How to Survive…and Thrive!

Strategies for Success in Medical Speech-Language Pathology
• I receive a salary from Genesis Rehab Services in my role as Regional Clinical Director

• I have no non-financial relationships to disclose
• 4 years school-based SLP

• 4 years acute & post-acute care (combo)

• 11 years exclusively post-acute care
  • 5 years staff SLP
  • 2 years Assistant Director of Rehab (ADOR)
  • 4 years Regional Clinical Director (RCD)
  • 8 years Master Clinician

• Kansas StAMP Representative (State Advocate for Medicare Policy): 2019 - present

• In process: National Academies of Practice Professional Member
Your perspective
Objectives

• Describe **5 concepts** important for current and future success in medical speech-language pathology

• Understand introductory information about **Medicare and the PDPM** reimbursement model, and discuss considerations for medical Speech-Language Pathologists

• Examine examples of **ICD-10 coding** related to SLP clinical practice and PDPM

• Understand and discuss the relationship between **documentation, denials and patient advocacy**
But first, let’s look into our crystal ball...

What will the future hold for Speech-Language Pathologists in the medical setting???
Age and Sex Structure for the Population of the United States

U.S. Census Bureau, 1945 to 2012 Population Estimates and 2012 National Projections

1945  2012
1965  2030
1990  2050
Percent Distribution of the U.S. Population by Age Group: 2010, 2030, and 2050

U.S. Census Bureau, 1945 to 2012 Population Estimates and 2012 National Projections

### 65-84 years old

- **2010**: 11.3%
- **2030 (projected)**: 17.8%
- **2050 (projected)**: 16.4%

### 85 and older

- **2010**: 1.8%
- **2030 (projected)**: 2.5%
- **2050 (projected)**: 4.5%
Alzheimer’s Disease
Facts and Figures

5.8 MILLION AMERICANS ARE LIVING WITH ALZHEIMER’S. BY 2050, THIS NUMBER IS PROJECTED TO RISE TO NEARLY 14 MILLION.

Every 65 SECONDS SOMEONE IN THE UNITED STATES DEVELOPS THE DISEASE.

BETWEEN 2000 AND 2017 DEATHS FROM HEART DISEASE HAVE DECREASED 9% WHILE DEATHS FROM ALZHEIMER’S HAVE INCREASED 145%.

https://www.alz.org/alzheimers-dementia/facts-figures
Alzheimer’s Disease
Kansas Facts and Figures

HOSPITALS (2015)
1,308
# of emergency department visits per 1,000 people with dementia

18%
dementia patient hospital readmission rate

65+ NUMBER OF PEOPLE AGED 65 AND OLDER WITH ALZHEIMER’S BY AGE*

<table>
<thead>
<tr>
<th>Year</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>7,400</td>
<td>22,000</td>
<td>24,000</td>
<td>54,000</td>
</tr>
<tr>
<td>2025</td>
<td>9,000</td>
<td>27,000</td>
<td>26,000</td>
<td>62,000</td>
</tr>
</tbody>
</table>

* Totals may not add due to rounding

Estimated percentage change
14.8%

https://www.alz.org/getmedia/be32492e-edf9-4dd1-9b37-1bb70a8d572a/kansas-alzheimers-facts-figures-2019
Percentage of Medicare enrollees aged 65 and older who were readmitted within 30 days of hospital discharge

The Dartmouth Atlas of Health Care, 2015
Hospital Readmission
Potentially Avoidable Reasons & Top Readmission Diagnoses

- Medication Errors
- Functional Status at Discharge
- Falls
- Transition / Discharge Planning
- Poor Health Literacy

- Heart Failure (HF)
- Myocardial Infarction (MI)
- Pneumonia (aspiration and sepsis)
- Chronic Obstructive Pulmonary Disease (COPD)
- Triad of Diagnoses (DM, CHF, COPD)
Why does it matter?

- U.S. Census & Baby Boomers
- Alzheimer’s Disease Facts and Figures
- Hospital Readmission Statistics
Strategies for Success
Important Concepts for Medical SLPs

- Medical Necessity & Skilled Need
- Skilled Therapy
- Value-Based Care
- Top of License Practice
- Lifelong Learning
Last, but DEFINITELY not Least…

Advocacy

Patient Advocacy

Legislative Advocacy

Advocacy for our profession
Patient Advocacy Opportunities

- Screening
  - Current system(s)
  - Cross-discipline referrals
  - Additional reports

- Comprehensive Assessment
  - Full SLP scope of practice
  - Dysphagia ➔ Cog-Comm
  - Cog-Comm ➔ S/L
  - S/L ➔ Voice

- Patient-Centered Care
  - Provide a valuable service
  - Prioritize
  - Health literacy
  - Does “one size fit all”?

