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# Medicare

## Comments and Responses Regarding Draft Local Coverage Determination: Swallow Evaluation and Dysphagia Treatment

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As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft **Swallow Evaluation and Dysphagia Treatment** LCD. The official notice period for the final LCD begins on October 1, 2008, and the final determination will become effective on November 15, 2008.

*Comment:* A commenter requested the inclusion of three CPT codes 70370 (Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique), 70371 (Complex dynamic pharyngeal and speech evaluation by cine or video recording) and 74230 (Swallowing function, with cineradiography/videoradiography) as well as numerous ICD-9-CM codes to the "ICD-9-CM Codes that Support Medical Necessity" section.

*Response:* We regret that we are unable to include additional CPT codes without re-sending the LCD for advice and comment. We will consider these codes for inclusion at a later date when the LCD is revised. We have added nine (9) additional ICD-9-CM codes to the LCD from the list of submitted ICD-9-CM codes because these conditions would nearly always require a dysphagia evaluation and treatment. We did not include the remaining ICD-9-CM codes because the coding convention used in the LCD reflects ICD-9-CM codes that represent a functional problem requiring dysphagia evaluation and treatment. The ICD-9-CM codes we did not add represent underlying medical conditions that may or may not require dysphagia evaluation and treatment. If an evaluation or treatment is required, then patients with these conditions will have a functional diagnosis to support medical necessity.

*Comment:* A commenter requested the inclusion of ICD-9-CM code 438.82 to the "ICD-9-CM Codes that Support Medical Necessity" section.

*Response:* We agree and we have added the requested ICD-9-CM code. The ICD-9-CM code is included in the nine (9) which were accepted in the preceding comment.

*Comment:* A commenter requested the inclusion of ICD-9-CM codes 438.1X (438.10, 438.11, 438.12 and 438.19) and 438.82 to the “ICD-9-CM Codes that Support Medical Necessity” section because dysphagia due to stroke is coded elsewhere in the classification (not in category 787).

*Response:* The ICD-9-CM codes cited, with the exception of ICD-9-CM code 438.82, represent a speech deficit not a swallowing deficit, and were therefore not added.

*Comment:* A commenter cited a typographical error in the “Dysphagia Categories” subheading.

*Response:* We have corrected the typographical error.

*Comment:* A commenter stated it may misrepresent the actual practice of dysphagia instrumental assessment to imply it is common and/or preferable that a physician conduct this functional assessment.

*Response:* We agree and we have changed the wording.

*Comment:* Two commenters indicated that an occupational therapist or speech language pathologist may appropriately establish a functional diagnosis directly related to the disorder to be treated.

*Response:* We have modified the wording regarding therapists’ ability to establish a functional diagnosis to include the statement “where allowed by state or local law”. Therapists are not licensed to render a diagnosis in every state.

*Comment:* A commenter indicated that a physician’s judgment is not the sole basis for determining if an instrumental assessment is not medically necessary, and that a therapist may make that determination.

*Response:* We agree and we have added “or qualified dysphagia therapists” to that language.

*Comment:* A commenter stated that maintenance programs are not limited to patients with chronic diseases.

*Response:* We agree and we have removed “in patients suffering from chronic disease” from that section.

*Comment:* Two commenters indicated that it should be the speech-language pathologist’s judgment, in consultation with the attending physician, whether “swallowing deficits that are resolving” require treatment in order to prevent aspiration.

*Response:* We agree that this clinical decision should be made in consultation with the clinician/occupational therapist/speech language pathologist whether a temporary loss or reduction of function may require treatment or will resolve spontaneously. This provision was included in the LCD

for those instances where there is spontaneous resolution of symptoms but treatment services are provided anyway. Because of the confusion, we removed this paragraph.

*Comment:* A commenter stated there are no procedures addressed in the LCD that require a physician to be immediately available except when the speech-language pathologist is an employee or contractor of a physician practice.

*Response:* We agree and we have clarified the wording that direct supervision is only required for services provided under the “incident to” provision.

*Comment:* A commenter stated that coverage for portable fluoroscopy with physician supervision should be allowed based Chapter 15, Section 80.4.4 of the *Medicare Benefit Policy Manual* because the heading in Chapter 15, Section 80.4 reads “Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician.”

