Climate Change
Impact of Health Care Economics on CSD Education and University Clinics

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Overview

- Health Care Economics 101 – How did we get HERE?
- Rules & Tools to Maximize Medicare Billing Efficiency
- Current Procedure Terminology
- International Classification of Diseases and Disorders
- Coding Edits and Modifiers
- Advance Beneficiary Notice
- SLP Clinical Supervision
- Looking Ahead to 2014
- University Clinics & Medicare - Q & A
- Evolution of Academic and Clinical Preparation
- Aligning Health Care Trends to Evidence-Based Practice and Outcome Measures

Health care economics: what got us into this mess?

Health Care Spending as a Share of GDP

Health Care Costs for American Families

Source: Milliman Medical Index

Per Capita Spending for Health Care; Source: Kaiser Family Foundation
### International Health Care Rankings

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Care</th>
<th>Per Capita Spending</th>
</tr>
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<tbody>
<tr>
<td>France</td>
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<td>4</td>
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<tr>
<td>Italy</td>
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<td>11</td>
</tr>
<tr>
<td>Spain</td>
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<tr>
<td>United States</td>
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</tr>
</tbody>
</table>

### Timeline of Events

- **1970s**: Reimbursement Freeze
  - Control health care costs
  - Ended in late 1970s
- **1980s**: Costs Rise Faster Than Inflation
  - Still based on “normal and customary” fee structure
- **1990s**: RBRVS and More Restrictive Reimbursement Guidelines
  - Initial valuation based on Harvard study
  - Technology explosion

### Timeline of Events

- **2000s**: Technology Advances Continue
  - Pharmaceutical direct marketing
  - Malpractice increases for high-risk specialties
  - Medicare Part D
  - End-of-life care advancements
  - Congressional “tinkering” of dollar multiplier for Medicare RVUs
  - RACs and MICS
- **2010s**: Desperation to Control Health Care Cost
  - ~800,000 households with health care insurance coverage declared medical bankruptcy
  - Revelation of uninsured, underinsured, cost-shifting

### Uninsured

- **313 Million**
  - **Uninsured: ~51 Million**
  - **Underinsured: ~60 Million**

### Accountability Care Act Health Care Reform

- Reduce Uninsured to ~18 Million

### Impact on Health Care Costs:

- Emergency room primary care
- Delay health care services until severity increases

### Health Insurance Exchanges

- Medicaid Expansion
- State Cooperation / Participation
Health Care Economics

- Cost inflation
  - Risen 78% since 2000 vs. 20% for salaries
  - Average 9% per year with range of 7%-13%
- Defensive medicine (malpractice)
- Unnecessary procedure/treatment (fee for service)
- Ineffective treatment
- Inefficient service delivery models
- Pharmaceuticals
- End of life care

PQRS: Doing the right thing at the right time, all the time

- Proposed new requirement: Medication management
- Proposed new requirement for audiology: Depression screening
- Must report one measure on one patient one time to avoid 2015 penalty

PQRS

- Began as a physician incentive to incorporate evidence-based procedures in daily clinical activities
- Information on current quality measures on the ASHAA, ADA, and AAA websites for audiology
- Has moved to mandatory participation
  - Penalty Adjustment: -1.5% in 2015; -2% in 2016 and beyond

New PQRS Requirements


- Procedural codes (CPT) describe what we do with the patient or client

Rules & Tools to Maximize Medicare Billing Efficiency

Current Procedure Terminology (CPT): What’s that and why do I care?
International Classification of Diseases and Disorders (ICD codes)
Coding Edits and Modifiers
Advance Beneficiary Notice (ABN)
SLP Clinical Supervision
Looking Ahead to 2014
- 5-digit numbers assigned to every procedure and service a medical practitioner may provide
- Medical
- Surgical
- Diagnostic
- Used to determine amount of reimbursement
- Ensure uniformity of communication
- Developed, maintained, and copyrighted by the American Medical Association (AMA)
- Updated annually

Relative Value Unit (RVU)
- Every CPT procedure or service has a resource-based relative value
- Standardized physician payment schedule
- Payments for services are determined by the resource costs needed to provide them
- Three components of resource-based relative value
  - Professional work (a.k.a. physician work)
  - Practice expense
  - Professional liability insurance

Three Components of Relative Value Unit
- **Professional Work**
  - Time it takes to perform the service
  - Technical skill and physical effort
  - Required mental effort and judgment
  - Stress due to the potential risk to the patient
- **Practice Expense**
  - Time of support personnel
  - Supplies
  - Equipment
  - Overhead
- **Professional Liability/Insurance Costs**

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
- **MIPPA - Effective July 1, 2009**
- Granted SLPs *direct billing* access to Medicare
- Changed our status with CMS to a Medicare Provider
- Recognized SLPs as **professionals** rather than technical assistants
- Allowed for the “relative value” of SLP CPT (procedure) codes to be re-valued to include a professional work component
- SLP clinical time was taken out of practice expense

How Does a CPT Code Get a Dollar Value?
- Relative Value Units (RVUs) are assigned thru a rigorous procedure developed by the AMA
- Recommendations for RVUs sent to Centers for Medicare and Medicaid (CMS)
  - Accepted, rejected, or adjusted
  - Ranked
- RVU x Monetary Conversion Factor (CF) = Medicare Payment per Procedure
  - Establishes the Medicare Physician Fee Schedule
  - Payment adjusted for geographic location

Examples of Common SLP CPT Codes
- **92506** Evaluation of speech, language, voice, communication, and/or auditory processing
- **92507** Treatment of speech, language, voice, communication, and/or auditory processing
- **92526** Treatment of swallowing dysfunction and/or oral function for feeding
- **92610** Evaluation of oral & pharyngeal swallowing function
Medicare Physician Fee Schedule (MPFS)

- “Full Medicare payment schedule” includes 80% Medicare pays and 20% patient coinsurance
- Must adjust for your geographic location
- Many private insurers and Medicaid programs model payment plans from MPFS
- Appears in Proposed Rule in late fall for the following year

2013 Medicare Physician Fee Schedule

- Conversion Factor (CF) set by Congress based on Medicare budget
- RVU x CF = Medicare Payment
- Proposed 2013 CF was originally $25.0008
  - 26.5% decrease from 2012
- Final 2013 CF = $34.0376

