QUICK FACTS
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Speech Eval/Re-Evaluation Minutes & MDS

In January 2014 CMS added new Speech Therapy evaluation CPT codes that were more specific than the CPT codes previously available to our Speech Pathologists. In response to questions from the industry CMS issued new guidance on how evaluation and re-evaluation minutes should be coded on the MDS. While CPT codes are used for Medicare B billing all therapy services time is still allocated to CPT codes and reported for all payers including Medicare A. A CMS official stressed however that CPT codes should not effect how the MDS is coded for Medicare Part A therapy Services.

Section O-18 of the CMS RAI Version 3.0 Manual states:

Minutes of Therapy

- *Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do **NOT** include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.*
- *If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted.*
- *The therapist's time spent on documentation or on initial evaluation is not included.*
- *The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.*

The RAI Manual hasn't changed but what is new is CMS officials' statements on their interpretation of the manual.*

"If a therapist is evaluating a resident for a condition that they have not been treating them for during their current therapy regimen, this is an evaluation and cannot be coded on the MDS." "Re-evaluations are part of the treatment process for how the conditions that were initially evaluated are reassessed in order to determine if the treatment plan should be continued or for other reasons. This time is allowed to be coded on the MDS."

"For Example, if a speech-language pathologist was treating a patient for cognitive deficits, and that patient developed a new swallowing problem, the therapist would do a new evaluation to treat for dysphagia, and that evaluation time would not be coded on the MDS. However, if the SLP re-evaluated the dysphagia to determine how therapy was working and to reassess whether the current plan of care should be continued, this would be considered part of the treatment process and considered reevaluation- and would be coded on the MDS."

The key clarification with evaluations is the statement addressing a new condition not previously addressed in the initial evaluation/plan of care. The initial evaluation should be comprehensive and address all problems/conditions the Speech Pathologist plans to address at the time the initial plan of care is established. This time should NOT be allocated to the MDS as treatment minutes. Any future reassessment time as part of the established plan of care should be counted as MDS treatment minutes.

If a new condition develops that was not previously addressed as part of the plan of care should be considered a new evaluation for the patient. Once the subsequent evaluation is done and new plan of care is established, future progress notes and documentation can be combined to address the entire patients status/condition at the same time. Two separate treatment plans do not need to be maintained.

Based on this new information from CMS we have made some changes to our SMART system to ensure reporting of Minutes on the MDS/ARD report is in compliance with this guidance.

We have had and will continue to have dialogue with various provider groups, ASHA, CMS and system vendors on this topic as there are still several questions that we are seeking further clarification on. Based on information we now have available we will be implementing two important changes to the SMART system when calculating MDS reportable minutes on the PPS planner, ARD report, and Resident Pathway reports.

1. Time associated with the following CPT codes by default will not be reported as MDS treatment minutes no matter when they are used during a patients stay:
   - Unlike the PT and OT disciplines SLP does not have reevaluation codes in which to code reevaluation time to.
   - The time spent reassessing the patient as part of treatment would be coded to the appropriate treatment CPT codes.
   - Documentation requirements for re-assements/re-evaluations are unchanged, and current documentation policies should be followed.
   - Time spent on documentation alone should not be counted in the treatment minutes
   - 92521: Evaluation of speech fluency (e.g., stuttering, cluttering)
   - 92522: Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
   - 92523: Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); **with** evaluation of language comprehension and expression (e.g., receptive and expressive language)
   - 92524: Behavioral and qualitative analysis of voice and resonance
   - 92597: Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech. Under Medicare, voice prostheses include tracheoesophageal prostheses, artificial larynges, as well as voice amplifiers
   - 92610: Evaluation of oral and pharyngeal swallowing function
   - 92607: Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
   - 92608: each additional 30 minutes (List separately in addition to code for primary procedure)
   - 92626: Evaluation of auditory rehabilitation status; first hour
   - 92627: Each additional 15 minutes (List separately in addition to code for primary procedure)
   - 96105: Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour – Time Based code