*Response:* We agree and we have revised the wording to be consistent with the heading in Chapter 15, Section 80.4 of the *Medicare Benefit Policy Manual*. We have also included non-physician practitioners (NPPs).

*Comment:* A commenter cited that Chapter 15, Section 220.1.2.B in the *Medicare Benefit Policy Manual* requires long term goals, at a minimum, in the plan of care, and does not mention short term goals.

*Response:* We agree and we have revised the wording to be consistent with Chapter 15, Section 220.1.2.B of the *Medicare Benefit Policy Manual*. This change was recently manualized in Transmittal 88/Change Request 5921.

*Comment:* A commenter indicated that evaluation and intervention for dysphagia are solidly within the occupational therapy scope of practice as supported by the Accreditation Council for Occupational Therapy Education (ACOTE®) educational standards, as well as official documents of the American Occupational Therapy Association (AOTA). Occupational therapy practitioners who are adequately prepared may intervene in any or all aspects of the eating/swallowing process, and may be the primary provider of dysphagia services. The commenter claimed an entry level speech-language pathologist (SLP) receives essentially the same training in swallowing issues as an entry level occupational therapist (OT). OTs that specialize in dysphagia services receive additional training, either formal or as employer-based in-services, before providing these types of specialized swallowing services. It is appropriate that the word “qualified” also be used before SLP throughout the LCD as follows: “Dysphagia services may be performed by a physician, *qualified* speech-language pathologist, or qualified occupational therapist.”

*Response:* We included “qualified” for occupational therapists because evaluation and treatment of swallowing disorders is not generally part of their core curriculum education but requires additional training. For speech language pathologists, the evaluation and treatment of swallowing disorders is

generally part of their core curriculum education, so the qualifier “qualified” to distinguish the need for speech language pathologists for any additional training was not included.

*Comment:* A commenter provided the following attachments:

- Scope of Practice from the American Occupational Therapy Association (AOTA)
- Definition of Occupational Therapy Practice for the AOTA Model Practice Act
- Occupational Therapy Profession – Scope of Practice Definitions (by state)
- Wound Management White Paper from the American Occupational Therapy Association

It is stated in the minutes from the Indiana Open Meeting that “Occupational therapists may intervene and may be the primary provider for this service. They also have specialized training in speech and language therapy. They would like to have additional language related to occupational therapists providing these treatments added to the LCD,” but no suggested language was provided.

*Response:* No change will be made based on the comment. We have included qualified occupational therapists as providers of these services, but have made no special effort to promote one provider type over another.

*Comment:* A commenter recommended that “laryngeal elevation” be added to the element of a therapy program for training in laryngeal adduction and compensatory swallowing techniques.

*Response:* We agree and we have added the proposed language.

*Comment:* A commenter recommended a change to the definition of oral dysphagia as an inability to coordinate chewing and swallowing a bolus of solids/liquids placed in the mouth. The oral stage of swallowing involves the lips, jaw, tongue, and soft palate to prepare the bolus for swallowing and to transport the bolus into the pharynx. Muscular weakness or in coordination, lack of sensation, or alteration of these structures can result in an inefficient and prolonged oral stage that leaves residue in the mouth, or can result in all bolus types ~~thin boluses~~ spilling prematurely into the pharynx.

*Response:* We have changed the wording to “solids or liquids” and we will remove “thin boluses”.

*Comment:* A commenter suggested the deletion of a sentence because patients do not need to lie down to experience esophageal reflux or regurgitation.

*Response:* We agree and we have revised the sentence to include “especially” after regurgitation.

*Comment:* A commenter indicated occupational therapists and speech language pathologists are not formally licensed in every state where the LCD would be applicable. For example, occupational therapists and speech language therapists are currently not licensed in the state of Michigan. It was suggested we add “if applicable” when discussing the definition of a skilled therapist as a speech-language pathologist, occupational therapist, physician, or non-physician practitioner (NPP) who is licensed or certified by the state to perform therapy services.

*Response:* We agree clarification is required and have revised the wording to “licensed, certified, or otherwise authorized by the state”.

*Comment:* A commenter indicated the term “licensed” was used in three separate locations in the LCD. They indicated occupational therapists and speech-language pathologists are not licensed in every state where this LCD would be applicable and recommended the removal of the word “licensed” wherever it appears in this section.

