LCD for Dysphagia/Swallowing Therapy (L26565)

Contractor Information

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Number

05101, 05201, 05301, 05401

Contractor Type

MAC - Part A

LCD Information

LCD ID Number

L26565

LCD Title

Dysphagia/Swallowing Therapy

Contractor's Determination Number

AMA CPT / ADA CDT Copyright Statement

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CMS National Coverage Policy

Social Security Act, Title XVIII, section 1834 (K)(5) incorporates the provisions in the Balanced Budget Act (BBA) of 1997; Section 4541 (a)(2) to require payment under a prospective payment system of outpatient rehabilitation services.

Social Security Act, Title XVIII, section 1835 (a)(C) establishes conditions for payment of claims to institutional providers of outpatient therapy services, including certification and plan of treatment requirements.

Social Security Act, Title XVIII, sections 1861(g)(p)(s)(u), and (cc)(ll) establish definitions for services, institutions, and other Medicare terms.

Social Security Act, Title XVIII, section 1862(a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and medically necessary.

42 Code of Federal Regulations (42CFR) Parts:

409 includes the definition of 'reasonable and necessary' therapy services that applies to both Part A and Part B services.

410 describes the benefits to be paid under Medicare Part B, including outpatient physical therapy services.

411 describes those specific services excluded from Medicare or that are subject to limitations on payment.

414 describes the provisions of payment for Part B services under a fee schedule and for payments for prosthetics and orthotics.

420 describes specific Medicare program integrity requirements to prevent fraud and abuse. It also sets forth appeal rights of providers.

421 identifies the activities required of the fiscal intermediaries and carriers that process Medicare claims.

424 describes the conditions for Medicare payment, including those governing Part B outpatient physical therapy services. In particular, it sets forth certification, plan of treatment, and CORF requirements.

484 includes the personnel qualifications that Medicare requires for identification as a speech-language pathologist.

485 sets forth conditions for providers in CORFs.
Medicare General Information, Eligibility, and Entitlement Manual (Pub 100-1), Chapter 4, Section 50.

Medicare Benefit Policy Manual (Pub 100-2), Chapters 12 and 15, Sections 220 and 230.

Medicare Claims Processing Manual (Pub 100-4), Chapter 5.

Medicare National Coverage Determinations Manual (Pub 100-3), Chapter 1, Sections 170.3.

Oversight Region

Region I

Original Determination Effective Date

For services performed on or after 02/01/2008

Original Determination Ending Date

Revision Effective Date

For services performed on or after 03/01/2008

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Dysphagia is a swallowing disorder that may be due to various neurological, structural, and cognitive deficits. Dysphagia may be the result of head trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, and encephalopathies. While dysphagia can afflict any age group, it most often appears among the elderly. Dysphagia services are covered under Medicare by therapists, regardless of the presence of a communication disability.

Indications

General Therapy Guidelines

The patient must be under the care of a:

Physician

Non-physician Practitioner (NPP): Nurse Practitioner, Physician's Assistant, or Clinical Nurse Specialist – subject to each state's Scope of Practice Dysphagia services are covered, provided such services are of a level of complexity and sophistication, or the patient's condition is such that the services can be safely and effectively performed only by a licensed qualified therapist. Services normally considered to be a routine part of nursing care are not covered.

The goal for a patient is to return to the highest level of function realistically attainable and within the context of the disability. The skills of the therapist may not necessarily be required to attain this goal but may be required initially to ensure safety, proper modality performance, etc. then transferring their care to a caregiver and home program.

Covered dysphagia services must relate directly and specifically to an active written treatment plan and must be reasonable and necessary to the treatment of the individual's illness or injury. The plan of treatment should address specific therapeutic goals for which modalities and procedures are outlined in terms of type, frequency and duration. The plan of care must be certified/approved by the Physician/NPP.

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, as defined by standards of medical practice. 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, after any needed consultation with the qualified therapist. The services must be necessary to establish a safe and effective maintenance program in connection with a specific disease state.

Dysphagia services are only covered when it is rendered under a written treatment plan to address specific therapeutic goals for which procedures are planned out specifically in terms of type, frequency, and duration.

