

## Final Comments and Response

### **LCD Title**

Dysphagia

### **Contractor's Determination Number**

PHYSMED-017

### **LCD Database ID Number**

DL 33065

We would like to thank those who suggested changes to the DRAFT Dysphagia LCD. The topics of concern are grouped below with a response.

**Comments:** Specific comments/edits to the DRAFT policy were received from a WI CAC member requesting inclusion of the following into the policy. Examples included: add to Indications - residue in the mouth or throat that must be expectorated or -an inability to swallow adequate food or liquids to maintain nutrition and/or hydration. Add to Non-instrumental Evaluation/Assessment -determination of tongue strength. Add to Swallowing Evaluation/Assessment - an additional objective finding or determining tongue strength, and also document if there is cricopharyngeal dysfunction or diminished tongue strength. Within the Instrument Evaluation section add, -determination of oral pharyngeal swallowing, strength, function utilizing a device with multiple tongue pressure sensors. The Plan of Care could include strengthening exercises. Final request was to add to the Billing and Coding Guideline a specific device/product name which would be utilized as a screening tool to measure tongue strength. There were also typographical and spelling corrections identified.

### **Response:**

Added the indications listed into the policy. The other recommendations were related to evaluation, plan of care and a device/product to measure and or strengthen the tongue. The specific device/product that was recommended is still in a NIH study which does not allow us to place it into the policy. Moreover, in general LCDs are not designed to identify or endorse products. We have corrected the typographical errors identified.

**Comments:** A physician recommended the policy could include documentation of quality of life, fear of eating in public, alterations of diet and if there are any weight loss issues related to dysphagia under non instrumental evaluation/assessment section. Also symptoms of dysphagia can occur due to food impaction, restriction of diet, difficulty swallowing with liquids, solids or both

### **Response:**

We would expect documentation would list the condition being treated and any complexities that make treatment more lengthy or difficult. Where it is not obvious, describe the impact of the conditions and complexities so that it is clear to the medical reviewer that the services planned are appropriate for the individual

**Comments** There were several physicians who asked if the diagnosis codes listed within the policy are inclusive. A specific request was submitted for these ICD-9 codes to be added: 787.20 Dysphagia Unspecified; 306.4 Globus Sensation; 786.5 Noncardiac Chest Pain; 530.5

Dyskinesia of esophagus; 530.3 Stricture and stenosis of esophagus; 530.19 Other esophagitis; 530.20 and 530.21 Ulcer of esophagus without/with bleeding; 530.89 Other disorders of esophagus; 935.1 Foreign body in esophagus; 750.3 Tracheoesophageal fistula, esophageal atresia and stenosis; 240.9 Thyroidmegaly, Goiter; 530.6 Diverticulum of esophagus, acquired; 793.4 Abnormal Xray of GI tract; 150.5 Esophageal Malignancy; 786.2 Cough.

**Response**

The additional ICD Codes submitted have been reviewed and although they could be appropriate, it was determined not to include additional ICD-9 codes as the causation of dysphagia. There are many medically necessary and appropriate diagnosis codes for the cause of dysphagia which can still be submitted. With that in mind, this LCD is focused on the diagnosis of dysphagia as the primary “functional” diagnosis which conveys coverage, not the clinical diagnosis or causation of dysphagia.

As stated, many diagnoses can lead to dysphagia, ultimately dysphagia has been diagnosed. The purpose of this policy is to identify indications for the assessment, evaluation, diagnosis and follow-up care of dysphagia. The purpose of the diagnosis codes are to identify the procedures performed to diagnose dysphagia.

**Comment:** A physician recommended adding CPT/HCPCS CODES: 43200 - 43259 Flexible Endoscopy With Or Without Collection Of Specimens By Brushings Or Washings And Esophageal Endoscopic Dilatation Codes; Non Sedated Esophageal Dilatation Code 43450 (Maloney); Esophageal Motility/Manometry 91010-012.

**Response**

The codes were reviewed and if these codes were added it would restrict the policy to the diagnosis codes.

**Comments:** There are concerns from various Physician specialty groups and the American Occupational Therapy Association (AOTA) that the policy is identifying Speech Language Pathologists (SLP) specifically and their scope of practice, excluding other providers. Physicians voiced concern on the widening SLP scope of practice supported by advanced degrees of education in Masters and Doctorate degrees, asking about supervision of procedures.

The biggest change is that SLPs are being told they can perform invasive endoscopies, flexible laryngoscope or stroboscopy tests involving local anesthetics without physician supervision in an independent setting. There is concern the DRAFT Dysphagia policy is allowing SLPs to perform these procedures, diagnosis and treat

Typically when a SLP evaluates a patient and if a swallow study is done, it is performed as a physician supervised procedure. SLPs should not be passing a scope independently, which is done by an ENT or GI Physician to assess the appropriate anatomy, make a diagnosis and order a treatment plan as physicians do. The policy doesn't even mention manometry which is typically more accurate for assessing complex swallowing issues. Video is worthwhile, in its own place. There are a lot of neglected areas in the policy.

There was another recommendation an instrumental evaluation/assessment should be done, only if there is adequate certainty and documentation there is no mechanical or treatable neoplastic condition present. When an instrumental evaluation is performed, the preferred procedure should be an endoscopy for those with persistent or progressive symptoms.

Lastly, a physician recommended adding otolaryngologists and dental professionals in the policy as providers who assess the pharynx for structural and/or mechanical abnormalities.

Gastroenterologists provide visual and tissue/biopsy documentation of physical abnormalities which contribute to causing interference in the normal function of esophagus and upper stomach. Also to include gastroenterologists and surgeons as providers involved in diagnosing and managing dysphagia.

