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Comments and Responses Regarding Draft Local Coverage Determination: Speech-Language Pathology

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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 Speech-Language Pathology 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: Several commenters requested that CPT code 96125 (standard cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified heath care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report) effective 01/01/2008, be included in the policy.

Response: Because the new code for 2008, 96125 (standard cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified heath care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report), was not included in the draft LCD does not mean that speech-language pathologists are prohibited to use it. The commenters did not send supporting documentation for what sorts of tests speech-language pathologists would administer in performing the services described by this code. We will revise the policy at a future date and solicit comments from providers concerning this testing.

Comment: Several commenters requested that we address the appropriate codes to use for re-evaluation that is necessary due to a significant change in functional status.

Response: Coding clarifications were added to the Supplemental Instructions Article (SIA).

Comment: One commenter questioned why speech therapists were not included as qualified therapists in this policy. The same commenter asked why speech-language evaluations performed prior to chemotherapy and radiation therapy to prevent dysphasia were not covered.

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Response: The sections in the policy that refer to qualified therapists are in italics and are taken directly from CMS manuals. The Contractor may not change this language. In addition, this commenter did not provide scientific literature to support speech-language pathologist services prior to chemotherapy or radiation therapy. No ICD-9-CM codes were offered to code for these services. Although such services may be medically necessary, we will await further information in order to reconsider the policy.

Comment: One commenter requested that further clarification be provided regarding the speech-language pathologist's role in choosing specific tests to be administered.

Response: We have revised the first paragraph under the "Evaluation of Language Disorders" to indicate that the physician, in consultation with the speech-language pathologist, designates the specific testing in areas of concern.

Comment: One commenter requested that we give examples to more clearly define screening services, similar to those contained in the LCD for Outpatient Physical and Occupational Therapy Services (L26884).

Response: Providers may use the descriptions in the LCD for Outpatient Physical and Occupational Therapy Services for examples of applicable screening services. In general, screening services are those services rendered in the absence of signs or symptoms. If a screening service is performed, the documentation should specify that it is such.

Comment: One commenter stated that throughout the draft LCD the terms "speech-language pathology" and "speech pathology" varied, and that the correct term is "speech-language pathology" (SLP).

Response: The terminology in the policy has been corrected to "speech-language pathology" throughout.

Comment: One commenter requested clarification on the supervision requirement of the speech-language pathologist by the physical therapist or occupational therapist in private practice.

Response: Speech-language pathologist services billed by a physical therapist or occupational therapist in private practice must meet all of the requirements of "incident to" services. The supervision requirement for "incident to" services is direct supervision, specifically, the supervising practitioner must be present within the same office suite, available, and able to intervene.

Comment: Several commenters stated that the first sentence of the "Evaluation of Language Disorder" section is an un-necessary requirement, since the physician has provided the patient a referral for speech-language pathology services, and that it is the referral and the physician's/non-physician practitioner's dated signature on the plan of care that supports the medical necessity for outpatient speech-language pathology services.

Response: This sentence has been removed from the "Evaluation of Language Disorder" section.

Comment: One commenter suggested that the term "order" be changed to "referral" as patients are referred to speech-language pathologists not "ordered to them".

Response: We have revised the term to state "order or referral."

Comment: One commenter is concerned with the last sentence in the first paragraph of the "Evaluation of Language Disorder" section which states "Evaluation in the absence of signs and symptoms are not covered". The speech-language pathologist must perform his or her own independent evaluation to obtain the patient's status and compare to the baseline. If the speech-language pathologist determines the patient does not require skilled therapy services and discharges the patient, the speech-language pathologist should still be reimbursed for the evaluation.

Response: It would be unusual for a physician to refer a patient for a speech-language pathology evaluation in the absence of any signs or symptoms. The sign or symptom for which the patient was referred, and with which the patient presents to the speech-language pathologist, will support medical necessity when coded on the claim, even if no subsequent therapy services are provided.

