Decoding the Coding Systems: When, How and Why to Code What

Presenter: Nancy B. Swigert, M.A., CCC-SLP, BRS-S

Moderated by:
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Decoding the Coding Systems:
When, How and Why to Code What

Nancy B. Swigert, MA, CCC-SLP, BRS-S

Disclosures

• Nancy Swigert has financial relationships to disclose
  ‣ She received an honorarium to present this webinar
Agenda

- Introduction
- Diagnostic Coding System
- Procedural Coding System
- New SLP Evaluation Procedure (CPT) Codes
- Scenarios for selecting diagnostic and procedure codes
- Functional outcomes reporting and G-codes

Course Objectives

- Describe the difference in diagnostic and procedural coding
- Discuss how ICD-10 differs from ICD-9
- Determine when to use each of the 4 new evaluation CPT codes
- Select the appropriate G-code and C (severity) modifier for sample scenarios
REVIEW OF CODING SYSTEMS

- Understanding the two coding systems is essential in any discussion of reimbursement and coding.

Two Health Care Coding Systems

- Procedural Codes – Describe what we DO with the client/patient
  - Current Procedural Terminology a.k.a. CPT codes
  - Owned by the American Medical Association
- Diagnostic Codes – Describe the REASON we are evaluating or treating the client/patient
  - International Classification of Diseases, 9th Revision, Clinical Modification a.k.a. ICD-9 codes
  - Overseen and maintained by U.S. Department of Health and Human Services
Purpose of Coding Systems

- Provides common language among providers, third party payers, and benefits administrators
- Standardizes descriptions of procedures, names of diagnoses, and names of items/supplies
- Provides data for government to evaluate utilization patterns and appropriateness of health care costs

International Classification of Diseases (ICD)
9th Edition Until October 1, 2014

- Coding the Diagnosis
- Principles for Use
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

- Numeric classification system of *diseases and disorders*
- Based primarily on body systems (e.g. circulatory, respiratory, nervous)
- Code or codes to describe the *problem or reason* for our procedure
- Issued by the U.S. Department of Health and Human Services
- Approximately 15,000 codes

**Principle #1**
*Code to the highest degree of medical certainty or specificity*

- ICD-9-CM codes are 3-, 4-, and 5-digit codes
- Number of digits indicates level of code specificity
- Codes are arranged by categories
- There are levels within each category
- Carry code to 5th digit when possible
  - 787.20 Dysphagia, unspecified
  - 787.22 Oral pharyngeal dysphagia
Principle #2
Avoid NOS and NEC Codes

- NOS, not otherwise specified, infers that condition was not adequately described by the provider
- NEC, not elsewhere classified, infers that no appropriate code was found in the tabular list based on information provided
  - Example - 478.7 Other diseases of larynx, not elsewhere classified
    - 478.70 Unspecified disease of larynx
    - 478.74 Stenosis of larynx
    - 478.75 Laryngeal spasm

Principle #3
Primary and Secondary Diagnoses

- Primary Diagnosis
  - Condition chiefly responsible for visit
  - Disease, condition, problem, symptom, injury, or reason for encounter
  - If multiple problems exist, select most resource-intensive diagnosis and list others as secondary
- Secondary diagnoses
  - Co-existing conditions, symptoms, or reasons
    - OR
  - Symptoms found after study
Example of Primary & Secondary Diagnoses

Your patient presents to you, the SLP, with hypokinetic dysarthria related to Parkinson’s Disease

- You evaluate the dysarthria so your primary ICD-9-CM code is 784.51 to denote “dysarthria” 
  (excludes late effects CVA)
- The dysarthria is due to the Parkinson’s Disease. The secondary code is 332.0 to denote “Parkinson’s Disease; paralysis agitans”
- This diagnosis would be supplied by the MD

Principle #4
Coding Normal Results

- If results of diagnostic testing are NORMAL, code signs or symptoms to report the reason for test/procedure and explain normal result in report
- For example, 3 y.o. child referred because pediatrician thinks child has articulation disorder (315.39), but your evaluation reveals child is within developmentally normal limits with mild frontal lisp
- You still code 315.39
Principle #5

ICD-9 & CPT Code Should Agree

- Disease codes (ICD-9-CM) should appropriately correspond to the procedure codes (CPT) and vice versa.
- If SLP treatment is the procedure (CPT 92507), then the diagnosis code should reflect the reason for the speech treatment (e.g., childhood onset fluency disorder ICD-9 315.15).
- If the only ICD-9 is unrelated (e.g., Failure to thrive 784.31), this would not relate to speech therapy.
- If this principle is not followed, your claim may be denied.