Table 1: Selected Medicare Part B Rates for Speech Language Pathologists

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>National Fee</th>
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<tbody>
<tr>
<td>9251</td>
<td>Speech Therapy</td>
<td>$58.00</td>
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<tr>
<td>9252</td>
<td>Language Therapy</td>
<td>$58.00</td>
</tr>
<tr>
<td>9253</td>
<td>Speech Therapy with Swallowing</td>
<td>$61.00</td>
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</tbody>
</table>

2013 Medicare Physician Fee Schedule

- RVU x CF = Medicare Payment

Effect of Sequestration on Medicare Reimbursement

- Automatic across-the-board cuts totaling $85 billion for 2013 effective March 1
- Mandated under the Budget Control Act of 2011
- 2% reduction in Medicare payment for services provided after April 1 (1st of month following sequester)
- Medicaid, Children’s Health Insurance Program (CHIP), and Social Security are exempt

Therapy Caps and Exception Process

- Extended thru 2013
- KX modifier on claim attests to
  - Medical necessity of continued services
  - Availability of documentation
- Combined SLP/PT cap increased from $1,880 to $1,900
- Therapy cap applied to
  - Private practitioners
  - Outpatient rehab facilities
  - Hospital outpatient services
- Critical Access Hospitals (new for 2013)
Manual Medical Review Process

- Began Oct 2012 for combined SLP/PT services over a $3,700 threshold; separate OT threshold of $3,700
- NEW Mar 22, 2013 – no longer an advanced request for exception process; replaced with prepayment review and postpayment review
- Effective April 1, 2013

Manual Medical Review Process
Prepayment Review

- Recovery Audit Prepayment Review Demonstration
  - Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, and Missouri
- If claim exceeds $3700 threshold, claim will be automatically stopped for prepayment manual medical review by your MAC
- MAC will send provider an additional development request (ADR) for documentation to be sent to Recovery Auditor Contractor (RAC) for determination of medical necessity
- Process for submission TBD by MAC and RAC
- Prepayment RAC review within 10 business days of receipt
- RAC notifies MAC of payment decision for processing
- MAC notifies provider??

Manual Medical Review Process
Postpayment Review

- Remaining states undergo immediate postpayment review by Recovery Auditors (Services rendered, claims submitted, and paid)
- MAC flags claims that meet $3,700 threshold and sends ADR to provider requesting documentation be sent to RA
- Process for documentation submission TBD by MAC & RAC
- Recovery Auditors conduct postpayment review and notify MAC of decision (as yet, no timeframe for notification)
- Results of Recovery Auditor Review
  - No change
  - Revised Determination if determined “not reasonable or necessary”
  - Pay back funds
  - Funds recouped from future payments
  - Apply for extended payment plan
  - Appeal

Manual Medical Review Process
Advanced Beneficiary Notice (ABN)

- Law requires providers to inform beneficiary if services exceed threshold by giving an ABN
- ABN must be signed prior to provision of service
- If NO ABN and service deemed NOT medically necessary by CMS, beneficiary NOT responsible for payment
- CMS does not approve of “blanket” use of ABN

Multiple Procedure Payment Reduction Policy (MPPR)

- Began in 2012
- When multiple therapy procedures are provided for same beneficiary on same day, there is a per-code reduction in reimbursement
- Per-day policy applies across disciplines
- PTs, OTs, and SLP services billed under same facility number for same day are subject to MPPR

Multiple Procedure Payment Reduction Policy (MPPR)

- Therapy service or unit with highest practice expense (PE) value receives full reimbursement
- For additional services provided on same day, CMS reduces PE value, but not professional work or malpractice expense components
  - 20% for services in office and non-institutions
  - 25% for Part B services in institutional settings
  - Will increase to 50% all settings April 1, 2013
Multiple Procedure Payment Reduction Policy (MPPR)

- MPPR applies to all codes billed that day regardless of discipline
- If SLP & PT both provide treatments to same patient on same day, code with highest PE gets full payment and others have PE reduced
- Primarily affect professions that bill multiple procedures, or bill a timed procedure more than once per visit

8 SLP Therapy Procedures Affected By MPPR

- CPT 92506  Eval of speech, language, voice, communication, and/or auditory processing
- CPT 92507  Treatment of above
- CPT 92508  Group Treatment
- CPT 92526  Treatment of swallowing dysfunction and/or oral function for feeding
- CPT 92597  Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
- CPT 92507  Evaluation for prescription of speech-generating device
- CPT 92609  Treatment for use of speech-generating device
- CPT 96125  Standardized cognitive performance testing

Multiple Procedure Payment Reduction Policy (MPPR)

- MPPR designed to save an estimated $1.8 billion in Medicare expenditures in 2013

$1,800,000,000

Coding Clarifications - Edits

- Two types of similar edit systems depending on setting
  - National Correct Coding Initiative (CCI) - any Part B services not rendered in a hospital
  - Outpatient Code Editor (OCE) - outpatient hospital services
- Automated edit systems used by CMS to control specific CPT code pairs that can be reported on the same day for the same patient
- CCI updated quarterly; OCE follows one quarter later
- Late 2010, CCI also applied to Medicaid per federal law
CCI Edit Page for SLP Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Code (group)</th>
<th>MD office</th>
<th>Other settings</th>
<th>If so, what modifier?</th>
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<tbody>
<tr>
<td>92506</td>
<td>92507</td>
<td>Y</td>
<td>Y</td>
<td>No modifier</td>
</tr>
<tr>
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<td>92526</td>
<td>92322</td>
<td>Y</td>
<td>Y</td>
<td>-59</td>
</tr>
<tr>
<td>92610</td>
<td>92611 (MIS)</td>
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<td>Y</td>
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<td>92612</td>
<td>31575, 92511, 92520, 92614</td>
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<td>N</td>
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</tbody>
</table>

Medically Unlikely Edits (MUEs)

- Subset of CCI edits also for Medicare Part B and Medicaid claims.
- Specifies maximum number of times that a CPT code can be reported on same day for same patient.
- Separate MUEs for office and hospital outpatient settings, but SLP MUEs are similar for both.
- 92507 1 speech tx
- 92526 1 dysphagia tx
- 92610 1 clinical eval of swallowing
- 96125 2 cognitive performance testing per hour

