Medicare 101

Presentation Compiled by the ASHA StAMP Network
Presented by: Rosalyn Davis, M.A., M.S., CCC-SLP
MSHA VP SLP Healthcare,
MSHA ASHA StAMP Representative

Disclaimer

- The information presented in this document is a working document by the ASHA StAMP committee.
- Please reach out to the Michigan StAMP representative for questions, comments or clarification regarding the content of this PowerPoint.

Medicare

- Part A and Part B

What is Medicare?

- Federal health insurance program for
  - Individuals 65 and older, or
  - Individuals who are permanently disabled
- Comprised of 4 “Parts”
  - Part A: Inpatient services such as hospital, inpatient rehabilitation, skilled nursing and home health
  - Part B: Outpatient services provided in private practices, university clinics, and to patients who do not meet inpatient admission criteria
  - Part C: Medicare Advantage
  - Part D: Prescription Drugs

Medicare Part A vs. Medicare Part B

Part A

- Hospital insurance
- Financed through federal taxes
- Helps cover hospital stays and limited skilled nursing facility care when daily skilled served are needed
- Helps cover home health and hospice.
- Most services for communication and swallowing disorders.
- Rehabilitation services when significant functional progress is expected and/or maintenance care is needed.

Part B

- Supplementary medical insurance
- Monthly premium
- Helps cover physician services, audiology testing services, outpatient hospital services, rehabilitation agency services and comprehensive outpatient rehabilitation
- Service for communication and swallowing disorders are covered in these settings.

What Does Medicare Cover?

- Services for assessing and treating speech, language, swallowing, hearing, and balance disorders
- Most hearing examinations
  - Does not cover hearing aids
  - Does not cover tests for hearing aids

Medicare Part A: Inpatient Rehabilitation Facilities

- 3 hour rule, 60% rule

Medicare Part A: Skilled Nursing Facilities

- Consolidated billing
- 3-day prior hospitalization

Skilled Nursing Facilities & PDPM

- ASHA previous and ongoing advocacy
- Impact of COVID on implementation?

Medicare Part A: Home Health Services

- Consolidated billing
- Homebound

Medicare Part B

- Voluntary supplementary program
  - Covers therapy services in addition to other areas (prosthetics and orthotics, x-rays, lab services, etc.)
- Fee for service based on CPT codes billed
- Therapy services are covered at 80% of allowable ancillary charges. A 20% copayment is required (paid by Medicaid, private insurance, or private pay)
- Updated fee schedule

Medicare Part B Coverage

- Physicians order must be provided for evaluation and treatment
- Physician should sign the plan of care
- Recertification required every 90 days or less
- Services must be reasonable, medically necessary, and skilled
- No duplication between therapies

Medicare Part B Service Delivery

- Group therapy is allowed. A single CPT code is billed for group therapy, regardless of the length of the session.
- Cotreatment
- Concurrent therapy not allowed
  - If a patient with MCB is seen with another patient, the group CPT code must be used.
- Students may participate in treatment delivery, but the cooperating therapist must be present and actively involved in the entire session.

Medicare Part B– Manual Medical Reviews

- The Deficit Reduction Act (2006) initiated cap amounts for therapy billing and were revamped with the American Tax Relief Act of 2012.
- Congress repealed the Medicare Part B caps in 2018
- PT and ST share the manual medical review amount of $3000
- Manual medical review process

How do I figure out What's Covered?

- Social Security Act
- Medicare Administrative Contractors
- Local Coverage Determination/Coverage Articles
- Medicare Benefit Policy Manual
- Medically necessary, skilled, maintenance/improvement

Medicare Administrative Contractors

- The country is divided into different regions for each MAC.
- Be sure to identify which MAC is responsible for processing your claim!
- Each MAC may have a different interpretation as to coverage criteria.
- The local coverage determination (LCD) for your MAC will outline their coverage determinations.

Medicare Coverage Criteria

- Medical Necessity: Is the provision of therapy the best method to help this patient? What is the current diagnosis that supports the need for treatment?
- Skilled Services: Are the professional skills of a therapist required to treat the patient? Could a lower cost alternative address the need as effectively?
- Improvement OR Maintenance of Function: What is the desired outcome of your treatment? Will your patient improve and move to a higher level of daily function?

Medicare and the SLP

SLP Components

- Acute Neurologic
- Comorbidities
- Swallow Disorder
- Mechanically Altered Diet
- Cognitive Impairment

What Constitutes Acute Neurologic?

