AGENDA ITEM 11

DISCUSSION AND POSSIBLE ACTION ON AD HOC COMMITTEE'S REPORT AND RECOMMENDATION(S) REGARDING OCCUPATIONAL THERAPISTS PERFORMING THE PHYSICALLY INVASIVE COMPONENTS OF AN INSTRUMENTAL EVALUATION (E.G., FIBEROPTIC ENDOSCOPY EVALUATION OF SWALLOWING)

The materials provided to the committee members are attached for review.

CBOT Ad Hoc committee on endoscopic evaluation of swallowing
Meeting Held January 27, 2016

MEETING HIGHLIGHTS

Current language restricts OTs' ability to perform FEES

This is perceived as an 'access' issue - defined by some as OTs' access to perform the modality, rather than consumers' access to services

- Dysphagia and feeding is turf warfare between SLP and OT
- SLP position statement affect: protectionism
- FEES is a gold-standard assessment tool, especially for breast-feeding infants;
- OTs can't provide an important type of care for the important mother/child dyad.
-

Modified barium swallow tests are another instrumental evaluation that OTs can perform

- Can't be used for breast-feeding infants
- Radiation exposure is contraindicated
- Logistics of mixing barium into food does not work for infants, barium cannot be introduced into the breast

OTs lose the ability to treat a population they have been treating historically because they do not have the ability to perform the instrumental evaluation of choice for the population.

Regulation prohibiting OT use of FEES is seen as unnecessarily restrictive, requires that OTs refer out to other providers for the test.

Effect on consumers from OTs not doing FEES, includes discontinuity of care due to:

- Consumers having to work with both OT and SLP - must develop 2 therapeutic relationships, when one might otherwise be enough. Can be time-consuming and inconvenient to the patient
- OTs must develop treatment plans based on assessment information received secondhand from SLPs. Potential handoff errors for consumers
- Access issue for consumers. Supervisors receiving referrals for FEES must schedule them with SLPs. Shortages of qualified staff result in long wait times and delayed FEES treatment planning. Consumers suffer.
- Billing 2 services, OT and SLP, adds costs to system and to consumers with copayments for each service.

Considerations in eliminating the prohibition on OTs performing endoscopy

- Would this enable OTs to perform endoscopies?
- Feeding and swallowing therapies are in the OT Practice Act as Advanced Practices.

Public Comment:
Packard Children's Hospital at Stanford (Kelly ANDRASIK, OT)

- NICU: OT feeds, ENT scopes, SLP writes analysis. (No SLPs are yet qualified to pass endoscopes at Packard, so the ENT does that).
- SLP has set up a "Speech and Swallowing Clinic" that does not include OT services, has billing structure set up.

Committee Recommendations:

- The Board take steps to allow OTs to perform the physically invasive components of swallowing evaluations.
- That Board charge the Ad Hoc committee to develop alternative regulatory language around the education, training, and other conditions under which some OTs might be able to perform FEES without harm to the public.

CURRENT LAWS AND REGULATIONS

B&P CODE SECTION 2570.3.
(a) No person shall practice occupational therapy or hold himself or herself out as an occupational therapist or as being able to practice occupational therapy, or to render occupational therapy services in this state unless he or she is licensed as an occupational therapist under the provisions of this chapter. No person shall hold himself or herself out as an occupational therapy assistant or work as an occupational therapy assistant under the supervision of an occupational therapist unless he or she is licensed as an occupational therapy assistant under the provisions of this chapter.

(b) Only an individual may be licensed under this chapter.

(c) Nothing in this chapter shall be construed as authorizing an occupational therapist to practice physical therapy, as defined in Section 2620; speech-language pathology or audiology, as defined in Section 2530.2; nursing, as defined in Section 2725; psychology, as defined in Section 2903; or spinal manipulation or other forms of healing, except as authorized by this section.

(d) **An occupational therapist may provide advanced practices if the therapist has the knowledge, skill, and ability to do so and has demonstrated to the satisfaction of the board that he or she has met educational training and competency requirements**. These advanced practices include the following:

(1) Hand therapy.

(2) The use of physical agent modalities.

(3) **Swallowing assessment, evaluation, or intervention.**

(h) The board shall develop and adopt regulations regarding the educational training and competency requirements for advanced practices in collaboration with the Speech-Language Pathology and Audiology Board, the Board of Registered Nursing, and the Physical Therapy Board of California.

(i) Nothing in this chapter shall be construed as authorizing an occupational therapist to seek reimbursement for services other than for the practice of occupational therapy as defined in this chapter.

ARTICLE 6. ADVANCED PRACTICES

§ 4150. Definitions
For the purpose of this article:
(a) "ACOTE" means the Accreditation Council for Occupational Therapy Education.
(b) **"Post professional education and training" means education and training obtained subsequent to the qualifying degree program or beyond current ACOTE standards for the qualifying degree program.**
(c) "Contact hour" means sixty (60) minutes of coursework or classroom instruction.
(d) "Semester unit" means fifteen (15) contact hours.
(e) "Quarter unit" means ten (10) contact hours.
(f) "Rehabilitation of the hand, wrist, and forearm" as used in Code section 2570.2(l) refers to occupational therapy services performed as a result of surgery or injury to the hand, wrist, or forearm.
(g) "Upper extremity" as used in Code section 2570.3(e) includes education relating to the hand, wrist, or forearm.

(h) "Swallowing" as used in Code section 2570.3 is the passage of food, liquid, or medication through the pharyngeal and esophageal phases of the swallowing process.
(i) "Instrumental evaluation" is the assessment of any aspect of swallowing using imaging studies that include, but are not limited to, endoscopy and videofluoroscopy
(1) "Endoscopic evaluation of swallowing" or "endoscopy" is the process of observing structures and function of the swallowing mechanism to include the nasopharynx, oropharynx, and hypopharynx.
(2) "Videofluoroscopic swallowing study" or "videofluoroscopy" is the fluoroscopic recording and videotaping of the anatomy and physiology of the oral cavity, pharynx, and upper esophagus using a variety of bolus consistencies to assess swallowing function. This procedure may also be known as videofluorography, modified barium study, oral-pharyngeal motility study and videoradiography.

§ 4153. Swallowing Assessment, Evaluation, or Intervention

(a) The role of an occupational therapist in instrumental evaluations is to observe structure and function of the swallowing mechanism in order to assess swallowing capability and determine swallowing interventions. **The occupational therapist may not perform the physically invasive components of the instrumental evaluation.**
(b) Swallowing assessment, evaluation or intervention may be performed only when an occupational therapist has demonstrated to the Board that he or she has met the post professional education and training requirements established by this section as follows:
(1) Education: Completion of 45 contact hours in the following subjects:
(A) Anatomy, physiology and neurophysiology of the head and neck with focus on the structure and function of the aerodigestive tract;
(B) The effect of pathology on the structures and functions of the aerodigestive tract including medical interventions and nutritional intake methods used with patients with swallowing problems;
(C) Interventions used to improve pharyngeal swallowing function.
(2) Training: Completion of 240 hours of supervised on-the-job training, clinical internship or affiliation, which may be paid or voluntary, pertaining to swallowing assessment, evaluation or intervention. An occupational therapist in the process of completing the training requirements of this section may practice swallowing assessment, evaluation or intervention under the supervision of an occupational therapist who has been approved under this article, a speech language pathologist with expertise in this area, or a physician and surgeon.
(c) An occupational therapist may provide only those swallowing assessment, evaluation or intervention services he or she is competent to perform.