Coding Clarification - Modifiers

- Provide more information about who used the code, or special circumstances regarding code use.
- Modifier to indicate type of therapist who provided service:
  - GN: Speech-language pathologist
  - GO: Occupational therapist
  - GP: Physical therapist
- -59 Distinct Procedural Service
  - the only modifier used with edits
  - For two procedures not ordinarily performed on the same day by the same practitioner but which, under certain circumstances, may be appropriate to perform and therefore code on the same day (e.g., different sites of origin)
- KX – Therapy Cap Exceptions
- New Severity Modifiers

Medicare Rule - Use of SLP Students

- Medicare requires 100% personal supervision of SLP students by qualified SLP in outpatient setting.
- Must be in the room directing the service.
- Must not be engaged in other activities.
- Student considered extension of qualified practitioner.
- Qualified* SLP (for Medicare) meets one of the following requirements:
  - The education and experience requirements for Certificate of Clinical Competence in SLP granted by ASHA; or
  - Meets educational requirements for certification and is in process of accumulating the supervised experience required for certification.
- Only services of qualified practitioner can be billed and paid.
- This does NOT apply to non-Medicare settings unless specified.

*(qualified not always same definition for Medicaid)

Middle Class Tax Relief & Job Creation Act of 2012 (Feb 17, 2012)

- Required CMS, by Jan 1, 2013, to implement a claims-based data collection strategy to collect data on “patient function during the course of therapy services in order to better understand patient condition and outcomes”.
- Mandated by Congress.
- 6-month testing period.
- July 1, 2013 - claims that do not comply will be returned UNPAID.
Claims-Based Outcomes Reporting

- Non-payable G-codes
- 7-point severity modifier scale
- CMS chose 7 Functional Communication Measures (FCMs) used by ASHA’s National Outcomes Measurement System (NOMS)
- CMS added an other SLP category
- Total of 8 categories

Claims-Based Outcomes Reporting

- Swallowing
- Motor-Speech
- Spoken Language Comprehension
- Spoken Language Expression
- Attention
- Memory
- Voice
- Additional code for “Other SLP Functional Limitation”

Functional Communication Measures

- ASHA has total of 15 FCMs
- Each FCM is 7-point rating scale, ranging from least functional (Level 1) to most functional (Level 7)
- Designed to describe functional abilities over time from admission to discharge in various SLP treatment settings
- Not dependent upon administration of any particular formal or informal assessment measures, but are clinical observations provided by the SLP

Functional Communication Measure for Swallowing

- LEVEL 1: Individual is not able to swallow anything safely by mouth. All nutrition and hydration is received through non-oral means (e.g., nasogastric tube, PEG).
- LEVEL 2: Individual is not able to swallow safely by mouth for nutrition and hydration, but may take some consistency with consistent maximal cues in therapy only. Alternative method of feeding required.
- LEVEL 3: Alternative method of feeding required as individual takes less than 50% of nutrition and hydration by mouth, and/or swallowing is safe with consistent use of moderate cues to use compensatory strategies and/or requires maximum diet restriction.
- LEVEL 4: Swallowing is safe, but usually requires moderate cues to use compensatory strategies, and/or the individual has moderate diet restrictions and/or still requires tube feeding or/and oral supplements.
- LEVEL 5: Swallowing is safe with minimal diet restriction and/or occasionally requires minimal use of compensatory strategies. The individual usually eats and drinks independently. All nutrition and hydration needs are met by mouth at mealtime.
- LEVEL 6: Swallowing is safe, and the individual eats and drinks independently and may need occasional minimal cues. The individual usually eats and drinks independently. May need to avoid specific food items (e.g., popcorn and nuts). May require additional time (due to dysphagia).
- LEVEL 7: The individual’s ability to eat independently is not limited by swallow function. Swallowing would be safe and efficient for all consistencies. Compensatory strategies are effectively used when needed.

Claims-Based Outcomes Reporting

- Required for all therapy services
- Each discipline reports status and severity for its plan of care
- Timing for outcomes reporting
  - First visit (including evaluation)
  - On or Before every 10th treatment day
  - Every time an evaluation code is billed for that functional measure (e.g., initial and re-evaluation)
  - Discharge

Claims-Based Outcomes Reporting

- Each reported G-code must also have therapy modifier indicating discipline providing service (e.g., -GN)
- Claims containing any G-codes MUST also contain another billable code (e.g., CPT 92506, 92507)
- For each line of institutional claim, a charge of $0.01 may be added for non-payable G-code
- For each line of professional claim submitted by private practice providers, a charge of $0.00 or $0.01 may be added, depending on requirements of your billing system
**Claims-Based Outcomes Claims Form**

- Services over therapy cap (PT/SLP) of $1900 require -KX modifier
- -KX modifier should **not** accompany the non-payable G-code
- -KX modifier goes only on the billable service for example CPT 92506, 92610, 92526, etc.

**Claims-Based Outcomes Reporting**

- Limited to **only one** condition/disorder/functional limitation at a time
  - Primary functional limitation chosen first
  - After primary achieved, subsequent functional limitation reported
  - Next functional limitation is reported on *first date of service after reporting ended* for previous functional limitation
- Therapy services for beneficiary **under more than one POC** (PT, OT, and/or SLP) will have more than one G-code set

**Claims-Based Outcomes Reporting Example Swallowing Functional Limitation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8996</td>
<td>Swallowing functional limitation, current status at time of initial therapy</td>
</tr>
<tr>
<td></td>
<td>treatment/episode outset and reporting intervals</td>
</tr>
<tr>
<td>G8997</td>
<td>Swallowing functional limitation, projected goal status, at therapy episode</td>
</tr>
<tr>
<td></td>
<td>outset, at reporting intervals, and at discharge from therapy</td>
</tr>
<tr>
<td>G8998</td>
<td>Swallowing functional limitation, discharge status, at discharge from therapy</td>
</tr>
<tr>
<td></td>
<td>end of reporting on limitation</td>
</tr>
</tbody>
</table>