The therapist must document the patient's functional limitations and therapeutic short and long term goals in terms that are objective and measurable. Dysphagia services are not covered when the documentation fails to support that the functional ability or medical condition was impaired to the degree that it required the skills of a therapist. Dysphagia services are not covered when the documentation indicates the patient has not reached the therapy goals and is not making significant improvement or progress, and/or is unable to participate and/or benefit from skilled intervention or refused to participate.

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.

The design of a maintenance regimen/home swallowing program to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease may be considered reasonable and necessary. Limited services may be considered reasonable and necessary to establish and assist the patient and/or caregiver with the implementation of a maintenance program. No more than 2-4 visits for completion of the maintenance program and instruction of the patient and supportive personnel or family are considered medically necessary without significant documentation. Documentation must indicate that the maintenance program has been designed for the patient's level of function and instructions to the patient and supportive personnel have been completed for them to safely and effectively carry them out. The initiation of a maintenance program should occur early in a course of therapy.

Dysphagia services are not covered to treat Skilled Nursing Facility patients whose care can safely and effectively be rendered by the Skilled Nursing Facility's trained professional staff.

Dysphagia services are not covered when a patient suffers a temporary loss or reduction of function and could reasonably be expected to improve spontaneously without the services of the therapist. For example, the patient with a TIA with swallowing deficits that are resolving.

Dysphagia services provided to screen patients who might need or benefit from dysphagia services(i.e. screening) intervention are not covered.

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.

Dysphagia services which are duplicative of other concurrent rehabilitation services are not covered.

Services which are related solely to specific employment opportunities (i.e., on-the-job training, work skills, or work settings) are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are not covered.

The educational component of treatment is included in the service described by the specific CPT code; therefore there is no separate coverage for education.

Documentation of services is part of the coverage of the respective CPT; therefore there is no separate coverage for time spent on documentation.

The ICD-9 coverage section of this LCD is meant to include 'functional' diagnoses. The functional diagnosis, not necessarily the clinical diagnosis, conveys coverage.

General Dysphagia Guidelines

In general, dysphagia therapy is indicated for:

History of aspiration problems or aspiration pneumonia, or definite risk for aspiration, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia.

Nasal regurgitation, choking, frequent coughing up food during swallowing, wet or gurgly voice quality after swallowing liquids or delayed or slow swallow reflex.

Presence of oral motor disorder.

Impaired salivary gland performance and/or presence of local structural lesion in the pharynx resulting in marked oropharyngeal swallowing difficulties.

Dyscoordination, sensation loss, postural difficulties, or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the buccal cavity and/or bite, chew, shape and squeeze the bolus into the upper esophagus, while protecting the airway.

Post-surgical reaction with specific signs, symptoms, and concerns supported in the documentation for the specific need of a qualified therapist to intervene.

Documented significant weight loss (5% in 1 month, 10% in 6 months) with documentation to support that the weight loss is directly related to reduced oral intake as a consequence of dysphagia, not merely reduced appetite (related to other medical/surgical illnesses, i.e. cachexia) or fluid shifting.

Existence of other conditions such as presence of tracheotomy or endotracheal tubes, ventilation management, nasogastric feeding or other enteral feeding, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, or pharyngeal peristalsis and cricopharyngeal dysfunction.

Dysphagia Evaluation

CPT 92610 - Evaluation of oral and pharyngeal swallowing

This evaluation is a clinical (usually bedside) one that does not involve the interpretation of dynamic radiologic studies or endoscopic studies.

The evaluation typically includes a bedside assessment of oral-motor functioning and signs and symptoms of pharyngeal dysphagia.

The evaluation is covered again after treatment has been initiated only if there is a change in the patient's overall condition of such significance that the plan of care cannot meet the beneficiary's goals with re-evaluation.

This code is an untimed code therefore only 1 unit is covered when reasonable and necessary.

