TREATING MEDICARE BENEFICIARIES

WHAT EVERY UNIVERSITY CLINIC MUST KNOW AND IMPLEMENT

MARK DERUITER

DANIELLE VARNEDOE

TIM NANOF, MSW

DISCLOSURES:

- **FINANCIAL**
  - TIM NANOF RECEIVES A SALARY FROM ASHA FOR HIS ROLE AS DIRECTOR OF HEALTH CARE POLICY & ADVOCACY.
  - MARK DERUITER RECEIVES A SALARY FROM THE UNIVERSITY OF ARIZONA FOR HIS ROLE AS ASSOCIATE DEPARTMENT HEAD AND CLINIC DIRECTOR.
  - DANIELLE VARNEDOE RECEIVES A SALARY FROM THE UNIVERSITY OF SOUTH CAROLINA FOR HER ROLE AS CLINIC DIRECTOR.
- **NON-FINANCIAL**
  - TIM NANOF CONTRIBUTES TO FOR-SALE PRODUCTS DEVELOPED BY ASHA
  - MARK DERUITER IS PRESIDENT OF CAPCSD AND IS A MEMBER OF THE ASHA HEALTH CARE ECONOMICS COMMITTEE.
  - DANIELLE VARNEDOE DOES NOT HAVE A NON-FINANCIAL INTEREST TO REPORT.

AGENDA:

- INTRODUCTIONS, DISCLOSURES AND RESOURCES
- COMPLIANCE DETAILS: RULES & REGS
- A COMPLIANCE EXPERIENCE: PRACTICAL DISCUSSION
- QUESTIONS & ANSWERS
- CONTACT INFORMATION & RESOURCES

MEDICARE OVERVIEW

THE ABCD'S OF MEDICARE:

- **PART A-** INPATIENT
- **PART B-** OUTPATIENT
- **PART C-** MEDICARE ADVANTAGE
- **PART D-** PRESCRIPTION DRUG BENEFIT
- MEDICARE BENEFICIARIES HAVE A DEDUCTIBLE
- MEDICARE BENEFICIARIES PAY A MONTHLY INSURANCE PREMIUM
- CO-INSURANCE
  - MEDICARE PAYS 80%
  - SECONDARY "ADDRESSES THE OUTSTANDING 20%

UNIVERSITY CLINIC (& PRIVATE PRACTICE) ENROLLMENT & COMPLIANCE

- OPT-OUT
- SUPERVISION REQUIREMENTS FOR STUDENTS & CF'S
- CLAIMS SUBMISSION
- PARTICIPATING & NON-PARTICIPATING OPTIONS
- ESTABLISHING RATES AND SLIDING SCALES
- MEDICALLY NECESSITY, SKILLED CARE AND COVERED SERVICE
  - DIAGNOSTICS, TREATMENT, MAINTENANCE CONSIDERATION

AUDIOLOGISTS & SLPS CAN'T OPT OUT OF MEDICARE

- CMS REQUIRES THAT COVERED SERVICES **MUST** BE SUBMITTED FOR MEDICARE BENEFICIARIES (**MANDATORY REPORTING REQUIREMENT**)
- TO BILL MEDICARE, YOU MUST BE ENROLLED IN MEDICARE
- APPROXIMATELY 30 DAYS TO OBTAIN PROVIDER STATUS

REPEAT

WHEN PROVIDING A COVERED, MEDICALLY NECESSARY, SKILLED SERVICE TO A MEDICARE BENEFICIARY AUDIOLOGISTS & SPEECH-LANGUAGE PATHOLOGISTS **MUST** COMPLY WITH MEDICARE RULES AND SUBMIT CLAIMS.

- BILLING
- SERVICE DELIVERY
- SUPERVISION

"EXCEPTION"

- DOES NOT APPLY TO NON-COVERED SERVICES
  - HEARING AIDS AND RELATED TESTING
  - NO-PHYSICIAN REFERRAL FOR AUDIOLOGY
  - NO MEDICAL NECESSITY
  - NON-SKILLED CARE

MEDICARE RULES DON'T APPLY TO NON-MEDICARE SERVICES

HOWEVER, IF A BENEFICIARY BELIEVES THAT A SERVICE MAY BE COVERED, A FORMAL MEDICARE DETERMINATION MUST BE GRANTED!!!!!!!

