Assuring Accuracy with Medicare Coding

Lisa Milliken, MA CCC-SLP
Mendi Lancaster, MS CCC-SLP, CBIS

Disclosures for Lisa Milliken
Lisa is a salaried employee of Select Rehabilitation
• She has no financial disclosures related to this course
• Nonfinancial disclosures include that she is a:
  o TSHA State Advocate for Medicare Policy, Liaison with ASHA
  o Chair of the TSHA Business Management Committee

Disclosures for Mendi Lancaster
Mendi is a salaried employee of Baylor Institute for Rehabilitation
• She has no financial disclosures related to this course
• Nonfinancial disclosures include that she is a:
  o TSHA State Advocate for Medicare Policy, Liaison with ASHA
  o Member of the TSHA Business Management Committee
  o Member of TSHA Medical Committee

Disclaimer
• The content contained in this presentation was current as of March 3, 2018. Insurance coverage guidelines, coding and billing requirements vary between insurers and change frequently. It is the responsibility of the provider to monitor their respective insurers for policy and procedure changes.
Learning Objectives

- List CPT coding rules per Novitas Solutions Local Coverage Determinations
- List ICD-10 rules for coding linguistic and cognitive communication.
- Identify the top coding and documentation mistakes that most often lead to denials.
- Identify ways to document skilled intervention to prevent denials.

Two Health Care Coding Systems

- **Diagnostic Codes**: Describe the REASON we are evaluating or treating the patient.
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10)
- **Procedure Codes**: Describe what we DO with the patient.

Purpose of Coding Systems

- Provide common language among providers, third party payers, and benefit administrators.
- Standardize descriptions of procedures, names of diagnoses, and names of supplies.
- Provide data for government to evaluate utilization patterns and appropriateness of health care costs.

CPT Coding Rules

*based on Novitas Solutions Local Coverage Determinations*
**Service-based or Untimed CPT Codes**

- Reimbursed same amount regardless of time spent delivering the service
- Can only bill one unit of each service-based code daily per discipline per patient
- Prices based on consensus from SLPs in ASHA survey that 45-60 minutes spent with patient
- Most ST codes are service-based or untimed

**Timed codes**

- Billed in per unit increments
- Documentation must support the time billed
- Examples:
  - **G0515** Cognitive skills development per 15 minutes (for Medicare only)
  - **96105** Assessment of aphasia per hour
  - **96125** Cognitive performance testing per hour
  - **92607** Eval for speech-generating device, first hour
  - **92608**, each addit. 30 minutes
  - **97533** Sensory integration per 15 minutes
- Medicare 8 minute rule: 1 unit: 8 minutes to < 23 minutes; 2 units: 23 minutes to < 38 minutes; 3 units: 38 minutes to < 53 minutes; 4 units: 53 minutes to < 68 minutes

**Coding Clarification--Edits**

- Some procedures are considered to be "mutually exclusive" and may not be billed together for the same patient on the same day:
  - **92507** (Speech, lang tx) and **G0515** (Cog tx)
  - **92607** (Eval SGD) and **97597** (Eval Voice Prosthetic)

**Medically Unlikely Edits (MUEs)**

- Subset of CCI edits for Medicare Part B and Medicaid claims
- The max number of times that a CPT code can be reported on the same day for the same patient
  - **92507** (Speech lang tx) may only be billed one time per day in office or hospital OP settings
  - **96125** can only be billed for 2 hours on same date of service; **96105** up to 3 hours
Examples of Modifiers Sometimes Used by SLPs

- "-52": an abbreviated procedure
  - 92523 (Eval of speech, lang) if only assessed language with no mention of motor speech
- "-22": a much longer than usual procedure

Coding Clarification--Modifiers

- -59 Distinct Procedural Service
  - For 2 procedures not ordinarily performed on the same day by the same practitioner, but under certain circumstances may be appropriate to perform
  - Severity Level Modifiers with G-codes for functional claims reporting
  - Who provided the service
    - GN: SLP
    - GO: OT
    - GP: PT

