Speech Language Pathology Payment Strategies

2003

ASHA

Health Care Economics Committee
Government Relations & Public Policy Board

Health Care Economics Committee

- ASHA Standing Committee
- 10 Members
  - 5 AUD
  - 5 SLP
- Appointed by ASHA Executive Board
- Serve for a 3 Year Period

Members

- Nancy Swigert, Chair
- Constance Barker
- Becky Cornett
- Kyle Dennis
- Robert Fifer
- R. Wayne Holland
- Dee Adams Nikjeh
- Thomas Rees
- Gwenlynn Reeves
- Walter Smoski
- Catherine Gottfred - ASHA Executive Board
- Steven White - National Office Ex-Officio

Purpose

- Assist GRPP to determine current economic issues
- Develop goals for equitable reimbursement for audiologists and speech language pathologists

Some committee activities include:

- Present and oversee new codes to the **AMA** CPT process
- Defend time and practice expense to the **AMA** RUC
- Defend existing codes through **AMA** PEAC
- Anticipate future needs and expand number of codes

Goals for the session:

- Overview of the AMA CPT process
- How this relates to the Medicare Fee Schedule and actions by CMS
- “Private Practice” legislation
- $1500 Cap
- Basics of documentation and privacy
- Coding correctly
- Role of FI and Carrier and LMRPs
- Procedure based planning with case studies

AMA Current Procedural Terminology

- Physicians' Current Procedural Terminology (CPT), Fourth Edition
- Purpose is to provide a uniform language that accurately describes medical, surgical, and diagnostic services
- Reliable nationwide communication among physicians, patients and third parties

Current Procedural Terminology - CPT

- Most widely accepted medical nomenclature
- Standard terms and descriptors
- 5-digit classification system

CPT Editorial Panel - WHO?

- **16 Members**
  - **11 nominated by AMA**
  - **5 appointed by the AMA Board of Trustees**
    - Blue Cross-Blue Shield
    - CMS
    - *HCPAC* - ASHA is represented here
    - American Hospital Association
    - Health Insurance Association of America

Health Care Professionals Advisory Committee - HCPAC (2)

- ASHA’s representation to the CPT Panel and to the RUC
- Represent limited license practitioners and allied health professionals
- ASHA’s representatives
  - R. Wayne Holland, PhD - CPT HCPAC
  - Robert Fifer, PhD - RUC HCPAC

"The Process"