MEDICARE IS AN ENTITLEMENT

- MEDICARE RULES APPLY TO ALL MEDICARE COVERED SERVICES PROVIDED TO ELIGIBLE BENEFICIARIES
- THE RULES ARE INTENDED TO ENSURE BENEFICIARIES HAVE ACCESS TO THE CARE THEY ARE ENTITLED TO AFTER PAYING INTO THE SYSTEM THROUGH FICA TAXES WHILE EMPLOYED
- POLICIES ARE ESTABLISHED TO PROTECT MEDICARE AND BENEFICIARIES FROM “BAD ACTORS”

SUPERVISION REQUIREMENTS

MEDICARE STANDARDS

- **STUDENTS**
  - PERSONAL (100% DIRECT)
    - PART A VS PART B

PERSONAL VS DIRECT

- **CLINICAL FELLOWS**
  - PROVISIONAL LICENSURE
  - REGISTRATION (AL, TN)
  - NO LICENSURE (MA, CT, HI)
  - RECENTLY ENACTED: NY, PA, DC, AL

CHECK WITH YOUR PAYER… MEDICAID AND PRIVATE HEALTH PLAN REQUIREMENTS VARY DRAMATICALLY FROM STATE TO STATE/PLAN TO PLAN.

SUPERVISION DETAILS CONTINUED…

- ALL STATE, PAYER AND PROFESSIONAL PRACTICE GUIDELINES FOR STUDENT SUPERVISION MUST BE FOLLOWED FOR REIMBURSEMENT.
- STUDENTS AND UNLICENSED CFS ARE CONSIDERED EXTENSIONS, NOT INDEPENDENT OF, THE PROFESSIONAL PROVIDER
- ALTHOUGH SNF SUPERVISION RULES FOR PART A SERVICES ARE LESS STRINGENT THAN PART B RULES, RESPONSIBILITY OF CARE REMAINS 100% WITH SUPERVISING PROVIDER

MEDICAL NECESSITY

- **NAIC DEFINITION:**
  - *HEALTH CARE SERVICES OR SUPPLIES NEEDED TO PREVENT, DIAGNOSE OR TREAT AN ILLNESS, INJURY, DISEASE OR ITS SYMPTOMS AND THAT MEET ACCEPTED STANDARDS OF MEDICINE.*

- **MEDICARE DEFINITION:**
  - *HEALTH CARE SERVICES OR SUPPLIES NEEDED TO DIAGNOSE OR TREAT AN ILLNESS, INJURY, CONDITION, DISEASE, OR ITS SYMPTOMS AND THAT MEET ACCEPTED STANDARDS OF MEDICINE.*

SKILLED CARE & COVERED SERVICES

- CRITERIA FOR SKILLED CARE
- CRITERIA FOR COVERED SERVICES
- CONSIDERATIONS FOR:
  - DIAGNOSTICS
  - TREATMENT
  - MAINTENANCE (JIMMO SETTLEMENT)
  - THERAPY CAP ($1980 FOR 2017 WITH EXCEPTIONS…)

FOR ALL MEDICARE SETTINGS

- PATIENT IS UNDER CARE OF PHYSICIAN AND REQUIRES SKILLED THERAPY SERVICES, AS DEMONSTRATED BY PHYSICIAN'S ORDER FOR SERVICE OR SIGNATURE ON THE PLAN OF CARE (POC)
- ALL COVERED MEDICARE SERVICES MUST BE REASONABLE AND NECESSARY AND PROVIDED AT A LEVEL OF COMPLEXITY THAT REQUIRES A QUALIFIED PROFESSIONAL FOR SAFE AND EFFECTIVE CARE
- MEDICARE BENEFIT POLICY MANUAL REFERS TO MEDICARE PART B OUTPATIENT SERVICES AS THE STANDARDS FOR DOCUMENTATION
  - WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/GUIDANCE/MANUALS/DOWNLOADS/BP102C15.PDF

SPEECH-LANGUAGE PATHOLOGY
WHAT IS UNSKILLED CARE?

- UNSKILLED SERVICES DO NOT REQUIRE THE SPECIAL KNOWLEDGE AND SKILLS OF AN SLP
- PERFORMANCE REPORTING WITHOUT DOCUMENTING MODIFICATION, TRAINING
- REPETITION OF SAME ACTIVITIES WITHOUT NOTING MODIFICATIONS OR OBSERVATIONS
- ACTIVITIES WITHOUT RATIONALE OR CONNECTION TO THE GOALS

SPEECH LANGUAGE PATHOLOGY WHAT IS UNSKILLED CARE?

