COURSE DESCRIPTION
Providing high quality documentation of skilled services to Medicare beneficiaries begins with an adequate understanding of regulations set forth via the Medicare Benefit Policy Manual and Local Coverage Determinations (LCDs) in regards to key areas including:
- skilled versus non-skilled procedures;
- traditional interventions versus maintenance based plans of care
- establishing interventions to promote return from baseline to prior level of function
- initiating caregiver training to promote carryover of skilled interventions upon discharge from care
- and documenting outcomes of reasonable and necessary services via goal targets which are functional and measureable.

OBJECTIVES:
1. Participant will be able to create functional goal targets to promote reimbursement of services and evidence outcomes.
2. Participant will be able to identify key areas for documenting reasonable and necessary services.
3. Participant will be able to describe procedures which support skilled care.

CODING: YOUR FIRST DEFENSE

CPT: Evaluation Codes
**EVALUATION OF ORAL & PHARYNGEAL SWALLOWING FUNCTION**

Medicare Benefit Policy Manual (MBPM), Dysphagia Defined:
Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and dehydration with resultant weight loss, failure to thrive, pneumonia, and death. It is most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neoplasm, or degenerative diseases of the head and neck, cancer, dementia, and encephalopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment (1).

MBPM, Swallowing Assessment Inclusions:
Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience, and demonstrated competencies. Competencies include but are not limited to:

- Identifying abnormal upper aerodigestive tract structure and function
- Conducting oral, pharyngeal, laryngeal and respiratory function examinations as it relates to the functional assessment of swallowing
- Recommending methods of oral intake and risk precautions
- Developing a treatment plan employing appropriate compensations and therapy techniques (1)

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**NEW EVALUATION CODES 2014**

**Background**
Effective January 1, 2014, Current Procedural Terminology (CPT, © American Medical Association) for code 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) will be deleted and replaced with four new, more specific evaluation codes related to language, speech sound production, voice and resonance, and fluency disorders.

**WHEN SHOULD I START USING THE NEW CODES?**

- You should have started using the new codes for billing patients on or after January 1, 2014.

**WHY DID FOUR NEW CODES REPLACE CPT 92506?**

- The four new evaluation codes were developed by ASHA’s Health Care Economics Committee (HCEC) in collaboration with experts in the field from ASHA’s Special Interest Groups.
- The HCEC has been working with the American Medical Association (AMA) to change most speech-language pathology codes since 2009, when new law took effect that allows private practice SLPs to bill Medica directly for their services. Because of that change, the AMA’s Relative Value Update Committee re-evaluated speech-language pathology codes to include “professional work” value (one of three components of a code’s value that reflects the amount of time, technical skill, physical effort, stress, and judgment required to provide the service). Prior to 2009, SLPs were considered “technical support” and their work was included in the “practice expense” component of the code’s reimbursement formula. During this process, the RUC recognized that CPT 92506 reflected more than one procedure, this recognition gave ASHA an opportunity to develop specific evaluation procedure codes to replace 92506 and more accurately and appropriately value the professional work performed.

**NEW CODES DEFINED**

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

**CAN NEW CODES BE BILLED TOGETHER SAME DAY?**

- The CPT Handbook does not include language to restrict an SLP’s ability to bill these codes together because there are circumstances when it is appropriate for a patient to be evaluated for multiple disorders on the same day.
- Note—In those cases, documentation should clearly reflect a complete and distinct evaluation for each disorder.
92521 - EVALUATION OF SPEECH FLUENCY

- Inclusions: Evaluation of Stuttering and Cluttering
- The following disorders are typically non-covered for the geriatric Medicare beneficiary:
  - Fluency disorder
  - Dysprosody
  - Stuttering and clapping (except neurogenic stuttering caused by acquired brain damage)

92522 - EVALUATION OF SPEECH SOUND PRODUCTION

- Inclusions: Articulation, Phonological Process, Apraxia, Dysarthria

92523 - EVAL OF SPEECH SOUND PRODUCTION WITH EVAL OF LANGUAGE COMPREHENSION AND EXPRESSION

- Inclusions: Articulation, Phonological Processes, Apraxia, Dysarthria; Receptive and Expressive Language

92523 IS COMBINED SPEECH SOUND PRODUCTION AND LANGUAGE? WHAT IF I ONLY EVALUATE LANGUAGE?

- If two or more procedures are billed together at least 51% of the time, it is standard to develop a bundled CPT code for that set of services.
- ASHA surveyed practices and clinics and confirmed that evaluations for language are accompanied by evaluations for speech sound production 80% of the time. However, the reverse is not true. It is common for speech sound production abilities to be evaluated independent of a language evaluation, which is why there is a stand-alone code for speech sound production evaluation.
- If a patient is evaluated only for language, SLPs should bill 92523 with the -52 modifier, which is used when the services provided are reduced in comparison with the full description of the service.

CAN I BILL 92522 AND 92523 SAME DAY?

No, you may only bill one or the other. A speech sound production evaluation (CPT 92522) is already included as a part of CPT 92523 (speech sound production evaluation with language evaluation).

