not contain an ICD-9 code from the above list should be subject to medical review.

### **Reasons for Denial**

#### **Statutory Exclusions**

Medicare will not pay for services that are statutorily excluded in Section 1862(a) of the Act

- 1862(a)(2): The service is one for which the individual has no legal obligation to pay;
- 1862(a)(3): The service is payable by another governmental agency;
- 1862(a)(4): The service was provided outside the United States;
- 1862(a)(5): The service was required as a result of war;
- 1862(a)(6): The items furnished constitute personal comfort items;
- 1862(a)(7): The service represents a routine screening;
- 1862(a)(8): The items furnished constitute non-covered supportive devices for the feet;
- 1862(a)(9): The services rendered constitute custodial care;
- 1862(a)(10): The services constitute cosmetic surgery;
- 1862(a)(11): The service was rendered by an immediate relative or member of the same household;
- 1862(a)(12): The services rendered constitute non-covered dental services; 1862(a)(13): Determine whether services constitute treatment of flat foot, treatment of subluxations of the foot or routine foot care;
- 1862(a)(14) The service constitutes other than physician services; or
- 1862(c) of the Act to determine whether services constitute "less than effective drugs."

### **Medical Necessity Denial ANSI Codes**

The following American National Standards Institute (ANSI) Claim Adjustment Reason Codes (OCI 17-007 R 02/2001) indicate to the provider the reason for claim or line denials for medical necessity.

- 11 – The diagnosis was inconsistent with the procedure.
- 49 – These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
- 50 – These are noncovered services because the payer does not deem them a “medical necessity”.
- 51 – These are noncovered services because this is a preexisting condition.
- 55 – Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer. <http://www.hcfa.gov/coverage/8d2.htm> Medicare Coverage Policy ~ Clinical Trials National Coverage Decision
- 56 – Claim/service denied because procedure/treatment has not been deemed “proven to be effective” by the payer.
- 57 – Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage, or this day’s supply.

### **Non-covered ICD-9 Code(s)**

### **Non-covered Diagnoses**

### **Coding Guidelines**

CMS developed the Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

CCI edits are updated quarterly and are available through the US Government’s National Technical Information Services (NTIS) at: 1-800-553-6847, or at the following website:

<http://cms.hhs.gov/physicians/ccredits/default.asp>

The most recent CMS instructions related to coding of Part B speech-language pathology and swallowing services are contained in Program Memorandum AB-01-68 ‘*Consolidation of Program Memorandums for Outpatient Rehabilitation Therapy Services*’ at: <http://www.hcfa.gov/pubforms/transmit/AB0168.pdf>

### **Documentation Requirements**

#### **Plan of Care**

Documentation must delineate the goals and the type of care planned which specifically addresses problems identified in the assessment, such as:

- Patient and care-giver training in feeding and swallowing techniques;
- Proper head and body positioning;
- Amount of intake per swallow;
- Appropriate and safest diet;
- Means of facilitating the swallow;
- Feeding techniques and need for self help eating/feeding devices;
- Food consistencies (texture and size);
- Facilitation of more normal tone or oral facilitation techniques;
- Oromotor and neuromuscular facilitation exercises to improve oromotor control;
- Environmental modifications (for reduced auditory or visual acuity);
- Training in laryngeal and vocal cord adduction exercises;
- Techniques to reduce shortness of breath or fatigue during duration of meal; and
- Oral sensitivity training.

#### **Chronic Progressive Conditions**

Patients with end stage progressive disorders, such as Parkinson’s Disease, Huntington’s Disease, Wilson’s Disease, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, or Alzheimer’s Disease and related dementias do not typically show improvement in swallowing function, unless they are recovering from an acute illness. However, they often are helped through short-term assistance/instruction in positioning, diet, feeding modifications, and in the use of self help devices. Clinical and instrumental assessments may be indicated to evaluate the patient’s aspiration risk and potential need for dietary adjustments or alternative feeding approaches. Intermediaries and carriers should medically review documentation in support of short-term assistance/teaching and establishment of a safe and effective maintenance dysphagia program.

Chronic conditions such as cerebral palsy, long-term status-post head trauma or stroke may require monitoring of swallowing function with occasional short-term intervention for safety and/or swallowing effectiveness. Documentation should relate to either loss of function, decreased safety, or potential for change. As with other conditions/disorders, the reasonableness and necessity of services must be documented. Documentation should include:

- Changes in condition or functional status which support the need for a new start of care for the chronic condition;
- History and outcome of previous treatment for the same condition; and
- Any other information that justifies the start of care.

#### **Safety**

Although the documentation must indicate appropriate treatment goals to improve a patient’s swallowing function, it must also indicate that the treatment is designed to ensure that it is safe for the patient to swallow during oral feedings. Improving the patient’s safety and quality of life by reduction or elimination

of alternative nutritional support systems and advancement of dietary level, with improved nutritional intake should be the primary emphasis and goal of treatment. The documentation must be consistent with these goals and indicate the reasonableness and need for skilled intervention.

### **Skilled Level of Care**

Documentation of ongoing dysphagia treatment should support the need for skilled services such as observation, treatment, and diet modification. Documentation, which is reflective of routine, repetitive observation or cuing, may not qualify as skilled rehabilitation. For example, repeated visits in which the care-giver appears only to be observing the patient eating a meal, reporting on the amount of food consumed, providing verbal reminders (e.g., slow down or cough) in the absence of other skilled assistance or observation suggests a non-skilled or maintenance level of care. The establishment of maintenance programs is covered for a brief period and is usually included during the final visits of the professional.

#### **Utilization Guidelines**

#### **Other Comments**

#### **Sources of Information and Basis for Decision**

Social Security Act  
Code of Federal Regulations  
CMS Program Manuals  
CMS Program Memorandums and Transmittals  
CMS website  
Carrier and Intermediary Local Coverage Determination (LCDs)  
Therapy Review Program Workgroups  
Interviews with intermediaries and carriers  
Interviews with treating clinicians and providers  
Therapy Review Program Literature Review Activities  
Documentation submitted by provider associations

#### **Advisory Committee Notes**

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which include representatives from (fill in appropriate specialty name).

Advisory Committee meeting date:

#### **Start Date of Comment Period**

Contractor Entry

#### **Ending Date of Comment Period**

Contractor Entry

#### **Start Date of Notice Period**

Contractor Entry

#### **Revision History**

Contractor Entry