KNOWLEDGE AND SKILLS FOR PERFORMING ENDOSCOPIC ASSESSMENT OF SWALLOWING FUNCTIONS – PROVIDED BY AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Purpose

Clinical evaluation of dysphagia typically begins with a noninstrumental examination. Subsequently, an instrumental procedure may be indicated. Two imaging procedures typically considered are fluoroscopy and endoscopy (ASHA, 1992). The videofluoroscopic examination is more commonly used in clinical practice and has frequently been described in peer-reviewed literature. This procedure is taught through a variety of means, including university coursework, regional workshops, and on-the-job training. Fiberoptic endoscopic assessment of swallowing functions is gaining widespread use as an instrumental procedure among speech-language pathologists who engage in the clinical management of dysphagia. Like videofluoroscopy, endoscopic assessment of swallowing function is a procedure that requires an advanced level of training and demonstration of knowledge, technical skill, and interpretative proficiency. Therefore, it is important that knowledge and skill requirements for clinical use of this procedure are clearly identified.

Description of the Procedure

Use of fiberoptic endoscopic instrumentation allows inspection of functions of the swallowing mechanism at the velopharynx, oropharynx, pharynx, and larynx. It does not permit any systematic evaluation of oral or esophageal components of swallowing. Endoscopic assessment of swallowing function is not a screening examination but a comprehensive assessment of the upper aerodigestive functions of swallowing. It includes five components:

1. assessment of anatomy involved in the pharyngeal stage of swallowing,
2. assessment of movement and sensation of critical structures within the pharynx,
3. assessment of secretions,
4. direct assessment of swallowing function for food and liquid, and
5. response to therapeutic maneuvers and interventions to improve the swallow.

The purpose of the procedure is the comprehensive evaluation of the pharyngeal stage of swallowing, leading to recommendations regarding the adequacy of the swallow, the advisability of oral feeding, and the use of appropriate interventions to facilitate safe and efficient swallowing. Following is a brief synopsis of the procedure. This description is intended to be merely introductory, not comprehensive or instructional. More detailed descriptions may be found in Langmore (2001) and Murray (1999).

Endoscopic assessment of swallowing function is a portable procedure that may be completed in the clinic office, at bedside, or wherever the patient needs to be examined. A fiberoptic endoscope is passed transnasally and permits inspection of swallowing mechanisms and functions from the velopharynx to hypopharynx and larynx. Status of standing secretions in the hypopharynx and frequency and effectiveness of spontaneous swallowing are noted, and potential implications for aspiration are taken into consideration as the examination proceeds. The patient is then directed to perform various tasks to evaluate the sensory and motor status of the pharyngeal and laryngeal mechanism. Sensation in the hypopharynx and larynx can be tested directly, and thresholds can be quantified if the appropriate equipment is used (FEESST procedure). The ability to maintain volitional closure of the vocal folds is assessed as a

potential airway protection mechanism. Food and liquid boluses are then presented to the patient so that the integrity of the pharyngeal swallow can be determined. Observations are made over several swallows to assess various foods and liquids and to evaluate the effect of fatigue, specific directions, and/or compensatory adjustments during swallowing. Passage of the bolus and movement of the structures cannot be observed during the swallow because tissue surrounds the end of the endoscopy, causing a brief condition referred to as "white-out." Preceding the swallow, the premature spillover of any material into the pharynx or larynx can be observed. At the completion of the swallow, the presence of any bolus residue material provides the examiner with certain clinical information regarding the nature of the pharyngeal swallowing impairment. Data relating to the relative timing of the endoscopically observed events during normal swallows are reported in Perlman and VanDaele (1993).

Knowledge and Skills for Conducting Endoscopic Assessments of Swallowing Function

Individuals must demonstrate that they have attained the basic knowledge and skills related to service provision for dysphagia (ASHA, 1990, 1992) as described below. Suggestions for verifying knowledge of items 1–6 below include observation, written or practical examination, or other form of knowledge evaluation by supervisor at host institution; a structured interpretative examination for items 7–12 is recommended. This examination may be provided by the mentor at the host institution, by an instructor in a formal course, or by another appropriate mechanism.
Suggestions for verifying skills: A local mentor qualified to perform the procedure can directly observe. It is recommended that a three-step process be followed for acquiring technical skill for the procedures listed below: (1) observation, (2) practice under direct supervision, and (3) independent practice with indirect supervision. No specific number of procedures has been identified as equivalent to a minimal skill level; however, the number of procedures at each level that were necessary for the individual to demonstrate her/his competence should be well documented.

Knowledge

1. Know normal and abnormal aerodigestive physiology for respiration, airway protection, and swallow.
2. Recognize anatomical landmarks as viewed endoscopically.
3. Recognize altered anatomy as it relates to swallowing function.
4. Recognize changes in anatomy and physiology of the swallow over the life span.
5. Identify the indications and contraindications for an endoscopic exam.
6. Identify the elements of a comprehensive endoscopic swallowing exam.
7. Detect and interpret abnormal findings in terms of the underlying anatomy and pathophysiology.
8. Apply appropriate treatment interventions, implement postural changes, and alter the bolus or method of delivery to determine the effect on the swallow.
9. Use the results of the examination to make appropriate recommendations and to guide treatment of the patient.
10. Make appropriate recommendations or referrals for other examinations as needed.
11. Know when to re-evaluate swallowing function.
12. Use endoscopy as a biofeedback tool and to educate patients, family, and staff using the endoscopic images either during or after the examination.

Skills

A comprehensive list of roles, range and scope of 6skills, and knowledge base needed to provide service to patients with dysphagia is included in "Knowledge and Skills Needed by Speech-Language Pathologists Providing Services to Dysphagic Patients/Clients" (ASHA, 1990). Knowledge and skills needed in the use of fiberoptic endoscopic evaluation of swallowing were first described in "Instrumental Diagnostic Procedures for Swallowing" (ASHA, 1992). The "Graduate Curriculum on Swallowing and Swallowing Disorders (Adult and Pediatric Dysphagia)" identifies specific educational outcomes that are intended to provide students with basic competencies relevant to swallowing and swallowing disorders (ASHA, 1997). Specific skills pertaining to endoscopic evaluation of swallowing are described, and suggestions are given below for verifying those skills.

1. Operate, maintain, and disinfect the equipment needed for an endoscopic examination.
2. Apply topical anesthetic when clinically appropriate and permitted by the licensing regulations of individual states.
3. Insert and manipulate the endoscope in a manner that causes minimal discomfort and prevents unpleasant complications.
4. Manipulate the endoscope within the hypopharynx to obtain the desired view.
5. Direct the patient through appropriate tasks and maneuvers as required for a complete and comprehensive examination.
6. Interpret and document findings in a written report.
7. Formulate treatment and management strategies based on test results.