92524 BEHAVIORAL & QUALITATIVE ANALYSIS OF VOICE & RESONANCE

Q: Does CPT 92524 (behavioral and qualitative analysis of voice and resonance) include instrumental assessments?

A: No. There are separate codes for instrumental assessments, such as CPT 92520 for laryngeal function studies.
ONE HOUR TIME BASED EVAL CODES

- 92626- Evaluation of Auditory Rehabilitation Status; First Hour
- 92627 Evaluation of Auditory Rehabilitation Status; Each addition 30 minutes
- 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. Per Hour.
- 96105- Assessment of Aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling and/or writing ex. by BDAE) with interpretation and report. Per Hour
- 92607 Evaluation for prescription for speech-generating AAC device face to face with the patient. First Hour.
- 92608 Evaluation for prescription for speech-generating AAC device face to face with the patient. Each additional 30 minutes.

92626- EVALUATION OF AUDITORY REHAB STATUS

Inclusions: Evaluation and treatment for disorders of the auditory system may be covered and medically necessary for example, when it has been determined by a speech-language pathologist in collaboration with an audiologist that the hearing impaired beneficiary’s current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient’s functional communication needs. Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologists may provide treatment.

96125- STANDARDIZED COGNITIVE PERFORMANCE TESTING

Inclusions: 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. Per Hour

Includes criterion referenced measures which combine standardized measures

96105- ASSESSMENT OF APHASIA

Inclusions: Assessment of Aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling and/or writing ex. by BDAE) with interpretation and report. Per Hour

BILLING TIME BASED CODES

Codes are timed and based on ONE HOUR increments. The number of units billed are based on time:
- 0 units = 0-30 minutes
- 1 unit = 31-90 minutes and
- 2 units = 91-150 minutes and soon.

Billing below 31 minutes is not recommended.

TIME BASED: MED A VERSUS MED B

- Medicare Part A
  - MDS Section O: Rules for Recording Treatment Minutes (Add Manual, Chapter 9, Section D; directly quoted text is in italics)
    - The therapist’s time spent on documentation or an initial evaluation is not included (Page O 17)
    - The therapist’s time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted (Page O 17)

- Medicare Part B
  - 96105 and 96125 billing for Medicare Part B beneficiaries follows the definition of codes set forth per LCD definitions therefore allowing ST to account for interpretation time in assessment.

http://www.asha.org/Practice/reimbursement/medicare/Medicare‐Guidance‐for‐SLP‐Services‐in‐Skilled‐Nursing‐Facilities/
96105/96125 "INTERPRETATION TIME" MED B

- 96105/96125 definitions include language which allows therapist to count interpretation for review of data obtained during evaluation.
- 96125 allows for use of norm-referenced (results are interpreted based on established norms and compare test-takers to each other) and/or criterion-referenced (results are interpreted based on the person’s performance/ability to complete tasks or demonstrate knowledge of a specific topic).
- 96105 allows for norm-referenced measures from standardized assessment of Aphasia (e.g. BDAE)

92607- EVALUATION FOR PRESCRIPTION FOR SPEECH GENERATING AAC DEVICE

- Inclusions- Evaluation for prescription for speech-generating AAC device face to face with the patient- First Hour Rec 31 mins minimum
  - 92607 Evaluation for prescription for speech-generating AAC device face to face with the patient. Each additional 30 minutes.
- Potential ICD-9 Codes appropriate for use
  - Code the underlying cognitive, expressive/receptive language, and/or motor-speech impairment that necessitates need for AAC device.

CASE STUDIES- EVAL CODING

Ms. Jones requires evaluation of expressive/receptive language; motor speech and voice secondary to progression of Parkinson’s disease.

Coding:
- 92523 and 92522
- 92523 and 92524
- 92522 and 92524

CASE STUDIES

Mr. Smith is admitted to SNF following acute onset of RCV requiring standardized measure of language and cognitive functions

- 96105- Assessment of Aphasia AND/OR
- 96125- Standardized Cognitive Performance Testing

** Think about clinical appropriateness when selecting evaluation type**

- Will I mentally fatigue if I assess all areas day one?

- After 6 weeks of intensive treatment you determine he will require speech generating AAC device to meet communicative needs. Use 92607- Evaluation for prescription for speech generating AAC Device

CASE STUDIES

Mr. Smith is referred for evaluation due to stuttering. He presents with Advanced Dementia
- Remember- Dysfluency services are not typically covered by Medicare, nor would interventions aimed at fluency be supported by Evidenced Based Practice Patterns.
- Use 92523 Eval of Speech Sound Production with Eval of Language Comprehension and Expression AND/OR
- 96105- Assessment of Aphasia if patterns follow diagnostic criteria for Primary Progressive Aphasia associated with Dementia OR
- 96125- Standardized Cognitive Performance Testing inclusive of Dementia Staging Tools when disease process follows AD type Dementia.