Comment: One commenter suggested that the evaluation and treatment CPT codes be listed with descriptors and examples of what may be included in each type of evaluation.

Response: We cannot make the requested revision without resending the policy out for additional advice and comment. However National Government Services will consider expanding the policy to include the scope of detail the commenter has suggested at a future date.

Comment: One commenter requested that the term "modalities" be changed to "interventions", since interventions encompass modalities in addition to therapeutic procedures, such as exercises, that are provided by speech-language pathologists.

Response: We agree and the language has been changed from "modalities" to "interventions."

Comment: One commenter questioned if audiologists are licensed in all the states to which this LCD applies.

Response: To our knowledge, each state we serve has licensure requirements for audiologists.

Comment: One commenter questioned which CPT code should be billed for speech reading when skilled interventions are provided by speech-language pathologists.

Response: Coding for aural rehabilitation (speech reading) depends upon whether those services are performed individually or in a group setting. We have included coding instructions in the SIA to indicate that CPT codes 92507 or 92508 should be used for aural rehabilitation.

Comment: One commenter requested clarification on the limitation that states: "Provision of practice for use of augmentative or alternative communication systems" is not covered by Medicare. Teaching the patient how to use their augmentative or alternative communication system is considered skilled therapy and should be reimbursed by National Government Services when supported by documentation.

Response: We agree that *teaching* the patient how to use their augmentative or alternative communication systems requires the skills of a therapist. However, sitting with the patient while *practicing* with these systems is not a skilled service.

Comment: One commenter stated that speech-language pathologists are not licensed in every state where this LCD is applicable, and that the word "licensed" should be removed from the sentence that states, "All SLP services provided by anyone other than a licensed SLP, including a speech-language pathology assistant or aide, are not covered."

Response: This sentence has been revised to state: "All SLP services provided by anyone other than an SLP who is licensed or otherwise authorized by the State in which they practice, including a speech-language pathology assistant or aide, are not covered."

Comment: One commenter requested that the language relating to hospital inpatients be removed from the "Other Comments" section, since this policy only applies to outpatient speech-language pathology services.

Response: Although in large part the policy refers to outpatient speech-language pathology services, these services may be provided to hospital inpatients, and the medical necessity parameters contained in the policy apply to all Medicare beneficiaries receiving these services regardless of setting.

Comment: One commenter stated that the coverage topic should only state "Speech Therapy" since this is the sole topic of the policy.

Response: CMS system requirements allow only the use of "Physical, Occupational and Speech Therapy" under coverage topics and cannot be changed.

Comment: One commenter stated that the Bill Types 11X and 21X should be removed.

Response: The medical necessity parameters in this policy apply to patients in all settings, including inpatient Bill Types.

Comment: Several commenters requested that CPT codes 92626 and 92627 be included since these codes are used for auditory (aural) rehabilitation evaluation following cochlear implantation or other hearing impairments.

Response: CPT codes 92626 and 92627 have been added to the policy in the "CPT/HCPCS Codes" section. A coding instruction has also been added to the Supplemental Instruction Article to state that "At the request of several commenters, CPT codes 92626 and 92627 have been added and are not restricted by the list of ICD-9-CM codes that support medical necessity."

Comment: Several commenters requested that the 4th paragraph in the "Documentation Requirements" section be removed since the physician's active participation in the care is demonstrated by his/her signature on the plan of care, which is established by the physician and the speech-language pathologist.

Response: This paragraph has been deleted and the reader is referred to CMS Pub 100-2, *Medicare Benefit Policy Manual*, Chapter 15, Section 220 for additional documentation requirements for speech-language pathology.

Comment: One commenter stated that CR 5921 has removed the word "audiology" from CMS publication 100-2, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3.B.

Response: The policy has been corrected to reflect this change.

Comment: The same commenter stated that the provision for billing SLP services by a physical therapist or occupational therapist in private practice has also been removed from CMS Publication 100-2, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3.B.