- Interprofessional Education
  - Culture—“poor candidates”
  - All are referral sources
  - Demonstrate your value
Legislative and Professional Advocacy
State-Specific Opportunities
Legislative and Professional Advocacy
National Opportunities

Visit the ASHA Advocacy Page for information and how to get involved!

Recent Examples:
• 8/8/19: New Resource on Habilitation and Rehabilitation Coverage
• 7/31/19: 2020 Medicare Proposed Rules for Outpatient Services Released
• 7/26/19: Proposed Legislation Improves Access to Audiologists for Medicare Patients

Take Action!
Medicare
<table>
<thead>
<tr>
<th></th>
<th>Four “Fast Facts” about Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Medicare is for seniors and disabled</td>
</tr>
<tr>
<td>02</td>
<td>&gt;58 million enrollees as of December 2017</td>
</tr>
<tr>
<td>03</td>
<td>Medicare is the largest insurer in the U.S.</td>
</tr>
</tbody>
</table>
| 04 | Part A aka “hospital insurance”  
Part B aka “medical insurance” |
While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MLN_Call_PDPM_Presentation_508.pdf
Patient-Driven Payment Model (PDPM)

Overview

- Effective October 1, 2019
- Applies to patients receiving Medicare Part A benefits
- Does not change the requirements for provision of skilled service
- Access the PDPM Final Rule here (under “Special Filings,” dated July 30, 2019)
- Access the MDS 3.0 RAI Manual here (Version 1.17.1 October 2019)
Requirements for a skilled service under Medicare Part A

- Services are related to reason for hospitalization or for a condition that arose while receiving care in a SNF
- Ordered by a physician
- Skilled services are required daily (and can only be provided on an inpatient basis)
- Services are reasonable and medically necessary
Goals of PDPM

- Improve Patient Outcomes
- Reduce burden through meaningful measures
- Account for individual severity of the patient’s needs
SLP-specific Case Mix Index

01 Clinical Category
MDS Section I, ICD-10 Codes
2 options for SLPs:
  • Acute Neurologic
  • Non-Neurologic

02 Cognitive Status
MDS Section C: BIMS or CPS score

03 Swallowing Disorder
MDS Section K

04 Mechanically-Altered Diet
MDS Section K

05 SLP-Related Comorbidity
MDS Section I, ICD-10 Codes
SLP - Related Comorbidities

<table>
<thead>
<tr>
<th>Condition</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aphasia</td>
<td>Laryngeal Cancer</td>
</tr>
<tr>
<td>CVA, TIA or Stroke</td>
<td>Apraxia</td>
</tr>
<tr>
<td>Hemiplegia or Hemiparesis</td>
<td>Dysphagia</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>ALS</td>
</tr>
<tr>
<td>Tracheostomy Care (While a Resident)</td>
<td>Oral Cancers</td>
</tr>
<tr>
<td>Ventilator or Respirator (While a Resident)</td>
<td>Speech and Language Deficits</td>
</tr>
</tbody>
</table>

See [CMS PDPM ICD-10 Mappings](#) for specific ICD-10 codes included in SLP-related comorbidities. *Additional codes listed as “return to provider” may be appropriate to include in order to code comprehensively.*
# Cognitive Scoring & Classification

<table>
<thead>
<tr>
<th>Cognitive Level</th>
<th>BIMS Score</th>
<th>CPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitively Intact</td>
<td>13 – 15</td>
<td>0</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>8 – 12</td>
<td>1 - 2</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>0 – 7</td>
<td>3 - 4</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>-</td>
<td>5 - 6</td>
</tr>
</tbody>
</table>
Under the final rule for a new payment system, skilled nursing facilities (SNFs) will receive reimbursement based on a patient’s clinical characteristics, rather than the amount of therapy the patient needs. The new system, which takes effect Oct. 1, 2019, removes incentives for SNFs to increase their reimbursement levels by providing more therapy than may be medically necessary. Over the past several years, many SNFs and rehabilitation companies have paid billions of dollars to settle allegations of this type of Medicare fraud.

“It certainly is about time [that] this is put into effect. The new rule allows us to provide services based on need and not on minutes especially if the patient is not well enough to be seen or is [not] ready for therapy…This does eliminate unnecessary services and the potential for fraud.”
“Further devaluing the SLP’s role in rehab. Supposedly, the opposite is supposed to happen; however, the majority of SNFs I am in/around are decreasing the number of SLPs and caseloads have plummeted.”

What are your concerns about the impact of the upcoming SNF payment changes (PDPM) on your service delivery?
What SLPs Need to Know About the New Medicare SNF Payment Model

The transition to PDPM will not lead to the end of employment for SLPs in SNFs. If PDPM is appropriately implemented by SNFs, SLPs will be empowered to identify and treat patients who need their clinically necessary services rather than count the minutes of therapy provided to each patient. SNFs who state that SLPs are being laid off because of the transition to PDPM are not being transparent about the rationale for terminating therapists. SNFs that plan for the transition and appropriately assess the role of SLPs are not likely to terminate employees.
Let’s Refocus…

Advocacy

Patient Advocacy

Legislative Advocacy

Advocacy for our profession
Becoming an Advocate

ASHA Scope of Practice in Speech-Language Pathology

**Practice within the full scope of your license**

Professional Practice Domains

- Advocacy and outreach
- Supervision
- Education
- Administration/Leadership
- Research

Service Delivery Domains

- Fluency
- Speech Production
- Language
- Cognition
- Voice
- Resonance
- Feeding and Swallowing
- Auditory Habilitation / Rehabilitation
Screen comments, but no ST orders were requested

At this time PT to evaluate and then determine if other disciplines indicated.

Secondary to poor cognitive function; attempted transfer alone.

Patient had items under w/c cushion which caused her to slip out of w/c - no therapy services indicated.

Pt is at prior level of function and is poor candidate for rehab as pt demonstrates with no carry over.

Resident was seen under Part B services earlier in year (Jan/Feb) and was discharged within age/gender-related norms on standardized tests. Resident with significant decline in functional mobility.

Is there an opportunity?
Documentation & Coding
Successful Documentation is…

• Accurate: describes the care provided
• Code-able: supports CPT & ICD-10-CM codes
• Understandable: clear to any reader
• Timely: recorded at time of service
• Error free: stands alone as a legal document

Module Three: Documentation of SLP Services in Difference Settings. (n.d.). Retrieved February 8, 2019, from https://www.asha.org/Practice/reimbursement/Module-Three/
Painting the Picture of Medical Necessity

ICD-10 Coding
Description of Illness
PLOF vs. CLOF
Clinical Impression
Individualized Reason for Referral
Objective Measures
Justification
Setting the Foundation…

- ICD-10
- CPT
- PLOF
- CLOF
- Standardized
- Objective
- Paint the picture
- Reason & History

Coding

Goals

Measures

Reason & History
ICD-10 & CPT Coding
Should...

01
Reflect the patient’s health condition and/or the procedures done to maintain or improve that condition

02
Support the goals and plan of care to demonstrate “value-based” and “accountable” services

03
Represent the severity, risk & complexity of the condition
Types of Codes

ICD-10
- Medical Diagnosis Codes (assigned by physician)
- Treatment Diagnosis Codes (assigned by therapist)
- Up to 7 digits
- Both numbers and letters
  • R13.12 (Oropharyngeal Dysphagia)

CPT
- Billing Codes
- 5-digit number sequence
  • 92523 (Speech & Language Evaluation)
  • 92526 (Dysphagia Treatment)
Medical Diagnoses

- Reason for SNF Care
- Pertinent Comorbidities
- Code to the highest degree of specificity
Medical Diagnosis Coding
Decisions, Decisions…

Does the diagnosis affect your clinical decision-making?

Will the diagnosis affect your outcomes?