**Claims-Based Outcomes Reporting Severity/Complexity Modifiers**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Impairment Limitation Restriction</th>
<th>NOMS Score</th>
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</thead>
<tbody>
<tr>
<td>CH</td>
<td>0% impaired, limited</td>
<td>7</td>
</tr>
<tr>
<td>CI</td>
<td>At least 1%, but less than 20% impaired, limited or restricted</td>
<td>6</td>
</tr>
<tr>
<td>CJ</td>
<td>At least 20%, but less than 40%</td>
<td>5</td>
</tr>
<tr>
<td>CK</td>
<td>At least 40%, but less than 60%</td>
<td>4</td>
</tr>
<tr>
<td>CL</td>
<td>At least 60%, but less than 80%</td>
<td>3</td>
</tr>
<tr>
<td>CM</td>
<td>At least 80%, but less than 100%</td>
<td>2</td>
</tr>
<tr>
<td>CN</td>
<td>100% impaired, limited, or restricted</td>
<td>1</td>
</tr>
</tbody>
</table>

CMS adopted a 7-point severity scale to coincide with NOMS scale.
Swallowing Functional Limitation

First Claim

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Severity Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8996</td>
<td>Swallowing functional limitation, current status at time of initial therapy treatment/episode outset, and reporting intervals</td>
<td>CL (60-80% impaired, NOMS Level 3)</td>
</tr>
<tr>
<td>G8997</td>
<td>Swallowing functional limitation, projected goal status at initial therapy treatment/episode outset, and at discharge from therapy</td>
<td>CI (1-20% impaired, NOMS Level 6)</td>
</tr>
</tbody>
</table>

Claims-Based Outcomes Reporting Example

Discharge or Primary Functional Goal Completion Swallowing Functional Limitation

Final claim – Projected Goal Status & Discharge Status

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Severity Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8997</td>
<td>Swallowing functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from therapy</td>
<td>CI (1-20% impaired, NOMS Level 6)</td>
</tr>
<tr>
<td>G8998</td>
<td>Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation</td>
<td>CJ (20-40% impaired, NOMS Level 5)</td>
</tr>
</tbody>
</table>

Scenario 1: Question

- What happens if you do an evaluation and begin therapy on the same day?

Scenario 1: Answer

- The evaluation would be reported as First Treatment Day…the first visit. The treatment provided on that day would not be recognized as separate, since the reporting is every 10th treatment day. The next treatment would be considered the second treatment day and so on.
Scenario 2: Question

- How do you code normal results from the evaluation?

Scenario 2: Answer

- When results of the evaluation are “normal” and patient is seen for only one visit, CMS requires reporting of ALL 3 G-codes (current, projected goal, and discharge) on the claim form with appropriate severity modifiers.
- When the result is “normal” and there is no impairment, the severity modifier for all 3 G-codes will be CH indicating 0% impaired, limited or restricted function (NOMS Level 7)

Scenario 3: Question

- Which G-codes do you code when you only do the evaluation and patient goes elsewhere for therapy?

Scenario 3: Answer

- For situations when the evaluation is performed by a provider in one setting (only one visit) and then the treatment takes place in another setting, CMS requires reporting of ALL 3 G-codes (current, projected goal, and discharge) on the claim form with appropriate severity modifiers.

Scenario 4: Question

- What day is Day One if you start therapy after someone else does the evaluation?

Scenario 4: Answer

- If the evaluation and the therapy are performed in the same facility, the evaluation day is first treatment day and the first treatment session is second treatment day.
- If you perform the evaluation and the patient goes elsewhere for therapy, the evaluation in your facility is first treatment day and the first treatment session in the new facility is also “first treatment day.”
- The SLP in facility providing treatment may use the discharge severity modifier from initial evaluation as the current status G-code severity modifier on Day 1 of treatment and may also use the same projected goal G-code severity modifier.
Scenario 5: Question

- At the 10th treatment reporting, our patient has progressed beyond our predicted goal and we need to reset the projected goal. Can we change the projected goal?

Scenario 5: Answer

- Report the new current status and reset the severity modifier and the projected goal.
- Provider can change the goal at any time when it is appropriate and document the reasons in the chart.

Scenario 6: Question

- If a speech therapist does a tracheoesophageal prosthesis (TEP) change for a patient and charges CPT 92597 (Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech) which is usually a one time visit, does the therapist need to report the 3 G-codes within the functional set for that visit?
- And, what functional set does the SLP use since there is not a specific set for alaryngeal speech?

Scenario 6: Answer

- For a one time visit or “diagnostic only” situation, report all 3 G-codes in the set with corresponding modifiers.
- For TEP change, recommend Voice Set since this relates to voice function rather than the “other” speech and language category.
- Example Reporting for Functional Voice Limitation for TEP:
  - CPT 92597, GN
  - G9171, GN, CM (Current Status at least 80% but < 100% impaired)
  - G9172, GN, CI (Goal 1% but < 20%, function anticipated after replacement)
  - G9173, GN, CI (Discharge, function that was achieved)

Scenario 7: Question

- Since CPT 92507 represents many areas of treatment (e.g., memory, motor-speech), what do you report when you are working on more than one treatment area?

Scenario 7: Answer

- Reporting but not treatment is limited to one condition/functional limitation at a time, even for those SLP patients who are treated for multiple limitations (e.g., swallowing, motor-speech).
- The primary functional limitation is reported first, and after treatment goal is achieved for primary, a subsequent functional limitation is reported.
- Reporting multiple conditions at the same time will result in unpaid claim.
Scenario 8: Question
- A patient who has had a CVA receives an initial aphasia evaluation on the first day (treatment day #1) and then has a swallowing eval on Day 2.
- Do treatment days start over on Day 2 because another evaluation is done?

Scenario 8: Answer
- Choose a primary functional goal (e.g., comprehension of spoken language, swallowing) and follow that through for G-code reporting and functional outcomes measurement.
- When primary goal is complete, then may add another.

Scenario 9: Question
- We have been under the impression that re-certification is based on 90 days, rather than the 10th treatment day within a certification period.
- Is a re-evaluation necessary on this 10th tx day?
- Does this replace the 90-day recertification?

Scenario 9: Answer
- No, reevaluation is not necessary. This is only a brief progress report and replaces the 30-calendar day progress note. That language will be (or has been) deleted from the Medicare policy manuals.
- 10 treatment days is the minimum; documentation can occur more often is necessary.
- The recertification at 90 days remains the same and not affected by this data collection.

Scenario 10: Question
- What happens when 2 different SLPs are addressing different goals simultaneously (e.g. acute care staff provides OP swallowing and OP Rehab Dept. provides aphasia tx)?
- Do we just chart as usual, using appropriate severity modifiers?