Scenarios Requiring -59 Modifier

- 92611 (MBS) & 92610 (Clinical swallow eval)
- 92526 (Dysphagia tx) & G0515 (Cog tx)
- 92508 (Group tx) & 92507 (Indiv tx)
- 92523 (Eval speech/lang) & 96105 (Aphasia Eval) or 96125 (Cognitive Eval)
- 92524 (Voice eval) & 96105 (Aphasia eval) or 96125 (Cognitive eval)
- 92607 (Eval SGD) & 92507 (Speech tx), 92508 (Group tx), 92521 (Eval fluency), 92522 (Eval speech), 92523 (Eval speech/lang), 92524 (Voice eval), 92609 (Therapy for SGD programming)

Rules for CPT Coding

- CMS uses automated edit system to control specific CPT code pairs that can and cannot be performed on the same day
- Updated annually:
  - http://www.asha.org/Practice/reimbursement/coding/CCI-Edit-Tables-SLP/
- New code modifiers to delineate whether service is habilitative (96) or rehabilitative (97)
- Functional limitation reporting (G codes)
Treatment Codes

Big change, effective 1/1/2018

- 97532 has been deleted/retired
- CMS (Medicare) is not allowing use of replaced 97127
- Other payer sources may accept 97127 but you must check with each one
- G0515 was added to the CMS therapy code list for 2018 with a “sometimes therapy” classification
- Until LCDs are posted by the Medicare Contractors, we cannot know the exact allowed usage of G0515

New Cognitive Code for NON-Medicare: 97127 Cognitive Function Intervention

- “Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem-solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks)”

97127

- Service-based code; billed only once per day
- Valued at a higher rate compared to timed code
- Follows same rules: cannot be used with 92507 or 92508
New Cognitive Code for Medicare: G0515

- Temporary code
- Mimics the original 15-minute timed CPT code 97532; Same descriptor; Same payment
- Still CANNOT use on same day of service as 92507 (Speech Treatment, indiv) or 92508 (Speech Treatment, group); CCI edits still apply
- This “G” code has nothing to do with claims-based functional outcome measures

Speech/hearing therapy (92507)

The treatment/intervention, (e.g., prevention, restoration, amelioration, and compensation) and follow-up services for disorders of speech, articulation, fluency and voice, language skills and the cognitive aspect of communication

1. Providing consultation, counseling, and making referrals when appropriate
2. Providing training and support to family members/caregivers and other communication partners of individuals with speech, voice, language, communication, fluency and hearing disabilities
3. Developing and establishing effective augmentative and alternative communication techniques and strategies, including selecting, prescribing and dispensing of aids and devices as identified by State Practice Acts; and training individuals, their family members/caregivers, and other communication partners in their use.
4. Establishing effective use of appropriate prosthetic/adaptive devices for speaking

5. Providing rehabilitation services for the auditory system, and related counseling services to individuals with hearing loss and to their family members/caregivers. Please see CR#5921, referenced in the CMS National Coverage Policy section, above, for further details. One portion of the instruction states: “Examples of rehabilitation include but are not limited to treatment that focuses on comprehension, and production of language in oral, signed or written modalities; speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile] training, communication strategies, education and counseling.”
6. Providing interventions for individuals with central auditory processing disorders; and /or
7. Modification or training in use of voice prosthetic. Modifications in voice prosthetic to supplement oral speech would be appropriate and should be carried out by a speech-language pathologist. The patient is seen for sizing, fitting, placement or replacement and training of the voice prosthetic.

How can 92507 cover the cognitive aspects?

- Is this cognitive decline affecting the person’s communication skills?
- Will the goals focus on communication, such as sequencing words or understanding directions or word finding skills/memory of words?
- Through 92507, we can address the cognitive aspect of language, which includes functional communication deficits secondary to cognitive deficits.
  (Unless the payer source is United Healthcare)
Speech/hearing therapy (group) (CPT code 92508)

- A group is defined as 2-4 patients receiving active therapy; patients may be performing the same therapy, or a different therapy, but the SLP is instructing all the patients in the group.
- The skills of the SLP must be required to safely or effectively carry out the group services.
- The group therapy satisfies all of the “reasonable and necessary criteria”
- Group therapy accounts for no more than 25% of the patient’s total time in therapy.