- OBSERVING CAREGIVERS WITHOUT PROVIDING EDUCATION OR FEEDBACK AND/OR WITHOUT MODIFYING PLAN
- RECORDING OBSERVATIONS OF BENEFICIARY WITHOUT PROVIDING ANY DIRECT TREATMENT STRATEGIES
- SERVICE CAN BE SELF-ADMINISTERED
- SERVICE MAY BE FURNISHED SAFELY AND EFFECTIVELY BY AN UNSKILLED PERSON WITHOUT DIRECT OR GENERAL SUPERVISION

SPEECH LANGUAGE PATHOLOGY WHAT IS UNSKILLED CARE?

- SERVICE IS RELATED TO ACTIVITIES FOR THE GENERAL GOOD AND WELFARE OF PATIENT (E.G., FITNESS, FLEXIBILITY, MOTIVATION, DIVERSION)
- THERAPIST PROVIDES AN IMPORTANT, YET NONSKILLED SERVICE IN THE ABSENCE OR UNAVAILABILITY OF A COMPETENT PERSON
- SERVICE IS NOT CONSIDERED A SKILLED THERAPY SERVICE MERELY BECAUSE THE ACTIVITY IS PROVIDED BY A QUALIFIED THERAPIST
- ASK YOURSELF, "CAN THIS BE DONE BY SOMEONE ELSE?"

MEDICARE BENEFIT POLICY MANUAL- SKILLED CARE

- 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 THERAPIST…

- 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.

SPEECH LANGUAGE PATHOLOGY WHAT IS SKILLED CARE?

- **ANALYZE** MEDICAL/BEHAVIORAL DATA AND SELECT APPROPRIATE EVALUATION TOOLS/PROTOCOLS
- **DESIGN** PLAN OF CARE **(POC)**
- DEVELOP AND DELIVER TREATMENT ACTIVITIES THAT FOLLOW A **HIERARCHY** OF COMPLEXITY TO ACHIEVE THE TARGET SKILLS FOR A FUNCTIONAL GOAL
- BASED ON EXPERT OBSERVATION, **MODIFY ACTIVITIES** DURING TREATMENT SESSIONS TO MAINTAIN PATIENT MOTIVATION AND FACILITATE SUCCESS.
- CONDUCT ONGOING **ASSESSMENT** OF PATIENT RESPONSE

SPEECH LANGUAGE PATHOLOGY
WHAT IS SKILLED CARE?

- DETERMINE APPROPRIATE TIME FOR **DISCHARGE** OR TERMINATION OF SLP SERVICE
- EXPLAIN **RATIONALE** AND EXPECTED RESULTS
- DEVELOP **MAINTENANCE** PROGRAM TO BE CARRIED OUT BY PATIENT AND CAREGIVER
- **TRAIN PATIENTS/CAREGIVERS** IN USE OF COMPENSATORY SKILLS AND STRATEGIES
  - WWW.ASHA.ORG/PRACTICE/REIMBURSEMENT/MEDICARE/DOCUMENTATION-OF-SKILLED-VERSUS-UNSKILLED-CARE-FOR-MEDICARE-BENEFICIARIES

SKILLED CARE & COVERED SERVICES CASE EXAMPLE:

- WOMAN AGE 73
- MEDICARE ENROLLED
- LATE EFFECT CVA RECEIVING TX 5-YEARS POST-STROKE
- MEDICAL NECESSITY CRITERIA?
- FUNCTIONAL IMPAIRMENT?
- TREATMENT GOALS?
- SKILLED CARE? (SLP TX, LPAA)

WHAT DETERMINES MEDICARE COVERAGE CRITERIA?

CLAIM SUBMISSION…

MEDICARE IS AN ENTITLEMENT PROGRAM.

- MEDICARE CLAIMS MUST BE SUBMITTED FOR MEDICARE BENEFICIARIES WHEN PROVIDING MEDICARE COVERED SERVICES.

- PARTICIPATING VS NON-PARTICIPATING

    - PROS & CONS

ESTABLISHING RATES & SLIDING SCALES

- **MEDICARE RATES MPFS**
  - NOVEMBER ANNUALLY
  - PARTICIPATING/NON-PARTICIPATING
  - THE "LIMITING CHARGE"

  THE LIMITING CHARGE APPLIES TO NON-PARTICIPATING PROVIDERS IN THE MEDICARE PART B PROGRAM WHEN THEY DO NOT ACCEPT ASSIGNMENT.