Additional Documentation Requirements

History

Oral sensorimotor exam

Cervical ascultation

Positioning

Current eating status including onset and duration of problem

Clinical observations such as:

Presence of a feeding tube;

Paralysis; Oral, pharyngeal, laryngeal

Coughing or choking;

Oral motor structure and function;

Oral sensitivity;

Muscle tone;

Oropharyngeal reflexes;

Swallowing function;

Positioning;

Laryngeal function and vocal quality and loudness; and

Cognition and communication skills
Diagnosis that describes the phase of swallow affected

Recommendations for further assessment or treatment/intervention
Dysphagia Instrumental Assessment

An instrumental assessment (e.g. Modified Barium Swallow Study, Flexible Fiberoptic Endoscopic Evaluation of Swallowing) may be indicated for patients with suspected (e.g. observations by clinical or support personnel of choking with meals, excessive drooling, etc.), or who are at high risk for pharyngeal dysphagia. Dysphagia treatment may occur prior to the instrumental assessment. The final analysis and interpretation of a instrumental assessment should include a definitive diagnosis, identification of the swallowing phase(s) affected, and a recommended treatment plan, including compensatory swallowing techniques and/or postures and food and/or fluid texture modification. An instrumental assessment is not indicated if findings from the clinical evaluation fail to support a suspicion of dysphagia; or, when findings from the clinical evaluation suggest dysphagia but include either of the following: (1) the patient is unable to cooperate or participate in an instrumental evaluation; or (2) the instrumental examination would not change the clinical management of the patient. Absence of instrumental evaluation does not preclude the patient from receiving dysphagia treatment. An instrumental assessment is not covered as a screening tool and should be considered only if (a) an appropriate referral for dysphagia by a qualified clinician is made and (b) the dysphagia evaluation supports proceeding with an instrumental assessment.

CPT 92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording

This assessment is covered one time after the therapist determines, based on the results of the initial evaluation (CPT 92610) that the patient requires and could benefit from further evaluation and treatment. This evaluation is not covered more than once unless the documentation supports there has been significant clinical change that would impact the course of therapy.

Goals for this evaluation include identifying structural causes of dysphagia, assessing the functional integrity of the oropharyngeal swallow, evaluating the risk of aspiration, and determining if the pattern of dysphagia is amenable to therapy. The effects of compensatory maneuvers and diet modification on aspiration prevention and/or bolus transport during swallowing are able to be studied radiographically to determine a safe diet and to maximize efficiency of the swallow.

This code is an untimed code therefore only 1 unit is covered when reasonable and necessary.

The patient's medical record should show evidence that the referring/attending qualified clinician ordered this test.

If the plan of treatment by the treating therapist is based on the results of a report not issued by the treating therapist then the results of the test or the test report should be part of the medical record.

CPT 92612 - Flexible Fiberoptic Endoscopic Evaluation Of Swallowing By Cine Or Video Recording

Endoscopic evaluation of swallowing by cine or video recording (also called Fiberoptic Endoscopic Evaluation of Swallowing (FEES) utilizes the fiberoptic nasopharyngolaryngoscope to evaluate the pharyngeal swallow. Detailed information regarding swallowing function and related functions of structures within the upper aerodigestive tract are obtained. Therapeutic maneuvers are attempted during this examination to determine a safe diet and to maximize the efficiency of the swallow.

This assessment is covered one time after the therapist determines, based on the results of the initial evaluation (CPT 92610) that the patient requires and could benefit from further evaluation and treatment. This evaluation is not covered more than once unless the documentation supports there has been significant clinical change that would impact the course of therapy.

The clinician performing this service should be appropriately trained.

The patient's medical record should show evidence that the referring/attending qualified clinician ordered this test.

This is an untimed code and is covered for only 1 unit when reasonable and necessary.

If the plan of treatment by the treating therapist is based on the results of a report not issued by the treating therapist then the results of the test or the test report should be part of the medical record.

Additional Documentation Requirements

Detailed findings of the endoscopic exam
CPT 92616 - Fiberoptic Endoscopic Evaluation of Swallowing with Sensory Testing by cine or video recording

This procedure, known as FEESST, is a modification of FEES, with the addition of specialized equipment that quantifies the sensory threshold in the larynx. 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.

All bullets under CPT 92612 above, are applicable to CPT 92616.

Additional Documentation Requirements

Detailed findings of the endoscopic exam

Dysphagia Treatment

CPT 92526 Treatment of Swallowing

The Plan of Treatment should delineate goals and type of care planned which specifically addresses each problem identified in the assessment, such as:

Compensatory swallowing techniques;

Proper head and body positioning;

Amount of intake per swallow;

Means of facilitating the swallow;

Appropriate diet;

Food consistencies (texture and size);

Feeding techniques and need for self-help eating/feeding devices;

Patient caregiver training in feeding and swallowing techniques;

Facilitation of more normal tone or oral facilitation techniques;

Oromotor and neuromuscular facilitation exercises to improve oromotor control;

Training in laryngeal and vocal cord adduction exercises;

Oral sensitivity training
For oralpharyngeal or esophageal (upper one-third) phase of swallowing, documentation should include one or more of the following:

History of aspiration problems, suspected aspiration, or definite risk of aspiration;

Presence of oral motor disorder;

Impaired salivary gland performance and/or presence of local structural lesion in the pharynx resulting in marked oropharyngeal swallowing difficulties;

Dyscoordination, 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 with specific signs, symptoms and concerns;

Documented significant weight loss directly related to reduced oral intake as a consequence of dysphagia; and

Existence of other conditions such as the presence of tracheotomy or endotracheal tubes ventilation management, nasogastric feeding tube, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, or pharyngeal peristalsis and cricopharyngeal dysfunction.
For esophageal (lower two thirds) phase of swallowing, documentation should consider the following:

Esophageal dysphagia (lower two thirds of the esophagus) is regarded as 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 these patients will experience esophageal reflux or regurgitation 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 have not generally been shown to be amenable to swallowing therapy techniques and should not be submitted. An exception might be made when discomfort from reflux results in food refusal. A therapeutic feeding program in conjunction with medical management may be indicated and could constitute reasonable and necessary care. You may submit for payment a reasonable and necessary assessment of function, prior to a conclusion that difficulties exist in the lower two thirds of the esophageal phase, even when the assessment determines that skilled intervention is not appropriate.

Routine periodic re-assessments are considered part of the on-going treatment sessions and are not reimbursable.
CPT 92508 Group Dysphagia Therapy

Group therapy coverage for dysphagia is covered using CPT 92508 and can be covered if the following criteria are met:

Rendered under an individualized plan of care;

Has less than five group members;

Does not represent the entire plan of treatment;

Requires the skills of a licensed therapist

Promotes independent swallowing

Additional Documentation Requirements

Documentation of the specific skilled treatments used in the group and how they relate to the Plan of Care

Documentation of number of members in group
Limitations

The patient's attending physician/NPP has established a diagnosis of dysphagia after a proper medical evaluation and/or in consultation with treating therapist.

Noncovered services include:

Screening assessments

Nondiagnostic/non therapeutic routine, repetitive observation or cueing services;

Procedures which are repetitive and/or that reinforce previously learned material which the beneficiary, staff or family may be instructed to repeat;

Procedures which can be safely and effectively carried out with the beneficiary by any non-professional (family or restorative aid) after instruction is completed;

Procedures which are given to patients with chronic progressive diseases (e.g., Parkinson's disease, Huntington's disease, Wilson's disease, Multiple Sclerosis or Alzheimer's disease) without documentation to support short-term assistance teaching.
E-stim as a sole modality is noncovered. However, when used during dysphagia treatment (CPT 92526) along with other reasonable and necessary services, it may be performed. It should not be billed as unattended e-stim (HCPCS G0283).

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.

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.

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.

043X	Occupational therapy-general classification
044X	Speech language pathology-general classification

CPT/HCPCS Codes

92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; GROUP, 2 OR MORE INDIVIDUALS
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;
92616	FLEXIBLE FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING AND LARYNGEAL SENSORY TESTING BY CINE OR VIDEO RECORDING;

ICD-9 Codes that Support Medical Necessity

141.0 - 141.8	MALIGNANT NEOPLASM OF BASE OF TONGUE - MALIGNANT NEOPLASM OF OTHER SITES OF TONGUE
144.0 - 144.8	MALIGNANT NEOPLASM OF ANTERIOR PORTION OF FLOOR OF MOUTH - MALIGNANT NEOPLASM OF OTHER SITES OF FLOOR OF MOUTH
145.2 - 145.3	MALIGNANT NEOPLASM OF HARD PALATE - MALIGNANT NEOPLASM OF SOFT PALATE
150.0	MALIGNANT NEOPLASM OF CERVICAL ESOPHAGUS
150.3	MALIGNANT NEOPLASM OF UPPER THIRD OF ESOPHAGUS
161.0 - 161.9	MALIGNANT NEOPLASM OF GLOTTIS - MALIGNANT NEOPLASM OF LARYNX UNSPECIFIED
240.9	GOITER UNSPECIFIED
300.11	CONVERSION DISORDER
438.82	DYSPHAGIA CEREBROVASCULAR DISEASE
478.30 - 478.34	UNSPECIFIED PARALYSIS OF VOCAL CORDS - COMPLETE BILATERAL PARALYSIS OF VOCAL CORDS
507.0	PNEUMONITIS DUE TO INHALATION OF FOOD OR VOMITUS
530.0	ACHALASIA AND CARDIOSPASM
530.3	STRICTURE AND STENOSIS OF ESOPHAGUS
530.5	DYSKINESIA OF ESOPHAGUS
530.6	DIVERTICULUM OF ESOPHAGUS ACQUIRED
530.81	ESOPHAGEAL REFLUX
530.85 - 530.87	BARRETT'S ESOPHAGUS - MECHANICAL COMPLICATION OF ESOPHAGOSTOMY
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT
787.20 - 787.24	DYSPHAGIA, UNSPECIFIED - DYSPHAGIA, PHARYNGOESOPHAGEAL PHASE
V41.6	PROBLEMS WITH SWALLOWING AND MASTICATION
V43.81	LARYNX REPLACEMENT STATUS
V44.0	TRACHEOSTOMY STATUS

Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

General Information

Documentation Requirements

For documentation requirements see the following reference: Medicare Benefit Policy Manual (Pub 100-2), Chapter 15, Section 220.3.5

Signature Requirements
Medicare requires a legible identity for services provided/ordered. The method used may be hand-written, electronic, or signature stamp; subject to state laws. The individual whose name is on the alternate signature method bears the responsibility for authenticity.

Review Documentation
If documentation is requested for review, please submit the following:

Physician/NPP's order/referral for therapy

Plan of Treatment(s) with certification and re-certification

Evaluations and Re-evaluations

Progress/Treatment Notes

Any other supporting documentation

Itemization of charges

Appendices

Utilization Guidelines

This determination should be interpreted to incorporate future changes in the ICD-9-CM or CPT/HCPCS coding systems such that its original intent and scope will not be substantively changed.

Programs

Medicare does not cover "packaged" or "constellation of predetermined" services (i.e. "programs"). Services must be individualized and reasonable and necessary for each beneficiary.

Treatment Time

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on any calendar day using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

3 units > 38 minutes to < 53 minutes
4 units > 53 minutes to < 68 minutes
5 units > 68 minutes to < 83 minutes
6 units > 83 minutes to < 98 minutes
7 units > 98 minutes to < 113 minutes
8 units > 113 minutes to < 128 minutes

Sources of Information and Basis for Decision

American Speech Language Hearing Association; 2004 Preferred Practice Patterns for the Profession of Speech-Language Pathology

Effective Documentation Strategies to Meet Medicare Requirements; Coleman and Riffe; ASHA Convention 2004

Other Intermediary Policies

A Diagnostic Approach to Dysphagia, Review Article; B Saud, MD, R. Szyjkowski, MD; Clinics in Family Practice; Vol 6; No. 3, September 2004

Aspiration Pneumonia and Dysphagia in the Elderly; P. Marik MD, D. Kaplan MD; Reviews, Chest; Vol 124; No. 1; July 2003

Dysphagia: evaluation and treatment; C. Lind MD; Gastroenterology Clinics; Vol 32; No. 2; June 2003

Advisory Committee Meeting Notes

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period

12/15/2007

Revision History Number

2

Revision History Explanation

added Iowa and Missouri

Reason for Change

Other

Last Reviewed On Date

11/01/2007

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

All Versions

Updated on 04/25/2008 with effective dates 03/01/2008 - N/A