92508 (continued)

- Requires an individualized POC with goals to support and are integral to the achievement of the patient’s individualized goals.
- Cannot be performed on a day where cognitive rehab CPT G0515 for Medicare or new 97127 for non-Medicare is used.

Therapeutic services for the use of speech-generating devices (CPT code 92609)

- Patient adaptation and training for the use of speech-generating devices includes:
  - The development of operational competence in using a speech-generating device or aids.
  - To include customizing the features of the device to meet the specific communication needs of each patient and
  - Providing opportunities for developing skill in all aspects of device use.

Assessment Codes
8/19/2018

- **92521**: Evaluation of speech fluency (e.g., stuttering, cluttering)
- **92522**: Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- **92524**: Behavioral and qualitative analysis of voice and resonance

- **92610**: Eval Oral pharyngeal swallow
- **92607**: Eval Speech-generating device
- **31579**: Laryngoscopy with stroboscopy
- **92597**: Eval for use/fitting voice prosthetic device

**92523**: Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language).

- For patients that have language deficits OTHER THAN aphasia (Use 96105 Aphasia evaluation code for patients that have aphasia in need of standardized assessment to assist diagnosis and treatment planning)
- Can use for informal cognitive assessments paired with language assessments (blanket cognitive-linguistic eval)
- Must assess MOTOR speech: intelligibility, articulation, phonation, resonance, prosody and severity of impairment (can put WFL for all)
- If you do NOT assess MOTOR speech you must use -S2 modifier (abbreviated procedure); may be denied ***

**96105**: Assessment of aphasia including expressive and receptive speech and language function, motor speech abilities, reading, writing, spelling, etc.

- Timed code, includes interpretation and documentation of findings
- Examples: standardized assessments such as BDAE, WAB, Minnesota, paired with informal
**96125: Standardized** cognitive performance testing including memory, reasoning, sensory processing, visual perceptual, orientation, pragmatics, executive function

- Timed code, includes interpretation and documentation of findings
- **CANNOT BE USED WITH MEDICARE; WILL BE DENIED!**
- Examples: *standardized assessments* such as: RIPA, Rivermead Behavioral Memory Test, TOMAL, TONI, SCATBI, BADS, FAVRES
- These tests may be norm-referenced (results are interpreted based on established norms and compare test-takers to each other) or criterion-referenced (results are interpreted based on the person’s performance/ability to complete tasks or demonstrate knowledge of a specific topic).

**For Cognitive Performance Testing and Assessment of Aphasia**

- Used for **STANDARDIZED** assessment; can combine with non-standardized
- Can bill in multiples; **31 minutes to 1 hour = 1 hour; 91-151 minutes = 2 hours** which includes administration, interpretation and documentation
- If using **ONLY informal tools and lasts less than 31 minutes** it is considered screening and will be denied

**Can Multiple Eval CPT Codes Be Billed On the Same Day?**

- Yes if there is a need to evaluate multiple disorders at the same time and if there are no exclusion edits
- Documentation must reflect a **distinct and complete evaluation to support** each CPT code used
- Can NEVER bill 92522 (Eval of Speech) and 92523 (Eval of Speech and Language)

**Plan of Care Needs to Justify Need for Multiple Assessments/CPT Codes**

- If it is determined during the initial evaluation that additional testing is needed, this should be stated in assessment section with justification.
- **Example:** Visit 1 perform 92523 (Speech/Language evaluation) and recognize need to perform 96105 (Aphasia evaluation) to further assess type and extent of aphasia, than document that in initial POC.
- **Example:** Visit 1 perform 92610 Clinical swallow eval and recognize need to perform 92522 Speech sound production to assess dysarthria, than document that in initial POC.
Novitas-Related Coding Rules

Novitas Local Coverage Determinations (LCD): “rulebook”
- 3 active Local Coverage Determinations (LCD) policies for communication disorders and dysphagia services that list coverage limitations and codes that denote medical necessity (must have one of listed codes on script or POC to be covered; on speech shared drive under Novitas folder):
  - Barium Swallow Studies, Modified L35433
  - Dysphagia L34891
  - Communication Disorders L35070