CPT- Treatment Codes

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<td>92507</td>
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<td>97532</td>
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92526- DYSPHAGIA THERAPY
Patient/caregiver training in feeding/swallowing techniques
Proper head and body positioning
Amount of intake per swallow
Appropriate diet (determining) texture and viscosity
Means of facilitating the swallow
Feeding techniques and need for self help eating/feeding devices
Facilitation of more normal tone or oral facilitation techniques
Laryngeal elevation training
Compensatory Swallow techniques
Oral sensitivity training
Techniques to reduce shortness of breath of fatigue during duration of meal.

DYSPHAGIA per MEDICARE Manual
- Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death.
- Most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementia, and enccephalopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment. (MBPM, 2016)

SPECIALIZED DYSPHAGIA CARE
Per the Medicare Benefit Policy Manual definition of SLP Scope:
Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies.
Competencies include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques (MBPM, 2016).

THINK... WHAT MAKES MY SERVICES UNIQUE?

92507 TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AUDITORY PROCESSING
Skilled interventions aimed at:
- Increasing expressive language skills including ability to communicate wants and needs and treatments to address appropriate syntax and morphosyntax.
- Increase receptive language skills for comprehension of spoken and written language impacting ability to respond to questions, follow directions, and comprehend structured and spontaneous interactions with others.
- Increasing speech intelligibility skills including interventions aimed at improving articulatory patterns and addressing motor speech impairments such as apraxia of speech and dysarthria.
- Improving pragmatic language skills related to social aspects of communication including adequate turn taking, using social and conversational cues and appropriate adaptations of language based on listening and conversational partner.
- Increase vocal function related to respiration, phonation, resonance, and pitch.
- Aural rehabilitation including provision of speech reading.
- Training and use of non-speech generating augmentative and alternative communication (AAC).
- Training and modification in the use of a voice prosthesis.
97532 - DEVELOPMENT OF COGNITIVE SKILLS
97532 is a time based code used for development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

- 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
- 5 units: 68 minutes to < 83 minutes
- 6 units: 83 minutes to < 98 minutes

97532 - CONSIDERATIONS FOR USE
- Providers should bill CPT 97532 only when cognitive treatment is truly a distinct, separate activity. When appropriate diagnostic assessment is conducted, should correspond with new onset for justification of decline.
- Differs from services provided for 92507 - Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.
- Can be used in conjunction with 92526, however should not be used simply due to the fact dysphagia services are being provided to an individual with cognitive impairment.
- Can only be used when appropriate differential diagnosis is completed to rule out the following as root cause:
  - AMS associated with period of delirium including those associated with infection (UTI)
  - Underlying language and/or auditory impairment as primary cause of communication breakdowns.

97532 AND 92526
- SLPs should not bill cognitive treatment when they provide only swallowing or language treatment to a patient who also has cognitive disorders.
- However, it may be appropriate to bill 97532 on the same day if there are distinct plans of care and specific goals and treatment activities for cognitive impairment and for swallowing.
- Take Home Point - Cognitive impairment alone does not necessitate use of 97532.

92507 AND 97532
Correct Coding Initiative (CCI) Edits
- 92507 and 97532 CANNOT be billed same day
- Determining appropriate coding use:
  - Differential diagnosis into root cause of functional impairments begins at SOC.
  - Examples:
    - Resident presents with decreased ability to follow commands.
      Root cause could be – Decreased immediate memory for directives (cog); decreased attention to task (cog); decreased auditory comprehension of directives (language); decreased auditory acuity (AR- 92507 per Medicare Regulations)

CASE STUDIES: 97532; 92526
- Ms. Smith presents with a severe oropharyngeal dysphagia following TBI with resulting increased oral processing of bolus, anterior spillage, pocketing/stasis after the swallow, delayed initiation of pharyngeal swallow and overt s/s aspiration with intake. Deficits are compounded by cognitive impairments including impulsivity with intake.
- Anticipated intervention coding:
  - 92526 for Swallowing Therapy
  - 97532 for Cognitive interventions r/t impulsivity and decreased attention to task.
CASE STUDIES: 92526;92507

- Mr. Jones presents with progression of dementia with resulting decreased oral coordination, anterior loss, increased processing and decreased ability to follow basic commands at meals in order to increase ability to follow swallow strategies.
- Anticipated intervention coding:
  - 92526 for increasing swallow functions
  - 92507 for increasing success with ability to follow commands.
  Note: language POC may be maintenance based in nature in that interventions will be short term in order to establish/train caregiver regarding techniques.

MRS. RAY- FREQUENT FALLS

Mrs. Ray was referred for Speech Therapy services secondary to increased falls in her room. During initial patient interview you note that Mrs. Ray presents with decreased ability to verbally sequence steps for ADL tasks she prefers to complete in her room (1) including: transferring from her bed to the walker; completing denture care; and completing UB dressing tasks. You determine the root cause of her impairments is based on declines in her receptive language abilities in addition to declines in expressive language limiting her ability to formulate thoughts and request assistance from caregivers.
- Anticipated intervention coding: 92507 language based interventions appear to be most appropriate to meet her current needs.