  THE LIMITING CHARGE IS 115 PERCENT OF THE PHYSICIAN FEE SCHEDULE AMOUNT. THE BENEFICIARY IS NOT RESPONSIBLE FOR BILLED AMOUNTS IN EXCESS OF THE LIMITING CHARGE FOR A COVERED SERVICE. (115% OF 95%...)

  FREE CARE OR REDUCED COST SLIDING FEE SCALES…

  KEY PRINCIPLES: <u>UNIFORM AND EQUAL APPLICATION ACROSS PAYERS.</u>

IS THERE AN ALTERNATIVE TO ENROLLING IN AND BILLING MEDICARE?

YES!

- DO NOT SCHEDULE MEDICARE BENEFICIARIES
- IF A MEDICARE BENEFICIARY APPROACHES YOU FOR TREATMENT AND YOU DO NOT WANT TO ENROLL IN AND BILL MEDICARE FOR THE SERVICES, THEN YOU MUST REFER THE PATIENT ELSEWHERE.
- YOU ARE ALLOWED TO SAY NO TO MEDICARE BENEFICIARIES.
  - EXAMPLE- PEDIATRIC PRACTITIONERS…
- EVEN IF A BENEFICIARY IS WILLING TO PAY YOU OUT OF POCKET, YOU CAN ONLY SEE HIM/HER IF YOU ENROLL IN AND BILL MEDICARE
- PROVIDE FREE SERVICES TO ALL CLIENTS.
- LIMIT SERVICE PROVISION TO UNSKILLED CARE OR TO INDIVIDUALS WITHOUT MEDICAL NECESSITY

"INCIDENT-TO" OPTION FOR SLPS WORKING UNDER DIRECT SUPERVISION OF A PHYSICIAN

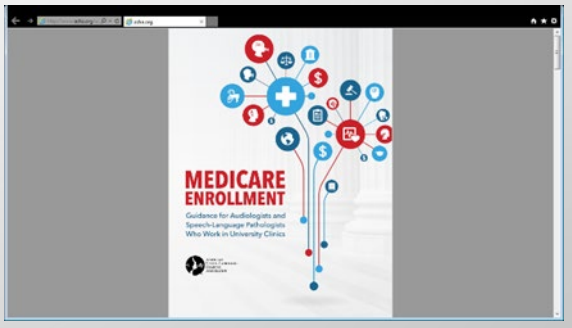
A PROGRAM'S EXPERIENCE

THE DECISION TO ENROLL

- COCHLEAR IMPLANT PROGRAM
- LARGE APHASIA RESEARCH LAB = ACCESS TO PATIENTS
- LSVT FOR INDIVIDUALS WITH PARKINSON'S DISEASE
- OTHERS - OVER 65 OR UNDER 65 SOCIAL SECURITY DISABILITY FOR NO LESS THAN 24 MONTHS

HOW WE STARTED

- ENROLLMENT
  - CMS-855-B FORM
    - COMPLETED APPLICATION INCLUDES INDIVIDUAL PROVIDER INFORMATION, INCLUDING NPI NUMBERS
    - PROVIDERS RE-ASSIGNMENT PAYMENT TO THE CENTER (FORM 855-R)
- TIME-FRAME: @3 MONTHS (?)
  - LEGAL REVIEW
  - CMS RETURNED THE APPLICATION
- RE-SUBMISSION – SUCCESS!



- LOCAL "MAC" (MEDICARE ADMINISTRATIVE CONTRACTOR): ESTABLISH WHICH SERVICES ARE "REASONABLE AND NECESSARY"

HOW TO GET STARTED

MEDICARE ENROLLMENT COMPLIANCE GUIDE FOR SPEECH AND AUDIOLOGY:

HTTP://WWW.ASHA.ORG/UPLOADEDFILES/MEDICARE-ENROLLMENT-FOR-UNIVERSITY-CLINICS.PDF

POSITIVE OUTCOMES

- ALTERNATE SERVICE DELIVERY MODELS
  - APHASIA PATIENTS WHO MEET THE THRESHOLD OF MEDICAL NECESSITY
    - INTENSIVE THERAPY VS. ONE TIME PER WEEK
    - INTENSIVE: 3-4 TIMES PER WEEK FOR 6 WEEKS

- PATIENTS WITH PARKINSON'S DISEASE (MEDICALLY NECESSARY)
  - LSVT IS INTENSIVE (FOUR TIMES PER WEEK FOR FOUR WEEKS)

WE WILL SEE A PATIENTS ONE TIME PER WEEK IF THERE ARE NO OTHER OPTIONS

THE CHALLENGES

- TRAINING CLINICAL FACULTY
  - GROUP TRAINING
  - 1:1 TRAINING ON HOW TO COMPLETE THE SUPERBILL, IF NEEDED
  - ROUTINELY REVIEW PROCEDURES AT CENTER FACULTY MEETINGS
  - PROVIDE A GUIDE (E.G. TRAINING MANUAL)

THE CHALLENGE

- YOU NEED SUPPORT STAFF
  - BUSINESS MANAGER (HANDLES ALL CONTRACTS AND BILLING DENIALS)
  - SCHEDULING COORDINATOR (HANDLES OBTAINING PHYSICIAN SIGNATURE ON POCS)
  - RECEPTIONIST (REVIEWS SUPERBILLS E-SUBMITTED BY FACULTY)
  - BILLING ASSISTANT (ALSO ASSISTS IN POC AND SCREENING SUPERBILLS AS NEEDED)

IMPLEMENTING TREATMENT FOR MEDICARE PATIENTS

- SERVICES MUST BE ***MEDICALLY NECESSARY, REASONABLE AND SKILLED***
- SERVICES MUST BE ***SKILLED*** (SERVICES THAT ONLY A SLP OR AUDIOLOGIST CAN PROVIDE)
- ESTABLISH/DOCUMENT MEDICAL NECESSITY
  - PHYSICIAN REFERRAL
  - PERTINENT MEDICAL HISTORY THAT RELATES TO COMMUNICATION DIS.
  - CONFIRMED DIAGNOSIS OF SPEECH, LANGUAGE, HEARING DISORDER
  - DATE OF ONSET OF SPEECH, LANGUAGE, HEARING DISORDER
  - INITIAL ASSESSMENT DATE
  - PLAN OF CARE SIGNED BY PHYSICIAN OR NPP ASAP OR WITHIN 30 DAYS
  - PROGRESS NOTES OR REPORTS

SUPERVISION REQUIREMENT

- SUPERVISION REQUIREMENTS UNDER PART B:
  - 100% OF THE TIME
  - IN THE ROOM
  - THE PROFESSIONAL IS THE PROVIDER, NOT THE STUDENT
  - PROVIDER "ACTIVELY" INVOLVED WITH THE PATIENT
  - **DECISION-MAKING** IS THE RESPONSIBILITY OF THE PROVIDER

- WE HAVE A "NATURAL" CAP ON THE NUMBER OF MEDICARE PATIENTS WE CAN SEE IN ANY ONE SEMESTER

SUPERVISION REQUIREMENT

WHAT DOES THE SUPERVISION REQUIREMENT LOOK LIKE?

- APHASIA TREATMENT
  - SPACE RETRIEVAL TASK – CLINICAL EDUCATOR MAKES THE DECISION TO INTERJECT A QUESTION WHILE STUDENT IS WORKING ON A TREATMENT OBJECTIVE/TASK.
  - CUEING – STUDENT PROVIDES THE CUE AS INDICATED ON THE LESSON PLAN; CLINICAL EDUCATOR MAKES THE DECISION TO USE A DIFFERENT CUE IF PATIENT IS OR IS NOT SUCCESSFUL.

SUPERVISION REQUIREMENT

WHAT DOES THE 100% SUPERVISION REQUIREMENT LOOK LIKE?

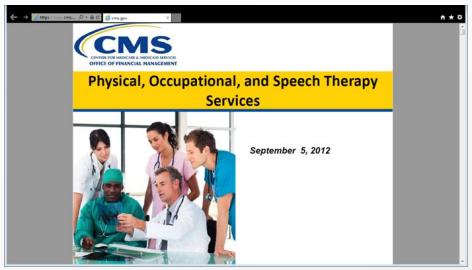
- LSVT
  - CLINICAL EDUCATOR MANAGES THE EQUIPMENT WHILE STUDENT PRESENTS TASK(S). CLINICAL EDUCATOR MODELS HOW TO ANSWER SPECIFIC QUESTIONS THAT STUDENT MAY NOT KNOW THE ANSWER (OUR ADULT PATIENTS ASK *MANY* QUESTIONS)

BRIEF OVERVIEW OF TRADITIONAL OUT OF THE ROOM CLINICAL TEACHING VERSUS IN THE ROOM CLINICAL TEACHING.