Coding issues specific to Novitas
- Cognitive Performance Testing 96125 will be denied therefore use 92523 Eval of Speech and Language
- Must find covered diagnosis to perform MBSS (ie cannot just use Dysphagia R13.10 diagnosis) as need supporting diagnosis; if in doubt can use: R63.3 Feeding Difficulties)

Coding issues specific to Novitas
- Any code with * requires a supporting diagnosis
- For Cognitive (attention, memory etc) deficits following stroke, you must use additional diagnoses (ie other speech and language deficits following stroke...) due to *
Coding issues specific to Novitas

- "Not elsewhere classified" (NEC) is used when a condition is recorded to a level of specificity not identified by a specific code
  - Example: R47 Speech disturbances, not elsewhere classified
- Codes titled "other" or "other specified"
  - Use when information in medical record provides detail for why a specific code does not exist
  - Example: R48.9 Other symbolic dysfunctions

- Unspecified codes are often denied; "Not otherwise specified" (NOS) and "unspecified" (US) codes
  - Avoid using whenever possible
  - Use only when information in EMR is insufficient to assign a more specific code
  - Example: F03.9 Unspecified dementia

- The code must be listed in the Novitas Solution LCDs under "Covered codes"

Coding Exclusions when searching ICD 10 codes

- Excludes 1: indicates codes that may not be listed together
- Excludes 2: indicates codes that may be listed together, even if unrelated

New Exclusion 1: Patient with G31.84 Mild Cognitive Impairment

- CANNOT use with the R41 Codes (Cognitive Communication, Attention, Anterograde amnesia, Executive Function etc)
- ASHA recommends using R48.8 Other Symbolic Dysfunctions
Exclusion 2
- ICD codes R40-R46 Symptoms and signs involving cognition, perception, emotional state and behavior CAN be combined with F01-F99 Symptoms and signs constituting part of a pattern of a mental disorder
- R41.84 Cognitive Communication Deficit may be combined with:
  - G30.1 Deficits related to Alzheimer’s
  - F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
  - **R48.8 Other symbolic dysfunction may also be used with above

Why would these code combinations be denied?
- G31.84 & F02.81
  - Because F codes are some of the many excludes of G31.84
- F01.50 & R48.8
  - Because R48.8 must be paired with a neuro dx that is not a CVA, and there must be a positive prognosis to return to PLOC
- 92507 & G31.84
  - Either because there was no secondary Med dx to support G31.84 or the secondary code was an exclude of G31.84
- 92528 & R13.10
  - R13.10 is an unspecified code - meaning you don’t know the type of dysphagia
- 92507 & S30.81 (GERD)
  - GERD does not explain the need for a sp/lang treatment

When is R48.8 Other Symbolic dysfunction appropriate?
- **R48.8** can be used to capture neurological language impairments when there is documented neurological information to support the diagnosis. (E.g., TBI)
- Unless caused by stroke (I69.-)

Points to know about G31.84
- The next rule is to follow the LCD of the respective MAC.
- In other regions, (e.g., Novitas Solution) it is listed as a covered diagnosis, but only when used with an additional code to clarify the reason/diagnosis for SLP services.
What language or cognitive codes are appropriate when there is a CVA?

- Determine based on the type of CVA and the type of language or cognitive deficit

169.0 Sequelae of nontraumatic subarachnoid hemorrhage

- 169.010 *Attention following nontraumatic subarachnoid hemorrhage
- 169.011 *Memory following nontraumatic SAH
- 169.014 *Frontal lobe/executive function following n/t SAH
- 169.020 Aphasias following nontraumatic SAH
- 169.022 Dysarthria following nontraumatic SAH
- 169.023 Fluency disorder following nontraumatic SAH
- 169.028 Other speech language deficits following nontraumatic SAH
- 169.090 Apraxia following nontraumatic SAH
- 169.091 Dysphagia following nontraumatic SAH
- 169.092 Facial weakness following nontraumatic SAH

169.10 Sequelae of nontraumatic intracerebral hemorrhage

- 169.110 *Attention following nontraumatic intracerebral hemorrhage (ICH)
- 169.111 *Memory following….ICH
- 169.114 *Frontal lobe/executive functioning ….ICH
- 169.120 Aphasia following ….ICH
- 169.122 Dysarthria following ….ICH
- 169.123 Fluency disorder following ….ICH
- 169.128 Other speech language deficits following ….ICH
- 169.190 Apraxia following ….ICH
- 169.191 Dysphagia following ….ICH
- 169.192 Facial weakness following ….ICH