Arduous

Complex

<u>Grueling</u>

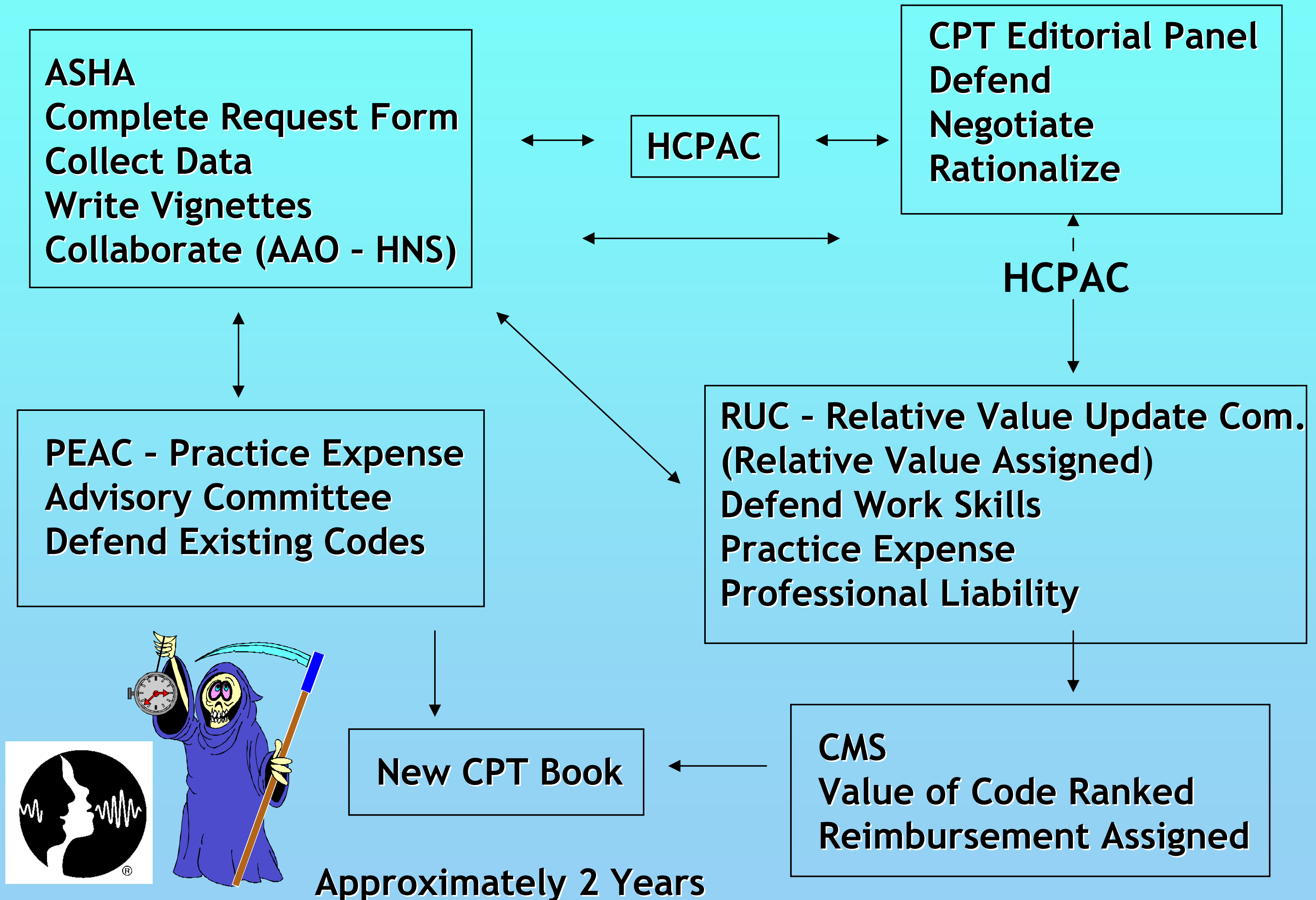
TEDIOUS

L e n g t h y

Not Easy or Expeditious!

…Exhilarating!!

CPT Process



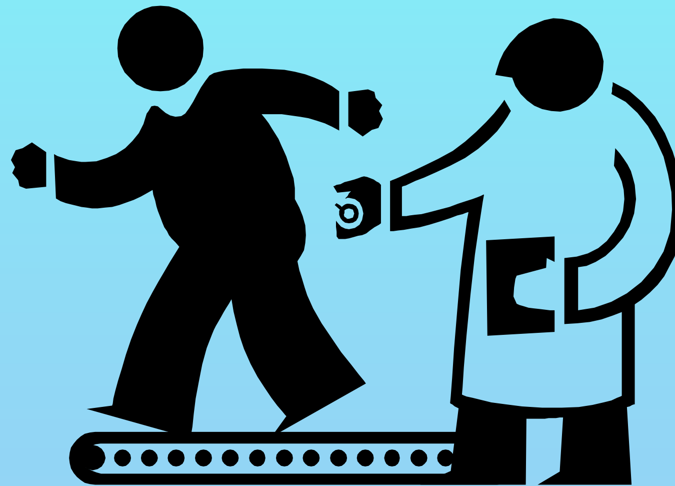
Medicare Physician Fee Schedule

- Developed by CMS based on the relative value assigned to each CPT code
- Relative value is determined by a formula that consists of factors including practice expense (time, supplies & overhead) and PHYSICIAN WORK
- This relative value is multiplied by an established conversion factor to determine the reimbursement rate.
- This framework of reimbursement is also used by private insurers

Clinical Dysphagia Evaluation & Modified Barium Swallow

What happened to reimbursement for 92610 and 92611?

