MEDICARE: ISSUES, REIMBURSEMENT, CODING AND OUTCOMES, PART 2

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ASHA Director, Health Care Regulatory Advocacy

DISCLOSURES

Financial
• ASHA Employee
  • Receive salary compensation

Non-Financial
• Lobbyist for ASHA with Centers for Medicare and Medicaid Services
  • No compensation
AGENDA

Part 1  Legs & Regs
Legislation & Regulation
Medicare 101
Payment Systems
Terminology
Documentation

Part 2  Application
Local Coverage Determinations
Quality and Outcomes
  • G-Codes
  • PQRS
Audits and Review

LOCAL COVERAGE DETERMINATIONS

• L33065
• L31533
• L31990 (Psych)
• L27039
**LCDS**

* Regional policies that define medical necessity
  * CPT codes
  * ICD codes
  * Definitions
* Medicare Administrative Contractors (MACs)
  * WPS – Part A and B
  * Palmetto – Home Health
  * NGS - Devices

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**LCD 33065: A/B DYSPHAGIA**

SLPs must meet the education and experience requirements of ASHA CCC

May also be performed by Occupational Therapists

Evaluations should address:

- History
- Prior level of swallowing function and diet
- Previous swallow treatment
- Current eating status (dietary restrictions)
- Cognition, motivation
- Positioning
- Coughing/choking
- Oral motor function, muscle tone, sensitivity
LCD 33065

CPT Codes:
74230: Swallow function with cine/videoradiography
92526: Treatment swallow
92610: Eval of oral & pharyngeal
92611 – 92617: FEES
92700: Unlisted procedure
97150: Therapeutic procedures for 2 or more individuals

ICD:
438.82: Dysphagia, cerebrovascular
787.21: Dysphagia, oral phase
787.22: Dysphagia, oropharyngeal
787.23: Dysphagia, pharyngeal phase
787.24: Dysphagia, pharyngoesophageal
787.29: other dysphagia

LCD 31533: HOME HEALTH SPEECH

Rehabilitation therapy
- “Skilled therapy must be reasonably expected to improve the patient’s functional capacity…”

Maintenance therapy
- “Even if no improvement is expected…skilled therapy services are covered when an individualized assessment of the patient’s condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program”

Re-evaluation
- Re-evaluation is reasonable when there is a
  - Change in functional speech or motivation
  - Clearing of confusion
  - The remission of another medical condition
L31533

CPT Codes

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>92507</td>
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<tr>
<td>92526</td>
<td>92627</td>
<td>97110</td>
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</table>

LCD 31533

ICD codes (too many to list)
- Dementia
- Fluency
- Developmental delay
- Abnormal auditory perception
- Hearing loss
- Apraxia
- Dysphagia
- Dentofacial functional abnormality
- Aphasia
- Hypernasality
- Cough
LCD 31990 (PSYCHOLOGY)

Covers assessment of aphasia (96105) and standardized cognitive test (96125)

Does not limit by ICD code or indicate limitations (or inclusion) for speech-language pathology

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LCD 27039: SGDS

Includes the requirements for coverage of Speech-Generating Devices
- Current communication impairment type
- Assessment of other natural modes of communication
- Functional communication goals
- Rationale for selected device
- Treatment plan and training schedule
- Cognitive and physical abilities
- If an upgrade, functional justification

- No limitations with diagnosis
NEW LCDS: OCTOBER 2014

LCDs are being updated to include ICD-10

State Medicare Administrative Contract (SMAC) Network is reaching out to MACs with “Ideal LCD”

Indiana: Not in bad shape with the current LCDs

SMAC

Susan Rockafellow (SLP)
http://www.asha.org/Practice/reimbursement/medicare/SMAC/
QUALITY AND OUTCOMES

REPORTING IS REQUIRED FOR

ALL Outpatient Services, including

• Comprehensive outpatient rehabilitation facilities (CORFs)
• Hospital patients who are not in a covered Part A stay, such as observation status
• Skilled nursing facilities not in a covered Part A stay
• Nonresidents who receive outpatient services
• Home health agencies for individuals who are not homebound or otherwise are not receiving services under a home health plan of care
REPORTING IS REQUIRED AT

Admission, or the 1st visit, including evaluation
Every 10th treatment day, at least on or before
* Consistent with documentation requirements for progress note every 10th treatment day
Every evaluation
Discharge

G-CODES FOR SWALLOWING

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

<table>
<thead>
<tr>
<th>Claim Modifier</th>
<th>Percent Impairment</th>
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<tbody>
<tr>
<td>CH</td>
<td>0% impaired</td>
</tr>
<tr>
<td>CI</td>
<td>1 - 20%</td>
</tr>
<tr>
<td>CJ</td>
<td>20 - 40%</td>
</tr>
<tr>
<td>CK</td>
<td>40 - 60%</td>
</tr>
<tr>
<td>CL</td>
<td>60 – 80%</td>
</tr>
<tr>
<td>CM</td>
<td>80 – 99%</td>
</tr>
<tr>
<td>CN</td>
<td>100% impaired</td>
</tr>
</tbody>
</table>

MULTIPLE EVALUATIONS!