169.20 Sequelae of nontraumatic intracranial hemorrhage

- 169.210 *Attention following nontraumatic intracranial hemorrhage
- 169.211 *Memory following …intracranial hemorrhage
- 169.214 *Frontal lobe/executive functioning …intracranial...
- 169.220 Aphasia following … intracranial hemorrhage
- 169.222 Dysarthria following … intracranial hemorrhage
- 169.223 Fluency following … intracranial hemorrhage
- 169.228 Other speech language deficits following … intracranial hemorrhage
- 169.290 Apraxia following … intracranial hemorrhage
- 169.291 Dysphagia following … intracranial hemorrhage
- 169.292 Facial weakness … intracranial hemorrhage


**I69.30 Sequelae of cerebral infarction**
- I69.310 *Attention deficits following cerebral infarction
- I69.311 *Memory following cerebral infarction
- I69.314 *Frontal lobe/executive function following cerebral infarction
- I69.320 Aphasia following cerebral infarction
- I69.322 Dysarthria following cerebral infarction
- I69.323 Fluency disorder following cerebral infarction
- I69.328 Other speech and language deficits following cerebral infarction
- I69.391 Dysphagia following cerebral infarction
- I69.392 Facial weakness following cerebral infarction

**I69.80 Sequelae of other cerebrovascular disease: (if no medical history use these)**
- I69.810 *Attention following other CVD
- I69.811 *Memory following other CVD
- I69.814 *Frontal lobe/executive function following other CVD
- I69.820 Aphasia following other CVD
- I69.822 Dysarthria following other CVD
- I69.823 Fluency disorder following other CVD
- I69.828 Other speech and language deficits following other CVD
- I69.890 Apraxia following other CVD
- I69.891 Dysphagia following other CVD
- I69.892 Facial weakness following other CVD

---

Patient has cerebral infarction with cognitive deficits: Medical code: I63.8 (Other cerebral infarction)
- Since all of the cognitive deficits following stroke codes have an * we must add another diagnosis to support those codes. Since the cognitive limitations impact language use:
  - I69.328 Other speech and language deficits following cerebral infarction
  - I69.310 Attention/concentration deficit following cerebral infarction
  - I69.311 Memory deficit following cerebral infarction
  - Any other cognitive or language codes needed
- **DO NOT use R41.841 Cognitive Communication Deficits as this is ONLY for NON-stroke related cognitive deficits**

Patient has cerebral infarction with dysphagia: Medical Code I63.8
- Treatment Codes:
  - I69.391 Dysphagia following cerebral infarction
  - Type of Dysphagia: R13.12 Oropharyngeal dysphagia
MBSS orders must contain additional diagnosis other than dysphagia to support the MBSS:

- See LCD 35433 Barium Swallow, Modified
- Only Aspiration Pneumonia J69.0 and the Dysphagia following stroke codes can stand alone with a dysphagia code (R13.10-R13.19) otherwise must list additional diagnoses to support the exam:
  - R63.3 Feeding Difficulties
  - K21.9 GERD etc.

TBI with cognitive deficits: Medical

- **Medical**: (Examples...)
  - S06.0X0S Concussion without loss of consciousness, sequela
  - S06.0X1S Concussion with loss of consciousness <30 minutes, sequela
  - S06.2X0S Diffuse traumatic brain injury without loss of consciousness, sequela
  - S06.2X1S Diffuse traumatic brain injury with LOC <30 minutes, sequela
  - S06.6X1S Traumatic SAH with LOC <30 minutes, sequela

- **Treatment**: R41.841 Cognitive Communication Deficits
  - Can also add the specific cognitive deficits:
    - R41.841 Attention and Concentration Deficit
    - R41.844 Frontal Lobe and Executive Function Deficit
    - R41.1 Anterograde amnesia (New memories)
    - R41.2 Retrograde amnesia

What if you assess for dysarthria and patient appears WFL: what to code?