Scenario 10: Answer
- The rule is that we only report on one functional measure at a time...no matter how many SLP functions are treated.
- In this case, when billing Medicare is from the same facility, there only needs to be one SLP functional measure reported on at a time.
- So CPT 92526 (swallowing) may have G-codes/severity modifiers while CPT 92507 (for aphasia tx) will not.
- Document somewhere in progress notes the choice.
- When goal is achieved for swallowing, and if pt still receives tx, then begin reporting on another functional measure (aphasia has a few FCMs to choose from).
Examples of Report Documentation

(1) One line
FUNCTIONAL VOICE STATUS (CPT 92506): NOMS Level __
Current: G9171-C__; Goal: G9172-C__; Discharge: G9173-C__

(2) Chart MEDICARE OUTCOMES REPORTING
Severity modifier determined using NOMS-FCM: _____________

<table>
<thead>
<tr>
<th>Code</th>
<th>Status</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Current</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Goal</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Discharge</td>
<td></td>
</tr>
</tbody>
</table>

Resources for Claims-Based Outcome Reporting for SLP Therapy Services


- More information and scenarios available in 2013 SLP Medicare Fee Schedule: [www.asha.org/practice/reimbursement/medicare/feeschedule/](www.asha.org/practice/reimbursement/medicare/feeschedule/)

Health Care Coding Systems

- Procedures
- What you DO
  - Diagnostic
  - Reason for the Visit
  - Devices
  - Health Care Common Procedure Coding System (HCPCS)
  - Part of CPT codes

ICD-9-CM

- Standard system of diagnostic codes of diseases and disorders
- Official classification system used in U.S.
- Based primarily on body system (e.g., circulatory, gastrointestinal, nervous system)
- Under auspices of U.S. Dept. of Health & Human Services \(\rightarrow\) regulated by a governmental agency

ICD -9-CM

- Government uses these data to:
  - Review utilization patterns
  - Evaluate appropriateness of health care costs
- Developed approximately 30 years ago
- Contains more than 15,000 codes

Looking Ahead 2014

- International Classification of Diseases and Disorders-10th Edition
- Expanded Medicare Coverage
- New SLP Evaluation Procedure Codes
- Mandatory Claims Submission
- Advanced Beneficiary Notice
ICD-10 includes approx. 160,000 codes
- ICD-10-CM diagnosis codes for all settings (> 68,000)
- ICD-10-PCS procedure codes for hospital inpatients
- Greater specificity (3-7 alphanumeric characters instead of 3-5 digits, ICD-9-CM)
- Code descriptors have more detail, less room for error
- Combination codes represent multiple conditions
- Clearer instructions than ICD-9-CM
- Accommodate current, complex, and future healthcare needs

ICD-10 Begins October 1, 2014

ASHA has developed:
- An online mapping tool for ICD-9 to ICD-10 codes
- Enter the ICD-9 code and a list of the corresponding ICD-10 codes is generated
- A list of ICD-10 codes, much like the current ICD-9 list on the ASHA website
- Both products are FREE and tailored for speech-language pathology and audiology
- Will be made available in summer or fall of 2013

ICD-10-CM Resources

- ASHA Website: www.asha.org/Practice/reimbursement/coding/ICD10/
- National Center for Health Statistics Website: www.cdc.gov/nchs/icd/icd10cm.htm
- Centers for Medicare & Medicaid Services Website: www.cms.gov/ICD10/

4 New SLP Evaluation CPT Codes for 2014 Will Replace CPT 92506

1. Evaluation of speech fluency (e.g., stuttering, cluttering)
2. Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
3. Evaluation of speech sound production with evaluation of language comprehension and expression (e.g., receptive and expressive language)
4. Behavioral and qualitative analysis of voice and resonance

Medicare Improvement Standard Eliminated

- Expansion of Medicare coverage effective January 2014
- Jan 24, 2013 – Federal judge ruled
  - CMS must allow coverage of therapy services that prevent deterioration
  - Therapy services must require skilled care
  - Coverage not dependent on potential for improvement
  - Outpatient services, Inpatient rehab, SNF, home health
- ASHA preparing clinical examples for CMS that differentiate skilled from unskilled services

Mandatory Claims Submission

- If an SLP or audiologist furnishes a Medicare-covered service to a beneficiary, then they must be enrolled as Medicare provider and are required to submit a claim on the beneficiary’s behalf unless the patient, of their own free will, requests in writing that their claim not be submitted
- If a university clinic offers services that meet Medicare coverage guidelines, but the clinic will not be able to enroll as a Medicare provider (for whatever reason), then Medicare beneficiaries should not be served for “medically necessary” therapy services unless the patient, of their own free will, requests in writing that their claim not be submitted
The patient or client may change their mind at any time and request that the service provider file the claim with Medicare. If the patient or client wants claims to be submitted to Medicare, then it requires the provider to enroll Medicare.

Refusal to submit billing and asking the patient to sign an Advance Beneficiary Notice of Noncoverage (ABN) is not acceptable. Medicare “opt out” allows the practitioner to enter into a private contract with the patient without enrolling as a Medicare provider; HOWEVER, there is no “opt out” privilege for audiologists or speech-language pathologists. “Opt out” only applies to physicians and certain other practitioners.

An ABN establishes patient liability for payment for services that do not meet Medicare coverage criteria, and must be signed by the patient prior to providing the service in order to collect payment.

An ABN is required when a service is determined to be “not medically necessary” or does not meet a Medicare requirement (e.g., physician referral) but could be covered under other circumstances.

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e., care that is never covered) or fails to meet a technical benefit requirement (i.e., lacks required certification). However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as hearing aids and related services.

A. Initiations
   - An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment. This will be for non-covered services.

B. Reductions
   - A reduction occurs when there is a decrease in a component of care (i.e., frequency, duration).

C. Terminations
   - Termination is the discontinuation of certain items or services.
Frequently Asked Questions about Medicare and University Clinics

QUESTION #1

If a university clinic does not currently bill private insurance, Medicaid, or Medicare, can it continue to bill patients privately and not bill Medicare?