Suggested Training Curriculum

The following curriculum is suggested in order to guide clinicians, mentors, faculty members, or instructors at a workshop through the areas of knowledge needed to understand swallowing as viewed endoscopically and to be able to use endoscopy effectively in dysphagia evaluation and management. It is anticipated that this curriculum will need to be updated regularly as new research and developments in the field advance this area of practice.

A. Introduction of flexible fiberoptics into medicine
    1. History of endoscopy
    2. Rationale for performing endoscopic evaluations
        a. Indications and contraindications for the procedure
        b. Objectives, goals of the examination
        c. Role of the speech-language pathologist; scope of practice
B. Evaluation of anatomy of the aerodigestive system
    1. Nasal passage
    2. Velum and nasopharynx
    3. Oropharynx and tongue base
    4. Hypopharynx
    5. Larynx
    6. Subglottic region
    7. Anatomical protections against aspiration
C. Evaluation of the physiology of the aerodigestive system
    1. Movement of the tongue base
    2. Epiglottic inversion
    3. Velopharyngeal competence
    4. Pharyngeal wall movement

5. Laryngeal movements
    a. Adduction on volitional cough
    b. Airway closure for breath hold, effortful breath hold
    c. Phonatory adduction
    d. Arytenoid abduction
6. Sensory function

D. Anatomical abnormalities
1. Nasal stenosis
2. Velopharyngeal incompetency
3. Palatal cleft
4. Pharyngeal stenosis
5. Postsurgical presentations
6. Mucosal changes (e.g., postradiation, connective tissue disease)
7. Pharyngeal, laryngeal lesions
8. Edema/erythema
9. Indirect evidence of reflux
10. Variance of normal anatomy

E. Neurologic vs. mechanical disruption
1. Characteristics of movement dysfunction
2. Unilateral vs. bilateral deficits
3. Postsurgical disruptions
4. Congenital birth defects
5. Distinction from normal aging
6. Tracheostomy and ventilator issues

F. Behavioral disorders
1. Psychogenic dysphagia with no overt etiology
2. Psychogenic dysphagia in cases of additional (primary or secondary) etiology

G. Endoscopic equipment
1. Flexible endoscope
2. Light source
3. Camera and adapter
4. Video recorder and monitor
5. Time-date generator
6. Video printer
7. Optional: Air pulse generator for sensory testing (FEESST)
8. Miscellaneous supplies
    a. 4x4 gauze pads, alcohol prep pads, tissues
    b. Lubricant
    c. Topical anesthesia, nasal spray
    d. Green or blue food color
    e. Food, liquid
    f. Spoons, cups, straws, etc.

H. Use of anesthetics [1]
1. Use of anesthetics is not mandatory. However, speech-language pathologists who perform flexible endoscopy for purposes of assessing swallowing function may find it beneficial and necessary to use topical anesthetics (note: one does not want to use a spray as it can pass to the pharynx) to optimize patient comfort, decrease gagging behavior, and perform a thorough and complete examination. In these instances, the speech-language pathologist must be familiar with state

licensure board regulations regarding scope of practice in her/his state and care setting.

2. Care should be taken to assure that only the nasal passage, not the pharynx, is anesthetized. All patients should be in the upright position for administration of the anesthetic.
3. Before administering the medication(s), the speech-language pathologist should check the patient's medical record for drug allergies, should question the patient about drug allergies, and should query the patient's physician if necessary about the safety of administering the drugs. There should be provisions for medical treatment in the case of adverse patient reaction to the test or medication.

I. Protocol for endoscopic swallowing procedure
   1. Patient preparation
      a. Patient consent
      b. Patient posture/positioning
      c. Optional application of topical anesthesia and nasal decongestant
   2. Technical considerations
      a. Optional defogging
      b. Endoscope handling, orientation
      c. Scope insertion, placement, maneuvering techniques
   3. Examination protocol: Many clinical protocols have been described for the endoscopic assessment of swallowing functions. General components follow without reference to any specific published or unpublished protocol.
      a. Positioning a scope for optimum view of velopharynx, oropharynx/hypopharynx, larynx during swallow function examination
      b. Evaluation of structures at each point in the examination
      c. Evaluation of basic movement abilities at each point in the examination. This includes completion of any specific maneuvers by the patient to examine individual movements (e.g., falsetto to evaluate pharyngeal wall medialization, breath hold or valsalva to evaluate vocal fold closure, etc.)
      d. Sensory testing
      e. Administration of liquid and/or food to assess swallowing functions. This may include maneuvers performed by the patient to evaluate impact of such maneuvers on swallowing safety (i.e., head turn, chin down, breath hold, etc.)

J. Interpretation of salient findings in terms of underlying deficit(s)
   In general, interpretation follows a consistent format:
   1. Anatomical/structural deviations
   2. Movement deviations
   3. Sensory deficits
   4. Specifics of swallowing function/dysfunction
   5. Interpretative assessment of swallowing safety

K. Treatment and management of patients during endoscopic evaluation
   1. Therapeutic portion of the diagnostic examination
   2. Involvement of the patient, caregivers, other medical staff; education of patient and other significant persons
   3. Repeat examinations - to monitor change, continued need for specific behavioral interventions, or diet
   4. Biofeedback as a treatment technique

L. Use of endoscopic swallowing assessments with different populations and diagnoses
    1. Pediatrics
    2. Head and neck cancer
    3. Traumatic injuries
    4. Neurogenic disorders, neurosurgical sequelae
    5. Chronic respiratory disease
    6. Post thoracic/cardiac surgery
    7. Medically compromised patients
M. Use of endoscopic swallowing assessments in different settings
    1. Critical care patients
    2. Acute care patients
    3. Rehabilitation settings
    4. Long-term care settings
    5. Home health
    6. Outpatients
N. Universal precautions
    1. Gloves
    2. Eye protection - optional
    3. Endoscope highlevel disinfection
        a. cleaning and sterilizing agents
        b. biohazard receptacles
    4. Endosheaths
O. Topical anesthesia, nasal decongestant, and disinfectant
   Monitor to ensure that no medication used has exceeded its expiration date. The supply and security of medications stored and used is ultimately the responsibility of the speech-language pathologist. The drugs should be stored in a closed cabinet. Each facility should have an established policy for monitoring the storage and use of medications in these procedures.
P. Adverse/allergic reactions
   Practitioners must be able to recognize and understand appropriate treatment for the following conditions:
    1. Tachycardia associated with epinephrine
    2. Vasovagal response
    3. Nasal inflammation
    4. Nasal turbinate hypertrophy
    5. Implications of blood thinners and hemophilia
    6. Dosage and side effects of any nasal decongestants or anesthesia used in the procedure
Q. Possible contraindications for performing endoscopic assessment of swallowing functions
    1. Patient is not sufficiently alert to be fed orally.
    2. Patient has severe nasal or pharyngeal stenosis.
    3. Patient is agitated and/or combative.
    4. Patient has movement disorder of sufficient severity to preclude safe completion of examination by endoscopy.
    5. Patient has a history of epistaxis.
    6. Patient has a bleeding disorder.
    7. Patient has an acute cardiac condition that predisposes patient to cardiac irregularities.