- In order to classify a guest into the Acute Neurologic Clinical Category, we would need to enter a primary diagnosis in I0020B that answers the question:
- "What is the main reason this person is being admitted to the SNF?"
  - Diseases of the Nervous System
  - Cerebrovascular Disease
    - Aphasia or Apraxia following Cerebral Infarction
    - Dysphasia following Cerebral Infarction
    - Dysphasia following Cerebral Infarction

SLP Related Comorbidities

- Special Treatments, Procedures and Programs (Section O)
  - Tracheostomy care
  - Ventilator or respirator
- Active Diagnosis (Section I)
  - Aphasia
  - Hemiplegia/hemiparesis
  - CVA, TIA, Stroke
  - TBI

SLP Related Comorbidities

- Other additional diagnosis (Section I)
  - Laryngeal cancer
  - Apraxia
  - Dysphagia
  - ALS
  - Oral and pharyngeal cancers
  - Speech and Language deficits
  - Voice disorders

Dysphagia and Altered Diets

- Another aspect of the SLP component centers around the presence or absence of:
  - Mechanically Altered Diet (Section K 0510 C 2, while a resident)
  - A Swallowing Disorder (Section K 0100)
    - Loss of liquids/solids from mouth when eating
    - Holding food in mouth/cheeks or residual food in mouth after meals.
    - Coughing or choking during meals or when swallowing medications
    - Complaints of difficulty or pain when swallowing.

Current Impact of PDPM on Rehab Services

- Financial impact still to be seen at the SNF level
- SLPs are reporting:
  - Increased caseloads in some sites of service
  - Increased utilization of group and concurrent modes of tx
  - Requests for intervention ideas for group
  - Increased collaboration with MDS staff regarding ICD-10 codes
  - Increased collaboration with SW regarding BIMs scores
  - Increased medical complexity of patients
  - Reduced temporary staff available

Medicare Documentation and Reimbursement

Resources for ICD-10 Coding

- ICD-10 Coding is utilized in the new Patient Driven Payment Model (PDPM) to capture patient characteristics to determine reimbursement and future reimbursement.
- CMS to assess data for present and future cases to modify PDPM as needed or develop future payment models.
  - This may occur later this year
- CMS Website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM
  - PDPM ICD-10 Mappings FY2020 SLP

Updated Fee Schedule

https://www.asha.org/news/2020/ashas-analysis-of-2021-medicare-fee-schedule-for-audiologists-and-speech-language-pathologists/

CPT Coding

- Timed and untimed codes: Evaluation and most speech treatment codes are all untimed, service based codes.
- Untimed codes means that you are reimbursed at a flat fee, regardless of the time spent the patient.
- There are a few timed codes that pay for each 15 minute interval of treatment.

ICD Coding: Treatment vs. Medical Diagnoses

- Medical Diagnoses for Part A patients, under PDPM, is critical to determine the overall payment for a Part A patient's stay in the SNF. The medical diagnosis should best describe **why** that patient is in the SNF setting.
- Medical Diagnoses for Part B patients should clearly show what in this patient's current condition has changed and he/she now needs skilled treatment.
- For both payers, treatment diagnoses should support the need for skilled intervention.

Medicare Documentation Requirements

- Direct Access (yes for SLP, no for audiology)
- Plan of Care (cert and recert)
- Progress Reports
- Daily Treatment Notes
- Discharge Notes

SLP Documentation: Evaluation

The initial evaluation, or the plan of care including an evaluation, should document the necessity for a course of therapy through objective findings. Documentation of the evaluation should list the conditions and complexities and, where it is not obvious, describe the impact of the conditions and complexities on the prognosis and/or the plan for treatment so that it is clear to a reviewer that the services planned are appropriate for the individual.

SLP Documentation: Evaluation

Evaluation shall include:

- A diagnosis (where allowed by state and local law) and
- Description of the specific problem(s) to be evaluated and/or treated.
- Diagnosis should be specific and as relevant to the problem to be treated as possible.
- Treatment diagnosis may or may not be identified by the therapist, depending on their scope of practice.
- Where a diagnosis is not allowed, CMS advises the use of a condition description similar to the appropriate ICD-9 code.
- Results of ASHA's national outcomes measurement system (optional). Additional information can be found on the NOMS section of the ASHA website.
- If NOMS is not used, the record shall contain documentation to indicate objective, measurable beneficiary physical function including
    - Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
    - Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
    - Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

SLP Documentation: Evaluation

When an evaluation is the only service provided in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/nonphysician practitioner (NPP). The goal, frequency, intensity and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician.

SLP Documentation: Plan of Care

The plan of care shall be consistent with the related evaluation. The evaluation and plan may be reported in two separate documents or a single combined document. The certified plan of care ensures that the patient is under the care of a physician or NPP.

SLP Documentation: Plan of Care

Long term treatment goals should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care. The plan of care shall contain, at minimum, the following information:

- Diagnoses;
- Long term treatment goals; and
- Type, amount, duration, and frequency of therapy services.