Answer to Question #1

- If the university does not wish to enroll in Medicare, it is suggested that those who qualify for Medicare benefits should be refused treatment and referred to other practitioners in the community.
- Enrollment would also not be required if all Medicare patients voluntarily request that Medicare claims not be submitted.
- Unless the clinic is a free clinic (i.e., never charge for services).
- SLPs may only test and treat and audiologists may only test Medicare beneficiaries if they are enrolled as Medicare providers.

QUESTION #2

What if the Medicare beneficiary instructs the provider NOT to submit a claim to Medicare and offers to pay out-of-pocket?
ANSWER to Question #2

- If a beneficiary, of their own free will, instructs a practitioner to not submit a claim to Medicare, the practitioner may treat the patient outside of Medicare.
- An ABN must be completed and signed by the beneficiary.
- However, there are two significant complications:
  - All beneficiaries must make this demand truly of their own free will.
  - A beneficiary is free to change his or her decision at any time and request that a claim be submitted to Medicare for current and/or past services.
- If the beneficiary includes dates of service in the signed agreement, they cannot change their decision during the time period specified in the agreement.

QUESTION #3

- May a university clinic bill a client privately if that person is a Medicare beneficiary who has exhausted Medicare funds?

Answer to QUESTION #3 - Audiology

- Medicare benefits are never exhausted for audiology services as long as "medically necessary” diagnostics are required for patient treatment.
- The rule of thumb is that the clinic should treat everyone the same with regard to providing services and charging for audiology services because of the "no opt out” provision for Medicare.

Speech-Language Pathology

- Short answer is “no”
- Regarding "exhausted Medicare funds," the annual therapy cap (combined SLP/PT services) has been largely circumvented by Congress by the “exceptions process” that allows coverage as long as documentation in the medical record clearly shows medically/functionally necessary services.
  - 2013 combined therapy cap for SLP and PT services is $1,900
  - Exceeding the cap does not automatically exclude speech-language services from Medicare coverage because of the exceptions process that allows coverage of medically necessary services beyond the cap.

QUESTION #4

- When can a Medicare patient be billed directly for services?

ANSWER to Question #4

- Services may be billed directly to Medicare recipient if:
  - Service is Statutorily Excluded
  - Denied for Reasons of Medical Necessity
  - Beneficiary requests that Medicare not be billed and an ABN is completed
ANSWER to Question #4
2 Parts

Statutorily Excluded
- The patient can be billed for services that are statutorily excluded from Medicare.
- This might include services such as hearing aid services or services from nonlicensed practitioners which might include unsupervised SLP students.
- In these circumstances it is not required to furnish an ABN.
- It will not be necessary to first bill the Medicare program unless a patient needs a denial for reasons of secondary insurance.

Denied for Reasons of Medical Necessity
- When services are rendered that are expected to be denied for reasons of medical necessity, the patient can only be billed if an ABN is provided to the beneficiary.
- This would include circumstances where the patient is not making any meaningful progress.
- When an ABN is provided, the patient is given the option of deciding whether he/she wants a claim to be submitted to Medicare.
- However, if an ABN is not provided in advance of the rendition of services and the claim is denied for reasons of medical necessity, the patient cannot be subsequently billed.

ANSWER to Question #5
2 Parts

No specific type of notice is required
- A sign may be posted informing clients that SLP or audiology services are not provided to Medicare beneficiaries in the clinic due to Medicare billing and coverage requirements.

ANSWER to Question #6
2 Parts

Do university clinics need to follow the Medicare student supervision rule (i.e., supervisor in the room all of the time and not engaged in other activities) if they provide a 100% discount to all Medicare beneficiaries?
- Same type of question – Can a university clinic waive all fees for Medicare and Medicaid clients (do not charge anyone 65 or older for services), but charge others for services?
- If all clients (not just Medicare clients) are seen free, the clinic need not enroll in Medicare and thus need not follow the supervision rules.
- Giving a 100% discount or not charging for anyone over the age of 65 is a practice that is discriminatory. This means private payers are subsidizing Medicare/Medicaid.
 QUESTION #7

Do private insurance companies follow Medicare regulations?

ANSWER to question #7

Private health plans selectively adopt Medicare coverage policies. All private plans require that services be rendered by a qualified health care practitioner. Rarely do they describe student involvement.

It is wise to inform the third party payer of the degree of supervision of students. This will prevent a future audit that could demand thousands of dollars in repayment.

 QUESTION #8

May a university clinic provide services to Medicaid recipients and not to Medicare beneficiaries?

ANSWER to question #8

Yes, if the clinic meets the state Medicaid supervision requirements but not the Medicare supervision requirements. Serving Medicaid clients does not obligate the provider to serve Medicare.

 QUESTION #9

Can a university clinic use a sliding scale of payment for Medicare beneficiaries who agree to pay privately b/c the clinic does not meet the statutory requirement for supervision?

ANSWER to question #9

Yes, as long as the Medicare client is informed and has given written consent and the qualifications for the sliding scale fee is the same for all clients.
QUESTION #10

- When Medicare beneficiaries have signed a waiver (statutorily excluded or medically necessary excluded) and agreed to pay fee-for-service, may I charge them the same as all of our private pay clients?

ANSWER to question #10

- Even when a Medicare beneficiary has signed an agreement of his own free will that the claim will not be submitted to Medicare, the service provider may not collect more than the Medicare rate for the procedure if the procedure is a covered service under Medicare.

Evolution of Academic and Clinical Preparation

- Value-Based Purchasing
  - Based on Medicare vision of “the right care for every person, every time”
  - Aligns payment to efficiency and quality of care delivery
  - Rewards providers for measured performance (read: outcomes)
  - Promotes evidence-based medicine
  - Requires clinical and financial accountability across all settings
  - Focus on episodes of care
  - Better coordination of care
  - Payment based on outcomes, not number of sessions (performance-based payment)
  - Focus on effectiveness of treatment

Increased Clinical Accountability

- How do we know, and how do we show, that what we do in therapy makes a difference? (R. Douglass, 1983)
- CMS is calling for increased professional self-scrutiny
  - Evidence-based practice → comparative-effectiveness research
  - Recovery audit contractor (RAC) and other Medicare & Medicaid auditing programs
  - Auditing by commercial payers
  - Payment systems based on outcomes, not fee-for-service

A Change in Perspective

- Patient centered care
  - Includes what patient wants / needs
  - Incorporates patient’s goals
  - Focuses on functional benefit to the patient for activities of life
- Measure and value outcomes
- Consistently use best practices
SLPs need to be successful in showing value of services as rules change

A move from “we want more visits” to “we can show you how the patient will function better”

Speech-language pathologists and audiologists will be paid for managing outcomes (value-based purchasing) not volume of visits or number of sessions or number of tests.