R. Indications for performing endoscopic assessments of swallowing functions
   Practitioners must be able to recognize and understand appropriate indications for performing endoscopic and/or fluoroscopic assessments, specifically:
   1. Indications for an instrumental procedure following a clinical examination [2]
   2. Indications for endoscopic assessment vs. or in addition to fluoroscopy as the preferred imaging procedure
S. Validity of endoscopic assessment as a diagnostic procedure and evaluation of dysphagia treatment outcomes after using endoscopy as a primary evaluation and management tool. Practitioners must be aware of the following:
   1. Sensitivity of the procedure for abnormal findings compared to the fluoroscopy and/or clinical, noninstrumental procedures
   2. Effectiveness of treatment/management of dysphagia after using endoscopy as an evaluation/management tool

Local Coverage Determination (LCD): Swallow Evaluation and Dysphagia Treatment (L31905)

Contractor Information

Contractor Name
CGS Administrators, LLC

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LCD Information

Document Information

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LCD Title
Swallow Evaluation and Dysphagia Treatment

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Revision Ending Date
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N/A

CMS National Coverage Policy
Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Code of Federal Regulations:

42 CFR Section 410.32, indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements) who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary (see Sec. 411.15(k)(1) of this chapter).

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12:
40.4 Speech - Language Pathology Services
CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:
80.4.4 Exclusions From Coverage as Portable X-Ray Services
CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:
220.1 Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:
220.1.3 Certification and Recertification of Need for Treatment and Therapy Plans of Care
CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:
220.3 Documentation Requirements for Therapy Services
CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15:

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CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1: 160.2 Treatment of Motor Function Disorders with Electric Nerve Stimulation

CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1: 170.3 Speech – Language Pathology Services for the Treatment of Dysphagia

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5: Section 10 Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5: Section 10 Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5: 20.1 Discipline Specific Outpatient Rehabilitation Modifiers – All Claims

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5: 20.2 (D) Reporting of Service Units with HCPCS

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6: 20.5 Therapy Services

CMS Transmittal No. 111, Publication 100-02, *Medicare Benefit Policy Manual*, Change Request #6005, September 25, 2009, advises that speech-language pathology therapy services are covered CORF services if physical therapy services are the predominate rehabilitation services.

CMS Transmittal No. 106, Publication 100-02, *Medicare Benefit Policy Manual*, Change Request #6381, April 24, 2009, advises that enrolled speech-language pathologists may bill for services provided on or after July 1, 2009.

CMS Transmittal No. 1717, Publication 100-04, *Medicare Claims Processing Manual*, Change Request #6381, April 24, 2009, advises that enrolled speech-language pathologists may bill for services provided on or after July 1, 2009.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

Dysphagia, or difficulty in swallowing, can cause solids or liquids to enter the airway, resulting in coughing, choking, aspiration, or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia, and death. Dysphagia is a swallowing disorder that may be due to various neurological, structural or cognitive deficits, and deconditioning. It may be the result of head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer and related treatment, as well as encephalopathies. Dysphagia most often reflects problems involving the oral cavity, pharynx, esophagus, gastroesophageal junction, or proximal stomach. While dysphagia can afflict any age group, it most often appears among the elderly. Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability.

Patients who are motivated, moderately alert, and have some capacity for deglutition and swallowing are appropriate candidates for dysphagia therapy. Elements of the therapy program can include thermal stimulation to heighten the sensitivity of the swallowing reflex, exercises to improve oral-motor control and laryngeal elevation training in laryngeal adduction and compensatory swallowing techniques, and positioning and dietary modifications. All programs are designed to ensure swallowing safety during oral feedings and maintenance of adequate nutrition.

Indications and Limitations:

Dysphagia Categories

Oral, pharyngeal, or upper esophageal dysphagia
Oral dysphagia is defined as an inability to coordinate chewing and swallowing a bolus of solids or 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 incoordination, 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 spilling prematurely into the pharynx.

Pharyngeal dysphagia is defined as an impairment of strength, timing, and/or coordination to propel a bolus through the pharynx into the esophagus while closing off the entrance to the larynx during the act of swallowing.

The pharyngoesophageal phase of swallowing (upper one-third of the esophagus) involves the passage of a bolus through the upper esophageal sphincter, into the esophagus, and through the lower sphincter into the stomach. Esophageal dysphagia is primarily addressed through medical assessment and management. Speech-language pathologists and qualified occupational therapists may be involved in evaluation of the upper third of the esophagus for esophageal motility and gastroesophageal reflux and provide counseling and exercises.

Lower esophageal phase of dysphagia
The esophageal (lower two thirds) phase of swallowing is associated with difficulty in passing food from the esophagus to the stomach. If peristalsis is inefficient, patients may complain of food getting stuck or of having more difficulty swallowing solids than liquids. Sometimes patients experience esophageal reflux or regurgitation, especially if they lie down too soon after meals.

Inefficient functioning of the esophagus during the esophageal phase of swallowing is a common problem in the geriatric patient. Swallowing disorders occurring only in the lower two thirds of the esophageal stage of the swallow are usually not amenable to swallowing therapy techniques.

Professional Qualifications

Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies

include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques.

A skilled therapist refers to a speech-language pathologist, occupational therapist, physician, or nonphysician practitioner (NPP) who is licensed, certified, or otherwise authorized by the state to perform therapy services. The services of speech-language pathology assistants are not recognized as skilled therapy services and are not covered by Medicare.

SWALLOWING EVALUATION

Evaluation of Oral and Pharyngeal Swallowing Function (CPT Code 92610)

An evaluation of the patient's swallowing mechanism may include a clinical bedside evaluation of swallowing, evaluation of oral-motor functioning, and/or instrumental assessment.

Clinical bedside examination consists of a pertinent medical history, careful examination of the lip function, tongue function, soft palate function, responses to oral sensitivity, and determination of the patient's memory, ability to follow directions and participate in therapy. If the bedside examination indicates that the patient may have a pharyngeal dysfunction or is at risk for aspiration, then additional evaluation with an instrumental assessment may be needed. The clinician's clinical assessment should document history, diagnosis, current eating and nutritional status, behavioral and cognitive status, pertinent clinical observations including oral functioning (swallowing positioning and general articulation), and signs and symptoms of possible dysphagia.

Instrumental Assessments Used to Study Swallowing (CPT Codes 92611, 92612, 92614, 92616, and 92700)

Instrumental assessment of swallowing may be indicated for the evaluation of a patient with dysphagia, who has a pharyngeal dysfunction or who is at risk for aspiration.