“The reporting of all 3 G-codes for the evaluative procedure for a second functional limitation and the ongoing reporting of a primary functional limitation can both occur on the same date of service.” Functional Reporting: PT, OT, and SLP Services Frequently Asked Questions (FAQs)

If an evaluation is performed on the same date of service that an on-going functional condition is reported, the claim should include both sets of functional conditions.

If two evaluations are billed, each one should include functional reporting.

Only one condition will continue to be reported as the primary condition.
EXAMPLE
You evaluate patient for speech/language, cognition, and swallowing. Speech/language is "primary" condition

<table>
<thead>
<tr>
<th>92523</th>
<th>96125</th>
<th>92610</th>
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</thead>
<tbody>
<tr>
<td>G9159 - CL</td>
<td>G9168 - CL</td>
<td>G8996 - CK</td>
</tr>
<tr>
<td>G9160 - CI</td>
<td>G9169 - CJ</td>
<td>G8997 - CI</td>
</tr>
<tr>
<td></td>
<td>G9170 - CL</td>
<td>G8998 - CK</td>
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</table>

PQRS ELIGIBILITY

Providers
Private Practice
Group Practice
University clinics

NOT
- Hospitals
- Skilled Nursing Facilities
- Medical centers
- ACOs

Patients
Medicare Part B
- Outpatient
- Fee-for-service

Measure requirements
- Age (e.g. 18 and older)
- Denominator
- CPT codes
- ICD codes
WHY PARTICIPATE?

2015 participation = \(-2.0\%\) on all Medicare Part B services provided in 2017
Proposed 2016 participation = \(-6.0\%\) on all Medicare Part B services provided in 2018

Congress is looking at further expansion

DOCUMENTATION OF MEDICATION (#130)

Perform on 50% of the Medicare eligible patient visits to avoid penalties

Ask the patient to bring a list of current medications: dosage, frequency, route
  * Make a copy or scan it into the patient’s chart
  * Provider must document he/she reviewed the list
    * Not a pharmacological assessment

For every patient visit, ask the patient if there have been changes to medications and document

If the patient reports no medications, document
#130 PROCEDURE CODES

**Speech-Language Pathology**

Speech/language treatment:
92507 92508

Swallowing treatment:
92526

Auditory rehab assessment:
92626

Cognitive treatment:
97532

REPORTING MEASURE #130

- Medications obtained, updated, or reviewed
  - **G8427**

- Medications not obtained, updated, or reviewed, reason unspecified
  - **G8428**

- Patient not eligible due to emergent situation
  - **G8430**
PAIN ASSESSMENT (#131)

Must use standardized tool for the presence and characteristics of pain
  * Tool must be normalized and validated for population which it is used

Must document a follow-up plan for positive findings, which includes:
  * Follow-up appointment for reassessment OR
  * Referral to other health care provider(s)

Report for each eligible patient visit

This measure should not be reported by SLPs who are not familiar with or do not regularly use standardized pain assessments in their clinical practices

# 131 PROCEDURE CODES

<table>
<thead>
<tr>
<th>Speech-Language Pathology</th>
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<tbody>
<tr>
<td>Speech/language treatment:</td>
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<tr>
<td>92507 92508</td>
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<tr>
<td>Swallowing treatment:</td>
</tr>
<tr>
<td>92526</td>
</tr>
<tr>
<td>Cognitive treatment:</td>
</tr>
<tr>
<td>97532</td>
</tr>
</tbody>
</table>
CLAIM EXAMPLE WITH PQRS

FUTURE FOR REPORTING

<table>
<thead>
<tr>
<th>Year</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>2015</td>
<td>Targeted manual medical reviews for claims over $3,700 (no later than 90 days after the date of enactment)</td>
</tr>
<tr>
<td>2016</td>
<td>CMS must draft and finalize a measure development plan</td>
</tr>
<tr>
<td></td>
<td>Claims data available for QCDRs to calculate risk/outcomes</td>
</tr>
<tr>
<td>2017</td>
<td>Quarterly performance reports for PQRS and Resource Use</td>
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<tr>
<td></td>
<td>Resource measures for analysis in 2019</td>
</tr>
<tr>
<td>2018</td>
<td>Episode grouper and patient relationship codes on the claim</td>
</tr>
<tr>
<td></td>
<td>Value-based payment modifier is sunset for services after Dec 31, 2018</td>
</tr>
<tr>
<td></td>
<td>QCDR for audiologists/SLPs for transition from claims to registry/EHR</td>
</tr>
<tr>
<td>2019</td>
<td>Analysis for Resource use</td>
</tr>
<tr>
<td></td>
<td>Performance period for 2021 MIPS payment adjustment</td>
</tr>
<tr>
<td>2021</td>
<td>MIPS payment adjustment applies</td>
</tr>
<tr>
<td></td>
<td>Meaningful use EHR required</td>
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</table>
MIPS