ICD-9-CM Coding Warnings

DO NOT...

- Code conditions previously treated that no longer exist.
- Code “probable,” “suspected,” “questionable,” or “rule out” diagnoses.
- Misrepresent the service that was provided in order to receive reimbursement or for your patient’s convenience = FRAUD!
ICD-9-CM Resources

- ICD-9-CM Codes for SLPs: www.asha.org/practice/reimbursement/coding/icd9SLP.htm
- Questions: e-mail reimbursement@asha.org

Coming soon …..

- International Classification of Diseases, 10th Ed
  October 1, 2014
ICD-10 Begins October 1, 2014

Will you be ready?

- **October 1, 2014** implementation date
- ICD-10 includes
  - ICD-10-CM diagnosis codes for all settings
  - ICD-10-PCS procedure codes for hospital inpatients
- ICD-10-CM diagnostic code set contains more than 68,000 codes
- Combined with ICD-10-PCS, there are about 150,000 total codes
- See: [www.asha.org/Practice/reimbursement/coding/ICD-10/](http://www.asha.org/Practice/reimbursement/coding/ICD-10/)

Who Does This Apply To?

- Everyone covered by HIPAA must use ICD-10 starting **October 1, 2014**.
- Am I covered by HIPAA?
Speech-Language Pathology Codes

- Some SLP codes are in **F00-F99, Mental, Behavioral, and Neurodevelopmental Disorders**
- Others are found in **R00-R99, Symptoms, Signs and Abnormal Clinical/Lab Findings**
  - Dysphagia (R13)
  - Speech and Voice (R47-R49)

Examples of ICD-10-CM

- **F80.1** Expressive language disorder
- **F80.81** Childhood onset fluency disorder
- **R13.11** Dysphagia, oral phase
- **R48.8** Other symbolic dysfunctions
- **R49.21** Hyponasality
Preparation Checklist

- **Identify** your current processes and systems that use ICD-9-CM codes. Wherever ICD-9-CM codes are now used, ICD-10 will take their place. For example:
  - Clinical documentation
  - Superbills
  - Billing software
  - Electronic health record system
  - Quality reporting systems

- **Update** your Superbill and other forms.
  
  The CMS 1500 form has been updated and Medicare providers will be required to use them by April 1, 2014.

- **Test** transactions using updated systems with your payers and others you do business with.

- **Be proactive!**
CMS Resources

**Timeline** preparation for small-medium practice:

**Transition Checklist** for small-medium practice:

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ASHA Resources

- ICD-10 website includes:
  1. ICD-9 to ICD-10 Mapping Tool
  2. ICD-9 to ICD-10 Mapping Spreadsheets
  3. ICD-10-CM Code Lists

All resources developed by ASHA are free and tailored specifically for audiologists and SLPs.
[www.asha.org/Practice/reimbursement/coding/ICD-10/](http://www.asha.org/Practice/reimbursement/coding/ICD-10/)
ICD-9 to ICD-10 Mapping Tool

www.asha.org/icdmapping.aspx

Search for ICD-9 to ICD-10 Mappings

A Tool for Audiologists and SLPs

The ICD-9 to ICD-10 mapping tool below allows audiologists and speech-language pathologists to compare ICD-9 to ICD-10 codes for conditions they treat. Please read more about this tool for important information, including how it works and how to interpret the results.

ASHA's ICD-10 website contains more information about the ICD-10 system, including ICD-10 code lists for audiologists and SLPs.