Examples of clinical syndromes where instrumental assessment of swallowing may be indicated are:

- Stroke or other central nervous system (CNS) disorder with associated impairment of speech and swallowing;
- Difficulty swallowing following surgical ablation, radiation, or chemotherapy for head and neck cancer;
- Documented difficulty swallowing in patients without obvious CNS disorder;
- Generalized debilitation with difficulty swallowing;
- Clinical history of aspiration or history of aspiration pneumonia; and
- Head or neck injury.

Instrumental assessment of swallowing may be needed for clinical decisions whether to place feeding gastrostomy tubes, in the dietary management of the impaired patient, and to plan and evaluate appropriate therapy programs.

Instrumental assessments used for diagnostic purposes, (e.g., fiberoptic endoscopic examination), should be performed and interpreted by speech language pathologists or occupational therapists under the general supervision of an otolaryngologist or other physician with training in these procedures or may be performed by an otolaryngologist or other physician with appropriate training. The functional assessment and management of dysphagia falls within the scope of practice of the speech language pathologist or other qualified dysphagia therapist, thus such practitioners may render a functional diagnosis of dysphagia where allowed by state or local law. Only physicians are qualified and licensed to render a medical diagnosis that identifies the pathology affecting swallowing. Care should be exercised to perform instrumental examinations in settings that assure patient safety.

Instrumental evaluation of swallowing is used for visualization, identification, and verification of:

- the location and nature of the swallowing impairment along the upper aerodigestive tract;
- movement patterns of structures in the oral cavity and pharynx;
- timing and duration of the oral and pharyngeal stages of swallowing.
- presence or absence of aspiration;
- timing and approximate percentage of aspiration; and
- effective treatment methods and strategies to improve swallow safety and efficiency;

Instrumental diagnostic procedures, and the behavioral or dietary interventions attempted during the examination, are used to assess their effects on reducing aspiration and improving bolus clearance. The final interpretation of an instrumental assessment should include a definitive diagnosis, identification of the swallowing phase affected, and a recommended treatment plan. The treatment plan should address appropriate therapeutic interventions such as compensatory swallowing techniques and postures, dietary recommendations including food and fluid texture modification, the safety of continued oral feedings, and recommendations for further investigations, if needed. The treating physician ultimately determines the diagnosis and need for further investigation.

An instrumental assessment is not medically necessary if findings from the clinical evaluation fail to support a suspicion of dysphagia; or, when findings from the clinical evaluation suggest dysphagia but include one or more of the following:

- the patient is unable to cooperate or participate in an instrumental evaluation; or
- the patient's safety is at risk,

> Example: The patient is unable to initiate a swallow response. In this case a patient would be at risk for aspiration, if given food or liquids during a swallowing study. However, the FEES or FEESST can yield adequate information about swallowing physiology without feeding the patient;

- in the physician's or qualifed dysphagia therapist's judgment, the instrumental exam would not change the clinical management of the patient; and
- the patient is too medically unstable to tolerate a procedure.

Absence of instrumental evaluation does not preclude the patient from receiving dysphagia treatment if that dysfunction has been reasonably identified by clinical means.

Motion Fluoroscopic Evaluation of Swallowing Function by Cine or Video Recording (CPT Code 92611)

Videofluoroscopic swallowing study, also known as the modified barium swallow (MBS), is a videofluoroscopic radiographic test that differs from the traditional barium swallow procedures (e.g., pharyngoesophagram and upper gastrointestinal series) in both procedure and purpose. During the MBS, the patient is seated in an upright or semi-reclined position and given various quantities and textures of food and/or liquids mixed with a contrast material.

The MBS demonstrates containment of food and liquid in the oral cavity, mastication, tongue mobility during oral bolus transport, elevation and retraction of the velum, tongue base retraction, upward and forward movement of the hyoid bone and larynx, laryngeal closure, pharyngeal contraction, and extent and duration of pharyngoesophageal segment opening. The presence, timing, and cause of penetration or aspiration into the upper airways are also observed. Observations of esophageal clearance, sensation, and muscle strength may be measured directly or inferred. Professional guidelines recommend that the service be provided in a team setting with a physician/NPP that provides supervision of the radiological examination and determination of the medical diagnosis.

The performance of a videofluoroscopic assessment is only medically necessary when the disorder cannot be substantiated through clinical examination. It is indicated to identify a pharyngeal deficit, aspiration is actually occurring, or the patient is at high risk for aspiration. A videoflouroscopy is also indicated when the clinician requires additional information to determine appropriate treatment strategies and diet textures.

Flexible Fiberoptic Endoscopic Evaluation of Swallowing by Cine or Video Recording (CPT Code 92612. If cine or video recording is not used, CPT Code 92700)

Endoscopic assessment of swallowing functions, also known as Fiberoptic Endoscopic Evaluation of Swallowing (FEES), involves placement of a flexible endoscope transnasally into the hypopharynx. The procedure permits direct visualization of anatomy as well as an assessment of amplitude, speed, briskness, and symmetry of movement of the velopharyngeal sphincter, base of tongue, pharynx, and larynx. Sensation is assessed by noting the reaction of the patient to the presence of the endoscope. Findings include briskness of swallow initiation, timing of bolus flow and swallow initiation, adequacy of bolus driving and clearing forces, adequacy of velar and laryngeal valving forces, penetration or aspiration before or after the swallow, and presence of hypopharyngeal reflux.

The patient may be evaluated at the bedside location. FEES may be performed by a physician, speech-language pathologist, or qualified occupational therapist.

Flexible Fiberoptic Endoscopic Evaluation, Laryngeal Sensory Testing by Cine or Video Recording (CPT Code 92614. If cine or video recording is not used, CPT Code 92700)

A flexible fiberoptic laryngoscope is used in laryngeal sensory evaluation. The sensory evaluation delivers pulses of air at sequential pressures to elicit and document the laryngeal adductor reflex and sensory threshold.

Flexible Fiberoptic Endoscopic Evaluation of Swallowing and Laryngeal Sensory Testing by Cine or Video Recording (CPT Code 92616. If cine or video recording is not used, CPT Code 92700)

Fiberoptic Endoscopic Evaluation of Swallowing with Sensory Testing (FEESST) is a modification of FEES, with the addition of specialized equipment that quantifies the sensory threshold in the larynx. FEESST may be performed by a physician, speech-language pathologist, or qualified occupational therapist. This may be a collaborative evaluation involving both disciplines.

The special equipment for FEESST includes a sensory stimulator that allows quantification of stimuli, a television monitor, a video printer, and a video storage device. As with the FEES procedure, velopharyngeal closure, anatomy of the base of the tongue and hypopharynx, abduction and adduction of the vocal folds, status of pharyngeal musculature and the patient's ability to handle his/her own secretions are assessed.

The sensory evaluation is completed by delivering pulses of air at sequential pressures to elicit and measure the laryngeal adductor reflex. As with the FEES procedure, motor evaluation is completed by giving various food items with different consistencies while factors such as oral transit time, inhibition of swallowing, laryngeal elevation, spillage, residue, condition of swallow, laryngeal closure, reflux, aspiration, and ability to clear residue are monitored. The entire procedure may be done at bedside. The use of anesthesia may interfere with the sensory test and is usually not indicated.