If “yes” to either question, add the code
Treatment Diagnoses

- Related to the Medical Diagnosis
- Accepted by insurance
- Code to the most specific degree
- Supported by objective measures
- Related to problems being addressed in therapy
## ICD-10 Coding

### Example #1

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
<td>F03.90</td>
<td>Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>Med</td>
<td>N19</td>
<td>Unspecified kidney failure</td>
</tr>
<tr>
<td>Med</td>
<td>F20.89</td>
<td>Other schizophrenia</td>
</tr>
<tr>
<td>Med</td>
<td>F41.9</td>
<td>Anxiety disorder, unspecified</td>
</tr>
<tr>
<td>Med</td>
<td>I10</td>
<td>Essential (primary) hypertension</td>
</tr>
<tr>
<td>Med</td>
<td>F31.9</td>
<td>Bipolar disorder, unspecified</td>
</tr>
<tr>
<td>Med</td>
<td>G47.00</td>
<td>Insomnia, unspecified</td>
</tr>
<tr>
<td>Med</td>
<td>E03.9</td>
<td>Hypothyroidism, unspecified</td>
</tr>
<tr>
<td>Med</td>
<td>R45.87</td>
<td>Impulsiveness</td>
</tr>
<tr>
<td>Med</td>
<td>R29.6</td>
<td>Repeated falls</td>
</tr>
<tr>
<td>Tx</td>
<td>R48.8</td>
<td>Other symbolic dysfunctions</td>
</tr>
<tr>
<td>Tx</td>
<td>R47.01</td>
<td>Aphasia</td>
</tr>
</tbody>
</table>
## ICD-10 Coding Example #2

Can there be **TOO MANY** codes???

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
<td>F33.1</td>
<td>Major depressive disorder, recurrent, moderate</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>F41.1</td>
<td>Generalized anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>I25.10</td>
<td>Atherosclerotic heart disease of native coronary artery without angina pectoris</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>R23.858</td>
<td>Other symptoms and signs involving the musculoskeletal system</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>M62.838</td>
<td>Other muscle spasm</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>F10.21</td>
<td>Alcohol dependence, in remission</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>E78.5</td>
<td>Hyperlipidemia, unspecified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>F31.9</td>
<td>Bipolar disorder, unspecified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>I10</td>
<td>Essential (primary) hypertension</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>K21.9</td>
<td>Gastro-esophageal reflux disease without esophagitis</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>G47.00</td>
<td>Insomnia, unspecified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>R13.12</td>
<td>Dysphagia, oropharyngeal phase</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>F34.1</td>
<td>Dysthyemic disorder</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>E55.9</td>
<td>Vitamin D deficiency, unspecified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>R46.9</td>
<td>Unspecified systemic dysfunctions</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>Z91.81</td>
<td>History of falling</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>K50.00</td>
<td>Constipation, unspecified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>Q80.20</td>
<td>Other chronic pain</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>I70.91</td>
<td>Generalized atherosclerosis</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>R32</td>
<td>Unspecified urinary incontinence</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>R20.2</td>
<td>Difficulty in walking, not elsewhere classified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>E53.9</td>
<td>Hypothyroidism, unspecified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>Z36.73</td>
<td>Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>D50.9</td>
<td>Iron deficiency anemia, unspecified</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>R27.8</td>
<td>Other lack of coordination</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>M82.81</td>
<td>Muscle weakness (generalized)</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>R26.9</td>
<td>Unspecified abnormalities of gait and mobility</td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>F20.0</td>
<td>Paranoid schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Tx</td>
<td>R13.10</td>
<td>Dysphagia, unspecified</td>
<td></td>
</tr>
</tbody>
</table>
ICD-10 Coding
Example #3

Not ENOUGH codes?

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
<td>F03.90</td>
<td>Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>Tx</td>
<td>R13.10</td>
<td>Dysphagia, unspecified</td>
</tr>
</tbody>
</table>
ICD-10 Coding
ASHA resource

2019 ICD-10-CM Diagnosis Codes
RELATED TO SPEECH, LANGUAGE, AND SWALLOWING DISORDERS

https://www.asha.org/uploadedFiles/ICD-10-Codes-SLP.pdf

I69.09 Other sequelae of nontraumatic subarachnoid hemorrhage

- I69.090 Apraxia following nontraumatic subarachnoid hemorrhage
- I69.091 Dysphagia following nontraumatic subarachnoid hemorrhage
  
  **Use additional** code to identify the type of dysphagia, if known
  (R13.1-)

- I69.092 Facial weakness following nontraumatic subarachnoid hemorrhage
- I69.092 Facial droop following nontraumatic subarachnoid hemorrhage
- I69.093 Ataxia following nontraumatic subarachnoid hemorrhage
- I69.098 Other sequelae following nontraumatic subarachnoid hemorrhage