No Physician Work



Implications

- The development of new procedure codes may suffer the same fate
- Reimbursement of our services may significantly decrease if there is no attributable physician work

HCEC Position on "new" or "revised" SLP codes at this time

- **Great concern that any codes that went before the AMA CPT Panel would be under the same scrutiny**
- **The codes have physician work now (we don't know how it got there in the first place)**
- **Risk of losing physician work**

HCEC Position

- The physician portion of the SLP evaluation and treatment codes represent about 35% of the total relative value.
- The physician portion of the dysphagia evaluation and treatment codes represented over 45% of the relative value – we found out what happened there!
- Conversion would yield a significant decrease in the dollar value assigned to each code.

HCEC Future Plans

- Move forward with timed coding and other new code proposals when Medicare has designated independent provider status for SLP's.
- SLP independent providers will occupy the same professional component slot as physicians.

SLP Private Practice Legislation

- This effects EVERY SLP not just those in private practice !!
- This legislation recognizes SLPs as independent providers (like PT and OT) who may bill Medicare directly.
- We must request access to the physician work component if we are to receive equitable reimbursement. PTs and OTs have this…we do not!

Advocacy in Action

- HCEC met with CMS officials in Baltimore in April
- ASHA sent formal response to fee schedule
- Shared information about impact on patient access to services
- And the good news is……

What's happening in 2004?

- **Clinical Dysphagia Evaluation rate increases from $42.30 to $122.20 ☺**
- **Motion fluoroscopic evaluation increases from $45.98 to $122.20 ☺**

What else is happening in 2004?

- CMS proposed 40% increase in value of speech-language evaluation (92506)
- 28% reduction in treatment (92507)
- These two changes are not related to the issue of physician work
- These codes were reviewed by the PEAC (looks at practice expense only)

Medicare Payment Rule

- All part B services require the patient to pay a 20% co-payment
- Fee schedule does NOT deduct the co-payment amount
- Therefore, the actual payment by Medicare is 20% less

2004 FEE CAP

- $1,590. limit for COMBINED PT and SLP services per year per beneficiary
- Applies to outpatient services under

  Medicare Part B
- Applicable deductible of $100. and 20% coinsurance
- Therefore, Medicare pays total of $1,272. and patient pays $318. in coinsurance
- Refer to ASHA Leader Sept 9, 2003

Thank You Very Much!

Documentation: Patient reports and claims

- How you document is as important as how you evaluate and treat
- These guidelines are for Medicare patients, but most are good to follow for any payer

Physician's order

- Order should specify patient's diagnosis for which the referral is being made
- Order should specify what is being requested:
  - E.g. "Evaluate receptive and expressive language"
  - E.g. "Voice evaluation for hoarseness related to vocal nodules"
  - E.g. "Therapy for slurred speech"

Evaluation Reports Should Include:

- Current functional abilities
- Estimate of potential for significant practical improvements
- Treatment goals that are objective and functional
- An estimate of the frequency and duration of treatment needed

Plan of Treatment

- **Diagnosis and onset**
- **Type, amount, frequency, and duration of services**
- **Anticipated reasonable goals**
- **Developed by qualified therapist or physician**
- **Signed by physician every 30 days (60 for CORF or Home Health)***
  - *** CMS plans to change this in the near future**

Progress Notes

- **Can be written daily or weekly**
- **Should contain objective data to demonstrate improvement**
- **Should contain statements to demonstrate functional improvement**

Progress Reports and Discharge Summaries Should Include:

- Objective statements of improvement
- Justification for the necessity of services
- Efficacy of the specific treatments (re: functional outcomes)

Enhancing the Efficiency of Clinical Documentation

- Streamline documentation forms
- Develop interdisciplinary report forms
- Eliminate redundant reporting within and across disciplines
- Use computer software programs and report templates
- Computer technology necessary for data transmission

Documentation and HIPAA privacy requirements

- Keep oral communication with or about patients as private as circumstances allow
- Never discuss patients in a public space
- Be careful about lists of patients, schedules, notes, etc.
- Watch the position of computer screens

Documentation and HIPAA privacy requirements

- Use passwords
- Never e-mail patient information outside the Health System Network
- Fax machines and printers in secure areas
- Verify correct fax numbers when sending patient information
- Don't fax info and leave it in the fax machine