Enter ICD-9 Code: 315.39
Type one ICD-9 code at a time, to the highest level of specificity possible.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>315.39</td>
<td>Other (developmental speech or language disorder)</td>
</tr>
<tr>
<td></td>
<td>Developmental articulation disorder</td>
</tr>
</tbody>
</table>

ICD-9 code 315.39 maps to

<table>
<thead>
<tr>
<th>F80.0</th>
<th>Phonological disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Functional speech articulation disorder</td>
</tr>
<tr>
<td></td>
<td>Speech articulation developmental disorder</td>
</tr>
</tbody>
</table>

Excludes: 1. speech articulation impairment due to aphasia NOS (R47.0), speech articulation impairment due to apraxia (R48.2)

Excludes: 2. speech articulation impairment due to hearing loss (F80.4), speech articulation impairment due to intellectual disabilities (F70-F79), speech articulation impairment with expressive language developmental disorder (F80.1), speech articulation impairment with mixed receptive expressive language developmental disorder (F80.2)

<table>
<thead>
<tr>
<th>F80.89</th>
<th>Other developmental disorders of speech and language</th>
</tr>
</thead>
<tbody>
<tr>
<td>F80.9</td>
<td>Developmental disorder of speech and language, unspecified</td>
</tr>
</tbody>
</table>
From Diagnostic Coding (ICD) to Procedure Coding (CPT)

- Diagnostic codes describe the **reason** you see the patient
- Procedure codes describe **what you do** for the patient

2014 CPT

- “... a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services.”

- CPT codes are 5-digit numbers assigned to every procedure and service a medical practitioner may provide
  - Medical
  - Surgical
  - Diagnostic
- Used to determine amount of reimbursement received by provider
- Ensure uniformity of communication
- Developed, maintained, and copyrighted by the American Medical Association (AMA)
- Updated annually

Relative Value Unit (RVU)

- Every CPT procedure or service has a resource-based relative value
- Standardized physician payment schedule
- Payments for services are determined by the resource costs needed to provide them
- All procedures are ranked on this same scale
Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

- MIPPA - Effective July 1, 2009
- Granted SLPs *independent billing* to Medicare
- Changed our status with CMS to a *Medicare Provider*
- Recognized SLPs as *professionals* rather than technical assistants
- Allowed for the “relative value” of SLP CPT (procedure) codes to be re-valued to include a professional work component

Three Components of Relative Value Unit

- *Professional Work*
  - Time it takes to perform the service
  - Technical skill and physical effort
  - Required mental effort and judgment
  - Stress due to the potential risk to the patient
- *Practice Expense*
  - Time of support personnel**
  - Supplies
  - Equipment
  - Overhead
- *Professional Liability/Insurance Costs*
How Does a CPT Code Get a Dollar Value?

- Relative Value Units (RVUs) are assigned thru a rigorous procedure developed by the AMA
- Recommendations for a relative value for a procedure sent to Centers for Medicare and Medicaid (CMS)
  - Accepted, rejected, or adjusted
  - Ranked
- RVUs X Monetary Conversion Factor =
- Medicare Payment per Procedure
  - Establishes the Medicare Physician Fee Schedule
  - Payment adjusted for geographic location
- Conversion Factor for 2013 = $34.0376
- Conversion Factor for 2014 =
  - Recommended 24.4% decrease

Conversion Factor: What’s That???

- CF based on the Medicare Sustainable Growth Rate (SGR)
  - SGR enacted by the Balanced Budget Act of 1997
  - Method currently used by CMS to control Medicare spending by physician services
- CF changes the payments for physician services for the next year in order to match the target SGR
- If expenditures for previous year exceed target expenditures, then conversion factor will decrease payments for the next year and vice versa
- CF is a recommendation by CMS to Congress
- Despite CMS recommendations for major cuts to the CF, Congress has not changed CF since 2011
Example: 3 Components of RVU