✓ Merit-Based Incentive Payment System combines:
  ✓ Electronic Health Records
  ✓ Quality Reporting (PQRS)
  ✓ Value-based Modifier (resource use)
  ✓ SLPs and Audiologists become eligible providers in Year #3
  ✓ Must meet a minimum number of claims (15???)
  ✓ Newly enrolled providers exempt for 1 year
  ✓ If payment for services is from an Alternative Payment Model, except from MIPS

PERFORMANCE CATEGORIES

Quality
* PQRS or Qualified Clinical Data Registries

Resource Use
* Calculations to determine cost of providing services

Clinical Improvement Activities
* Expanded office hours, plan of care development

Electronic Health Records
* Medicare approved system
PERFORMANCE STANDARDS

Composite score for each individual 0-100
Adjustment factors raise from 4% to 9% (negative)
Positive adjustment to be determined
Scores must be published on the Physician Compare website

NEW CLASSIFICATION CODES

✓ Patient relationship categories on the claim
✓ Primary practitioner for overall care
✓ Lead practitioner for episode of care
✓ Supporting rule during acute episode
✓ Provides occasional service upon request of physician
✓ Provides services or items as ordered by a physician
MEASURE DEVELOPMENT

Priority for
  * Outcome measures
  * Patient experience
  * Care Coordination
  * Appropriate use/overuse

In the domains of
  * Clinical care
  * Safety
  * Care coordination
  * Patient and caregiver experience
  * Population health and prevention

ASHA PLANS

Have a registry system for SLPs and audiologists that is:
  * Clinically meaningful
  * Not a burden to the clinician to enter data
  * Meets Medicare requirements (minimal expectation)
  * Includes patient-reported outcomes
  * Works with electronic health records (future)

  * Ready for Medicare purposes by early 2018
IMPACT ACT

Law signed in October, 2014 that requires Post-Acute Care (PAC) to have interoperable, standardized data for patient condition and outcomes

- Intent to inform consumers of PAC options
- Intent to help physicians determine most appropriate PAC setting
- Data follows the patient
- Outcomes capture data for site-neutral payment

AUDITS AND REVIEW

✓ Fraud and Abuse
✓ Skilled/Unskilled
DOCUMENATATION

If you didn’t document it, it didn’t happen!

AUDIT PROOF DOCUMENTATION

“Insufficient documentation” has been cited by Medicare as the 2nd highest cause for improper payment

Documentation did not match the claim or was not detailed enough to justify the services that were billed

Match the claim!!!
FRAUD

Making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person’s own benefit or for the benefit of some other party.

Examples of Medicare fraud may include:
- Knowingly billing for services that were not furnished and/or supplies not provided, including billing Medicare for appointments that the patient failed to keep
- Knowingly altering claims forms and/or receipts to receive a higher payment amount.

- Medicare Fraud & Abuse:
  Prevention, Detection, and Reporting

ABUSE

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Examples of Medicare abuse may include:
- Misusing codes on a claim
- Charging excessively for services or supplies
- Billing for services that were not medically necessary

- Medicare Fraud & Abuse:
  Prevention, Detection, and Reporting
MEDICARE FRAUD AND ABUSE LAWS

False Claims Act
- Civil liability who knowingly submits a false or fraudulent claim, including by “deliberate ignorance” or “reckless disregard”

Anti-Kickback Statute
- Criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.

Physician Self-Referral Law (Stark Law)
- Prohibits a physician from making a referral for certain designated health services to an entity in which the physician has an ownership/investment interest or a compensation arrangement

MEDICARE CLAIMS AUDITORS

Medicare Administrative Contractors (MACs)
- Regionally manage policy and payment
- Can perform medical reviews for all claims at their discretion

Recovery Audit Contractors (RACs)
- Incentivized for recovery of funds

Comprehensive Error Rate Testing (CERT) contractors
- Statistically analyze estimates of improper payments
- Not required to notify providers of their intention to begin a review

Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractor (PSCs)
OTHER TYPES OF FRAUD AND ABUSE

Unreported income or insurance
Drug seeking behavior or incarceration
Services never provided
Provider billing irregularities or errors
Over utilization of health care services
Misrepresentation of credentials

OTHER TYPES OF HEALTHCARE AUDITS

Medicare and Medicaid – Survey and Certification (Provider Enrollment)
- Has failed to supply information necessary
- Refuses to permit examination of fiscal and other records (including medical records)
- Refuses to permit photocopying of any records

HIPAA Privacy, Security, and Breach Notification Audit Program
MANUAL MEDICAL REVIEW

Therapy claims that reach $3,700 are automatically suspended for medical review
$3,700 includes SLP and PT services combined
Total is based on fee schedule amount, including deductible

Lack of Recovery Audit Contractors and new legislation has put MMR on hold.

QUESTIONS?

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