MR. SMITH- FREQUENT FALLS

Mr. Smith was referred for Speech Therapy services secondary to frequent falls which occur in his room. He was admitted to your facility ~1 week ago s/p TBI which occurred in the home environment.
Baseline measures during ST evaluation reveal intact language abilities, however he presents with significant declines in cause‐effect problem solving and short term memory tasks. Falls appear to be subsequent to overall decreased ability to negotiate obstacles in room environment when performing ADL tasks.
- Anticipated intervention coding: 97532 to address cognitive impairments related to memory and problem solving.

MEDICARE BENEFIT POLICY MANUAL
CHAPTER 15
"REASONABLE AND NECESSARY"

**INDICATIONS FOR SPEECH THERAPY SERVICES**

- Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists
- Necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia)
- Regardless of the presence of a communication disability.

(See CMS Publication 100‐02, Medicare National Coverage Determinations (NCD) Manual, Part 3, Section 170.3; CMS Publication 100‐03, Medicare Benefit Policy Manual, Chapter 15, Section 230.3(A))
**PLAN OF CARE REQUIREMENTS**

**“REASONABLE AND NECESSARY” EVIDENCED BASED PRACTICE**

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition. Acceptable practices for therapy services are found in:
  - Medicare manuals (such as this manual and Publications 100-03 and 100-04).
  - Local Coverage Determinations (LCDs) are available on the Medicare Coverage Database: http://www.cms.hhs.gov/nctd and
  - Guidelines and literature of the professions of physical therapy, occupational therapy, and speech-language pathology.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(1)(f))

**“REASONABLE AND NECESSARY” MEDICAL DIAGNOSIS**

- While a beneficiary’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary’s diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See item C for descriptions of skilled (rehabilitative) services.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(1)(f))

**“REASONABLE AND NECESSARY” COMPLEXITY AND SOPHISTICATION**

- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist.
- Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(1)(f))

**“REASONABLE AND NECESSARY” DETERMINING APPROPRIATE FREQUENCY AND DURATION**

- There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services), and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

**STEPS**

1. Order Received
2. Screen
3. Evaluate and Determine if Skilled Intervention is Necessary
4. Establish POC
5. Write Clarification Order
6. Get POC Certified
7. Re Eval as appropriate
8. Recertify when necessary
Overview: Plan of Care (POC) Requirements

- Order or Referral
  - Clear distinction for Evaluation/Re-evaluation or Screening
  - Beneficiary’s History and the Onset or Exacerbation Date of the current disorder.
  - History in conjunction current symptoms must establish support for additional treatment.
  - Prior Level of Functioning should be documented
  - Baseline abilities should be documented
  - PLOF + Baseline establish the basis for the therapeutic interventions.
- Plan, Goals (realistic, long-term, functional goals)
- Duration of therapy, Frequency of therapy, and definition of the Type of Service.
- Diagnostic and assessment testing services to ascertain the type, causal factor(s) should be identified during the evaluation.
  - Clarify if plan is anticipated to be rehabilitative/restorative or maintenance based

Step 1: Order/Referral

- Needed for initial evaluation
- MD signature on POC acts as certification/clarification of services after evaluation
- New signature/certification needed for:
  - Any significant updates to POC affecting LTG (will require re-eval or recertification)
  - Addition of new interventions not included on initial plan.
  - Example: ST begins services for dysphagia alone, as resident progesses with laryngeal function further eval is warranted for voice and motor speech
  - PT completes initial POC for wound care and progresses patient to point where standard PT eval is reasonable and necessary
  - Recertification of POC

Step 2: “Screening”

- Screening assessments are non-covered and should not be billed.
- The initial screening assessments of patients or regular routine reassessments of patients are not covered.

Think…. Screening Tells you Eval or Not Eval
No Clinical judgments or Skilled Recommendations Should be Made from Screen Alone

Step 3: Evaluation

- The order or referral for the evaluation and any specific testing in areas of concern should be designated by the referring physician in consultation with the therapist.
- The documentation of the evaluation or re-evaluation by the therapist should demonstrate that an actual hands-on assessment occurred to support the medical necessity for reimbursement of the evaluation or re-evaluation.

Determines Need for Skill

Evaluation Defined

Evaluation is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities (Baselines).

Evaluation is warranted e.g., for a new diagnosis (change from plof).

These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

Medical History

Onset or Exacerbation Date

- Onset/Exacerbation Date: the date of the functional change which as a result of dx indicated the need for skilled care
- Chronic Conditions: May not be the date of dx for condition, however related to exacerbation of dx process
- New Conditions: CVA/TBI will be date of new insult

- Provide correlation of why new onset has resulted in symptoms requiring your unique skilled services.
**Determine Need for Skill**

- Evidenced Based Practice
- Complexity and Sophistication
- Medical Diagnoses
- Individualized Frequency and Duration

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**Reasonable and Necessary**

**Evidenced Based Practice**

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition. Acceptable practices for therapy services are found in:
  - Medicare manuals (such as this manual and Publications 100-03 and 100-04).
  - Contractors Local Coverage Determinations (LCDs and NCDs) are available on the Medicare Coverage Database: [http://www.cms.gov/mcd](http://www.cms.gov/mcd) and
  - Guidelines and Notation of the professions of physical therapy, occupational therapy and speech-language pathology.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B)).