  The amount of treatment refers to the number of times in a day the type of treatment will be provided. The frequency refers to the number of times in a week the type of treatment is provided. The duration is the number of weeks, or the number of treatment sessions.

SLP Documentation: Progress Report

The progress report provides justification for the medical necessity of treatment. A clinician must complete a progress report at least once every 10 treatment days or at least once during each certification interval, whichever is less. The beginning of the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation, or treatment.

SLP Documentation: Progress Report

Progress notes should contain:

- An assessment of improvement, extent of progress (or lack thereof) toward each goal;
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's progress report; and
- Changes to long or short term goals, discharge, or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.

SLP Documentation: Progress Report

- Documentation should justify the necessity of the services provided during the reporting period, and include, for example, objective evidence or a clinically supportable statement of expectation that the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- Objective evidence consists of standardized patient assessment instruments, outcome measurements tools, or measurable assessments of functional outcome such as NOMS. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.

SLP Documentation: Treatment Note

The purpose of the treatment note is not to document medical necessity, but to create a record of all encounters and skilled intervention. Documentation is required for every treatment day, every therapy service, and must include the following information:

- the encounter note must record the name of the treatment, intervention of activity provided;
- total treatment time; and
- signature of the professional furnishing the services.

SLP Documentation: Treatment Note

- If a treatment is added or changed between the progress note intervals, the change must be recorded and justified in the medical record. Frequent professional judgments resulting in upgrades to the patient's activity show skilled treatment. Objective measurement showing improvement is also helpful.
- If there is no improvement, the clinicians should provide information to explain the setbacks, illness, new condition, or social circumstances that are impeding progress and why it is believed that progress is still attainable.

SLP Documentation: Discharge Note

The Discharge Note is required and shall be a progress report written by a clinician and shall cover the reporting period from the last progress report to the date of discharge. The discharge note shall include all treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge.

Audiology Documentation

https://www.asha.org/practice/reimbursement/medicare/audiology-medicare-documentation-faqs/

Medicare and Service Delivery Models

- Documentation and Reimbursement

Modes of Therapy (Individual, Group, Concurrent)

https://www.asha.org/practice/reimbursement/modes-of-service-delivery-for-speech-language-pathology/

Individual Therapy

- **One-on-one** treatment to address a patient's functional clinical needs.
- It is typically the primary mode of therapy.
- Individual therapy is used to help a patient improve or maintain function.
- Documentation should support medical necessity and the skilled nature of the services provided.
- Bill for the code defined in the treatment.

Group Therapy

- **Two or more** individuals performing the ***same or similar activities.*** Participants do not have to have the same or similar ***goals.***
- To help a patient improve or maintain function.
- An **adjunct to**—not a replacement for—individual therapy.
- The needs of the patient and their targeted goals should drive the use of group therapy. It is **not** used due to staffing inefficiencies.
- Size of group and any rules associated with groups are defined in the local coverage determinations of your local MAC.

Group Therapy Documentation

- Documentation must include:
  - justification for a group
  - goals targeted and how the group activity supports goals
  - skilled interventions that were reasonable, medically necessary, and supported the patient's established plan of care
  - size of group

Group Therapy Coverage

- Medicare Part A:
  - Inpatient rehab: cleared to use if supported in documentation
  - Home health: not covered
  - Skilled nursing: 2-6 patients and can comprise no more than 25% of the episode of care. This 25% limitation is combined with concurrent therapy
- Medicare Part B: dictated by your local MAC's LCD.

Group Therapy Billing

- CPT code **92508** describes *treatment of speech, language, voice, communication, and/or auditory processing disorder; individual; group, **two or more individuals**.*
- **No CPT** codes describe group treatment of **swallowing or cognition** (unless specific payer allows).
- Payers may permit the use of CPT code 97150 to represent group therapy not associated with speech and language. Check local MAC LCD guidelines for rules.

Concurrent Therapy

- Treating **two** patients performing **different activities, at the same time.**
- Concurrent therapy should be skilled and medically necessary. It can be used to help a patient improve or maintain a level of function.
- Based on the patient's needs and targeted goals.
- Not a solution to operational efficiencies targeted by the clinician or the facility.
- An **adjunct to**—not a replacement for—individual therapy.
- Clients with **varying diagnoses and levels of severity can effectively participate** in a concurrent session.
- All activities used as part of the session need to be **skilled and medically necessary.**

Concurrent Therapy

- when the clinician treats two patients performing different activities, at the same time. Concurrent therapy should be skilled and medically necessary. It can be used to help a patient improve or maintain a level of function.
- based on the patient's needs and targeted goals.