<table>
<thead>
<tr>
<th>CPT/HCPCS Mod</th>
<th>Description</th>
<th>Physician Work RVUs</th>
<th>Non-Facility Practice Expense RVUs</th>
<th>Midpractice RVUs</th>
<th>Non-Facility Total RVUs</th>
<th>Fee (see geographic adjusters in Table 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31575*</td>
<td>Diagnostic laryngoscopy</td>
<td>1.19</td>
<td>1.80</td>
<td>0.10</td>
<td>3.00</td>
<td>$509.41</td>
</tr>
<tr>
<td>31579*</td>
<td>Diagnostic laryngoscopy with stroboscopy</td>
<td>2.26</td>
<td>3.18</td>
<td>0.21</td>
<td>5.65</td>
<td>$160.49</td>
</tr>
<tr>
<td>70371* 26</td>
<td>Pharyn. &amp; speech eval., cine/video</td>
<td>0.84</td>
<td>1.67</td>
<td>0.02</td>
<td>2.53</td>
<td>$73.87</td>
</tr>
<tr>
<td>70371* 26</td>
<td>Pharyn. &amp; speech eval., cine/video</td>
<td>0.84</td>
<td>0.28</td>
<td>0.01</td>
<td>1.5</td>
<td>$38.10</td>
</tr>
<tr>
<td>70371* TC</td>
<td>Pharyn. &amp; speech eval., cine/video</td>
<td>0.00</td>
<td>1.39</td>
<td>0.01</td>
<td>1.40</td>
<td>$39.77</td>
</tr>
<tr>
<td>74230* 26</td>
<td>Modified barium swallow</td>
<td>0.53</td>
<td>1.83</td>
<td>0.03</td>
<td>2.39</td>
<td>$67.89</td>
</tr>
<tr>
<td>74230* 26</td>
<td>Modified barium swallow</td>
<td>0.53</td>
<td>0.19</td>
<td>0.02</td>
<td>0.74</td>
<td>$21.02</td>
</tr>
<tr>
<td>74230* TC</td>
<td>Modified barium swallow</td>
<td>0.00</td>
<td>1.64</td>
<td>0.01</td>
<td>1.65</td>
<td>$46.87</td>
</tr>
<tr>
<td>76356* 26</td>
<td>Ultrasound exam of head and neck</td>
<td>0.56</td>
<td>2.43</td>
<td>0.03</td>
<td>3.02</td>
<td>$85.79</td>
</tr>
<tr>
<td>76356* TC</td>
<td>Ultrasound exam of head and neck</td>
<td>0.56</td>
<td>0.19</td>
<td>0.02</td>
<td>0.77</td>
<td>$21.87</td>
</tr>
</tbody>
</table>

Table 2. National Medicare Part B Rates for Speech-Language Pathology Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>National Fee 2013 Rates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>31579</td>
<td>Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy</td>
<td>$217.64</td>
<td>This procedure may require physician supervision based on MACC (Medicare Administrative Contractors) local coverage policies or state practice acts.</td>
</tr>
<tr>
<td>92556</td>
<td>Evaluation of speech, language, voice, communication, and/or auditory processing</td>
<td>$237.16</td>
<td></td>
</tr>
<tr>
<td>92557</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</td>
<td>$71.14</td>
<td></td>
</tr>
<tr>
<td>92558</td>
<td>group, 2 or more individuals</td>
<td>$28.76</td>
<td></td>
</tr>
<tr>
<td>92551</td>
<td>Nasopharyngoscopy with endoscope (separate procedure)</td>
<td>$461.64</td>
<td>This procedure may require physician supervision based on MACC local coverage policies or state practice acts.</td>
</tr>
<tr>
<td>92552</td>
<td>Nasal function studies (e.g., rhinomanometry)</td>
<td>$62.97</td>
<td></td>
</tr>
<tr>
<td>92553</td>
<td>Laryngeal function studies (e.g., aerodynamic testing and acoustic testing)</td>
<td>$74.88</td>
<td></td>
</tr>
<tr>
<td>92556</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding</td>
<td>$77.37</td>
<td></td>
</tr>
<tr>
<td>92567</td>
<td>Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech</td>
<td>$69.18</td>
<td></td>
</tr>
<tr>
<td>92566</td>
<td>Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</td>
<td>$0.00</td>
<td>CMS will not pay for this code and instructs SUPs to use 92566 for non-SDI evaluation (Federal Register, December 31, 2002, p. 88053).</td>
</tr>
<tr>
<td>92568</td>
<td>Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)</td>
<td>$0.00</td>
<td>This is an add-on code for $2605. CMS will not pay for this code and instructs SUPs to use 92566 for a non-SDI evaluation.</td>
</tr>
</tbody>
</table>
replace with new page if possible
Get this each year from the ASHA website

2013 Medicare Fee Schedule for Speech-Language Pathologists
American Speech-Language-Hearing Association

Coding Clarification
- National Correct Coding Initiative Edits
- Modifiers
Coding Clarifications - Edits

- Two types of similar edit systems depending on setting
  - National Correct Coding Initiative (CCI) – any Part B services not rendered in a hospital
  - Outpatient Code Editor (OCE) – outpatient hospital services
- Automated edit systems used by CMS to control specific CPT code pairs that can be reported on the same day for the same patient
- CCI is updated quarterly and OCE follows one quarter later
- Since late 2010, CCI also applies to Medicaid per federal law

Coding Clarifications - Edits

- Some procedures considered to be “mutually exclusive” and may not be billed together for the same patient on the same day
- Examples for SLP
  - 92607 (Speech-generating device evaluation) & 92597 (Voice prosthetic evaluation)
  - 92507 (Speech, lang. tx) & 97532 (Cog tx)
- SLP CCI Edits can be found at www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm
Medically Unlikely Edits (MUEs)

- Subset of the CCI edits, also for Medicare Part B and Medicaid claims
- An MUE is the maximum number of times that a CPT code can be reported on the same day for the same patient
- Example: CPT 92507 may only be billed one time per day in office or hospital OP settings
- For a complete list of SLP-related MUEs, see: www.asha.org/Practice/reimbursement/coding/Medically-Unlikely-Edits-SLP/

Coding Clarification - Modifiers

- Special circumstances regarding code use
  - **-59** Indicates Distinct Procedural Service
    - Only modifier used with NCCI edits
    - For two procedures not ordinarily performed on the same day by the same practitioner, but which, under certain circumstances, may be appropriate to perform and therefore code on the same day (e.g., different site or organ system)
- Who provided the service
  - **GN**: Speech-language pathologist
  - **GO**: Occupational therapist
  - **GP**: Physical therapist
- Severity Level Modifiers with G-codes for functional claims reporting
Examples of Modifiers
Sometimes used by SLPs

- "-52" indicates an abbreviated procedure
- "-59" indicates that two procedures are distinct and separate
  - CPT 92611 (MBS) & 92610 (Clinical Swallow Eval)
  - CPT 92526 (Dysphagia tx) & 97532 (Cog tx)
  - CPT 92508 (Group tx) & 92507 (Indiv tx)
  - CPT 31579 (Laryngeal videostroboscopy) & 92520 (Laryngeal function study)
- "-22" indicates a much longer than usual procedure
- "-76" indicates a repeat procedure by the same provider on the same date of service

CCI Edit Page for SLP Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Code 2</th>
<th>Can be used on same date?</th>
<th>If so, what modifier?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MD office</td>
<td>Other settings</td>
</tr>
<tr>
<td>92506</td>
<td>92507</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92508 (SLP group)</td>
<td>92507</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92526</td>
<td>92520</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92526</td>
<td>97532</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92610</td>
<td>92611 (MBS)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>92612 (FEES)</td>
<td>31575, 92511, 92520, 92614</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm
New SLP Evaluation Procedure
CPT Codes

2014 - 4 New SLP Evaluation CPT Codes
Will Replace CPT 92506

- 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
CPT 92521 - Evaluation of Speech Fluency (e.g., stuttering, cluttering)

Vignette for CPT 92521

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

CPT 92522 - Evaluation of Speech Sound Production (e.g., articulation, phonological process, apraxia, dysarthria)

Vignette for CPT 92522

- A 6-year-old male presents with age-appropriate language comprehension and expression; yet, his speech sound production is unintelligible and negatively impacts his abilities to successfully communicate with others.
CPT 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)

Vignette for CPT 92523

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

CPT 92524 - Behavioral and Qualitative Analysis of Voice and Resonance

Vignette for CPT 92524

† A 38 year-old female diagnosed with bilateral vocal cord nodules was referred for an evaluation of functional voice use and resonance to facilitate the design of a voice therapy/behavioral treatment plan. The patient complains of progressive hoarseness, inadequate projection, altered resonance, vocal fatigue, and tightness and pain in her throat which compromises her ability to communicate effectively.
Why is there not a language-only evaluation procedure code?

- For children, rare for only language to be evaluated in the absence of speech sound production
- Survey of practices/clinics confirmed that this occurs less than 20% of the time
- Reverse is not true
- Speech-sound production commonly evaluated in absence of language testing
- If two or more procedures are billed together more than 51% of the time, CMS considers them to overlap and will bundle the procedures and decrease the reimbursement
- If evaluating only language, code 92523 with the -52 modifier indicating reduced service
- Keep in mind SLPs have other evaluation procedure codes to evaluate cognitive impairment or aphasia

Billing Codes Together?

- There are circumstances when it is appropriate for more than one disorder to be evaluated on the same day
- The CPT Handbook does not include language to restrict ability to bill these codes together
- Documentation should clearly reflect a complete and distinct evaluation for each disorder
- Evaluation codes should not be billed for brief assessments that could be considered screenings
- Time for identification of other disorders is already built into the value of each code
- Inappropriate use of multiple evaluations on same day will result in restrictions through the National Correct Coding Initiative (CCI) edits
- While no restrictions appear in the CPT Handbook, the 2014 quarterly CCI edits have not yet been published
Questions and Answers: New SLP Procedure Codes

- CPT 92521
- CPT 92522
- CPT 92523
- CPT 92524

Scenario 1: SLP CPT Question

- May I bill CPT 92522 and 92523 together on the same day?

  - CPT 92522 - Evaluation of Speech-sound production (e.g., articulation, phonological process, apraxia, dysarthria)
  - CPT 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)
Scenario 1: SLP CPT Answer

- No, do NOT Code these two together, only one or the other
- CPT 92523 INCLUDES the evaluation of speech sound production

Scenario 2: SLP CPT Question

- When I evaluate a child who has a cleft palate and speech and language problems, what procedures may I code?
Scenario 2: SLP CPT Answer

- CPT 92523 Speech-sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
- CPT 92524 Behavioral and qualitative analysis of voice and resonance

Scenario 3: SLP CPT Question

- I evaluate an adult with a voice disorder, using behavioral analysis and instrumental analysis. There is no resonance disorder.

- Do I code CPT 92524 with -52 modifier to indicate a shortened evaluation?
Scenario 3: SLP CPT Answer

-52 modifier is not required if only voice or only resonance is evaluated
Descriptor of CPT 92524 is written so that voice and/or resonance may be evaluated
  Recommend a statement of observation that one or the other is not impaired
Code developed so that those who work with cleft palate have appropriate choices of procedure codes
Because instrumental assessment was also completed, add code 92520

Scenario 4: SLP CPT Question

I am evaluating a child with apraxia of speech who also has vocal nodules. May I do two evaluation procedures and which procedures codes may I use?
Scenario 4: SLP CPT Answer

- Pending any NCCI edits that may come about, if your patient’s communication impairment warrants the evaluation of both apraxia and voice, then YES do both and document completely including your recommendations for plan of care based on your two evaluations
- CPT 92522 Speech-sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- CPT 92524 Qualitative and behavioral analysis of voice and resonance

Scenario 4 cont’d

- If instrumental assessment of the voice was also completed
  - Could also code 92520 Laryngeal function studies
Scenario 5: SLP CPT & ICD-9 Question

- I am seeing a patient who started stuttering after a stroke. I used to code this kind of evaluation under 92506. What should I do now?
- Which of the ICD-9 codes best describes the dysfluency?
- 784.52 Fluency disorder in conditions classified elsewhere
- Stuttering in conditions classified elsewhere
  - Code first underlying disease or condition, such as Parkinson’s disease (332.0)
  - Excludes:
    - Adult onset fluency disorder (307.0)
    - Childhood onset fluency disorder (315.35)
    - Fluency disorder due to late effect of CVA (438.14)

Scenario 5: SLP CPT Answer

- You may use CPT 92521 - Evaluation of speech fluency (e.g. stuttering, cluttering)
- The most appropriate ICD-9 code would be:
  - Fluency disorder due to late effect of CVA (438.14)
Scenario 6: SLP CPT Question

- I am evaluating an adolescent after a closed head injury
- What if I provide both a cognitive assessment AND a speech sound production with language evaluation? How do I code this?

Scenario 6: SLP CPT Answer

- If you complete both a full cognitive evaluation and a speech & language evaluation, you may bill CPT 96125 AND 92523
  - Documentation must show separate and distinct procedures
  - Pending publication of 2014 CCI edits
Scenario 7: SLP CPT Question

- I see a child for a speech fluency evaluation and also perform an oral peripheral examination.

- Can I bill CPT92521 (Evaluation of speech fluency) and 92522 (Evaluation of speech sound production)?