- R 47.1 Dysarthria along with whatever medical code is available
- Code the INTENT of the evaluation

ICD 10 resources

- [www.icd10data.com](http://www.icd10data.com)
- ASHA website: [http://www.asha.org/uploadedFiles/ICD-10-Codes-SLP.pdf](http://www.asha.org/uploadedFiles/ICD-10-Codes-SLP.pdf)
Top Coding Mistakes That Most Often Lead To Denials

“Documentation fails to support that services provided were medically reasonable and necessary.”

This is the most frequent denial statement and can be due to numerous issues from coding to lack of objective assessment data.

“This payment is adjusted based on the diagnosis.”

Example: the SLP used a Medical Dx code that was not listed on the list of covered codes in the LCDs, so all of the treatments were denied.

Appropriate CPT coding: some errors noted

- Charge 92523 Eval of Speech and Language without assessment or documentation of motor speech: Either need to do addendum and add the speech assessment (fully intelligible at conversation level with adequate breath support and phonation...) or add -52 modifier (see below)
- Charge 92522 Eval of Speech on evaluation and later need to do full blown cog-linguistic eval so charge 92523 at a later visit (Eval of Speech and Language)
- ****Must use -52 modifier, which is used when the services provided are reduced in comparison with the full description of the service and documenting in your note why the charge is shortened (because you already assessed speech)

- Charging for Cognitive Eval 96125: NOVITAS WILL DENY and many insurance companies are as well; charge 92523 and relate to language/communication making sure to assess language, speech too

- Accidentally charging Speech Treatment 92507 for Dysphagia Treatments 92526
- Charging for Speech Treatment 92507 and Cognitive Retraining 97127 or G0515
- Cannot do as this is called unbundling of services as speech treatment includes the cognitive aspects of language/communication; must use one or the other; cannot bill 92507 one day and then 97127 the next for the same task
- This rule is the same for groups: ST Group 92508 cannot be billed on same day as Cognitive Therapy 97127 for above reason

Documentation Pitfalls: lead to denial
Documentation is the KEY
- This is our only record of what we did and justification to be paid.
- It’s essentially the invoice/itemized statement to the payor who is reviewing it.
- We have to show thought process, progression, changes over time….

The Medical Reviewer…
- Does not see or know the patient so their review is based solely on what is recorded in your documentation.
- Your best defense is an offense….
  - Do it right up front and save the hassle of addendums and appeals down the road that may result in denials….

Documentation and Compliance
- Focus on function
- Write patient-centered functional goals
- Comply with Functional Outcomes Reporting with use of G-codes and severity modifiers using outcome tools for justification
- Write in terms payers, consumers, and other health care professionals can understand
- Tell why you want to improve a skill

Prior & Current Level of Function (PLOF & CLOF)
- Prior – (Pre-Morbid)
  - “Works 40 hours/week as a teacher, lives with spouse, manages finances and yard work, driving, Sunday school teacher and sings in church choir.”
- Current –
  - Unable to work (on disability) or drive. Wife handles financial matters due to cognitive decline, not able to attend church or any other outside social events due to physical and communication deficits.

Must demonstrate a need for skilled therapy services.
SMART Goals
- Specific
- Measurable
- Attainable
- Realistic
- Time-bound

Goals
- Tied to functional limitations and reported in a measurable format
- Relate to improvements in self-management, independence, communication and functional deficits (i.e. related to ADL’s, community, home management, functional communication, swallow safety, etc.)
- “In order to……”
- Do NOT mention return to WORK instead return to premorbid level of functioning
- Do NOT set goals to improve test results or to advance levels on API or an outcome measure. Instead put that into functional terms based on the intent of that test, treatment or measure
- Measurement: cues, level of complexity, percentages, assistance needed

Target Phrases for the functional component of goals
- To improve functional communication
- To improve cognitive-communication skills for increased safety and participation
- To improve voice production
- To improve swallow function
- To reduce risk of aspiration

Functional Goal Writing...
- Increase communication
- Patient to increase functional communication of simple ideas and needs to familiar caregiver using speech, gestures and augmentative device with minimal cues.
Increase airway protection

Patient will improve laryngeal elevation during swallowing to protect the airway. Mendolsohn maneuver and supraglottic swallow in 8/10 thin liquid swallows with minimal cues so that no liquid enters the lungs.