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**Reasonable and Necessary**

**Complexity and Sophistication**

- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist.
- Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B)).

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**Reasonable and Necessary**

**Medical Diagnoses**

- While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary’s diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See item C for descriptions of skilled (rehabilitative) services.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B)).

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**Reasonable and Necessary**

**Determining Appropriate Frequency and Duration**

- There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific illness state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

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**Treatment: “Skilled Procedures”**

- Analysis of actual progress toward goals.
- Establishment of treatment goals specific to dysfunction and designed to specifically address each problem identified in initial assessment.
- The selection and initial training of a device for augmentative or alternative communication systems.
- Patient and family training to augment restorative treatment or to establish a maintenance program. Education of staff and family must begin at the time of evaluation.
LIMITATIONS: “NOT SKILLED”
- Non-diagnostic, non-therapeutic, routine, repetitive and reinforcing procedures (e.g., the practicing of word drills without skilled feedback).
- Procedures which are repetitive and/or that reinforce previously learned material which the beneficiary, staff or family may be instructed to repeat.
- Procedures which may be effectively carried out with the beneficiary by any non-professional (family or restorative aide) after instruction is completed.

REHAB THERAPY DEFINED
- Rehabilitative/Restorative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being (i.e. PLOF).
- Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment.

MAINTENANCE PROGRAMS DEFINED
- MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

INDIVIDUALS WITH CHRONIC CONDITIONS
- Rehabilitative therapy may be needed, and improvement in a patient’s condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists.
- For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full (full movement from baseline to plof) or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient’s condition or to maximize his/her functional abilities.
- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient’s condition and require the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel.

STEP 4: ESTABLISH POC
Establish POC:
- Goals
- Frequency
- Duration
  - Comparison of PLOF and Evaluation Baseline
  - Deficits that require skilled care MUST have goals
  - No Goal = No Treatment Can Occur

BASELINE
The initial assessment establishes the baseline data necessary for evaluating expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals.

Methods for obtaining baseline function should include objective or subjective baseline diagnostic testing (standardized or non-standardized) followed by interpretation of test results, and clinical findings.

Goals should not be created for areas which do not have documented baseline measures, hence “DNT” or “Will not be addressed during POC” should not be used for target areas.
**Diagnostic Testing**
- Diagnostic and assessment testing services to ascertain the type, causal factor(s) should be identified during the evaluation.
- Includes standardized and non-standardized functional assessment tools.
- Where can I find these resources?

**Prior Level of Function**
The residents’ **prior level of function** refers to the functional level of independence prior to onset of decline which necessitated need for skilled therapy screening, and if deemed necessary, further evaluation and skilled intervention.

**The Space Between**
- **Lower Levels of Support Needed for Success**
- **Greater Level of Support Needed for Success**

**Goals/Treatment Measures**
- **REALISTIC/LONG TERM/FUNCTIONAL**

**Frequency and Duration**
- **Frequency** refers to the number of times in a week or # of visits over a specific time frame the type of treatment is provided.
- **Duration** is the number of weeks, or the number of treatment sessions, for THIS PLAN of care.

If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

**Frequency and Duration Changes**
- The **frequency** or **duration** of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patient’s goals.
  - For example, it may be clinically appropriate, medically necessary, most efficient and effective to provide short term intense treatment or longer term and less frequent treatment depending on the individual's needs.
- It may be appropriate for therapists to taper the frequency of visits as the patient progresses toward an independent or caregiver assisted self-management program with the intent of improving outcomes and limiting treatment time.
  - Think... As the **Space Between** decreases, preparations for discharge planning should be in action, frequency should be tapered, in order to promote carryover of newly learned skills and promote highest level of independence upon d/c from skilled care.
**STEP 5: WRITE CLARIFICATION ORDER**

Patient to receive skilled (insert discipline) (insert frequency) (insert duration) in order to (insert reason)

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**STEP 6: CERTIFICATION OF EVAL/POC**

- **CERTIFICATION** is the Physician's/Non Physician Practitioner's (NPP) approval of the plan of care (evaluation).
- Certification requires:
  - Signature must be from the physician or NPP
  - **Timely certification occurs within 30 days**
  - A dated signature on the plan of care or some other document that indicates approval of the plan of care
  - When initial cert expires, a recert must then be completed certified within 30 days (needs MD signature and date which can be added as receipt date).

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**STEP 7: RE-EVAL AS NEEDED**

- Re-evaluation may be covered if necessary because of a change in the beneficiary’s condition.
  (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.C)
- Covered only if the documentation supports the need for further tests and measurements after the initial evaluation.
- Indications for a re-evaluation include new clinical findings, a significant change in the patient’s condition, or failure to respond to the therapeutic interventions outlined in the plan of care.
- May be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued.

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**STEP 8: RECERT WHEN NECESSARY**

Requires completion of recert document within Optima

Requires MD signature obtained in timely manner (30 days)

Additional clarification orders

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**REAL WORLD APPLICATION**

ASHA PRACTICE PORTALS

http://wwwasha.org/practice-portal/

Contain:

- Evidenced Based Maps;
- Clinical Tools

ASHA PREFERRED PRACTICE PATTERNS

MAINTENANCE PROGRAMS

The services of a maintenance program themselves are not covered. However, the development of a functional treatment plan for patient maintenance including evaluation, plan of treatment, and staff and family training, is covered, but it must require the skills of an SLP, and be a distinct and separate service which can only be done safely by a SLP.

