Codify
BY AAPC

Eli's Rehab Report

Get Paid for Stroke Rehab Care Services by Speech-Language Pathologists

Kirk Douglas, Princess Margaret, Quincy Jones ... all of these celebrities have suffered strokes, and then reappeared in the public eye. Stroke patients who recover and continue performing their pre-stroke activities usually have a full team of rehabilitation professionals to thank, including physiatrists, neurologists, physical and occupational therapists, dietitians, social workers, and speech-language pathologists.

Many physiatrists who concentrate on stroke rehabilitation work closely with speech-language pathologists, but billing for their services can be difficult because, for the most part, they use codes outside of the physical medicine range (97001-97799). Knowing the proper codes to bill for speech evaluations and procedures can help PM&R practices identify the full range of stroke therapy services.

The first point to note regarding speech-language pathologist (SLP) billing is that these professionals can bill incident to as employees of a physician practice, whether part-time or full-time. Or, they can submit claims independently as contractors who come into the practice on a regular basis.

All of the provisions of incident to are necessary when billing, says **Mark Kander,** director of healthcare regulatory analysis at the American Speech-Language-Hearing Association in Rockville, Md. They include the following:

The physician be on-site at the time of treatment;

The doctor saw the patient for the first visit;

The physician must see established patients for any new medical problems; and

Service may only be provided in the physicians office, patients home or an institutional office setting.

In this situation, the SLPs claims would be submitted under the supervising physicians identification number.

When billing independently, claims would be reported with his or her own provider identification number.

Initial Evaluations

An initial evaluation for a stroke patient involves determining their needs and finding out what types of communication skills they had before the stroke, says **Julie Gatts, MA, CCC-SLP,** a speech-language pathologist who is director of the Shiefelbusch Speech Language Hearing Clinic at the University of Kansas in Lawrence. The SLP talks with the patients family, the physiatrist in charge of the rehabilitation, and with the patient to evaluate which methods are most appropriate.

This initial evaluation is billed using **CPT 92506** (evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status). However, Medicare stipulates that any SLP evaluation must be ordered by a referring physician, and that the documentation must demonstrate that the evaluation was performed for a covered condition, and not for screening purposes. For example, a patient presents to an SLP stating that she is concerned that her speech is slurring. The SLP performs a series of word drills with the patient to determine whether the patient is suffering from any speech problems. This evaluation would be considered a screening, and would not be covered by Medicare.

For Medicare to reimburse for stroke rehabilitation services, the SLPs documentation must include:

specific information about the patients history;
the date of the stroke;
the patients prior level of functioning, and current baseline abilities;
plan goals;
expected duration and frequency of speech therapy; and
what types of tests were performed.

Progress toward a functional goal is a must for a treatment plan, Gatts says. The first step is determining the patients needs and where theyre starting, and then we look at their speech, language, pragmatic language, and cognition skills to figure out what kind of progress we think they might be able to make.

Insurers will not cover maintenance-type treatment, she says. For example, if a patient has reached a plateau in his treatment and doesnt seem to be improving, often, the patients family is concerned that he may slide downhill again, so they choose to keep him on a speech therapy regimen. However, if the patient is working to keep the skills that he or she has, and is not working toward a goal, Medicare will deny the claims.

Also, Medicare does not pay for SLP services unless the physician reviews the plan of care and signs it every 30 days. Most carriers require that the same physician who approves the plan must certify the necessity for any ordered services.

About 25 percent of stroke patients suffer from aphasia, 784.3 (problems using or understanding language) and, therefore, this is the specific diagnosis that the SLP is treating. According to section 6.1 of the Medicare Program Integrity Manual, diagnoses for stroke patients receiving speech therapy only on a particular date should be coded first using the V code for speech therapy, followed by the code for aphasia, and then the code for stroke.

Therefore, diagnoses for SLP services for aphasia patients recovering from strokes would be coded as V57.3 (speech therapy), 784.3 and 436 (stroke).

Treatment Documentation

Treatment of aphasia patients is coded using 92507 (treatment of speech, language, voice, communication and/or auditory processing disorder [includes aural rehabilitation]; individual). Treatment usually lasts between 30 and 60 minutes, Gatts says, and involves activities such as repeating after the speech language pathologist, practicing following directions, reading and writing words, and other focused tasks based on the patients needs.

Each time a patient is seen by the SLP, documentation in the medical record must include the sessions objective and progress made.