Do not set goal to return to work or to drive instead:

- On evaluation be specific in what premorbid level of functioning was re: work, coursework/load, financial matters, driving, I ADL’s etc
- LTG could be set to return patient to:
  - Premorbid level of functioning
  - Simplified premorbid level of functioning (doing some or bits and pieces of PLOF)
  - Modified premorbid level of functioning: (work as teacher’s aide instead of teacher)

Report objective data showing progress toward goal and relate to function:

- **Accuracy of task performance** (i.e., 50% accuracy in word retrieval in sentence completion tasks in order to increase functional communication)
- **Frequency/number of responses or occurrences** (i.e., Patient swallowed 6/10 trials of ½ tsp boluses of honey thick liquid with no delay in swallow initiation in order to decrease risk of aspiration)

Common Denials

- Stagnant therapy that does not change in complexity
- Lacking objective data
- Goals not updated
- Unskilled care and services (maintenance therapy)
- Missing documentation
- Services not reasonable and necessary
- Incorrect ICD 10 coding
- Forgetting G-codes
Dysphagia Pitfalls

- Do not set goals for “tolerate NMES” as this is a modality and your goals should be for their swallow function or strength, performance of exercises etc.
- Do not set goal to “tolerate MBSS” as this is your plan not patient’s goal.

Documenting Skilled Intervention To Prevent Denials

Which factors determine “Skilled Care”

- Use of expert knowledge for clinical decision-making
- Developing and modify treatment programs
- Must be medically necessary
- Training and instructing clients & caregivers
- Analyzing medical/behavioral data and select appropriate assessment tools to determine diagnosis and prognosis
- Design POC
- Develop/deliver therapy activities following hierarchy of complexity to achieve target skills for functional goal.

Skilled Care

- Modify activities to maintain patient motivation and facilitate success (complexity of task; cueing; criteria for successful performance (accuracy, reps, response latency)
- Introduce new tasks to evaluate patient’s ability to generalize skill
- Conduct ongoing assessment of progress to modify POC
- Explain rationale for treatment and expected results
- Develop maintenance program and training
Describe skilled intervention
Changes made to treatment due to assessment of patient’s needs, patient’s progress or regression
Reason for lack of progress and justification for continued therapy
Provide feedback about the performance including subjective changes (i.e. “He can now swallow without drooling.”)
Patient/caregiver’s accuracy, frequency of performing activities

Skilled Intervention Speech Examples
- To provide training for compensatory strategies for XXX, to maximize independence for return to premorbid home and community responsibilities.
- To provide restorative skill building for deficits outlined in assessment and provide compensatory strategy training for XXX to maximize independence with cognitive communication skills.
- To strengthen musculature through exercises and NMES in order to improve swallow function.

Ex note showing Skilled Care
“Patient performed tongue sweeps of buccal cavity with min cues on 80% of solid bolus trials to eliminate residue in mouth which puts patient at risk of aspirating the material.”

Skilled Care for Patients with Chronic or Degenerative Conditions
- Evaluate patient’s current functional performance
- Provide treatment to optimize current functional ability or to prevent deterioration
- To modify maintenance program
Maintenance: Jimmo vs. Sebelius Settlement
(1/24/2013)

Determined coverage NOT dependent on potential for improvement but rather on NEED FOR SKILLED CARE

- To improve patient’s current condition
- Maintain current condition
- Prevent or slow further deterioration of abilities
- Carry out communication or feeding activities
- NOT COVERED if maintenance care needs can be addressed through unskilled personnel or family

What is Unskilled Care?

- Report observations and behaviors without interpretation, analysis or clinical judgment
- Report on activities without connecting performance to patient’s goals
- Perform activities as instructed

Unskilled Care

- When there is no connection between task and long or short term goals
- Observing caregivers with no education, feedback or modification of plan of care
- Reporting performance by patient on carryover activities without education, feedback, or modification of instructions to caregiver/patient

Ex of Unskilled Documentation

- Repetition of the same activities as in previous sessions without notation of modifications, cueing level, or observations that would change plan of care
- Report on performance during activities with no description of modification, cueing level, feedback or caregiver training provided during the session
- Report on performance that reflects patient’s skill level is static, with no notation of modifications to activities and cueing level
Example of Documentation of Unskilled Care

- Patient performed 10 reps of oral motor exercises.
- PO trials of thin liquid performed.
- Vitalstim used on placement 2b at 15 mAmmps.