DOCUMENTING “ABILITY TO LEARN”

- Documentation is expected to support the ability of the beneficiary to learn and retain instruction.
- Absence of such documentation may result in a denial of services.
- If the patient has questionable cognitive skills, a brief cognitive-communication assessment should be performed in order to establish the patient’s learning ability. The brief cognitive assessment may also determine the need for more comprehensive cognitive performance testing.

TREATMENT MEASURES

- There should be an expectation of measurable functional improvement.
- Think:
  - Measureable component (percentile) needs to be attached to all short and long term goals
  - Functional component (in order to ...) needs to be attached to all short and long term goals.

TREATMENT: “SKILLED PROCEDURES”

- Design of a treatment program addressing the beneficiary’s disorder. Continued assessment and analysis during the implementation of the services is expected at regular intervals.
- Establishment of compensatory skills for communication (e.g., air injection techniques or word finding strategies).
- Establishment of a hierarchy of speech-language tasks and cueing that directs a beneficiary toward communication goals.

TREATMENT: “SKILLED PROCEDURES”

- Analysis of actual progress toward goals.
- Establishment of treatment goals specific to speech dysfunction and designed to specifically address each problem identified in initial assessment.
- The selection and initial training of a device for augmentative or alternative communication systems.
- Patient and family training to augment restorative treatment or to establish a maintenance program. Education of staff and family must begin at the time of evaluation.

LIMITATIONS: “NOT SKILLED”

- Services rendered by a SLP assistant or aide.
- Provision of practice for use of augmentative or alternative communication systems after being taught their use.
- Although speech-language pathologists may perform laryngoscopy for the assessment of voice production and vocal function, laryngoscopy for medical diagnostic purposes must be performed by a physician.
**LIMITATIONS: “NOT SKILLED”**

- Non-diagnostic, non-therapeutic, routine, repetitive and reinforcing procedures (e.g., the practicing of word drills without skilled feedback).
- Procedures which are repetitive and/or that reinforce previously learned material which the beneficiary, staff or family may be instructed to repeat.
- Procedures which may be effectively carried out with the beneficiary by any non-professional (family or restorative aide) after instruction is completed.

**AURAL REHAB**

- The terms, aural rehabilitation, auditory rehabilitation, auditory processing, lip reading and speech reading are among the terms used to describe covered services related to perception and comprehension of sound through the auditory system. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 230.3.D.3)
- Coverage for speech reading is only allowed with documentation that supports a loss of hearing sensitivity that cannot be corrected with a hearing aid or amplification. Documentation should also support visual acuity of the beneficiary sufficient to participate in aural rehabilitation.

**AURAL REHAB: "MEDICAL NECESSITY"**

- Speech reading is considered medically necessary when determined by a licensed audiologist that the use of a hearing aid or other amplification would not significantly improve the beneficiary's understanding of speech.
- Speech reading training is not medically necessary for beneficiaries who refuse to wear a hearing aid. Routine screening for hearing acuity or evaluations aimed at the use of hearing aids is not a covered service.

**DETERMINATION OF THE MEDICAL NECESSITY FOR THE SPEECH READING WILL BE BASED ON THE FOLLOWING CRITERIA**

- Documentation of basic hearing evaluation and audiogram;
- Documentation identifying type and extent of hearing loss;
- Documentation of adequate cognitive and memory skills;
- Documentation that visual acuity with glasses if applicable, is sufficient to allow the beneficiary to participate in the therapy;
- Documentation of the beneficiary's motivation to participate in therapy in order to improve understanding of speech.

**COGNITIVE IMPAIRMENTS: “MEMORY AIDES”**

- Speech-language pathology services provided for chronic disorders of memory and orientation are covered services when significant functional progress is demonstrated at early stages of the disorder. When functional progress plateaus, the development of a maintenance program, including training of caregivers and family members is covered.
- Preparation of memory aids such as memory books, memory boards, or communication books may be covered. Supervision of the use of such aids is not covered as these services do not require the skills of a qualified therapist.

**MEDICAL DIAGNOSES “NOT COVERED”**

- The following disorders are typically non-covered for the geriatric Medicare beneficiary:
  - Fluency disorder
  - Conceptual handicap
  - Dysprosody
  - Stuttering and cluttering (except neurogenic stuttering caused by acquired brain damage)
  - Myofunctional disorders, e.g., tongue thrust
ENGLISH AS A SECOND LANGUAGE

- Speech therapy interventions to instruct the beneficiary in English phrases, who has a primary language other than English, are not covered.

- However, when the primary language of the beneficiary is other than English, speech therapy interventions in the patient's primary language will be covered within the parameters of this LCD.

CAN I SKILL FOR THAT??

