Getting Paid: Billing Codes
What You Need To Know
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Disclaimer
• The world of reimbursement is complicated, detailed, and changes often.
• The information presented in this short course is the latest available from a number of sources.
• Just the same, it is always prudent to confirm any billing information (codes to be used, etc) with the payer's provider relations department.

Sources
• ASHA Leader Bottom Line articles, available in every issue of The ASHA Leader.
• Coding and billing experience at CHSC
Public Health Insurers
In general, funded by tax revenues:
• Medicare
• Medicaid
• IDEA
• Bureau of Children with Medical Handicaps
• Bureau of Vocational Rehabilitation
• Bureau of Workers’ Compensation

Medicare
• 100% Federally-funded program
• Beneficiaries include those:
  – 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 (CORF) 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/

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 CCC in SLP granted by the ASHA; or
  – Meets educational requirements for certification and is 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

Medical Necessity
• Reasonable: appropriate amount, frequency, and duration of treatment per 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 SLP, that is, complex and sophisticated.
**Medicare Physician Fee Schedule (MPFS)**
- “full Medicare payment schedule” includes 80% Medicare pays and 20% patient co-payment
- Must adjust for your geographic location
- Many private insurers and Medicaid programs model payment plans from MPFS
- Appears in Final Rule in late fall for the following year

**Delay in 2014 Medicare Physician Fee Schedule**
- Due to the government shutdown, the 2014 MPFS was published around November 27th
- We will not be able to address exact rates for next year
- Check [www.asha.org/practice/reimbursement/medicare/feeschedule/](http://www.asha.org/practice/reimbursement/medicare/feeschedule/) for the latest information!

**The Medicare Physician Fee Schedule (MPFS)**
- RVU X Conversion Factor = Payment
- Conversion Factor recommended by CMS to Congress based on Sustainable Growth Rate
  - 2013 = $34.0376
- **2014 Conversion factor = 24.4% decrease**
- Affects all payments under the MPFS
- Congress typically takes action to prevent reduction

**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**

**Medicaid**
- The country’s largest single health program
- Jointly funded by the federal and state 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 provider qualifications
- Oversight of the State Medicaid plans
- Processes plan amendments and waiver requests from states
- Ensures program integrity

Medicaid - State Role

- Administers the program
- Determines beneficiary 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, even if the service isn’t available to the rest of the State’s population

Private Health Insurance

- Offered by commercial insurance companies (e.g., Aetna, Blue Cross/Blue Shield)
- Coverage can vary widely
- Exclusions can include:
  - Developmental speech disorders
  - Disorders that are not acquired
  - Habilitative services
- See also: www.asha.org/practice/reimbursement/private-plans/overview/

Overview of CPT & ICD

Two coding systems
- International Classification of Diseases (ICD)

Why and What

- 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
  - U.S. going to ICD-10 on October 1, 2014
- Procedural Codes – Describe what we DO with the client/patient
  - Current Procedural Terminology a.k.a. CPT codes
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 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 Hypermastality
- 784.69 Other symbolic dysfunction

Changes are Coming…ICD-10-CM

ICD-10 Begins October 1, 2014!
Will you be ready?

- 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/

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 Hypermastality

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/
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


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 now available for audiologists, SLPs, PTs, OTs, psychologists, 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

CPT Codes = $$$
- Professional work relative value units for CPT codes are assigned by the AMA Relative Value Update Committee (RUC)
- The RUC’s recommendations are based on survey data gathered from SLPs by ASHA.
- HCEC members defend the data we gather before the AMA-RUC

Example Skilled vs Unskilled Documentation: Treatment Note

**Goal**

Improve speech intelligibility of functional phrases to 75% with minimal verbal cues from listener.

**Unskilled treatment note**

Pt continues to present with unintelligible speech. Treatment included conversational practice. Recommend continue POC.

**Skilled treatment note**

Pt continues to have unintelligible speech production, unable to consistently make needs known. Intelligibility at single word level 60%, phrase level 30%. Pt benefits from SLP's verbal cues to reduce rate of speech and limit MLU to 1–2 words. Listener has better understanding if pt points to 1st letter of word first. Pt demonstrated improved self-awareness of intelligibility relative to last week’s session.
New Speech-Language Pathology Evaluation: CPT Codes

Bye-Bye 92506!

Reimbursement for New SLP Evaluation CPT Codes

- Reimbursement rates may be lower for each new code when compared to payment for 92506
- New codes are "subcomponents" of old "umbrella" code - 92506
- Now includes the professional work of the SLP
- Practice expense is decreased
- More on the new codes later!

Four New SLP Evaluation Codes Replace 92506 in 2014

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

CPT 92521: Clinical Example (vignette)

- A 7-year-old male presents with stuttering that includes behavioral (e.g., repetitions, prolongations, and blocks) and affective (e.g., avoidance and/or reduction of communication interaction) responses that negatively affect his communication function.