TAKE-AWAY ON 100% SUPERVISION

- MEDICARE WANTS TO ENSURE THAT THE THERAPY SESSION STAYS ON TRACK AT ALL TIMES FOR THE BENEFIT OF THE **PATIENT**.
- CLINICAL TEACHING IN THE ROOM ENSURES THAT REAL-TIME DECISION MAKING ADVANCES **PATIENT** PROGRESS ON OBJECTIVES. (PATIENT SUCCESS).
- THINK ABOUT 100% IN THE ROOM SUPERVISION AS "STUDENT COACHING".

DOCUMENTATION REQUIREMENTS: SPEECH SERVICES



- DOCUMENTATION REQUIREMENTS AND GUIDELINES
  - EVALUATIONS AND RE-EVALUATIONS
  - PLAN OF CARE
  - THERAPY GOALS (APPROPRIATE/FUNCTIONAL AND MEASURABLE)
- CERTIFICATION/RECERTIFICATION BY PHYSICIAN (EVERY 90 DAYS) OR WHEN A SIGNIFICANT CHANGE TO THE PLAN IS MADE
- TREATMENT NOTES FOR EACH TREATMENT SESSION
- PROGRESS REPORTING EVERY 10TH TREATMENT DAY OR THE 30TH CALENDAR DAY OF THE EPISODE OF TREATMENT, WHICHEVER IS SHORTER. SUPERBILL MUST DOCUMENT PROGRESS TO DATE (SEVERITY MODIFIER CHANGE?)
- DISCHARGE SUMMARY

HTTPS://WWW.CMS.GOV/RESEARCH-STATISTICS-DATA-AND-SYSTEMS/MONITORING-PROGRAMS/MEDICAL-REVIEW/DOWNLOADS/THERAPYCAPSLIDESV10_09052012.PDF

DOCUMENTATION REQUIREMENTS: AUDIOLOGY

HTTP://WWW.AUDIOLOGIST.ORG/MEDICARE-FAQS

HTTPS://WWW.ASHA.ORG/PRPSPECIFICTOPIC.ASPX?FOLDERID=8589942637&SECTION=KEY_ISSUES

MEDICARE COVERAGE

MEDICARE PAYS:

- THE EVALUATION OF COMMUNICATION AND HEARING DISORDERS WHEN ORDERED BY A PHYSICIAN (NOT SCREENINGS)
- MEDICALLY NECESSARY TREATMENT
- MAINTENANCE THERAPY
- COCHLEAR IMPLANT SUPPLIES (BILLED BY COCHLEAR)
- SPEECH GENERATING DEVICES (REFER TO THE BELOW LINK FOR REQUESTING THE FUNDS FROM MEDICARE)

HTTP://WWW.ASHA.ORG/SLP/HEALTHCARE/MEDICARE-SPEECH-GENERATING-DEVICES-INFORMATION/

MEDICARE DOES NOT PAY FOR:

- HEARING AIDS OR SUPPLIES

FEE SCHEDULES FOR AUDIOLOGY AND SPEECH

HTTP://WWW.ASHA.ORG/UPLOADEDFILES/2018-MEDICARE-PHYSICIAN-FEE-SCHEDULE-AUDIOLOGY.PDF

HTTP://WWW.ASHA.ORG/UPLOADEDFILES/2018-MEDICARE-PHYSICIAN-FEE-SCHEDULE-SLP.PDF

CODING RULES

HTTP://WWW.ASHA.ORG/PRACTICE/REIMBURSEMENT/MEDICARE/SLP_CODING_RULES/

HTTPS://WWW.ASHA.ORG/PRACTICE/REIMBURSEMENT/MEDICARE/AUD_CODING_RULES/

CODING RULES

- THERE ARE SOME TIMED CODES
  - EVALUATION OF SGD (92607, FIRST HOUR; 92608, EACH ADD. 30 MIN
  - ASSESSMENT OF APHASIA (96105 PER HOUR)
  - EVALUATION OF AUDITORY REHABILITATION STATUS (92929, FIRST HOUR; 92627 EACH ADD. 30 MIN)