- Nursing refers a resident for diet change due to losing their dentures
- Family refers a new resident for AB services after receiving a cochlear implant
- Daughter of a resident with advanced dementia wants treatment because her mom "stutters"
- A new admission currently on ABT for UTI is referred for cognitive therapy due to "behaviors"
- Your facility MDS Coordinator refers a resident who presents with decreased BIMS scores in Section C of the MDS
- Your Rehab Director refers a resident for speech clarity because "his dentures move around when he talks"
- The facility Administrator wants you and OT to both treat a patient for problem solving because "if you both treat, they will get better sooner"

CASE STUDY- “REHAB THERAPY”

Ms. Jones is referred for Bedside Swallow Evaluation, baseline measures reveal moderate oropharyngeal dysphagia with significant impairments in oral processing and coughing/wet voice after the swallow with regular textures and thin liquids

ST determines initially frequency and duration of 5 times a week for 4 weeks is essential in order to increase swallow function, allow for LRPD diet and prevent aspiration risks

THE JIMMO AFFECT... CAN’T I TREAT ANYONE NOW?

Clarified with Jimmo versus Sebelius Final Ruling:
- Establishment or Design of a Maintenance Program
- Delivery/Performance of a Maintenance Program
- Delivery of Rehabilitative/Restorative Therapy
**Maintenance Sample: Voice**

Motor Speech/Voice:

Skilled ST services may be deemed reasonable and necessary in order to maintain vocal clarity and intensity for an individual with Parkinson's Disease in order to continue training via use of the Silverman Voice Therapy (LSVT) technique for maintenance. Note: Consideration of therapy services aimed at coordination and rhythm in speaking, including determining that vocal clarity and intensity has been achieved in a particular environment (ie: work, family, social).

Skilled ST services may be deemed reasonable and necessary in order to maintain vocal clarity and intensity for an individual with Parkinson's Disease in order to continue training via use of the Silverman Voice Therapy (LSVT) technique for maintenance. Note: Consideration of therapy services aimed at coordination and rhythm in speaking, including determining that vocal clarity and intensity has been achieved in a particular environment (ie: work, family, social).

**Maintenance Sample: Cog-Language**

Auditory Comprehension/Cognition:

Skilled ST services may be deemed reasonable and necessary in order to maintain auditory comprehension skills in the following instances:

- An individual with a new neurological insult following a period of intensive skilled ST interventions aimed at increasing deficits in comprehension language and perform cognitive tasks (sequencing, problem solving) at the highest level possible continued services for maintenance may be warranted to continue skills already acquired.

**Maintenance Sample: Dysphagia**

Skilled ST services may be deemed reasonable and necessary in order to maintain adequate swallow functions for the Medicare Beneficiary.

**Considerations Prior to Creating Goals**

- **Step One:** What is the gap between current baseline and the individual's prior level of function? What intensity of services are needed to return individual to PLOF?
- **Step Two:** What is the individual's desired long term outcome?
- **Step Three:** Will the plan be **restorative or maintenance** based in nature?

**Can I Use Cues in My Goals?**

- **Pros:**
  - Can assist at the start of care with documenting stimulability for tasks and ability to learn
  - Can be beneficial for short term maintenance based plans to reflect level of assist needed from caregivers at end of skilled care
  - Can be beneficial for showing increased "I" for patients when we are able to wean in conjunction with reflecting increased functional abilities

- **Cons:**
  - If you use in goal you MUST measure consistently at all PRs and Recert
  - Once deemed repetitive in nature difficult to show skilled need
  - Clinician must show unique skilled need via increased overall function in conjunction with reduction of cues
  - Medicare will NOT ALLOW continued skilled need for cues alone
GOALS/TREATMENT MEASURES

- REALISTIC/LONG TERM/FUNCTIONAL
  - There should be an expectation of measurable functional improvement.
  - Measureable component (percentile) needs to be attached to all short and long term goals.
  - Functional component (in order to...) needs to be attached to all short and long term goals.
  - SUB-TASK functional impairment areas in order to measure more specific changes in function.

LONG TERM VERSUS SHORT TERM GOALS

- LONG TERM GOALS should reflect the highest level of desired function anticipated upon discharge. In most cases will be reflective of patient’s prior level of function (PLOF).
- SHORT TERM OBJECTIVES are the stepping stones, targeted specific areas that are used to increase overall function in order to achieve LTGs.

SAMPLE LONG TERM

<table>
<thead>
<tr>
<th>Auditory Comprehension</th>
<th>Patient will improve auditory comprehension to Independent in order to improve receptive communication skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognition</td>
<td>Patient will increase cognitive skills to Independence to improve ability to participate in meaningful interactions</td>
</tr>
<tr>
<td>Cognitive Communication</td>
<td>Patient will exhibit adequate cognitive-communicative skills for discharge home with the supervision with environmental modifications as training to facilitate safety and independence</td>
</tr>
<tr>
<td>Motor Speech</td>
<td>Patient will increase speech intelligibility at the highest functional verbal expression level to 100% with familiar listeners, unfamiliar listeners and within groups</td>
</tr>
</tbody>
</table>

