AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Statement

of the

American Speech-Language-Hearing Association

to the

Practicing Physician Advisory Council

Regarding the
2003/2004 Medicare Physician Fee Schedules

February 10, 2003

The American Speech-Language Hearing Association (ASHA) appreciates the opportunity to provide this statement to the Practicing Physicians Advisory Council (PPAC) as it develops recommendations to the Secretary of Health and Human Services (DHHS) in preparation of the 2004 Medicare Physician Fee Schedule. ASHA is the professional and scientific association representing more than 110,000 speech-language pathologists, audiologists and speech/language/hearing scientists. Our members work extensively with the Medicare population in all provider settings, and are greatly impacted by the rules and payment methodologies of the Medicare physician fee schedule.

2003 Medicare Fee Schedule

ASHA supports CMS efforts to minimize the decreases in the conversion factor by incorporating changes in the methodology for calculating the Medicare Economic Index (MEI) and the sustainable growth rate (SGD). However, we continue to be alarmed by the severe decrease in Medicare payments to all providers. CMS has stated its intent to work with Congress to resolve this issue. ASHA recommends that CMS guide the Congress to examine other issues related to calculation of fees for Medicare payment.

2003 Payment for Fluoroscopic Evaluation of Swallowing

As part of the 2003 fee schedule, a new CPT code was introduced for the fluoroscopic evaluation of swallowing that supersedes the Medicare G code. The conversion to the new CPT code did not represent any change whatsoever in the procedure, yet the payment was dramatically cut by almost 70 percent. This substantial decrease may have a negative impact on a beneficiary's access to this evaluation, as hospitals will lose money each time the procedure is rendered.

Proposed Changes for the 2004 Fee Schedule

Physician Supervision of Endoscopy Procedures

ASHA is concerned that progress in the efficient evaluation and treatment of dysphagia is being hindered by the decisions of some Medicare fiscal intermediaries and carriers ("contractors") that prohibit the speech-language pathologist from passing the endoscope without direct supervision by a physician. CMS regulations or policy do not support this restriction found in Local Medical Review Policies (LMRP). These LMRPs improperly limit patient access to a diagnostic procedure that is included in the medical review guidelines for dysphagia services. The restriction on speech-language pathologists is especially significant because many of these intermediaries require an instrumental assessment before proceeding with dysphagia treatment. In skilled nursing facility settings (SNFs), it can be extremely difficult to successfully arrange for the physician's visit in a timely manner (e.g. within 1 to 3 days). Consequently, patients who need an instrumental assessment are sometimes being served inappropriately. The common

instrumental assessment, the fluoroscopic evaluation of swallowing (modified barium swallow or MBS), is often dependent upon availability at a hospital and is more expensive than the endoscopic procedure due to the necessity of ambulance transportation. Delays in dysphagia treatment increase the risk of aspiration and other complications, especially for frail elderly patients.

ASHA requests that the Council recommend that CMS develop clear policy which allows for general supervision of a speech-language pathologist performing an endoscopic evaluation of swallowing function. General supervision, as defined at 42 CFR 410.32 (b)(3)(i), states that the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Such a policy would be in concert with a joint position statement of the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) and ASHA that recognizes the properly trained speech-language pathologist's ability to independently perform endoscopic evaluations of swallowing function. The statement differentiates between a *medical procedure* (the physician's role in the diagnosis of underlying medical conditions) and a *functional assessment* (the speech-language pathologist's role in the functional evaluation of swallowing).

Thirty-Day Recertification of Care for Therapy Services

ASHA requests that PPAC support the elimination of a Medicare requirement that beneficiaries receiving outpatient rehabilitation see a physician every 30 days. Eliminating this requirement would reduce costs for the Medicare program and its beneficiaries and ensure necessary treatment is not interrupted.

Existing regulations require that outpatient rehabilitation services be furnished while under the care of a physician. The regulations also require that a plan of care is established and that a physician review the plan of care and recertify the need for additional care 30 days. For comprehensive outpatient rehabilitation facilities (CORFs) and home health agencies, the physician requirement to recertify the need for care is every 60 days.

In its program manuals, CMS has interpreted the recertification requirement to mean that a patient must physically see the physician every 30-days to receive care. This requirement does not exist in Medicare regulations. The need for physician visits every 30 days is costly, leads to unnecessary visits to the physician and may create logistical problems for those living in rural areas.

Safeguards are in place that require rehabilitation providers to notify the physician of any change in the patients condition or in the plan of care during course of treatment and to review the plan of care every 30 days. This is sufficient to ensure that the patient is receiving care that is reasonable and necessary.

ASHA respectfully requests that PPAC incorporate the elimination of this requirement from CMS policies.

Outpatient Therapy Caps

ASHA strongly urges the Council to make recommendations to DHHS to support a statutory repeal of the $1500 cap on therapy services. This arbitrary limitation on coverage of medically necessary therapy services can have a devastating effect on beneficiaries who have experienced a major stroke or other illness, or accident and need extensive rehabilitation services. The effect of the cap is to require patients who need prolonged rehabilitation to pay out of pocket for such services, to do without needed care, or to seek to receive such services in a costly Part A SNF setting. None of these alternatives are desirable or in keeping with the objectives of the Medicare program.

The Part B $1500 cap, especially when viewed in 2002 fees versus 1999 fees when the law was implemented, will drastically reduce the number of visits available to Medicare beneficiaries. For example, in 1999 the fee for 92507 (speech-language pathology treatment) was $30.56 and the beneficiary could have received approximately 49 sessions under the cap. However, using the 2002 payment rate of $75.29, a Medicare beneficiary could only receive about 19 sessions.

Speech-Language Pathologists in Private Practice

Under the Medicare program, beneficiaries may receive speech-language pathology care in settings such as a hospital, skilled nursing facility or rehabilitation agency/facility. However, the Medicare benefit does not extend to speech-language pathologists in private practice settings. This has the indirect and negative effect of limiting beneficiary access to speech-language pathology care, particularly in rural communities.

Access is limited because of an anomaly in drafting the Medicare statute. Speech-language pathology services were added to the Medicare program in 1972, as a subset of the physical therapy rehabilitation agency benefit in the Medicare statute. In 1986, Congress added occupational therapy services as a separate statutory section. As a result, a beneficiary can receive both physical and occupational therapy care from and independent practice setting, but cannot similarly receive speech-language pathology care in a private setting.

To ensure access to needed speech-language pathology care, ASHA requests that PPAC recommend to DHHS to work with Congress in fixing the drafting anomaly and recognize speech-language pathologists in private practice as Medicare providers.

Conclusion

ASHA applauds the work of PPAC in input and guidance to the Secretary of Health and Human Services (HHS) in the development of the Medicare physician fee schedule. We are pleased that HHS has scheduled this meeting of the PPAC so that comments next year's fee schedule can be made at this time. If the Council has any questions regarding our statement, or requires additional information, please contact Ingrida Lusis, ASHA

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