Scenario 7: SLP CPT Answer

- No.
- An oral peripheral examination is an integral part of every speech, language, fluency, and voice evaluation and the time spent on the examination of it is already built into each evaluation code.
Scenario 8: SLP CPT Question

- I am evaluating an adult who has aphasia and mild dysarthria. Which evaluation procedures and CPT codes may I use?

Scenario 8: SLP CPT Answer

- You may code CPT 96105 for the aphasia evaluation.
- *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination (with interpretation and report, per hour))*
  - This is a timed, per hour code
  - 31 minutes is allowable for one hour
- Because the description specifically mentions speech production ability, I would be hesitant to also code CPT 92522 - *Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)*
  - 2014 CCI edits pending
- Document each procedure with results, interpretation, recommendations, etc.
Functional Outcomes Reporting

- aka, G-Code Reporting
- A reporting system on the claim form that collects data regarding patient function, based on condition and severity
- Mandated by Congress in Middle Class Tax Relief and Job Creation Act that CMS implement claims-based data reporting by January 1, 2013 with no end-date
- Intent to assist in the payment reform for outpatient therapy services

Reporting is required for:

- Fee-for-Service procedures billed to Medicare, Part B for all therapy evaluations and treatment provided under the therapy plan of care
Part B Services

- Outpatient services
  - Private and group practices
  - Outpatient hospital clinics

- Therapy services not covered by Part A:
  - Comprehensive outpatient rehabilitation facilities (CORFs)
  - Hospital patients who are not in a covered Part A stay, such as observation status (2 midnights)
  - 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 date of service for evaluation
- Discharge
G-code Format

Each condition has 3 G-codes for reporting

- **Current status** at time of initial episode outset and every 10th treatment day
- **Projected goal** status
- Status at **discharge** or end of reporting

G-codes for Swallowing

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

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<thead>
<tr>
<th>Claim Modifier</th>
<th>Percent Impairment</th>
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<tbody>
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<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>

### Severity Modifier/NOMS FCM crosswalk

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<thead>
<tr>
<th>CMS</th>
<th>Description</th>
<th>FCM</th>
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<tbody>
<tr>
<td>CH</td>
<td>0% impaired</td>
<td>7</td>
</tr>
<tr>
<td>CI</td>
<td>0-20%</td>
<td>6</td>
</tr>
<tr>
<td>CJ</td>
<td>20-40%</td>
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<tr>
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<td>4</td>
</tr>
<tr>
<td>CL</td>
<td>60-80%</td>
<td>3</td>
</tr>
<tr>
<td>CM</td>
<td>80-99%</td>
<td>2</td>
</tr>
<tr>
<td>CN</td>
<td>100% impaired</td>
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</tbody>
</table>
Reporting Conditions

- Only 1 condition at a time
  - Treat and document more than one at a time if medically necessary
- Only 1 set per discipline per date of service
  - If multiple SLP evaluations are performed on the same day, just report 1 G-Code set
- If the condition that is reported resolves and treatment continues, another condition is reported

Report for each Condition

- Current status G-Code and projected goal G-Code for evaluations and treatment days
  - Current status reflects the results of the evaluation or the status of the patient at treatment session
  - Projected goals severity can change as needed
- Discharge status G-Code and projected goal G-Code at last visit
One-Time Visit

If a patient is seen for an evaluation only, all three codes should be reported:

- Current status (results of evaluation)
- Projected goal (as determined by evaluator)
- Discharge status (modifier same as current status)

Snapshot of Claim Form
New G-code Information

In October 2013, CMS changed its guidance on reporting multiple conditions on the same day!

- **Previously:** Do **NOT** report two functional limitations on the same day.
- **Now:** All evaluations should be **reported**, even on the same day as other ongoing G-code reporting for the primary functional limitation.
- **Note:** Although more than one evaluation may be reported on the same day, **ongoing reporting** is still only allowed for one functional limitation.

For more information, see: [www.asha.org/Practice/reimbursement/medicare/Guidance-on-Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/](www.asha.org/Practice/reimbursement/medicare/Guidance-on-Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/)

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

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For Further Information on Coding and Reimbursement

[www.asha.org/practice/reimbursement](www.asha.org/practice/reimbursement)

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