Concurrent Therapy Coverage

- Medicare Part A:
  - Inpatient rehab: cleared to use if supported in documentation
  - Home health: not provided in this setting
  - Skilled nursing: restricted to 2 patients and can comprise no more than 25% of the episode of care. This 25% limitation is combined with group therapy.
- Medicare Part B: not a billable service

Concurrent Therapy Documentation

- Clinical rationale for employing a concurrent (vs. individual or group) mode of service delivery for that treatment session
- Specific goal targeted and how the activity supported it, in ways unique to the concurrent mode of service delivery
- How activities used skilled interventions that were reasonable, medically necessary, and supported the patient's established plan of care

Concurrent Therapy Billing

- Use the individual treatment code
- For timed codes (e.g., 97129, 97130), report the number of minutes spent in ***direct one-on-one treatment*** with each patient.
- For untimed codes (e.g., 92507), bill once per patient. Time is an important consideration, even for untimed codes. If clinicians spend only a short amount of direct one-on-one time with each patient, it **may not be appropriate** to bill for a full therapy session.

Medicare Telehealth Coverage

During the PHE:

Medicare has authorized SLPs to provide a narrow subset of telehealth services during the federally-declared PHE. SLPs should be aware of two key considerations during this time.

- You cannot charge Medicare beneficiaries for these specific services and must bill Medicare directly.
- If a service is not on the temporarily authorized telehealth services list, you may enter into a private pay arrangement with the Medicare beneficiary for that specific service (dysphagia evaluation or treatment, for example).

Medicare Telehealth Coverage

After the PHE Ends:

Once the federally-declared PHE ends, Medicare will no longer reimburse SLPs directly for any telehealth services. SLPs will have two options for reimbursement for Medicare telehealth services.

- You can enter into private pay arrangements with Medicare beneficiaries.
- You can provide select telehealth services "incident to" a physician, meaning these services would be provided under the direct supervision of a physician and billed under the physician's NPI. This option is only available through the remainder of 2021.
  - Direct supervision means the physician is in the office suite (but not necessarily in the same room) or available through real time audio-visual communication technology.
  - The services SLPs may provide incident to a physician are 92507 (speech, language, communication treatment), 92521 (fluency evaluation), 92522 (speech sound evaluation), 92523 (speech and language evaluation), and 92524 (voice evaluation).

Medicare Telehealth Coverage

ASHA will continue advocating with Congress for a change in federal law that would permanently extend Medicare reimbursement for telehealth services provided by SLPs.

Services Provided by Assistants

- Assistant are not currently recognized as providers
- Several states have started to license assistants
  - Because Medicare does not recognize assistants as skilled professional, they cannot treat or assist in Medicare A or B patients.
- As most Medicare Advantage plan follow traditional Medicare rules
  - They also do not recognize assistants.

Services Provided by Students

- Supervision Level:
  - Medicare recognizes students only as an extension of the licensed provider.
  - Students must have 100% line-of-sight supervision while treating patients.
  - The supervising clinician cannot be treating a different patient at the same time.
  - While the student is working with a patient, however, the supervising clinician can work on documentation.

Services Provided by Students

- Documentation:
  - It is recommended that notes include a statement similar to "services provided by a licensed SLP with assistance from a graduate student in training“.
  - Any documentation created by a student should be reviewed and co-signed by the supervising clinician.
  - The student's e-signature should be clearly labeled that they are a student.
  - Some states have protected title regulations.
    - Most states accept "Speech-Language Pathology Student" as appropriate labeling.

Becoming a Medicare Provider

Enrollment as a Medicare Provider

- Enrollment via PECOS
  - The online Medicare enrollment management system
  - Paperless
  - Tends to process more quickly
- Enrollment via paper forms
  - Can be used for initial enrollment, revalidations, changes in status, & voluntary termination
  - Requires a handwritten signature
- For more information:
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Enrollment-Applications

Enrollment as a Medicare Provider

- Obtain an NPI
  - A 10-digit numeric identifier
  - Stable despite name, address, taxonomy, or other information changes
  - All health care providers who are HIPAA-covered entities, whether individuals or organizations, must obtain an NPI
- Individual NPI versus Business
  - Organization health care providers may have a single employee or thousands of employees. They need to ensure the health care providers for whom the organization will apply do not already have NPIs.
  - If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself and an NPI for your corporation or LLC.
- For more information:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf

Obtaining an NPI

- Option 1: Apply through a web-based application process. Visit the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website. This requires creating a username and password through the Identity & Access Management (I&A) System, logging in using that username and password.
- Option 2: A paper application to the NPI Enumerator address listed on the form.
  - https://www.cms.gov/Medicare/CMS-Forms/CMSForms/Downloads/CMS10114.pdf
  - Call 1-800-465-3203 (or TTY 1-800-692-2326)
  - Send an email to customerservice@npienumerator.com.
- Option 3: Electronic File Interchange Organization (EFIO) to submit application data through bulk enumeration process
  - https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/apply. html.