Documentation and HIPAA privacy requirements

- Dispose of unneeded patient information in locked bins or use a shredder
- Careful with patient appointment reminder calls
- Never use postcards as reminders or with results
- Watch “sign in” sheets

Documentation and HIPAA privacy requirements

- Helpful websites
  - Hhs.gov/ocr/hipaa
  - Healthprivacy.org
  - Hillphysicians.org
  - Hipaacomply.com
  - Complianceinfo.com

Documentation and Claims

- **Make sure to list ICD-9CM codes that accurately describe the diagnosis related to the communication/swallowing problem**
- **If a Medicare patient, check the LMRP to see if the code is listed/excluded**

Claims documentation: PracticeSource

- **New ASHA enterprise**
- **Simplifies the claims process**
- **Secure method for submitting HIPAA-compliant claims to all payers**
- **Increases productivity, cash flow, and client service**

PracticeSource

- **Automated claims service**
- **Reduces paper work with online claims submission and record keeping**
- **Tracks patient and claims information**
- **Data transfer connectivity to all payers**

Benefit

- Reduces time with less paperwork
- Improved efficiency, by reducing administrative errors
- Cleaner submissions
- Better patient satisfaction by reducing hassle and increasing procedure time
- Security

Information

- Visit www.practicesource.net
- call 410-308-8672

Current Procedural Terminology

- Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying five-digit codes
- American Medical Association (AMA) publishes the codes annually
- Codes are grouped by medical specialty (i.e., surgery, medicine, etc.)
- Codes for rehabilitation services are found within the medicine specialty (Codes 90000-99600)

Speech Language Pathology

- **CPT codes used to describe speech-language services are divided into two areas:**
  - **Special Otorhinolaryngologic Services (92507-92526)**
  - **Evaluative and Therapeutic Services (92607-92617)**

CPT Code Descriptions

- **An individual CPT code description includes: a <u>therapeutic function</u>, a <u>time component</u> and depending upon the procedure, a <u>body part designation</u>**

Time Component

- **A CPT code may be timed or untimed**
- **92526 (Swallowing treatment) does not have a time variable**
- **96105 (Assessment of aphasia, per hour) has a time variable**

Correct Coding Initiative

- National Correct Coding Initiative
- Commonly called CCI
- Applies to all settings except OP hospital

- Outpatient Code Edits
- OCE
- Applies to OP hospital settings

Comprehensive/Component Codes

- **Code pairs in which one of the codes is considered a component of a more comprehensive code**
- **A comprehensive code and a related component code should not be billed on the same day (considered unbundling)**
- **In certain circumstances, the code pairs may occur on the same day when each is performed as a <u>separate and distinct procedure</u>**

Comprehensive/Component Codes Example

- **Example:** 92526 **– Swallowing Treatment (comprehensive code)**

  97532 – **Cognitive Skills Dev., each 15 min.(component code)**
- **The CCI edit for the code pair 92526 and 97532 describes cognitive skills development as a component of swallowing treatment**

Mutually Exclusive Codes

- **Code pairs in which the services/procedures delivered cannot reasonably be performed on the same day**
- **Code pairs that accomplish the same outcome**
- **In certain circumstances, the code pairs may occur on the same day when each is performed as a separate and distinct procedure**

Mutually Exclusive Codes Example

- **Example:** 92508 **– Speech/hearing treatment,**

  group

  92507 **– Speech, language, aural**

  rehabilitation treatment
- **The CCI edit for the code pair 92508 and 92507 describes speech treatment (1:1) as mutually exclusive of speech treatment (group)**

Modifiers

- **Modifiers provide the means by which the clinician can report that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code**
- **A modifier is a two-digit addition to the five digit CPT code**

Rehabilitation Modifiers

- **Modifiers typically used to report alterations in rehabilitation codes are modifier – 59 and modifier – 76**

Modifier - 59

- **Modifier – 59 = Distinct Procedural Service**
- **Intended to describe instances in which a physician (clinician) provides separate and distinct services and distinct multiple services to a patient on a single date of service**