Example Skilled Dysphagia Daily Note in SNF:

92526: Skilled ST implemented dysphagia management in order to provide education and dysphagia management exercises. Implemented pharyngeal function exercises with increased resistance to address pharyngeal and base of tongue musculature. Exercises assisted with increased base of tongue retraction and pharyngeal contraction. Educated resident regarding reasons for exercises.

Example Skilled Cog-Comm Daily Note in SNF:

92507: Skilled ST facilitated cognitive training in order to address recall. SLP implemented spaced retrieval and repetition. Resident with accurate recall verbally with use of strategies and use of carrier phrases minimally, but required moderate/max verbal/cues for task execution 80-100% of the time. Visual cues increased accuracy with task execution. Resident requires visual and verbal cues for accurate carryover of therapeutic activity.

Example Unskilled Daily Notes in SNF

- The patient was seen for therapy in the speech office. She was alert, oriented x2, and participated well in therapy.
- Patient seen for therapy to address expressive language. Patient communicated wants and needs with nursing staff with maximum verbal and picture cues.

Where’s the professional required skills of a SLP?
If Cognitive Therapy is NOT a covered benefit

- **DO NOT** bill payer unless:
  - Focus of treatment is on cognitive-communication and the POC and goals are **language-based** you can bill 92507 Speech Therapy

UHC Denials

- UHC claims to cover speech therapy 92507 to:
  - Diagnoses of TBI or BI due to CVA, aneurysm, anoxia, encephalitis, brain tumors and brain toxins, vocal cord injury, CP, encephalopathy
  - Services related to language, speech and communication
  - Documentation that hinges on **cognitive deficits and goals** while charging 92507 (Speech Therapy) as they think we should charge Cognitive Function Intervention 97127
  - Solution: focus more on the communication and language aspects making sure to highlight language and speech and charge 92507 (Speech Therapy); make sure that you have an ICD-10 code “other speech and language” deficits following stroke or Cognitive-Communication Deficits R41.941 to support in addition to the other cognitive deficits following stroke codes

UHC non-coverage

- For diagnosis other than TBI or BI due to CVA, aneurysm, anoxia, encephalitis, brain tumors and brain toxins, vocal cord injury, CP, encephalopathy: UHC is **NOT covering** for speech 92507 or cognitive 97127
UHC: Cognitive Rehabilitation on Fully-Funded Plans ("underwritten by")

- Unproven and not medically necessary for CP, Down Syndrome, Alzheimer’s disease, Parkinson’s.
- **State mandates**: Medically necessary for treatment of TBI or BI due to CVA, aneurysm, anoxia, encephalitis, brain tumors and brain toxins to include:
  - Intervention for functional communication deficits including pragmatic conversational skills
  - Compensatory memory training
- Documentation that hones in on cognitive deficits and goals while charging 92507 (Speech Therapy) is being denied stating "incorrect code billed" therefore we need to charge 97127 Cognitive Function Intervention which these plans **COVER** for cognitive related problems and tasks; covers 92507 Speech for speech and language deficits

UHC: Cognitive Rehabilitation on Self-Funded Plans ("administered by"): UHC Choice Plus...

- Plan **excludes state mandates** because it is a consumer choice plan or an association plan
- Will **NOT** cover cognitive rehabilitation regardless of the diagnosis
  - 97127 is **NOT** covered
  - Documentation that hones in on cognitive deficits and goals while charging 92507 (Speech Therapy) is being denied stating "incorrect code billed" as they think we should charge Cognitive Function Intervention 97127 which these plans **WILL NOT COVER**
- Solution: focus more on the communication and language aspects making sure to highlight language and speech and charge 92507 (Speech Therapy); make sure that you have an ICD-10 code "other speech and language" deficits following stroke or Cognitive-Communication Deficits R41.841 to support in addition to the other cognitive deficits following stroke codes

Questions?

Imilliken@selectrehab.com
MeLancaster@BSWRehab.com