CPT 92522: Clinical Example

- A 6-year-old male presents with age-appropriate language comprehension and expression, yet his speech sound production is unintelligible and negatively affects his abilities to successfully communicate with others.
CPT 92523: Clinical Example

• A 5-year-old male presents with significant deficits of receptive, expressive, and social language and highly unintelligible speech sound production that limit his abilities to understand and communicate effectively in daily social and educational activities with family and peers.

CPT 92524: Clinical Example

• A 38-year-old female diagnosed with bilateral vocal cord nodules was referred for an evaluation of functional voice use and resonance to facilitate the design of a voice treatment plan. The patient complains of progressive hoarseness, inadequate projection, altered resonance, vocal fatigue, and tightness and pain in her throat that compromise her ability to communicate effectively.

More Information

See also: on.asha.org/new-SLP-codes: This site is continuously updated with new coding tips and FAQs.

Don’t Forget the Other Codes!

• CPT 96105: Assessment of aphasia (includes assessment of receptive and expressive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

Don’t Forget the Other Codes!

• CPT 96125: Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

Games Payers Play

• Setting reimbursement rates that are well below your actual costs = discourages access
• Slow walking (i.e., taking their time): credentialing your org., contracts, payments, reviews of denials (can take several months to get paid)
• Frequent, unannounced changes in billing practices: Onus is on your billing dept to keep checking for changes. (OCSHA on-line manual at Google Docs.)
• Denials based upon minutiae: “you didn’t put X in line 7”; reject claim for payment by doing corrections one at a time vs. all at once
Managing Denials

- Denial rate: can be as high as 21% and usually correlates directly with CEO’s compensation.
  - *The Higher Health Insurers’ Claim Denial Rate, the Higher the CEO Pay*, By Wendell Potter: April 23rd, 2013.

Increasing Level of Advocacy

- Contact insurer’s provider relations dept:
  - Never too early to start: Xavier calling provider relations to get coverage for “my ear hurts and I have a tummy ache.”
- Ohio Department of Insurance:
  - ODI has to take action if certain number of complaints are filed against a particular insurer
- Legislator from your district
- Media: “Live on 5”; “We’re on your side.”

Documentation

- Simple! If it’s not documented in the record/chart, it didn’t happen. Period!
  - “Oh, and btw we want all our money back, including the payments for others you’ve served. We are assuming that there was inadequate documentation for those patients/clients’ services as well.”
  - CHSC chart audits confirm 82 different factors
- Insurer provides specifics re: what documentation is required.

Writing Functional Goals

- Patient-centered
- Individually meaningful activities that a patient wants to accomplish through therapy but cannot perform as a result of injury, illness, congenital, or acquired condition
- Patients who focus on goals that are meaningful to them make the greatest gains in therapy.

From: *Writing Patient-Centered Functional Goals* (http://ptjournal.apta.org/content/80/12/1197.full)
Functional Goals

• Should be **measurable** and address:
  – Who
  – Will do what
  – Under what conditions
  – How well
  – By when

From: Writing Patient-Centered Functional Goals
(http://ptjournal.apta.org/content/80/12/1197.full)

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**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

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

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
    • 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**

<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 sinusity</td>
<td>$217.75</td>
<td>$159.71</td>
<td>$220.18</td>
</tr>
<tr>
<td>92507</td>
<td>Speech, ling, and pursed lip 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>Airway evaluation</td>
<td>$143.96</td>
<td>$117.43</td>
<td>$156.57</td>
</tr>
<tr>
<td>92512</td>
<td>Nasal function studies</td>
<td>$62.04</td>
<td>$45.05</td>
<td>$58.09</td>
</tr>
<tr>
<td>92520</td>
<td>Laryngeal function studies</td>
<td>$74.65</td>
<td>$54.74</td>
<td>$71.11</td>
</tr>
<tr>
<td>92526</td>
<td>Swallowing treatment</td>
<td>$77.23</td>
<td>$56.67</td>
<td>$70.21</td>
</tr>
<tr>
<td>92567</td>
<td>Voice prothesis evaluation</td>
<td>$69.07</td>
<td>$52.38</td>
<td>$68.05</td>
</tr>
</tbody>
</table>

**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
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

Basic guidelines for CPT & ICD coding

CODING RULES & TOOLS

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 the level of code specificity
- Codes are arranged by categories
- There are levels within each category
- Carry code to 5th digit whenever 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 Hypernasality
    - 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
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 principal 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
• ICD Home Page: www.cdc.gov/nchs/icd9.htm
• Questions: e-mail reimbursement@asha.org