MOST CODES ARE UNTIMED

CODING RULES

- THERE ARE CODE MODIFIERS COMMON TO SPEECH SERVICES
  - -22 MODIFIER (WORK IS SIGNIFICANTLY GREATER THAN TYPICALLY REQUIRED
  - -52 MODIFIER (FOR AN ABBREVIATED PROCEDURE)
  - -59 MODIFIER (SAME DAY BILLING; USED TO DISTINGUISH ONE SERVICE FROM THE OTHER

    HTTP://WWW.ASHA.ORG/PRACTICE/REIMBURSEMENT/CODING/CCI-EDIT-TABLES-SLP/
  - -KX MODIFIER (FOR SERVICES THAT EXCEED THE ANNUAL THERAPY CAP (SERVICES MUST BE MEDICALLY NECESSARY WITH DOCUMENTATION FOR REVIEW IF REQUESTED)

CODING RULES

- CODE MODIFIERS FOR AUDIOLOGY SERVICES
  - GY: SERVICE IS STATUTORILY EXCLUDED. IT IS USED TO INDICATE THAT A DENIAL IS REQUIRED FOR BILLING A SECONDARY INSURANCE FOR REIMBURSEMENT. COMMONLY UTILIZED FOR A HEARING AID BENEFIT.
  - GX: IT IS TO BE USED WHEN A VOLUNTARY ABN WAS ISSUED. AUDIOLOGISTS WOULD TYPICALLY REPORT THIS MODIFIER WHEN PERFORMING STATUTORILY EXCLUDED, NON-COVERED SERVICES.

CODING RULES

- GN MODIFIER/SUFFIX FOR SPEECH SERVICES
  - CPT CODES (REFER TO PREVIOUS LINK ON SLIDE 40)
  - **G-CODES FUNCTIONAL OUTCOMES**

HTTP://WWW.ASHA.ORG/PRACTICE/REIMBURSEMENT/MEDICARE/G-CODES-AND-SEVERITY-MODIFIERS-FOR-OUTCOMES-REPORTING/

HTTP://WWW.ASHA.ORG/UPLOADEDFILES/G-CODE-SCENARIOS.PDF

CLAIMS-BASED OUTCOMES REPORTING

- G-CODES AND SEVERITY MODIFIERS MUST BE INCLUDED ON ALL REQUIRED DOCUMENTATION FOR SPEECH SERVICES
  - EVALUATION/RE-EVALUATION
  - POC
  - PROGRESS REPORTS
  - DISCHARGE SUMMARY
  - SUPERBILL

OTHER RESOURCES

ABN (ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE)

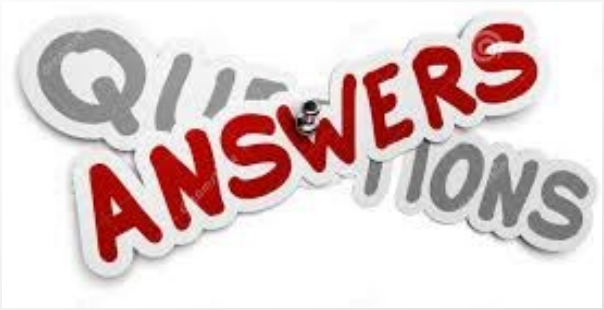
HTTPS://WWW.CMS.GOV/MEDICARE/MEDICARE-GENERAL-INFORMATION/BNI/ABN.HTML

HTTPS://WWW.MEDICARE.GOV/CLAIMS-AND-APPEALS/MEDICARE-RIGHTS/ABN/ADVANCE-NOTICE-OF-NONCOVERAGE.HTML

SAMPLE ABN

HTTPS://WWW.CORCORANCCG.COM/DIGITAL_FILES/FORMS/ABN%20CMS-R-131_0617.PDF

QUESTIONS AND DISCUSSION



CONTACT INFORMATION:

- **TIM NANOF**: TNANOF@ASHA.ORG
  - SARAH WARREN: SWARREN@ASHA.ORG
- **DANIELLE VARNEDOE**: DANIELL@MAILBOX.SC.EDU
- **MARK DERUITER**: MDERUITER@EMAIL.ARIZONA.EDU

Treating Medicare Beneficiaries: What Every University Clinic Must Know and Implement

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