Response: The text that the commenter referred to has been retained in CMS Publication 100-2, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.2.B, and has not been revised by CR 5921.

Comment: One commenter requested that "the physician's certification of the need for care (e.g., approval of the plan of care) may substitute for the order" be added to the "Evaluation of Language Disorders" section.

Response: We've adapted the language to address the commenter's concerns.

Comment: One commenter requested that additional reasons for re-evaluation that are stated in CMS Publication 100-2, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3.C be added to the policy.

Response: We have added the re-evaluation language that is in the CMS Manual to the policy.

Comment: One commenter requested that the following sentence be added to the last paragraph in the "Skilled Procedures and Modalities" section: "The brief cognitive assessment will also determine the need for standardized cognitive performance testing."

Response: The following sentence has been added to the last paragraph in the "Skilled Procedures and Modalities" section: "The brief cognitive assessment may also determine the need for more comprehensive cognitive performance testing."

Comment: One commenter stated that aural rehabilitation by speech-language pathologists is not limited to speech reading as implied by the heading to the Aural Rehabilitation section.

Response: The reference to speech reading has been removed from the section heading on Aural Rehabilitation.

Comment: One commenter requested that the statement in the limitation section: "Speech-language pathology services provided for chronic disorders of memory and orientation are non-covered services and do not require the skills of a qualified therapist" be revised to

state: "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."

Response: This limitation has been deleted and the provider's suggestion has been substituted. However providers are reminded that speech language pathology services are only medically necessary as long as the beneficiary is able to make use of the therapy, and is able to retain what is being taught. Services such as sitting with demented patients while they are eating and prompting them to swallow is not a skilled service, and is not covered by Medicare.

Comment: One commenter stated that Chapter 2, Sections 80-80.2 does not exist in the *Medicare Claims Processing Manual.*

Response: The chapter and section have been corrected to: "Chapter 1, Sections 60-60.1.1" of the *Medicare Claims Processing Manual.*

Comment: One commenter submitted a list of ICD-9-CM codes that they felt should be added to the policy since they represent anatomic anomalies, respiratory or neurologic conditions, and other disorders that may cause speech, language, and voice disorders.

Response: There are many underlying medical disorders that may be associated with speech-language pathology, but coding the underlying disorder itself does not support medical necessity for speech-language pathology services. For example, a patient with Parkinson's disease may or may not have a need for speech-language pathology services, depending on the progression of the disease and the functional limitation the patient may have. The signs or symptoms of the speech difficulties, such as dysphasia, should be coded on the claim to support medical necessity for the speech-language pathology services provided.

Comment: One commenter stated that National Government Services should list the latest sources of information available from the American Speech-Language-Hearing Association (ASHA).

Response: The sources of information have been revised to include these additional sources.

Comment: One commenter suggested that we consider moving the section on group therapy to follow the section on aural rehabilitation (speech reading).

Response: We've made the suggested change.

Comment: One commenter suggested that additional language added to Pub 100-2, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3.D.3, published in CR 5921, for aural rehabilitation be added to the policy.

Response: Information from this section has been added.

Comment: One commenter suggested that we include the new language for combined ABN/NEMB forms.

Response: This information has been added.

Comment: One commenter suggested that we add fiscal intermediary billing information on the therapy cap in the "Other Comments" section.

Response: The requested language has been added.

Comment: Several commenters suggested that Bill Type 34X be added to the Bill Type list.

Response: Bill Type 34X has been added.

Comment: One commenter requested that specific language be added to the "Documentation Requirements" about documenting the skilled treatment provided.

Response: Language addressing this has been added to the "Documentation Requirements."

Comment: One commenter suggested that language from CMS Publication 100-4, *Medicare Claims Processing Manual*, Chapter 12, Section 30.3 on units for untimed codes be added to the SIA.

Response: Language from CMS' Manual has been added to the SIA.

Comment: One commenter pointed out that specific information regarding the therapy cap in the SIA is incorrect.

Response: The information on therapy caps has been corrected.