For example, June 15, 2001. John Smith scored 89 percent on the word subtest on the Michigan test of aphasia, as compared with his test score of 72 percent last month. He read two paragraphs aloud from the newspaper and afterward explained the meaning of the text. This nearly completes the goals that we outlined last month, and we estimate that treatment will be completed within the next two months. In addition, he scored 92 percent on word naming, as compared with last months score of 86.

Progress reports that do not outline improvement, or include vague statements such as Mr. Smith bit his tongue this morning and slurred his speech more than usual, are not viewed by Medicare as supportive of coverage.

Evaluating Swallowing Tests

In addition to evaluation and treatments provided by SLPs, they also perform swallowing tests. For example, they use the modified barium swallow, which is frequently performed on stroke and aphasia patients to document how the oral cavity, pharynx and the upper esophagus perform while a patient swallows. The test helps in evaluation because it shows therapists exactly what has been affected regarding the tongue, mouth, throat and esophagus.

The radiologist and SLP conduct a fluorographic study, which is recorded on video for in-depth analysis. The radiologist bills using 74230 (swallowing function, pharynx and/or esophagus, with cineradiography and/or video) while the SLP bills for the procedural component using 92525 (evaluation of swallowing and oral function for feeding).

Some Part B carriers limit payment for 92525 to physicians only, so in those regions, SLPs would have to bill for these services using the incident to guidelines and under the direct supervision of a physician. (For more information on billing for incident to, see the May 2001 Nonphysician Practitioner Reimbursement Alert or call 800-508-2582 for information about this publication).

Evaluating for AAC Devices

Medicare and Medicaid now pay for augmentative and alternative communication [AAC] devices, Gatts says. Many stroke patients are candidates for this equipment because it gives them a voice until they learn to speak again. Last year, HCFA announced that it would allow regional Medicare carriers to decide whether to cover these devices on an individual-carrier basis, and many SLPs have been choosing appropriate candidates for the equipment. There is still no national decision, so each local carriers decision designates guidelines on a region-to-region basis.

Although listed in CPT 2001, codes 92597 (evaluation for use and/or fitting of voice prosthetic or augmentative/ alternative communication device to supplement oral speech) and 92598 (modification of voice prosthetic or augmentative/alternative communication device to supplement oral speech) were replaced effective Jan. 1, 2001, with the following new HCPCS codes:

G0197 evaluation of patient for prescription of speech-generating devices;

G0198 patient adaptation and training for use of speech-generating devices;

G0199 re-evaluation of patient using speech-generating devices;

G0200 evaluation of patient for prescription of voice prosthetic; and

G0201 modification or training in use of voice prosthetic

Note: If 92597 or 92598 is accidentally used, the insurer will most likely replace them with the HCPCS codes, but some may not and the claim will be denied.

Re-evaluating a Patient

Although no specific code covers speech language re-evaluation, SLPs can bill for them using 92506. Most carriers cover these only if the patient shows a change in functional speech or motivation, or if he or she recovers from an illness that had previously been inhibiting rehabilitation.

Codify
BY AAPC

When Dietitians Take Part in Stroke Rehabilitation

Stroke patients often experience problems swallowing and/or chewing and, therefore, some rehabilitation plans involve dietitians who help patients find appropriate food. However, PM&R practices that plan to hire dietitians should be aware that Medicare does not allow them to bill codes higher than 99211 (office or other outpatient visit), says **Barbara Cobuzzi, MBA, CPC, CHBME,** the president of Cash Flow Solutions, a physician group billing company based in Lakewood, N.J.

For a nonphysician provider to bill higher than 99211, they have to be either a nurse practitioner, physicians assistant, psychologist, clinical social worker or certified nurse midwife, Cobuzzi says. In addition, reimbursement for 99211 (about $13) is inadequate for the services provided by the nutritionist, who often has to spend a significant amount of time with the patient.

Any services offered to Medicare patients by dietitians should essentially be viewed as noncovered services, and you should collect payment directly from them.

Patients should be informed up front that the services are not covered, and they can choose whether to proceed. Because it is noncovered, an advance beneficiary notice (ABN) is not required, Cobuzzi says, but, you may want to get one anyway to better protect your practice.

The introduction of 97802-97804 (medical nutrition therapy) in CPT 2001 led some practices to believe that Medicare will pay for these services, but no RVUs have been established. Medicare will reimburse for these codes beginning in 2002, but these services will only be covered for diabetic and prerenal patients.

Some private carriers reimburse for dietitians services, and may recognize the new codes. Each private insurer dictates whether nutritionists should bill incident to or whether they should use their own personal identification numbers.