DYSPHAGIA TREATMENT

Medical evaluation including the appropriate use of the swallowing evaluation techniques listed above should result in an understanding of the disordered swallowing mechanics and their etiology. From this a treatment plan should be developed that may include a variety of treatment modalities. Note that CMS Publication 100-03, *Medicare National Coverage Decisions Manual*, Chapter 1, Section 170.3 requires that patients appropriate for dysphagia therapy be *motivated, moderately alert, and have some degree of deglutition and swallowing functions.*

Dysphagia services are covered provided the services can only be safely and effectively performed by a qualified therapist licensed, certified, or otherwise authorized by the state in

which they practice. Services normally considered to be a routine part of nursing care are not covered as skilled dysphagia services.

The goal for a patient is to return to the highest level of function realistically attainable within the context of the disability. The skills of a therapist may not necessarily be required to attain this goal, but may be required initially to ensure safety, select proper modalities for treatment, then transferring the patient to a self management or caregiver assisted treatment program.

In order for the plan of care to be covered, it must address a condition for which dysphagia services are an accepted method of treatment. There must be an expectation that the condition will improve significantly in a reasonable and generally predictable period of time based on the assessment of the patient's rehabilitation potential.

Dysphagia services are not covered when the functional disability or medical condition do not require the skills of a qualified therapist.

Dysphagia services are not covered when the documentation indicates that a patient has attained the therapy goals or has reached the point where no further significant practical improvement can be expected; or when the services no longer require the skills of a therapist and could be transitioned to a self management or caregiver assisted program, such as when repetitive cues are required.

The development of a maintenance regimen or home swallowing program to delay or minimize muscular and functional deterioration may be considered reasonable and necessary. Limited services (2-4 visits) may be covered to establish and train the patient and/or caregiver in a maintenance program. The skills of a therapist are not necessary to carry out the maintenance program under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members. When patients with chronic, progressive conditions experience an exacerbation or deterioration in condition, rehabilitative therapy may be appropriate and reasonable to assist the patient to regain lost function.

Dysphagia services visits would not be routinely covered on a daily basis through discharge. Normally, visit frequency would decrease as the patient's condition improves.

It may not be reasonable and necessary to extend the time of dysphagia treatment visits for a patient, if the purpose of the extended visits is to:

- remind the patient to ask for assistance;
- offer supervision of activities to monitor safety awareness;
- remind a patient to slow down;
- offer routine verbal cues for compensatory or adaptive techniques already taught;
- train multiple caregivers; or
- begin a maintenance program after development and training is accomplished.

In these instances, the care should be turned over to supportive personnel or caregivers since repetitive cues and reminders do not require the skills of a therapist.

Treatment of Swallowing Dysfunction and/or Oral Function for Feeding (CPT Code 92526)

Dysphagia treatment commonly addresses the following issues:

- patient caregiver training in feeding and swallowing techniques;
- proper head and body positioning;
- amount of intake per swallow;
- appropriate diet;
- means of facilitating the swallow;
- feeding techniques and need for self help eating/feeding devices;
- food consistencies (texture and size);
- facilitation of more normal tone or oral facilitation techniques;
- oromotor and neuromuscular facilitation exercises to improve oromotor control;
- laryngeal elevation training;
- training in laryngeal and vocal cord adduction exercises;
- compensatory swallowing techniques; and
- oral sensitivity training.

Patients with chronic progressive disorders, such as Parkinson's disease, Huntington's disease, Wilson's disease, multiple sclerosis, or Alzheimer's disease and related dementias, do not typically show improvement in swallowing function, but will often be helped through short-term assistance/instruction in positioning, diet, feeding modifications, and in the use of self-help devices. The medical record should support short-term assistance/teaching and the establishment of a safe and effective maintenance dysphagia program.

Chronic diseases such as cerebral palsy, or previous head trauma or stroke, may require monitoring of swallowing function with short-term intervention for safety and/or swallowing effectiveness. Documentation should support loss of function and potential for change.

The presence of a nasogastric or gastrostomy tube does not preclude need for treatment. Removal of a nasogastric or gastrostomy tube may be an appropriate treatment goal.

CPT code 92526 is a comprehensive code that includes most aspects of dysphagia treatment. Do not use additional CPT codes in combination with 92526 when the focus of the treatment is for swallowing. CPT code 97150 should be reported for group dysphagia treatment. *Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.* (See CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 230) CPT code 92526 is an untimed code, billed as 1 unit per day. If two or more shorter sessions are performed during the same day, these should be combined and billed as 1 unit.

Other Comments:

For claims submitted to the Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated CGS Administrators to process their claims.

Bill type codes only apply to providers who bill these services to the Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Speech language pathology therapy services are covered CORF services if physical therapy services are the predominate rehabilitation services provided in the CORF. (See CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12, Section 40.4) To determine whether SLP therapy services are being given in conjunction with core CORF services, see CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12, Section 20.1 for a description of required CORF services.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Therapy Cap

Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims). These excluded hospital services are reported on types of bill 12x or 13x on intermediary claims. The annual limit on the allowed amount is combined for outpatient physical therapy and speech-language pathology, with a separate allowed amount for occupational therapy. For more information on the therapy cap, see CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Section 10.2.

Swallow evaluations (CPT codes 92610, 92611, 92612, 92614, 92616, and 92700) may be performed by physicians, speech pathologists or occupational therapists but speech-language pathologists may not enroll and submit claims directly to Medicare. The services of speech-language pathologists may be billed by providers such as rehabilitation agencies, HHAs, CORFs,

hospices, outpatient departments of hospitals, physicians, qualified NPPs, and physical therapists and occupational therapists in private practice under the "incident to" provision.

For services provided under the "incident to" provision, direct supervision does not mean that the physician must be physically present in the same room with the qualified personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the qualified personnel is performing services. Availability of the physician by telephone does not constitute direct supervision.

Under the Medicare Program, an independently practicing speech pathologist may now bill the Medicare program directly. *Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.* (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Section 10)

However, the services of speech-language pathologists may continue to be billed by providers such as rehabilitation agencies, HHAs, CORFs, hospices, outpatient departments of hospitals, and suppliers such as physicians, non-physician practitioners (NPPs), physical and occupational therapists in private practice. When these services are billed by physicians or NPPs, they are covered when billed under the "incident to" provision. "Incident to" services or supplies are defined as those furnished as an integral, although incidental, part of the physician's or NPPs personal professional services in the course of diagnosis or treatment of an injury or illness. These services must be related directly and specifically to a written treatment regimen established by the physician/NPP, after any needed consultation with a qualified speech pathologist, or by the speech pathologist providing such services.

For CPT codes 92613, 92615 and 92617 to be considered for payment, a physician must review and interpret the fiberoptic endoscopic evaluation.

Swallowing evaluations for patients with decreased oral intake, refusing oral intake, malnutrition, failure to thrive, or recent weight loss, may not require the unique skills of a therapist (and therefore would be noncovered) unless documentation clearly supports that these conditions are suspected to be directly related to a swallowing disorder. In these instances applicable observations and assessments from physicians and nursing staff should be included in any documentation sent for review to support the need for a skilled therapy dysphagia evaluation.