2. 96125- Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report –Time Based Code.
   - This code would be used when completing standardized cognitive assessments after the initial comprehensive evaluation. This code is grouped with other similar test and measure codes and is set in the SMART system to count as treatment minutes for MDS calculations. This code is not just used by SLP but also by OT.
   - In situations where cognition is the primary impairment/focus of an evaluation, 92523 should be coded. The minutes would not be reported as treatment minutes on the MDS.
   - Coding of MDS Treatment minutes and CPT coding for Med B purposes have different guidelines. Refer to ASHA website for additional CPT coding guidance. http://www.asha.org/Practice/reimbursement/coding/New-CPT-Evaluation-Codes-for-SLPs/

   Why it is best practice to bill 92523 initially, followed by 96125……?

   - Since 92523 includes language comprehension and expression it is inherently the code that best represents evaluation of communication abilities. Communication skills include attention, concentration, short and long-term memory, sequencing, organization, problem solving, insight, judgment and executive functions. Cognitive skills may directly or indirectly impact communication skills (i.e. language). Therefore, it is important to evaluate communication/ language first (92523) and then drill down to cognitive skills (96125) for more standardized information regarding not only the relationship between the two, but also the cognitive-linguistic strengths and challenges to be considered in treatment interventions.
   - Determining the meaning of "cognitive-linguistic": From WiseGeek.com - At its simplest, the connection between language and cognition for normal human adults, no matter their ethnicity or culture, is profound. Speech gives voice to thoughts. Although individual cognitive processes are internalized and therefore silent, language — whether spoken or written — allows for knowledge and information to be shared.
   - Importance of establishing a **functional cognitive-linguistic outcome:**
   - Memory and orientation interventions, without a functional link, are often not sufficient to support skilled billable services.

Steps to developing a functional cognitive-linguistic outcome that positively impact specific communication abilities:

- Consider how communication/language (auditory processing, auditory, gestural & reading comprehension, verbal, written & gestural expression) are impacted by cognitive skills such as attention, memory, and organization.
- Consider assessment of visual versus auditory attention, concentration, and memory.
- Use standardized cognitive/communication assessments tools and document their results.
- Evaluate reading comprehension and written expression as acuity and clinical appropriateness permits – skills may be a strength.
- Determine and document preserved abilities and how they may assist in the ability to gain and retain information to compensate for weaknesses (i.e. procedural memory, written expression, reading comprehension).
- Consider assessment & amelioration of sensory deficits.
- Document the patient's preferred learning style (visual, auditory, tactile/kinesthetic) as a strength and how you are capitalizing on that strength to assist in safety and functional gain.
- Specific cognitive treatment procedures should be implemented and documented as clinically appropriate depending on patient's ability to gain and retain information/new learning.

Cognitive treatment procedures may include:

- **For mild – moderate cognitively impaired patients**: spaced retrieval; memory journals/wallets; rehearsal; repetition; word/mental picture association; following written and verbal directions; recalling boxed information; mnemonics; associated visual pairs; safety strategies; sequencing and problem solving strategies for all daily activities and responsibilities.
- **For moderate – severe cognitively impaired patients**: validation therapy techniques; augmentative communication tools; sensory integrative techniques; reminiscence, Montessori based techniques; environmental modification.
- Conduct and document caregiver education and training, including specific individualized, effective cognitive strategies from week one to discharge.

3. 92611- Motion fluoroscopic evaluation of swallowing function by cine or video recording; 92612- Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (FEES).
    - Both codes would be used after a dysphagia plan of care is established. Minutes associated with these codes would count as treatment minutes on the MDS as they would be considered reassessment of the patient providing additional information for established dysphagia plan of care.

*CMS Skilled Nursing Facility (SNF)/Long Term Care (LTC) Open door forum call May 6, 2014