### **Response**

We have clarified this LCD further to delineate which part of the assessment/evaluation/plan of care/treatment/re-evaluation; non-instrumental and instrumental assessments can be performed by physicians and non-physicians by directing providers to the Medicare Physician Fee Schedule. The Medicare Physician Fee Schedule is updated quarterly. The regulations for supervision, specifically therapists in private practice, as well as incident to regulations are required by Medicare. All providers need to follow individual state scope of practice and licensing laws along with the regulations in the CMS Internet Only Manuals which are CMS' program issuances and day-to-day operating instructions. Other procedure codes which are medically necessary are still covered.

**Comments:** During a CAC meeting, a physician explained he is a board member and many of his colleagues do not agree with the “payment committee” setting the scope of practice for speech therapists and further explained they did not feel it is in the public's best interest to have invasive procedures performed without physician supervision. In regard to federal law, SLP are not physicians and not registered with the DEA, therefore should not be prescribing and dispensing medications or local anesthetics without a medical degree and DEA license.

### **Response:**

Procedures which are diagnostic need to be performed by a physician or under supervision by ‘incident to’. It is important to review updates to the Medicare Physician Fee Schedule Database (PFS) which clarifies professional and technical components (Field 20). Some codes currently cannot be split into professional and technical components such as the endoscopic evaluation codes. Some of the codes are identified as Private practice therapist’s service where payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. Also review Physician Supervision of Diagnostic Procedures (Field 31A) which identifies and defines the level of supervision required. CMS Publication 100-04 Medicare Claims Processing Change Request 7554. The Medicare Physician Fee Schedule Database 2012 File Layout Manual which provides the annual file layout for 2012 Medicare Carriers/A/B/MACs. This recurring Update Notification applies to Chapter 23, Addendum.

**Comments:** During the CAC meetings many physicians made recommendations. For example, a physician commented the plan of care for dysphagia should include the need for esophageal dilation or medication to treat acid reflux disorders as well as possible feeding tube placement if swallowing problems are interfering with adequate nutrition. Also, there is concern gastroenterologists are not identified as involved with the evaluation of swallowing problems. It was explained during the meeting different physician specialties are responsible for the initial assessment, unless it is

determined that the problem is restricted entirely to the pharynx which is then within the domain of the otolaryngologist and/or the oral surgeon/dentist.

Another comment from a CAC member was to add to the list of indications and limitations; chest pain and/or globus sensation (feeling of a lump or retained bolus near the sternal notch or elsewhere in the chest). Dysphagia could also be a result of acid reflux with or without peptic stricture, often appearing in middle age or older

### **Response**

The purpose or rationale of LCDs is to identify “reasonable and necessary” guidelines to assist providers in submitting correct claims for payment. The LCDs are to present an objective and positive statement and should not malign any segment of the medical community. The policy has been revised in several areas and clarification that the definition of “physician” includes multi-specialties. Also, “individual state scope of practice and licensing laws” was added throughout.

**Comment:** A physician asked what the rationale for the new policy was.

### **Response:**

During transition of contracts, WPS had multiple policies. Currently, there is Dysphagia, Diagnostic Evaluation L26689 in J5B; Dysphagia/Swallowing Therapy L26565 in J5A; and Speech-Language Pathology in J8. CMS has directed contractors to develop uniform LCDs across all jurisdictions. The decision was necessary to develop a new jurisdictional policy and retire the other policies. See CMS Pub Medicare Program Integrity Manual, Chapter 13, Section 13.4.

### **Comments**

American Occupational Therapy Association (AOTA) requests Occupational Therapists be included as providers of dysphagia services. Recommendations included adding - Occupational Therapists to section III. Professional qualifications for Providers, Speech-Language Pathologists, and Occupational Therapists. Also, to revise the ‘Incident to’ Benefit section to read: “Swallow evaluations/assessments (CPT codes 74230, 92610, 92611, 92612, 92614 and 92616 may be performed by physicians, NPP, or Speech and Language Pathologists, or Occupational Therapists. When these services are performed by a SLP or OT then billed by Physicians or NPPs, they are covered under the ‘incident to’ provision if the service is rendered in a physician/NPP owned and operated clinic.” Add the following revenue code in the Coding Information section: 043X Occupational Therapy – General Classification. Add occupational therapists to section II. Instrumental Evaluation/Assessment: “An instrumental evaluation/assessment is not medically necessary if clinical judgment by the Physician or, Speech-Language Pathologist, or Occupational Therapist indicates: and “The instrumental evaluation/assessment of swallowing, the functional physical assessment, interpretation and management of dysphagia when used for diagnostic purposes can be performed and interpreted by Speech-Language Pathologists with certification of clinical competency or Occupational Therapists and it is within their individual state scope of practice law.”

### **Response**

The policy has been modified to include Occupational Therapists in the “incident to” section as well as in the revenue code. It is not the intent of this policy to exclude Occupational Therapist from providing services and caring for patients with dysphagia. This LCD is required to clarify the procedure codes supported by CMS regulations for provider billing. Specialty 15 (Speech

Language Pathologists (SLPs)) was added as a valid specialty by CMS in July of 2009 documented in CR 6292.

The services of occupational therapists and/or aids require general supervision in all settings except private practice which requires direct supervision by the physician. Again, the instrumental evaluation/assessment of swallowing, the functional physical assessment, interpretation and management of dysphagia when used for diagnostic purposes can be performed and interpreted by Speech-Language Pathologists with certification of clinical competency, working within their individual state scope of practice and licensing laws, while following supervision requirements according to the Medicare Physician Fee schedule.

Occupational Therapists need to be held to their individual state scope of practice laws which identifies interventions / management /rehabilitation of feeding, eating and swallowing. According to each individual state scope of practice Occupational Therapists provide assessment and rehabilitation with goal directed activities providing interventions for individuals who have a diagnosis of dysphagia.