*Response:* We agree and we have revised the first occurrence to “a qualified therapist licensed, certified, or otherwise authorized by the state in which they practice”. We have removed the second and third occurrences of “licensed.”

*Comment:* A commenter suggested adding a bullet point for laryngeal elevation to the conditions which dysphagia treatment commonly addresses (for CPT code 92526).

*Response:* We agree and we have added a bullet point for “laryngeal elevation training”.

*Comment:* A commenter to the phrase “Medical documentation” and suggested the removal of the word “Medical” and either begin the sentence with “Documentation” or start the sentence with “Therapy documentation”.

*Response:* We have revised the wording to “The medical record”, since we wished to refer to the record as a whole.

*Comment:* A commenter questioned if CPT code 92526, which is an untimed code, could be billed as 2 units/day for a patient who was seen twice on the same day for skilled therapy services related to dysphagia treatment.

*Response:* 92526 is a once per day code and we have added a clarification that even if two shorter sessions were performed during the same day, these should be combined and billed as 1 unit.

*Comment:* A commenter stated that in addition to physician services provided by speech language pathologists in private practice may also be billed “incident to” by physical therapists and occupational therapists in private practice.

*Response:* We agree and we have revised the wording to include physical therapists and occupational therapists in private practice.

*Comment:* A commenter requested a citation to a relevant reference in the CMS *National Coverage Determinations Manual* (CMS Pub 100-03, Chapter 1) where it specifically states electrical stimulation for the treatment of dysphagia (e.g., VitalStim) is not covered.

*Response:* CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 160.2 does not specifically exclude VitalStim from coverage. However, it does exclude from coverage electrical nerve stimulation to treat motor function disorders. It is this contractor's interpretation that noncoverage of VitalStim falls under this national coverage determination. We will revise the citation from Coverage Issues Manual (CIM) 35-20 to CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 160.2.

*Comment:* A commenter requested clarification that if an occupational therapist or speech language pathologist utilizes VitalStim during the course of dysphagia treatment (CPT code 92526), the supplier or provider should have the patient sign an Advanced Beneficiary Notice for VitalStim in order that they can bill the Medicare beneficiary for the VitalStim portion of the treatment. The supplier or provider would bill the VitalStim using HCPCS Level II code G0283 and append the GA modifier to G0283 on the claim form.

*Response:* It is not appropriate to give coding advice in an LCD. Please refer to the Supplemental Instructions Article (SIA) which complements the LCD for Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient services).

*Comment:* A commenter recommended the removal of the reference to physical therapy in the "Coverage Topic" section of the LCD.

*Response:* The coverage topics utilized in LCDs are determined by the Centers for Medicare & Medicaid Services. We are unable to make the recommended change.

*Comment:* A commenter indicated they were under the impression the LCD only applies to outpatient speech-language pathology services. They recommended the contractor remove Bill Type Codes 11x and 21x.

*Response:* The medical necessity parameters contained in the LCD apply to dysphagia services regardless of the setting.

*Comment:* A commenter requested a clarification regarding whether an occupational therapist is considered a qualified therapist in terms of collaborating with the physician in the medical evaluation.

*Response:* We agree and we have added "occupational".

*Comment:* A commenter disagrees that a physician must personally perform a medical evaluation prior to referring the patient for dysphagia evaluation and treatment by an occupational therapist or speech language pathologist.

*Response:* We agree and we have added "prior to the start of therapy".

*Comment:* A commenter stated it is the occupational therapist or speech language pathologist's impairment interpretation that should be submitted for each diagnostic test performed if the medical records are requested for review. If the supplier or provider has the physician's interpretation of the diagnostic test(s), they may also be submitted.

*Response:* We agree that the therapist's interpretation is an important, but we feel not sufficient part of the diagnostic test interpretation and we have changed the language to not exclude the occupational therapist or speech language pathologist's functional impairment interpretation from the requested records, and have changed the wording to simply the test "results."

*Comment:* A commenter requested the "required" items versus the "recommended" items should be clearly stated for a certification and recertification.

*Response:* We agree and we have changed the wording. We have also added wording to refer to CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.1.3 for additional information regarding certification and recertification requirements as well as to CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3 for documentation requirements for therapy services.