Modifier –59

- **Modifier –59 is applied to the component code (97532-59 –Cog. Skill Dev., each 15 min.) when reported on the same day as a comprehensive code (92526-Swallowing Treatment)**
- **Modifier – 59 is applied to the second code in a mutually exclusive code pair (92507-59 –Speech Treatment,1:1) when reported on the same day as (92508 –Speech Treatment, group)**

Significant CCI Edits

92507 Speech Tx	92526 Swallow Tx	92508 Speech, group	92506 Speech Eval	96115 NeuroB. Status Exam	92508*
97110 97112 97150 97530 97532	**97110 97112 97150 97530 97532 92511**	**97110 97112 97150 97530 97532**	**92507 92508**	**96105**	**92507* *Mutually Exclusive**

Modifier - 76

- **Modifier – 76 = Repeat procedure by the same professional**
- **Intended to describe instances in which the physician (clinician) needs to indicate that a procedure or service was repeated subsequent to the original procedure or service (BID treatment)**

Comprehensive Evaluation Codes

- 92610
- 92506
- 92607
- 92597
- 92608
- 92611
- 92612
- 92614
- 92616

Treatment Codes

- 92526
- 92507
- 97532
- 92609
- 92508
- 97150

Web Resources

- http://www.cms.hhs.gov
- http://professional.asha.org
- http://www.ptmanager.com
- http://www.veritusmedicare.com
- http://www.trispan.com
- http://www.adminastar.com
- http://www.ugsmedicare.com

So, all we have to know about coding is what CMS and the edits say?!??

- Local Medical Review Policy
- Fiscal Intermediaries (vs. Carriers)
- Know who your intermediary is

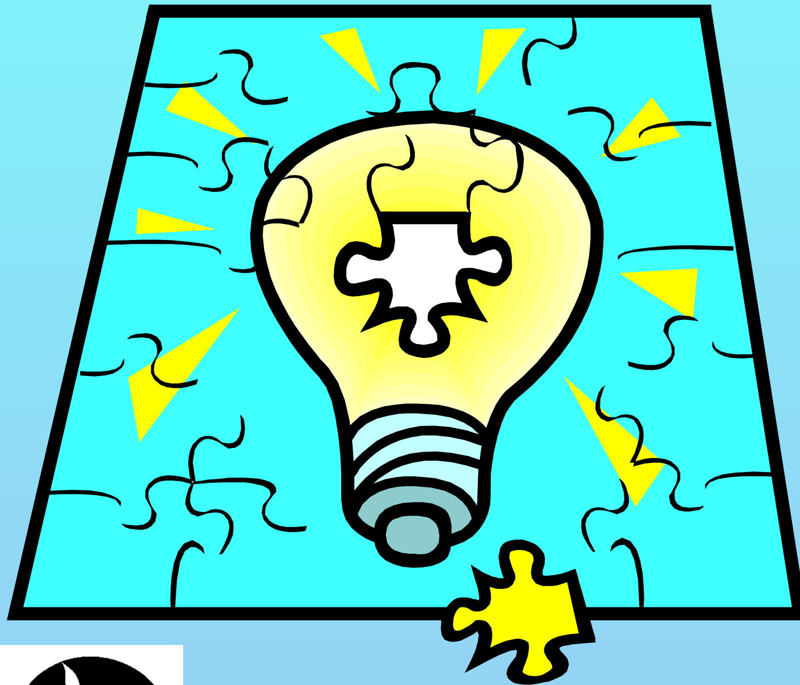
Do LMRPs always mirror national policy? NO…

- Some fiscal intermediaries (FI) have published LMRP’s that are in direct conflict with PM released by HCFA

Administar(IL,IN,OH,KY)

- Example: Administar LMRP for SLP
  - excluded the 97000 series codes
- "Although the scientific literature does not fully support the efficacy of cognitive rehab, we added CPT code 97770…"(code change -- we'll talk about in a minute)
- Did not add "…neuropsychological testing" as it "did not apply to SLP, were outside scope of SLP, or duplicated CPT codes already available to SLPs"

Case studies with procedure based planning



- Adult neuro
- Dysphagia
- SGD vs. Non-SGD
- Voice

Case study #1

83-year-old female with history of CHF, cognitive decline, and dysphagia. Recent exacerbation of choking triggered a referral to speech pathology.