Think…… VALUE NOT VOLUME

Think……. How am I improving his/her life?

Speech-language pathologists and audiologists who provide service in the most efficient manner and obtain the best outcomes for the people they serve will thrive under this model!

International Classification of Functioning, Disability and Health (ICF)

Describes body functions, body structures, activities, and participation

Useful for understanding and measuring outcomes

ASHA has information available online

Combined Effects on the Professions

Determine cost of service delivery

Carefully evaluate each procedure being performed (e.g., develop a clinical question and determine what tools are necessary; stay away from graduate school protocols)

Be prepared mentally for ongoing changes …

Graduate training should include:

- Reimbursement models
- Hair cell regeneration, vestibular prostheses, cell and gene therapy, biotechnology
- Using outcome measures that evaluate the impact of HL on quality of life and communication functioning
- Outcome measures to evaluate impact of intervention and demonstrate value
- Create academic training models focused on preferred practice patterns
Effect on Graduate School Training

- Move away from procedure-based training and toward clinical question, patient-centered based training
- Not to de-emphasize procedures as important, but increase the understanding of WHY a procedure is done rather than automatic inclusion
- Learn how to take a case history directed toward development of a clinical question
- Select test procedures based on that clinical question and stop when question is answered
- Each test selected on the basis of history or outcome of an earlier test
- Create independent thinking rather than graduate school protocols

Value of Health Care

“Value of Health Care”

“We practice according to how we are paid”

Peter Hollmann, MD
Chair, AMA CPT Editorial Panel
October 2011

Margaret Rogers, Ph.D.
Chief Staff Officer for Science & Research
American Speech-Language-Hearing Association

Disclosures:
- Employed by ASHA (since 2007)
- University of Washington (1992-2007)
- Serve on advisory boards and technical expert panels related to measurement and payment systems in health care with agencies such as CMS, MedPAC, RTI, NIH, NIDRR, PCORI, & VARRD

Outcomes Measurement & Learning Health Care Systems

1. Why is measurement central to the changing landscape in health care?
2. What types of measures are needed and for what purposes?
3. How can measurement improve quality and value in health care?
Why is Measurement Central to the Changing Landscape in Health Care?

Health care spending continues to grow more rapidly than inflation and population growth, despite initiatives implemented to curb this growth.

- Health Maintenance Organizations
- Preferred Provider Organizations
- Prospective Payment

Transformation of the infrastructure currently supporting health care in the U.S. is necessary to develop new payment systems that can sustain affordable & accessible high quality health care.

U.S. Highest in Cost & Lowest in Quality

Waste, Fraud, & Abuse

- IOM (2012) reported that $765 billion wasted annually on:
  - provision of unnecessary services
  - inefficiently delivered services
  - excessive prices and administrative costs
  - missed prevention opportunities
  - fraud and abuse

- Former CMS Administrator, Donald Berwick and Andrew Hackbarth (RAND, 2012) estimated that fraud and abuse added as much as $98 billion to Medicare and Medicaid spending in 2011.

STEEP Aims

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient-Centered

Why is Measurement at the Center of Health Reform?

- Faced with the alarming implications of health care spending growth and suboptimal quality, many nations are turning to market-based reforms, in U.S. - Value-based Purchasing
- The rationale behind market-based approaches is age-old – Competition boosts quality & innovation, and lowers costs
- But in health care, this logic hasn’t held, and largely because we do a terrible job of measuring and disclosing the results especially on the things patients care about and notice - their survival, quality of life, complications after care, and accessible and affordable health care.

“The universal development and reporting of outcomes is the single highest priority to improve the performance of the health care system.”

From Redefining Health Care, Michael E. Porter, 2006
Chair, Harvard Business School

Why Measure?

Quality Improvement & Standardization
- What works best for whom & under what circumstances?
- Which procedures and care pathways yield the best results for which patients most efficiently?

Public Reporting
- Which provider should one chose?
- Which providers do care delivery organizations want to engage?

Regulation and Monitoring
- How can waste & fraud be minimized most cost-effectively?

Valuation, Reimbursement & Accountability
- How much is the service worth?
- What outcomes can be expected as a result of the service?

Value Defined

Value = Outcomes/Total Costs

“Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent.”

What Is Value in Health Care: Michael E. Porter, Ph.D.
Value, Not Volume

- “The creation of value for patients should determine the rewards for all other actors in the system.”
- “Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge.”


Predictive Modeling Based on Large-Scale Datasets

- Payment systems built on predictive modeling need to be founded on large-scale datasets to:
  - Predict the rehabilitation potential of individual patients (based on historical data from similar patients)
  - Indicate which approach to intervention is likely to be most effective for a given type of patient in a given circumstance
  - Predict the resources that will be required to achieve pre-specified rehabilitation goals

Four Data Elements Required for Estimating Value, Predicting Outcomes & Learning

Case-Mix Risk Adjustment

- Case-mix adjustment - adjustments made on the basis of the characteristics of those receiving services, is crucial in reimbursement for health services, especially in any prospective reimbursement model.
- Equitable and effective reimbursement models must take such differences into account.

NOMS: Case-Mix Data

- Collected
  - Age
  - Race/ethnicity
  - Gender
  - Primary language
  - Medical diagnosis
  - SLP diagnosis
  - Co-morbidities
  - Severity
  - Facility
  - Clinician
- Not Collected
  - SES
  - Educational attainment
  - Motivation/self-actualization
  - Family support
  - Community support

NOMS Patient Characteristics

Primary Medical Diagnosis

SLP Diagnosis
Complexity: Number of Domains

- Speech: 24%
- Cognition: 9%
- Swallowing: 39%
- Speech & Cognition: 12%
- Speech & Swallowing: 9%
- Cognition & Swallowing: 3%
- Everything: 4%

Case-Mix Factors that Predict the Amount of SLP Treatment

- Severity: 0.21
- Complexity: 0.17
- SLP dx: 0.11

Data on patients’ Severity, Complexity, and SLP diagnosis are important case-mix factors for predicting utilization of SLP treatment.