- Code typically used by SLPs
- Additional digits not listed here
### PDPM SLP – Related Comorbidities
#### ICD-10 Code Mapping

<table>
<thead>
<tr>
<th>Aphasia</th>
<th>Laryngeal Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVA, TIA or Stroke</td>
<td>Apraxia</td>
</tr>
<tr>
<td>Hemiplegia or Hemiparesis</td>
<td>Dysphagia</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>ALS</td>
</tr>
<tr>
<td>Tracheostomy Care (While a Resident)</td>
<td>Oral Cancers</td>
</tr>
<tr>
<td>Ventilator or Respirator (While a Resident)</td>
<td>Speech and Language Deficits</td>
</tr>
</tbody>
</table>

**Examples included in SLP Comorbidity mapping:**
- **Dysphagia**: 169.991
- **Apraxia**: 169.990
- **Laryngeal Cancer**: C32.0, C32.1, C32.2, C32.3 and C32.8
- **Speech and Language Deficits**: I69.928, I69.920, I69.921, I69.922, I69.923 and I69.928
## PDPM SLP – Related Comorbidities
## ICD-10 Code Mapping

<table>
<thead>
<tr>
<th>Sort Order</th>
<th>Comorbidity Description</th>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>ALS</td>
<td>G12.21</td>
<td>Amyotrophic lateral sclerosis</td>
</tr>
<tr>
<td>7</td>
<td>Apraxia</td>
<td>I69.090</td>
<td>Apraxia following nontraumatic subarachnoid hemorrhage</td>
</tr>
<tr>
<td>8</td>
<td>Apraxia</td>
<td>I69.190</td>
<td>Apraxia following nontraumatic intracerebral hemorrhage</td>
</tr>
<tr>
<td>9</td>
<td>Apraxia</td>
<td>I69.290</td>
<td>Apraxia following other nontraumatic intracranial hemorrhage</td>
</tr>
<tr>
<td>10</td>
<td>Apraxia</td>
<td>I69.390</td>
<td>Apraxia following cerebral infarction</td>
</tr>
<tr>
<td>11</td>
<td>Apraxia</td>
<td>I69.890</td>
<td>Apraxia following other cerebrovascular disease</td>
</tr>
<tr>
<td>12</td>
<td>Apraxia</td>
<td>I69.900</td>
<td>Apraxia following unspecified cerebrovascular disease</td>
</tr>
<tr>
<td>13</td>
<td>Dysphagia</td>
<td>I69.091</td>
<td>Dysphagia following nontraumatic subarachnoid hemorrhage</td>
</tr>
<tr>
<td>14</td>
<td>Dysphagia</td>
<td>I69.191</td>
<td>Dysphagia following nontraumatic intracerebral hemorrhage</td>
</tr>
<tr>
<td>15</td>
<td>Dysphagia</td>
<td>I69.291</td>
<td>Dysphagia following other nontraumatic intracranial hemorrhage</td>
</tr>
<tr>
<td>16</td>
<td>Dysphagia</td>
<td>I69.391</td>
<td>Dysphagia following cerebral infarction</td>
</tr>
<tr>
<td>17</td>
<td>Dysphagia</td>
<td>I69.891</td>
<td>Dysphagia following other cerebrovascular disease</td>
</tr>
<tr>
<td>18</td>
<td>Dysphagia</td>
<td>I69.991</td>
<td>Dysphagia following unspecified cerebrovascular disease</td>
</tr>
<tr>
<td>19</td>
<td>Laryngeal Cancer</td>
<td>C32.0</td>
<td>Malignant neoplasm of glottis</td>
</tr>
<tr>
<td>20</td>
<td>Laryngeal Cancer</td>
<td>C32.1</td>
<td>Malignant neoplasm of supraglottis</td>
</tr>
<tr>
<td>21</td>
<td>Laryngeal Cancer</td>
<td>C32.2</td>
<td>Malignant neoplasm of subglottis</td>
</tr>
<tr>
<td>22</td>
<td>Laryngeal Cancer</td>
<td>C32.3</td>
<td>Malignant neoplasm of laryngeal cartilage</td>
</tr>
<tr>
<td>23</td>
<td>Laryngeal Cancer</td>
<td>C32.8</td>
<td>Malignant neoplasm of other specified sites of larynx</td>
</tr>
</tbody>
</table>

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html
Commonly Used SLP Treatment Diagnosis Codes that (Currently) Do Not Map

Treatment ICD-10 codes commonly used by Speech-Language Pathologists such as R13.12 (Oropharyngeal Dysphagia), R41.841 (Cognitive Communication Deficit) and R48.8 (Other Symbolic Dysfunction) do not currently map to the “Acute Neurological” category and are not included in the SLP comorbidity mapping.

However, these diagnoses may be appropriate coding to support medical necessity of SLP services.
ICD-10 Coding
Additional Resources

**ASHA ICD-10 Guidance**
Codes typically used by SLPs

**CMS ICD-10 Website**
Guidance for use of Z-codes
Excludes notes (“Excludes1” and “Excludes2”)

**ICD10data.com**
Look up codes—including history
Description & Synonyms
Excludes notes

**CMS ICD-10 Tabular Index**
Similar information to ICD10data.com but different format
For additional coding questions, contact your Kansas State Advocate for Medicare Policy Network (StAMP)

Jeanne.Copeland@genesishcc.com

https://www.asha.org/Practice/reimbursement/medicare/StAMP/
Denial Prevention
Reasons cited for SLP denials

“Lack of required ICD-10 coding required by the LCD to support medical necessity”

“Speech therapy services denied as not reasonable and necessary.”

“Section ‘B’ of the MDS assessment, ARD 7.2.2017, supported he had clear speech with distinct intelligible words, he made himself understood and he understood with clear comprehension.”
More reasons cited for SLP denials

“Section ‘C’ of the MDS assessment, ARD 7.2.2017, supported his BIMS (brief interview for mental status) was 14/15 indicating he was not cognitively impaired, additionally, section ‘C’ supported he did not have an acute mental status change and did not exhibit inattention, disorganized thinking or altered level of consciousness.”

“Nurse practitioner documentation supported his judgement and insight were intact, he oriented to time, place, person and situation and his long and short term memory were intact. Nursing documentation supported he was alert and oriented and able to make his needs known. Physical therapy noted he was alert and oriented with communication intact. For these reasons, Speech therapy is denied in full.”
MDS Sections
Important for SLPs

• Section B: Hearing, Speech, and Vision
• Section C: Cognitive Patterns
• Section I & O: Clinical Category (including comorbidities)
• Section K: Swallowing & Nutritional Status

Other sections may also be clinically relevant to SLPs, especially during an interdisciplinary (IDT) screening process (e.g., pain, recent falls, shortness of breath, skin conditions, functional status).
ASHA support for SLP involvement in MDS

Demonstrating the Value of SLP Services in the New SNF Payment Model

Involve SLPs in the completion of the Minimum Data Set (MDS)

Engaging SLPs in the completion of relevant sections of the minimum data set (MDS) ensures accuracy of the data, helps identify patients who need speech-language pathology services, and facilitates interprofessional practice. SLPs can contribute to this process either directly or in consultation with the MDS coordinator.
### Section B

**Hearing, Speech, and Vision**

**B0100. Comatose**
- Extra Code: Persistent vegetative state/no discernible consciousness
  - No: Continue to B0200. Hearing
  - Yes: Skip to B0300. Activities of Daily Living (ADL) Assistance

**B0200. Hearing**
- Extra Code: Ability to hear (with hearing aid or hearing appliances if normally used)
  - 0: Adequate - no difficulty in normal conversation, social interaction, listening to TV
  - 1: Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
  - 2: Moderate difficulty - speaker has to increase volume and speak distinctly
  - 3: Highly impaired - absence of useful hearing

**B0300. Hearing Aid**
- Extra Code: Hearing aid or other hearing appliance used in completing B0200. Hearing
  - 0: No
  - 1: Yes

**B0600. Speech Clarity**
- Extra Code: Select best description of speech pattern
  - 0: Clear speech - distinct intelligible words
  - 1: Unclear speech - slurred or mumbled words
  - 2: No speech - absence of spoken words

**B0700. Makes Self Understood**
- Extra Code: Ability to express ideas and wants, consider both verbal and non-verbal expression
  - 0: Understood
  - 1: Usually understood - difficulty communicating some words or missing thoughts but is able if prompted or given time
  - 2: Somewhat understood - ability is limited to making concrete requests
  - 3: Rarely/never understood