How Do We Use CPT Codes?
National Correct Coding Initiative (CCI) Edits

• Automated edit system that applies to all provider settings
• CCI edits control which procedure codes can 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: CPT 92507 may only be billed one time per day in office or hospital OP settings
- For a complete list of SLP-related MUEs, see: www.asha.org/Practice/reimbursement/coding/Medically-Unlikely-Edits-SLP/

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 must reflect unusual and extenuating circumstances as well as the rationale for use of a modifier

Examples: Modifiers SLPs sometimes Use

- "-52" = an abbreviated procedure
- "-59" = two procedures distinct and separate
  - CPT 92526 (Dysphagia tx) & 97532 (Cog tx)
- "-22" = a much longer than usual procedure
- "-76" = 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 minutes
- www.asha.org/practice/reimbursement/coding/timedcodes.htm

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

- 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

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?
  - CPT 92506 Evaluation of speech, language, voice, communication, and/or auditory processing – 4x for each 15 minutes of the evaluation
  - CPT 92523 – once for the entire session

Scenario 2

- Patient seen for speech therapy
  - Articulation treatment
  - Oral-motor development
- How do you code the session?
  - 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
  - Only CPT 92507
  - 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 1

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

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 inclusive 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.
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
  • 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
• 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 4
• 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.

CPT Coding Resources
• CPT Codes for SLPs: www.asha.org/practice/reimbursement/coding/default.htm
• Questions: e-mail 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”

G-Codes for Swallowing Functional Limitation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8996</td>
<td>Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals</td>
</tr>
<tr>
<td>G8997</td>
<td>Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy</td>
</tr>
<tr>
<td>G8998</td>
<td>Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation</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

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>

Dr. Henri, my brain is full. May I be excused?
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

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

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/
- Questions? Contact Lisa Satterfield (lsatterfield@asha.org)

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>Code</th>
<th>Description</th>
<th>Total Payment</th>
<th>Total Payment w/MPPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Speech-lang tx, indiv</td>
<td>$32.07</td>
<td>$20.48</td>
</tr>
<tr>
<td>92526</td>
<td>Swallow tx</td>
<td>$33.06</td>
<td>$25.41</td>
</tr>
</tbody>
</table>

Medicare Physician Fee Schedule (MPFS)
Questions?

- www.asha.org/practice/reimbursement/coding/new codes_slp.htm
- Contact ASHA at reimbursement@asha.org

Advocacy in Audiology and Speech-Language Pathology

Advocacy Defined

Educating and influencing key decision makers concerning issues that are important to our clients/patients and to our profession.

Why Do We Need To Advocate?

- Competing for diminishing resources
- Ensuring patient/client access to care
- Improving quality of care
- Decreasing bureaucratic hurdles

Why Do We Need To Advocate?

- Educating decision makers
- Balancing concept of “basic needs”
- Counteracting impact of term limits
- Ensuring continued viability of A/SLP

Levels of Advocacy: National

ASHA’s Government Relations and Public Policy Board (GRPPB)
- Establishes ASHA’s annual Public Policy Agenda
- Four priority levels (On ASHA website)

Health Care Economics Committee
- Addresses coding and reimbursement issues
- Addresses health care “mega-trends”
  - E.g., Affordable Care Act
  - Medicaid program implementation

Levels of Advocacy: National

- ASHA STARS (State Advocates for Reimbursement) Network
  - Launched here in Ohio; now have STARS in nearly 50 states;
  - Addresses insurance companies coverage and reimbursements for A/SLP services
  - Now addresses all payers, public and private.
Levels of Advocacy: National

- ASHA SMAC (State Medicare Administrator Contractor) Network:
  - Similar to STARS, though smaller in number
  - Emphasis is on Medicare problems, e.g., cap on annual reimbursements ($1,880)

Levels of Advocacy: National

- Medicaid Subcommittee:
  - Of Health Care Economics Committee:
    - Identifies national Medicaid problems:
      - Documentation
      - Reimbursement & audits (MICs)
      - Managed Care contractors
      - Credentialing
      - Supervision
      - Medicaid Schools Program

Levels of Advocacy: National

- Medicaid Subcommittee cont’d:
  - Telemedicine
  - EPSDT
  - Medical necessity
- Goal is to resolve problems via national & state actions, and within ASHA membership
  - Developing national strategies and “toolkit”

Levels of Advocacy: National

- Tri-Alliance: ASHA, APTA, and AOTA
  - Addresses rehabilitation and therapy issues collaboratively at the national level, such as the Medicare $1880 cap;
  - On a PRN (as needed) status.