Examinations of the larynx and the pharynx done during gastroesophagoscopy are not considered to be part of a swallow evaluation, and are not separately payable.

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 80.4.4 excludes coverage of portable x-ray services not under the direct supervision of a physician/NPP for

procedures involving fluoroscopy, procedures involving the use of contrast media, and procedures requiring the administration of a substance to the patient or injection of a substance into the patient and/or special manipulation of the patient.

Electrical stimulation for the treatment of dysphagia (e.g., VitalStim) is not covered. (See CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 160.2) However, if electrical stimulation is used in addition to the reasonable and necessary standard of care dysphagia treatment (CPT code 92526), the use of the electronic stimulation will not cause denial of the otherwise reasonable and necessary care.

Efficacy for deep pharyngeal neuromuscular stimulation (DPNS) treatment of dysphagia has not been clearly demonstrated as reasonable and necessary. DPNS for the treatment of dysphagia is not covered. However, if DPNS is used in addition to the reasonable and necessary standard of care dysphagia treatment (CPT code 92526), its use will not cause denial of the otherwise reasonable and necessary care.

Dysphagia services rendered by a speech-language pathologist or other qualified therapist are not reimbursed separately in a skilled nursing facility under a qualified Part A stay under prospective payment.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x Hospital Inpatient (Including Medicare Part A)
012x Hospital Inpatient (Medicare Part B only)
013x Hospital Outpatient
021x Skilled Nursing - Inpatient (Including Medicare Part A)
022x Skilled Nursing - Inpatient (Medicare Part B only)
023x Skilled Nursing - Outpatient
034x Home Health - Other (for medical and surgical services not under a plan of treatment)
074x Clinic - Outpatient Rehabilitation Facility (ORF)
075x Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians or other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

0320 Radiology - Diagnostic - General Classification
0430 Occupational Therapy - General Classification
0434 Occupational Therapy - Evaluation or Reevaluation
0440 Speech Therapy - Language Pathology - General Classification
0444 Speech Therapy - Language Pathology - Evaluation or Reevaluation
0750 Gastro-Intestinal (GI) Services - General Classification
0960 Professional Fees - General Classification
0971 Professional Fees - Laboratory
0972 Professional Fees - Radiology - Diagnostic
0973 Professional Fees - Radiology - Therapeutic
0974 Professional Fees - Radiology Nuclear
0975 Professional Fees - Operating Room
0976 Professional Fees - Respiratory Therapy
0977 Professional Fees - Physical Therapy
0978 Professional Fees - Occupational Therapy
0979 Professional Fees - Speech Pathology
0981 Professional Fees - Emergency Room Services
0982 Professional Fees - Outpatient Services
0983 Professional Fees - Clinic
0984 Professional Fees - Medical Social Services
0985 Professional Fees - EKG
0986 Professional Fees - EEG
0987 Professional Fees - Hospital Visit
0988 Professional Fees - Consultation
0989 Professional Fees - Private Duty Nurse

CPT/HCPCS Codes

Group 1 Paragraph: N/A

Group 1 Codes:

92526 TREATMENT OF SWALLOWING DYSFUNCTION AND/OR ORAL FUNCTION FOR FEEDING
92610 EVALUATION OF ORAL AND PHARYNGEAL SWALLOWING FUNCTION
92611 MOTION FLUOROSCOPIC EVALUATION OF SWALLOWING FUNCTION BY CINE OR VIDEO RECORDING
92612 FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING BY CINE OR VIDEO RECORDING;
92613 FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING BY CINE OR VIDEO RECORDING; INTERPRETATION AND REPORT ONLY
92614 FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION, LARYNGEAL SENSORY TESTING BY CINE OR VIDEO RECORDING;
92615 FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION, LARYNGEAL SENSORY TESTING BY CINE OR VIDEO RECORDING; INTERPRETATION AND REPORT ONLY
92616 FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING AND LARYNGEAL SENSORY TESTING BY CINE OR VIDEO RECORDING;
92617 FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING AND LARYNGEAL SENSORY TESTING BY CINE OR VIDEO RECORDING; INTERPRETATION AND REPORT ONLY
92700 UNLISTED OTORHINOLARYNGOLOGICAL SERVICE OR PROCEDURE
97150 THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph: It is the responsibility of the provider to code to the highest level specified in the *ICD-9-CM* (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Group 1 Codes:
438.82 DYSPHAGIA CEREBROVASCULAR DISEASE
464.01 ACUTE LARYNGITIS WITH OBSTRUCTION
464.51 SUPRAGLOTTITIS UNSPECIFIED WITH OBSTRUCTION
478.30 UNSPECIFIED PARALYSIS OF VOCAL CORDS
478.31 PARTIAL UNILATERAL PARALYSIS OF VOCAL CORDS
478.32 COMPLETE UNILATERAL PARALYSIS OF VOCAL CORDS

478.33 PARTIAL BILATERAL PARALYSIS OF VOCAL CORDS
478.34 COMPLETE BILATERAL PARALYSIS OF VOCAL CORDS
478.6 EDEMA OF LARYNX
507.0 PNEUMONITIS DUE TO INHALATION OF FOOD OR VOMITUS
787.20 DYSPHAGIA, UNSPECIFIED
787.21 DYSPHAGIA, ORAL PHASE
787.22 DYSPHAGIA, OROPHARYNGEAL PHASE
787.23 DYSPHAGIA, PHARYNGEAL PHASE
787.24 DYSPHAGIA, PHARYNGOESOPHAGEAL PHASE
787.29 OTHER DYSPHAGIA

ICD-9 Codes that DO NOT Support Medical Necessity
Paragraph: Not applicable

N/A

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General Information

Associated Information
The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Medical evaluation by the physician must establish a preliminary diagnosis and form the basis for estimates of potential for rehabilitation prior to the start of therapy. This evaluation may be performed in collaboration with a speech language pathologist, qualified occupational therapist, or radiologist. The medical evaluation must document whether the difficulty involves the oral, pharyngeal, or esophageal phase of swallowing.

Therapy services shall be payable when the medical record and the information on the claim consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the medical necessity of the services billed.

The medical record information submitted should:

- paint a picture of the patient's impairments and functional limitations requiring skilled intervention;
- describe the prior functional level to assist in establishing the patient's rehabilitative potential and prognosis;
- include the results of each diagnostic test performed;
- describe the skilled nature of the therapy treatment provided, including the identification of each skilled intervention or modality provided; and
- justify that the type, frequency and duration of therapy is medically necessary for the individual patient's condition.

Initial Evaluations

Dysphagia evaluations should include:

- relevant history, including the change in condition that lead to the evaluation and date of onset or exacerbation;
- prior level of swallowing function and diet;
- previous swallowing treatment;
- current eating status, including dietary restrictions or instructions;
- level of alertness, cognition, motivation and deglutition;
- presence of feeding tubes, tracheotomy tubes, paralysis;
- positioning;
- description of coughing and/or choking;
- oral motor functioning, muscle tone, sensitivity;
- description of the swallowing function and any variances from normal; and
- interpretation of the swallow examination.