**B0800. Ability To Understand Others**
- Extra Code: Understanding verbal content, however able (with hearing aid or device if used)
  - 0: Understands - clear comprehension
  - 1: Usually understands - misses some part/element of message but comprehends most conversation
  - 2: Sometimes understands - responds adequately to simple, direct communication only
  - 3: Rarely/never understands

**B1000. Vision**
- Extra Code: Ability to see in adequate light (with glasses or other visual appliances)
  - 0: Adequate - uses fine detail, such as regular print in newspapers/books
  - 1: Impaired - sees large print, but not regular print in newspapers/books
  - 2: Moderately impaired - limited vision not able to see newspaper headlines but can identify objects
  - 3: Highly impaired - object identification in question, but eyes appear to follow objects
  - 4: Severely impaired - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

**B1200. Corrective Lenses**
- Extra Code: Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000. Vision
  - 0: No
  - 1: Yes

---

*Look back period for all items is 7 days unless another time frame is indicated.*
Brief Interview for Mental Status (BIMS)

Repetition of Three Words
Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words."

Number of words repeated after first attempt:

- 0. None
- 1. One
- 2. Two
- 3. Three

After the resident’s first attempt, repeat the words using cues (“sock, something to wear; blue, a color; bed, a piece of furniture”). You may repeat the words up to two more times.

Temporal Orientation (orientation to month, year and day)
Ask resident: "Please tell me what year it is right now."

Able to report correct year

- 0. Missed by > 5 years, or no answer
- 1. Missed by 2-5 years
- 2. Missed by 1 year
- 3. Correct

Ask resident: "What month are we in right now?"

Able to report correct month

- 0. Missed by > 1 month, or no answer
- 1. Missed by 6 days to one month
- 2. Accurate within 6 days

Ask resident: "What day of the week is it today?"

Able to report correct day of the week

- 0. Incorrect, or no answer
- 1. Correct

Recall

Ask resident: "Let’s go back to the earlier question. What were the three words that I asked you to repeat?" If unable to remember a word, give cue (“something to wear; “a color; “a piece of furniture”) for that word.

Able to recall “sock”

- 0. No - could not recall
- 1. Yes, after cueing (“something to wear”) required

Able to recall “blue”

- 0. No - could not recall
- 1. Yes, after cueing (“a color”) required

Able to recall “bed”

- 0. No - could not recall
- 1. Yes, after cueing (“a piece of furniture”) required

BIMS

Section C
15 point scale
Not sensitive to MCI
Section C, cont.

Cognitive Performance Scale (CPS)

Do not conduct if BIMS was completed.

### Section C

<table>
<thead>
<tr>
<th>Cognitive Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium</td>
</tr>
<tr>
<td>1. Yes (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK</td>
</tr>
</tbody>
</table>

### Staff Assessment for Mental Status
Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

| C0700. Short-term Memory OK |
| Enter Code |
| Seem or appear to recall after 5 minutes |
| 0. Memory OK |
| 1. Memory problem |

| C0800. Long-term Memory OK |
| Enter Code |
| Seem or appear to recall long past |
| 0. Memory OK |
| 1. Memory problem |

| C0900. Memory/Recall Ability |
| Check all that the resident was normally able to recall |
| A. Current season |
| B. Location of own room |
| C. Staff names and faces |
| D. That he or she is in a nursing home/hospital swing bed |
| Z. None of the above were recalled |

| C1000. Cognitive Skills for Daily Decision Making |
| Enter Code |
| Made decisions regarding tasks of daily life |
| 0. Independent - decisions consistent/reasonable |
| 1. Modified Independence - some difficulty in new situations only |
| 2. Moderately impaired - decisions poor; cues/ supervision required |
| 3. Severely impaired - never/rarely made decisions |
### Section I