SHORT TERM: AUDITORY COMPREHENSION

- Patient will demonstrate auditory comprehension of ___
- CHOOSE SPECIFIC LEVEL (biographical yes/no; environmental yes/no, simple yes/no, complex yes/no, common ADL objects, association objects/items, simple questions, simple instructions/commands, complex questions, simple conversation, complex conversation, various levels of functional communication, specific medications)

ADD MEASURABLE COMPONENT with 100% accuracy and no cues in
ADD FUNCTIONAL ASPECT order to improve receptive communication skills

SHORT TERM: AUDITORY COMPREHENSION

- Patient will follow 1-step commands with 100% accuracy in order to enhance patient’s ability to follow directions for activities and ADLs
- Patient will follow multi-step verbal commands with 100% accuracy and 25% verbal cues in order to enhance patient's ability to increase ability to participate in ADLs

REMEMBER TO SUB-TASK

- Expressive Language
  - Establish and advance goals across communication levels from automatic; word-conversation
- Receptive Language
  - Responding to yes/no, open ended versus closed ended ?’s
- Swallowing
  - Break down goals by phase of swallow: oral prep, oral, pharyngeal, upper 1/3rd esophageal
- Voice
  - Obtain baselines on specific areas: quality, pitch, intensity and create goals across these areas
- Cognition
  - Remember higher level executive function includes many areas: breakdown specific for problem solving, sequencing and instrumental actiess of daily living.
PART II: PUTTING THE PIECES TOGETHER

DOCUMENTATION & GOAL BUILDING

**Regulations**

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Incorporating into Documentation</th>
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<tbody>
<tr>
<td>Documenting the skilled components of activities will assist in supporting that the services are medically necessary.</td>
<td>Includes, treatment plan development, strategies, frequency of tasks, noting if, analysis of progress, establishment of specific goals, selection and initial training of AAC, patient and family training.</td>
</tr>
<tr>
<td>Documentation of speech language services, like other therapy services, must be objective, clear, concise, and must show evidence of the beneficiary's progress in meeting treatment goals.</td>
<td>Utilize builders to appropriately create targets for areas of impairment on evaluation.</td>
</tr>
<tr>
<td>Documentation in the clinical record must be descriptive, clearly related to functionality, and complement and correlate with other disciplines.</td>
<td>Descriptive: Document all skilled interventions in YNML II; utilize Addendum as needed.</td>
</tr>
</tbody>
</table>

**Statements such as “ability impaired to moderately impaired” or “far from good minus” do not offer sufficient objective and measurable information to support progress and may result in denial of services as not medically necessary.**

**Medical necessity may not be established if there is conflicting documentation between disciplines or widely fluctuating problems indicating an unstable condition.**

**Prior level of function must be documented and considered in the patient’s treatment plan.**

**Statements such as “ability impaired to moderately impaired” or “far from good minus” do not offer sufficient objective and measurable information to support progress and may result in denial of services as not medically necessary.**

**Always document prior level of function for areas that will be targeted during plan of care that may require retraining.**

**Prior level of function must be documented and considered in the patient’s treatment plan.**

**Effectively utilize goal builders to measure short-term targets via use of percentiles tied to function.**

**Strenuous training programs necessary when retraining required.**

**Problem solving skills necessary for effective function.**

**Effectively utilize goal builders to measure short-term targets via use of percentiles tied to function.**

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**Problem solving skills necessary for effective function.**
### Regulations

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<td>Discharge planning should be indicated early in the treatment plan.</td>
<td>Utilize “Assessment Summary/Patient care plan” section to document training provided to promote carryover into settings outside of ST; Complete “Patient Response” section that allows statements regarding progress towards POC; decrease frequency of visits as warranted in prep for d/c.</td>
</tr>
<tr>
<td>Where a valid expectation of improvement existed at the time services were initiated, or thereafter, the services may be covered even though the expectation may not be realized.</td>
<td>Establish POC to outline “expected” outcomes, however be flexible/Fluid and make changes in accordance with changing goals/Abnormalities/Intervening medical complications</td>
</tr>
<tr>
<td>Progress reports must document a rational and reasonable expectation that the patient’s condition will improve significantly, or demonstrate improvement toward the patient’s best level of communication, independence, and functional competence.</td>
<td>Complete thorough progress reports ensuring to obtain measures of all short term and long term goals; Utilize “Additional Analysis” section of PR</td>
</tr>
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</table>

### Incorporating into Documentation

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<td>Documentation should include improvements, setbacks, and intervening medical complications—whatever is deemed pertinent to justify the need for continued interventions.</td>
<td></td>
</tr>
<tr>
<td>Improvements should be appropriately documented on PRs via use of functional, measurable targets. Utilize the “Additional Analysis” section of progress reports to document “setbacks” and “intervening medical complications.”</td>
<td></td>
</tr>
</tbody>
</table>

### Go To Resources

- ASHA- Medicare CPT Coding Rules for SLP: [http://www.asha.org/Practice/reimbursement/medicare/SLP_coding_rules/](http://www.asha.org/Practice/reimbursement/medicare/SLP_coding_rules/)

### References

- CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Part 3, Section 170.3 (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 230.3)