For oral, pharyngeal, or esophageal (upper one third) dysphagia, at least one of the following conditions must be present and documented:

- a history of aspiration pneumonia, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia, or for the patient at definite risk for aspiration. The following findings are often present: nasal regurgitation, choking, frequent coughing during swallowing, wet or gurgly voice quality after swallowing liquid, or delayed or slow swallow reflex;
- presence of oral motor disorders such as drooling, oral food retention, and/or leakage of food or liquids placed into the mouth;
- impaired salivary gland performance and/or presence of local structural lesions in the pharynx resulting in marked oropharyngeal swallowing difficulties;
- incoordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the buccal cavity and/or bite, chew, suck, shape and squeeze the food bolus into the upper esophagus while protecting the airway;
- post-surgical reaction affecting ability to adequately use oropharyngeal structures in swallowing;

- significant weight loss directly related to non-oral nutritional intake (g-tube feeding) and/or reaction to textures and consistencies; or documented weight loss and/or malnutrition of undetermined etiology that would require an evaluation to rule out dysphagia; and
- existence of other conditions such as presence of tracheostomy tube, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, laryngeal closure, or pharyngeal peristalsis, and cricopharyngeal dysfunction.

For many patients a clinical evaluation is adequate for substantiating the type of dysphagia and determining appropriate interventions. If the clinical evaluation indicates a question of pharyngeal deficit or risk of aspiration, an instrumental assessment may be indicated.

Each therapy discipline must have a separate plan of care that must contain diagnosis, type, amount, frequency, and duration of treatment, and long and short term goals.

Certification and Recertification

Certification, a coverage requirement for outpatient therapy payment, requires a dated physician/NPP signature on the therapy plan of care or some other document that indicates approval of the plan of care. A certification differs from an order or referral in that it must approve all required elements of a plan of care. For additional information regarding certification and recertification requirements, refer to CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.1.3.

Plan of Care

Plan of care should, at a minimum, include the following elements:

- the effective date for the plan of care being certified (for initial certifications, the initial evaluation date will be assumed to be the start date of the certified plan of care);
- medical and functional diagnoses;
- long term treatment goals;
- type, amount, duration and frequency of therapy services;
- signature, date, and professional identity of the clinician who established the plan; and
- a dated physician/NPP signature indicating that the therapy services are or were in progress and the physician/NPP approves of the plan. (Note: The CORF benefit does not recognize an NPP for certification.)

Effective January 1, 2008, the interval length between certifications shall be determined by the patient's needs, not to exceed 90 days. Certifications which include all the required plan of care elements will be considered valid for the number of treatments specified in the physician-signed certification (such as "3x/wk for 6 weeks", which will be considered as a total of 18 treatments). If treatment continues past the specified number of visits, a recertification will be required.

Progress Reports

Progress reports provide justification for the medical necessity of treatment. Progress reports must be documented at least once every 10 treatment days or every 30 calendar days, whichever is less. Writing progress notes more frequently than the minimum is encouraged to support the medical necessity of treatment. A progress report without a patient visit is not a separately payable service.

Treatment Notes

Medical record documentation is required for every treatment day and for each therapy service. The treatment note must include the following information:

- date of treatment;
- identification of the specific treatment, intervention or activity provided;
- record of the total treatment time in minutes; and
- signature and credentials of each individual that provided skilled interventions.

Skilled Level of Care

Documentation of ongoing dysphagia treatment should support the need for skilled services. Documentation which is reflective of routine repetitive observation or cueing will not support skilled therapy services

For additional information concerning the documentation requirements for therapy services, refer to CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3.

Not applicable

Not applicable
Sources of Information and Basis for Decision
This bibliography presents those sources that were obtained during the development of this policy. CGS Administrators is not responsible for the continuing viability of Web site addresses listed below.

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Denk DM, Swoboda H, Schima W, Eibenberger K. Prognostic factors for swallowing rehabilitation following head and neck cancer surgery. *Acta Otolaryngol*. 1997;117:769-774.

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Other Medicare contractor policies consulted in development of this draft:

- Empire Medicare Services carrier LCD New Jersey [L4801], New York [L7761]
- Empire Medicare Services fiscal intermediary LCD Connecticut, Delaware New York [L686]
- AdminaStar Federal fiscal intermediary LCD Illinois [L13499], Indiana [L1540], Kentucky [L13500], Ohio [L13501]

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Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
10/17/2011	R3	Revision#:R5 Revision Effective date: N/A	• Other (Annual Review)

10/17/2011 R2	Revision Explanation: Annual review no changes. Revision#:R4 Revision Effective date: N/A Revision Explanation: Annual review no changes. Revision#:R3 Revision Effective date: N/A Revision Explanation: Annual review completed 08/28/12. Corrected CIGNA Government Services to CGS Administrators. Revision Effective date: 10/17/11 Revision Explanation: Added MAC Part A Contractor #'s 15101 and 15201 to all MAC Part B Contractor # 15102 LCDs. Contractors 15101 and 15201 will be part of the Jurisdiction 15 MAC Contract as of October 17, 2011.	• Other (Annual Review)
10/17/2011 R1	Revision#:R2 Revision Effective date: 10/17/11 Revision Explanation: Added the following Part A revenue code(s) per CMD, Dr. Pilley's request: 0320, 0960. This/These code(s) will become effective for CGS with the Part A transition. Revision#:R1 Revision Effective date: 06/18/11 Revision Explanation: Added MAC Part B Contractor # 15202 to all MAC Part B Contractor # 15102 LCDs. Contractor 15202 will be part of the Jurisdiction 15 MAC Contract as of June 18, 2011. This LCD was converted from L27364 for Jurisdiction 15 A/B MAC on 04/30/2011. All prior notes were retained with the previous carriers version that has been archived in the Medicare Coverage Database.	• Automated Edits to Enforce Reasonable & Necessary Requirements

07/02/2011 - The J15 Contractor adopted a new business name. This LCD revision only includes the change from CIGNA Government Services to CGS Administrators, LLC. No coverage information was included in this revision and no provider action is needed regarding this revision.

11/25/2012 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
92613 descriptor was changed in Group 1
92615 descriptor was changed in Group 1
92617 descriptor was changed in Group 1

Associated Documents

Attachments
N/A
Related Local Coverage Documents
Article(s)
A50849 - Swallow Evaluation and Dysphagia Treatment – Supplemental Instructions Article
Related National Coverage Documents
N/A
Public Version(s)
Updated on 08/20/2014 with effective dates 10/17/2011 - N/A
Updated on 08/16/2013 with effective dates 10/17/2011 - N/A
Updated on 11/25/2012 with effective dates 10/17/2011 - N/A
Updated on 09/27/2012 with effective dates 10/17/2011 - N/A
Updated on 08/28/2012 with effective dates 10/17/2011 - N/A
Updated on 09/27/2011 with effective dates 10/17/2011 - N/A