Coding Assessment & Intervention Services

<table>
<thead>
<tr>
<th>Case-Mix</th>
<th>Services</th>
<th>Outcomes</th>
<th>Resource Utilization</th>
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“The lack of treatment specifications is the most glaring omission in research on rehabilitation outcomes. The unspoken assumption has been that treatment programs for the same condition are fairly standard, but research on practice patterns has shown that such assumptions are unwarranted... lack of identification of the components of treatment has meant that we do not know which procedures in rehabilitation are essential to produce improvement.”

With a Typology or Taxonomy of Assessment & Treatment Services...

- Advance our understanding of what works best for whom
- Design, implement and evaluate new & extant treatment programs
- Educate students and other professionals about our practices
- Communicate explicit information concerning treatment procedures to consumers and payers
- Conducting systematic reviews & meta-analyses of treatment effects
- Accelerate clinical practice research

“Standardize then Customize”

- Can the intervention be clearly described?
- Can the intervention be faithfully implemented in clinical environments?
- What does the intervention target?
- With whom does the intervention work?
- Is the intervention effective in the clinical setting in which it is being implemented?
- Are there explicit and measurable outcomes associated with the intervention?

Outcomes Measurement

“Speech-language pathology and other disciplines are advancing knowledge concerning what works best for whom and under what circumstances, but no discipline will be able to satisfactorily address this multifaceted question without large-scale data collection efforts that amass information across each of these critical data elements in a centralized repository so that adequately powered analyses can be conducted to examine the effects that case-mix and service delivery factors have on patient outcomes.”

Outcomes are Multidimensional & Condition-Specific

Health Status
- Special Needs
- Impairment
- Conditions
- Complications
- Medications
- Functional Status
- Communication
- Feeding
- Swallowing
- Participation
- Work
- Engagement in Life Roles & Responsibilities

ASHA’s National Outcomes Measurement System (NOMS)

- Data are collected by specially trained and calibrated SLPs
- Upon the completion of the first treatment session, SLP fills out an Admission Form (~3 minutes)
  - Contains demographics, diagnostics, and level of functional communication and or swallowing
- Upon the patient’s discharge from SLP services, SLP fills out a Discharge Form (~2 minutes)
  - Contains characteristics of service delivery, and level of functional communication and or swallowing
- Outcomes measurement
  - Functional Communication Measures (FCMs)
  - 15 disorder-specific seven-point scales
  - SLP scores only those related to the patient’s treatment plan

Functional Communication Measures (FCM)

- Attention
- Fluency
- Memory
- Motor Speech
- Problem Solving
- Reading
- Spoken Language Expression
- Voice
- Spoken Language Comprehension
- Writing
- Alaryngeal Communication
- Swallowing
- Voice Following Tracheostomy
- Pragmatics
- Augmentative-Alternative Communication

LEVEL 1: The individual is unable to use voice to communicate. Alternative means for communicating are used all of the time. The individual cannot participate in vocational, avocational, and social activities requiring voice.

LEVEL 2: Voice is not functional for communication most of the time. Alternative means for communicating must be used most of the time. The individual’s participation in vocational, avocational, and social activities is significantly limited all of the time.

LEVEL 3: Voice is functional for communication, but is consistently distracting and interferes with communication by drawing attention to itself. Participation in vocational, avocational, and social activities is limited most of the time.

LEVEL 4: Voice is functional for communication, but sometimes distracting. The individual’s ability to participate in vocational, avocational, and social activities requiring voice is occasionally affected in low-vocal demand activities, but consistently affected in high-vocal demand activities.

LEVEL 5: Voice occasionally sounds normal with self-monitoring, but there is some situational variation. The individual’s ability to participate in vocational, avocational, and social activities requiring voice is rarely affected in low-vocal demand activities, but is occasionally affected in high-vocal demand activities.

LEVEL 6: Voice sounds normal most of the time across all settings and situations. Self-monitoring is consistent when needed. The individual’s ability to participate in vocational, avocational, and social activities requiring voice is not affected in low-vocal demand activities, but is rarely affected in high-vocal demand activities.

LEVEL 7: Normal…

International Classification of Functioning, Disability, & Health (ICF)

Impairment of Body Structures & Functions
- Speech, Language, Executive Functions, Voice

Activity Limitations
- Speaking, Understanding, Communicating

Participation Restrictions
- Engaging in Social Interaction, Employment

http://www.who.int/classifications/icf/en/

ICF Codes & Corresponding Functional Communication Measure (FCM)

Body Functions - ‘b’ codes

3. Voice and Speech
- b310 Voice functions (FCM: Voice)
- b320 Articulation functions (FCM: Motor Speech)
- b420 Fluency & rhythm of speech functions (FCM: Fluency)

5. Functions of the Digestive, Metabolic, & Endocrine Systems
- b510 Ingestion functions (FCM: Swallowing)
Activities and Participation - ‘d’ codes

1. Learning and Applying Knowledge
   - d160 Focusing attention (FCM: Attention)
   - d166 Reading (FCM: Reading)
   - d170 Writing (FCM: Writing)
   - d175 Solving problems (FCM: Problem Solving)

2. General tasks and demands
   - d220 Undertaking multiple tasks (FCM: Problem Solving, Memory)
   - d230 Carrying out daily routine (FCMs: Problem Solving, Memory)

3. Communication
   - d310 Communicating with—receiving—spoken messages (FCM: Spoken Language Comprehension)
   - d325 Communicating with—receiving—written messages (FCM: Reading)
   - d330 Speaking (FCM: Spoken Language Expression)
   - d345 Writing message (FCM: Writing)
   - d350 Conversation (FCMs: Spoken Language Expression and Comprehension, Pragmatics)
   - d360 Using communication devices and techniques (FCM: Augmentative and Alternative Communication)

7. Interpersonal Interactions and Relationships
   - d720 Complex interpersonal relationships (FCM: Pragmatics)

Contextual Factors

Environmental Factors
- Societal Attitudes & Beliefs
- Family Attitudes & Beliefs
- Care Giver Support
- Community Support
- Gov’t Policies
- Health Care Economics
- Facility Specific Factors

Personal Factors
- Case Mix Data
- