

Draft LCD for Dysphagia (DL30717)

Draft

Please note: This is a Draft policy.

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Contractor Information

Draft Draft Draft

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Number

00951, 00952, 00953, 00954, 52280, 05101, 05201, 05301, 05401, 05102, 05202, 05302, 05402

Contractor Type

Carrier - FI - MAC

LCD Information

Draft Draft Draft

LCD ID Number

DL30717

LCD Title

Dysphagia

Contractor's Determination Number

PHYSMED-015

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CMS National Coverage Policy

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

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

CMS Publication 100-04, Medicare Claims Processing Manual (MCPM), Chapter 5, Section 10)

CMS Publication 100-02, MCPM, Chapter 15, 80.4.4 Exclusions from coverage as Portable X-ray Services

CMS Publication MBPM, 100-02, Chapter 15 – 60.3 incident to services rendered in a physician/NPP owned and operated clinic

CMS Publication MBPM, 100-2, Chapter 15, Section 80.4; and Medicare Claims Processing Manual, 100-4, Chapter 13, Section 90, excludes coverage by portable x-ray services 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.

Primary Geographic Jurisdiction

Oversight Region

Projected Determination Effective Date

Original Determination Ending Date

Revision Effective Date

For services performed on or after 10/18/2010

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

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 can be 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 should be 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.

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 videofluoroscopy is also indicated when the clinician requires additional information to determine appropriate treatment strategies and diet textures.

Instrumental Assessments Used to Study Swallowing (CPT Codes 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 qualified 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.

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.

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.

Speech-language pathology therapy services are considered "optional" CORF services. They are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program and performed in conjunction with core CORF services. (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 for dysphagia services 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.)

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.

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.

'Incident to' Benefit

Swallow evaluations (CPT codes 92610, 92611, 92612, 92614, 92616, and 92700) may be performed by physicians, NPP, speech pathologists physical therapists or occupational therapists. When these services are billed by physicians or NPPs, they are covered when billed under the "incident to" provision if the service is 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 the speech pathologists physical therapists or occupational therapists

The incident to benefit is only available for services performed in place of service office or a service rendered in a physician/NPP owned and operated clinic. The incident to benefit is not available for services rendered in a nursing home, hospital, or any other facility.

For services provided under the "incident to" benefit, direct supervision does not mean that the physician or NPP billing the service must be physically present in the same room with the qualified personnel. However, the provider billing the service 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 provider by telephone does not constitute direct supervision.

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.

Under consolidated billing regulations, dysphagia services rendered by a speech-language pathologist or other qualified therapist are not reimbursed separately when the beneficiary is in a skilled nursing facility under a qualified Part A stay.

Note: CPT codes 70370 (Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique) and 70371 (Complex dynamic pharyngeal and speech evaluation by cine or video recording) do not specifically address dysphagia and will not be discussed in or limited by this LCD.

Modified Barium Swallow Studies CPT code 74230

This procedure will be reimbursed only when medically necessary and performed in the following locations:

- Office (11)
- Inpatient hospital (21)
- Outpatient hospital (22)
- Emergency room hospital (23)
- Comprehensive inpatient rehabilitation facility (61)
- Comprehensive outpatient rehabilitation facility (62)

Data from swallowing studies should be used for clinical decision-making as to placing a feeding gastrostomy tube, in the every day dietary management of the impaired patient and to order/plan/evaluate appropriate therapy programs.

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.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

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.

012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
014x	Hospital - Laboratory Services Provided to Non-patients
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
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.

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.

032X	Radiology - Diagnostic - General Classification
0440	Speech Therapy - Language Pathology - General Classification

CPT/HCPCS Codes

74230	SWALLOWING FUNCTION, WITH CINERADIOGRAPHY/VIDEORADIOGRAPHY
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; PHYSICIAN 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; PHYSICIAN 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; PHYSICIAN INTERPRETATION AND REPORT ONLY
92700	UNLISTED OTORHINOLARYNGOLOGICAL SERVICE OR PROCEDURE

ICD-9 Codes that Support Medical Necessity

Note: ICD-9 codes must be coded to the highest level of specificity.

438.11	APHASIA
438.12	DYSPHASIA
438.82	DYSPHAGIA CEREBROVASCULAR DISEASE
464.01	ACUTE LARYNGITIS WITH OBSTRUCTION
464.51	

SUPRAGLOTTITIS UNSPECIFIED WITH
OBSTRUCTION

478.30 - 478.34

UNSPECIFIED PARALYSIS OF VOCAL CORDS -
COMPLETE BILATERAL PARALYSIS OF VOCAL
CORDS

478.6	EDEMA OF LARYNX
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
530.86	INFECTION OF ESOPHAGOSTOMY
530.87	MECHANICAL COMPLICATION OF ESOPHAGOSTOMY
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT
784.49	OTHER VOICE AND RESONANCE DISORDERS
784.51	DYSARTHRIA
784.52	FLUENCY DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE
784.59	OTHER SPEECH DISTURBANCE
784.99	OTHER SYMPTOMS INVOLVING HEAD AND NECK
786.2	COUGH
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
793.1	NONSPECIFIC (ABNORMAL) FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF LUNG FIELD
933.1	FOREIGN BODY IN LARYNX
934.0	FOREIGN BODY IN TRACHEA
934.1	FOREIGN BODY IN MAIN BRONCHUS
V41.6	PROBLEMS WITH SWALLOWING AND MASTICATION
V48.3	MECHANICAL AND MOTOR PROBLEMS WITH NECK AND TRUNK

Diagnoses that Support Medical Necessity

See above list of ICD-9-CM Codes that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

All ICD-9-CM codes not listed in this policy under ICD-9-CM Codes that Support Medical Necessity above.

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

All ICD-9-CM codes not listed in this policy under ICD-9-CM Codes that Support Medical Necessity above.

General Information**Documentation Requirements**

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 document the patient's impairments and functional limitations requiring skilled intervention and:

1. Describe the prior functional level to assist in establishing the patient's rehabilitative potential and prognosis;
2. List the results of each diagnostic test performed;
3. Describe the skilled nature of the therapy treatment provided, including the identification of each skilled intervention or modality provided; and
4. Justify that the type, frequency and duration of therapy is medically necessary for the individual patient's condition.

The initial dysphagia evaluations should include:

1. Relevant history, including the change in condition that leads to the evaluation and date of onset or exacerbation;
2. Prior level of swallowing function and diet;
3. Previous swallowing treatment;
4. Current eating status, including dietary restrictions or instructions;
4. Level of alertness, cognition, motivation and deglutition;
5. Presence of feeding tubes, tracheotomy tubes, paralysis;
6. Positioning;
7. Description of coughing and/or choking;
8. Oral motor functioning, muscle tone, sensitivity;
9. Description of the swallowing function and any variances from normal; and
10. 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:

1. A history of aspiration pneumonia, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia, or for the patient at definite risk for aspiration.
2. 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:

1. 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);
2. Medical and functional diagnoses;
3. Long term treatment goals;
4. Type, amount, duration and frequency of therapy services;

5. Signature, date, and professional identity of the clinician who established the plan; and
6. 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:

1. Date of treatment;
2. Identification of the specific treatment, intervention or activity provided;
3. Record of the total treatment time in minutes; and
4. 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.

Non-Covered Services

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

Procedures and examinations which are not covered under the portable x-ray provision include the following (Section 100-2; Chapter 15; 80-4.4.):

- Procedures involving fluoroscopy;
- Procedures involving the use of contrast media;
- 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;
- Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
- Procedures requiring special technical competency and/or special equipment or materials;
- Routine screening procedures; and
- Procedures which are not of a diagnostic nature.

Appendices

Utilization Guidelines

None

Sources of Information and Basis for Decision

This policy does not reflect the sole opinion of the contractor or the Contractor Medical Director(s). Although the final decision rests with the contractor, this policy was developed in cooperation with the Carrier Advisory Committee(s), which include representatives of various medical specialty societies.

This medical policy consolidates and replaces all previous policies and publications on this subject by predecessors for Medicare Part B and WPS LCD's including PHYSMED-515 L26689, Dysphagia; Diagnostic Evaluation, L26565 MAC Part A Dysphagia/swallowing Therapy, Legacy Part A L2603 Dysphagia

Federal Register/Volume 65, NO. 212/Wednesday, November 1, 2000/ Rules and Regulations
Braunwald, Eugene et al, eds Harrison's Principles of Internal Medicine, New York, McGraw-Hill 2005
Humbert, IA, Ludlow CL. (2004, March 16). Electrical Stimulation Aids Dysphagia. The ASHA Leader, pp. 1, 23.

Humbert IA, Poletto CJ, Saxon KG, et al. The Effect of Surface Electrical Stimulation on Hyolaryngeal Movement in Normal Individuals at Rest and During Swallowing. J Appl Physiol 2006;101: 1657-1663.

Advisory Committee Meeting Notes

Meeting date:

Wisconsin: 2/12/2010

Illinois: 1/13/2010

Michigan: 1/27/2010

Minnesota: 1/14/2010

J-5 MAC

(IA,KS, MO, NE) 2/19/2010

Start Date of Comment Period

02/19/2010

End Date of Comment Period

04/05/2010

Start Date of Notice Period**Revision History Number****Revision History Explanation**

04/05/2010, This LCD combines all previous contractor LCDs on this subject including L26565 (PHYSMED-015) Dysphagia/Swallowing Therapy, L2603 Dysphagia (2000-04R1), and L26689 Dysphagia, Diagnostic Evaluation (PHYSMED-515).

04/19/2010—In accordance with Section 911 of the Medicare Modernization Act of 2003, the states of American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands were removed from this LCD because claims processing for those states are transitioning from FI Contractor Wisconsin Physician Services (WPS - 52280) to MAC Part A Contractor Palmetto.

8/1/2010 - The description for Bill Type Code 12 was changed
8/1/2010 - The description for Bill Type Code 13 was changed
8/1/2010 - The description for Bill Type Code 14 was changed
8/1/2010 - The description for Bill Type Code 21 was changed
8/1/2010 - The description for Bill Type Code 22 was changed
8/1/2010 - The description for Bill Type Code 23 was changed
8/1/2010 - The description for Bill Type Code 74 was changed
8/1/2010 - The description for Bill Type Code 75 was changed
8/1/2010 - The description for Bill Type Code 85 was changed

8/1/2010 - The description for Revenue code 0320 was changed
8/1/2010 - The description for Revenue code 0321 was changed
8/1/2010 - The description for Revenue code 0322 was changed
8/1/2010 - The description for Revenue code 0323 was changed
8/1/2010 - The description for Revenue code 0324 was changed
8/1/2010 - The description for Revenue code 0329 was changed
8/1/2010 - The description for Revenue code 0440 was changed
8/1/2010 - The description for Revenue code 0750 was changed

8/1/2010 - Revenue code 0759 was deleted

*10/01/2010, one, added new 2011 ICD-9 code 784.52,

10/18/2010 - In accordance with Section 911 of the Medicare Modernization Act of 2003, the states of Colorado, New Mexico, Oklahoma and Texas were removed from this LCD because claims processing for those states are transitioning from FI Wisconsin Physicians Service (52280) to MAC Part A Trailblazer (04901).

Reason for Change

Last Reviewed On Date

10/01/2010

Related Documents

This LCD has no Related Documents.

LCD Attachments

[Coding and Billing Guidelines for DRAFT Physmed-015 \(DL30717\) 10/01/2010 \(PDF - 26,788 bytes\)](#)

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All Versions



Updated on 10/06/2010 with effective dates 10/18/2010 - N/A
Updated on 10/04/2010 with effective dates 10/01/2010 - N/A
Updated on 09/23/2010 with effective dates 10/01/2010 - N/A
Updated on 08/01/2010 with effective dates 04/19/2010 - N/A
Updated on 04/14/2010 with effective dates 04/19/2010 - N/A
Updated on 12/11/2009 with effective dates N/A - N/A