**Active Diagnoses & Comorbidities**

**I0020: Indicate the resident’s primary medical condition category**

Complete only if A0310B = 01 or 08

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Indicate the resident’s primary medical condition category that best describes the primary reason for admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.</td>
<td>Stroke</td>
</tr>
<tr>
<td>02.</td>
<td>Non-Traumatic Brain Dysfunction</td>
</tr>
<tr>
<td>03.</td>
<td>Traumatic Brain Dysfunction</td>
</tr>
<tr>
<td>04.</td>
<td>Non-Traumatic Spinal Cord Dysfunction</td>
</tr>
<tr>
<td>05.</td>
<td>Traumatic Spinal Cord Dysfunction</td>
</tr>
<tr>
<td>06.</td>
<td>Progressive Neurological Conditions</td>
</tr>
<tr>
<td>07.</td>
<td>Other Neurological Conditions</td>
</tr>
<tr>
<td>08.</td>
<td>Amputation</td>
</tr>
<tr>
<td>09.</td>
<td>Hip and Knee Replacement</td>
</tr>
<tr>
<td>10.</td>
<td>Fractures and Other Multiple Trauma</td>
</tr>
<tr>
<td>11.</td>
<td>Other Orthopedic Conditions</td>
</tr>
<tr>
<td>12.</td>
<td>Debility, Cardiorespiratory Conditions</td>
</tr>
<tr>
<td>13.</td>
<td>Medically Complex Conditions</td>
</tr>
</tbody>
</table>

**I0020B. ICD Code**

[ ] [ ] [ ] [ ] [ ] [ ] [ ]
<table>
<thead>
<tr>
<th>Section O</th>
<th>Special Treatments, Procedures, and Programs (last 14 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tracheostomy care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mechanical Ventilation</strong></td>
<td></td>
</tr>
</tbody>
</table>

### O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last 14 days:

1. **While NOT a Resident**
   - Performed *while NOT a resident* of this facility and within the **last 14 days**. Only check column 1 if resident entered (admission or reentry) *IN THE LAST 14 DAYS*. If resident last entered 14 or more days ago, leave column 1 blank.

2. **While a Resident**
   - Performed *while a resident* of this facility and within the **last 14 days**

#### Cancer Treatments
- **A. Chemotherapy**
- **B. Radiation**

#### Respiratory Treatments
- **C. Oxygen therapy**
- **D. Suctioning**
- **E. Tracheostomy care**
- **F. Invasive Mechanical Ventilator** (ventilator or respirator)
- **G. Non-Invasive Mechanical Ventilator** (BiPAP/CPAP)

#### Other
- **H. IV medications**
- **I. Transfusions**
- **J. Dialysis**
- **K. Hospice care**
- **M. Isolation or quarantine for active infectious disease** (does not include standard body/fluid precautions)

**None of the Above**
- **None of the above**
### Section K: Swallowing / Nutritional Status

#### K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

- [ ] A. Loss of liquids/solids from mouth when eating or drinking
- [ ] B. Holding food in mouth/cheeks or residual food in mouth after meals
- [ ] C. Coughing or choking during meals or when swallowing medications
- [ ] D. Complaints of difficulty or pain with swallowing
- [ ] E. None of the above

**Check all that apply**

#### K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

- **Height (in inches)**
  - [ ] __________
- **Weight (in pounds)**
  - [ ] __________

#### K0300. Weight Loss

- Loss of 5% or more in the last month or loss of 10% or more in last 6 months
  - [ ] 0. No or unknown
  - [ ] 1. Yes, on physician-prescribed weight-loss regimen
  - [ ] 2. Yes, not on physician-prescribed weight-loss regimen

#### K0310. Weight Gain

- Gain of 5% or more in the last month or gain of 10% or more in last 6 months
  - [ ] 0. No or unknown
  - [ ] 1. Yes, on physician-prescribed weight-gain regimen
  - [ ] 2. Yes, not on physician-prescribed weight-gain regimen

#### K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 days

1. **While NOT a Resident**
   - Performed while NOT a resident of this facility and within the last 7 days. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank.

2. **While a Resident**
   - Performed while a resident of this facility and within the last 7 days

- [ ] A. Parenteral/IV feeding
- [ ] B. Feeding tube - nasogastric or abdominal (PEG)
- [ ] C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- [ ] D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- [ ] E. None of the above

**Check all that apply**

**Swallowing Disorder**

**Weight Loss**

**Mechanically Altered Diet**
Key Point for Denial Prevention under PDPM

Does rehab documentation support what’s been captured on the MDS???
Back to our view from 30,000 feet

- U.S. Census & Baby Boomers
- Alzheimer’s Disease Facts and Figures
- Hospital Readmission Statistics
Summary of critical concepts for SUCCESS!

- Provide reasonable and necessary services
- Provide (and document) skilled therapy
- Provide services that others see as valuable
- Work at the top of your license
- Be a lifelong learner
- Be an ADVOCATE!
Thank you!
References


References