Assessment Problem List:

- **Oral and pharyngeal muscle weakness, limited range, incoordination**
- **Moderate swallowing deficit with oral transit delays and delayed swallow initiation liquids aspiration before the swallow due to delay, residual solids in oral cavity**
- **Moderate attention deficits**
- **Moderate memory deficits**

Short term goals

1. 80% accuracy with lingual anterior-posterior movement; tongue tip into cheeks bilaterally
2. Swallowing reflex will trigger consistently within one second following thermal-tactile stimulation
3. 80% accuracy incorporating chin tuck compensatory strategy without cues
4. 80% accuracy incorporating lingual sweeps after swallow
5. Increased attention to treatment tasks and strategies to 10 minutes with two cues

Plan

1. Therapeutic exercise: lingual coordination and accuracy exercises; thermal stimulation (97110)
2. Dysphagia treatment: compensation training and lingual sweeps (92526)
3. Cognitive skills development: attention training (97532)
4. As the patient progresses and skilled intervention becomes focused on safety at meals, carry-over of compensation strategies, and staff training goals, the plan may be expanded to include:
5. Functional therapeutic activity (97530)

Case Study #2

79-year-old male with history of CVA and right hemiplegia. Recent exacerbation aphasia secondary to TIA triggered a referral to speech pathology.

Assessment Problem List:

- Moderate auditory comprehension deficit
- Moderate to severe oral expression deficit
- Moderate to severe writing deficit

Short term goals

1. 80% accuracy comprehending 10 ADL directives
2. 80% accuracy verbally generating family names
3. 80% accuracy verbally generating 10 common phrases to direct situational ADLs
4. 80% accuracy graphically producing names of ADL objects
5. 80% accuracy responding to structured queries from staff with 10 common ADL phrases

Plan

1. Treatment of speech (92507)
2. Therapeutic activity: functional verbal and graphic applications (97530)
3. Treatment of speech, group (92508)

Case Study #3

- **70 year old male with a brainstem CVA resulting in high level quadriplegia and locked in syndrome. "Assumed" normal cognition but inability to communicate verbally, as well as the need to rely on eye blinks for functional communication was the impetus for a referral to an SLP for an AAC/SGD evaluation and recommendations.**

Assessment Problem List

- **Complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement**
- **Inability to speak or to make definitive vocalizations**
- **Inability to produce written communication**

Short term goals

1. Develop reliable control of switch or eye gaze to control AAC/SGD device at an accuracy level of 80%.
2. Develop 80% accuracy navigating the alphanumeric keyboard to generate language for 10 spontaneous (novel) messages.
3. Develop 80% accuracy graphically producing messages of 3-5 words in length.
4. Develop 80% accuracy directing 2/3 of the daily care with care givers using the AAC/SGD system.

Plan

1. Initial AAC/SGD assessment (92605) for first hour.
2. Additional AAC/SGD assessment (92608) for five hours (10 thirty minute segments) to complete the assessment.
3 Therapeutic services for use of AAC/SGD, including programming and modification (92609). Will need 10 hours of therapy for first phase.

Case Study # 4

A 63 year old male with a history of sore throat for 2 months and intermittent loss of voice during the past 20 day period. Had Otolaryngologist treatment with antibiotics during the last 6 months on 2 occasions. Ceased a 20 year smoking habit 5 years ago.

Assessment problem list

- Arytenoid edema and redness x4
- Inconsistent right true vocal fold movement
- Vocal fold edema and erythema
- Ventricular fold hyperfunction

Short term goals

1. Request approval of pharmacological intervention for 7 days
2. Initiate laryngeal pharyngeal reflux (LPR) diet with 90% compliance
3. Decrease ventricular fold hyperfunction by 80%
4. Refer to Otolaryngologist for biopsy of the true vocal folds

Plan

1. Videostroboscopy with rigid and flexible scope 31579
2. Laryngeal function studies 92520
3. Voice therapy intervention for vocal fold hyperfunction 92507

Questions & Answers ?