Recent Victories on National Issues:

- SLPs can now bill Medicare independently.
- Patients receiving SLP services under Medicare no longer need to see physician every 30 days.
- Medicare Plan of Care (POC) reauthorization every 90 days, rather than every 30 days.
Current National Issues

• Decreases in some Medicare payments
• Impact of $1,920 Medicare cap, which is still in place
• Expand reimbursement coverage for Audiology services under Medicare
• Medicaid payments “all over the place”
• Early Hearing Loss, Detection and Intervention (EHDI) bill signed by President Obama.

Current National Issues

• Impact of Patient Protection and Affordable Care Act of 2010
  - Now called Affordable Care Act (ACA)
  - Still learning how this legislation will affect A/SLP services;
  - Need to ensure coverage of habilitation & rehabilitation services;
  - ASHA is very much staying on top of this.

Levels of Advocacy: Ohio

• Ohio Speech Language & Hearing Association:
  - Legislative Advocacy Division
• Ohio Speech & Hearing Governmental Affairs Coalition (OSHGAC):
  - Oh. Speech-Language-Hearing Association
  - Oh. Council of Speech and Hearing Administrators
  - Oh. Academy of Audiology
  - Oh. School Speech Pathology Educational Audiology Coalition
  - Only such entity in US!

Ohio Speech-Hearing Governmental Affairs Coalition (OSHGAC)

Works with Governmental Policy Group: Ohio’s largest lobbying firm which:

• Provides guidance & reports to OSHGAC re: legislation, rules or regulations that affect SLP/A services and our clients/patients
• Facilitates meetings with elected and agency officials.

Current Issues in Ohio

– Biennial budget: impact on Regional Infant Hearing Programs (RIHPs) and Medicaid coverage.
– Medicaid re: hearing aids: coverage for digital aids for adults; kids have it.
– Medicaid rates and Medicaid HMOs: limited access, visits and payments
  • Providers will have to contract with 5 HMOs!
  • Launched July 1st, 2013.

Current Issues in Ohio

• Other Medicaid issues:
  • “Medical Necessity” now narrowly defined: illness, injury, or disease
  • Aud & SLP combined: 30 visits/yr
  • Five Medicaid HMOs across Ohio: new restrictions and problems
  • Several procedural problems with Medicaid HMOs: e.g., provider credentialing; authorizations; slow payments; “games”
US Dept of Justice vs. CareSource

- $26 MM finding vs. CareSource (Dayton OH) for:
  - Knowingly failing to provide services for beneficiaries with special health needs
  - Billing for services that were not provided (fraud)
  - Collecting unearned incentives

- Source: Gregg Blesch, Modern Healthcare (www.modernhealthcare.com), 2-1-2011

Current Issues in Ohio

- Oh. Dept of Education:
  - SLP shortages in certain areas of OH.
  - Recently-ended OMNIE funding for SLP interns program to address shortage
  - Caseload size, workload, documentation, and work environment issues

Legislative Reception

Please attend:
Columbus reception
In the State Office
Building: Capitol Atrium
April 8th, 2014

“Papa, I’m so happy that we’re almost done. This is just so much stuff!” - Caleb

Current Issues In County and Local Government

- Impact of declining county economies upon health and human services funding
- Financial stresses on county Developmental Disabilities boards
- Access to SLP services by Head Starts and other preschool settings (big problem in southern OH)

Impact of New State Budget

- Services to children usually take major hits, i.e., defunding:
  - Early Learning Initiative (ELI);
  - Help Me Grow (HMG);
  - Regional Infant Hearing Programs (RIHP)
    - Statewide: $1.5 MM down to $830,000.
    - CHSC: $375,000 down to $168,000.
    - Centers for the Deaf: $28,000 GRF
Who can advocate?
The client/patient is by far the most effective anyone affected by a law, policy, rule or regulation can advocate:
- Parent coalitions representing special needs populations:
  - MOMs (Mothers on a Mission)
- Clinicians
- Professional organizations, e.g., ASHA and OSLHA

Other Advocates
- Voices for Children
- Agency representatives, e.g., Head Start directors
- Educators: professors & teachers
- Administrators
- Lobbyists

Creating an Advocacy Plan
To influence public policy, you have to:
- Work closely with your lobbyists: absolute must!
- Be strategic—long range oriented;
- Identify a specific issue.

Creating an Advocacy Plan
- Focused—don’t hit legislators, gov’t officials with many concerns at once; shotgun approach doesn’t work.
- Do your homework: prepare, prepare, and then...prepare some more;
- Anticipate questions and prepare well supported answers.

Creating an Advocacy Plan
- Demonstrate the “Return on Investment.”
- Your issue must be “carried by a champion(s),”
- Need to follow through—success requires repeated meetings/contacts.
- HB 386 efforts: Bingo tickets for kids’ services

Creating an Advocacy Plan
- Go to ASHA’s website:
  - Over 160 Advocacy references!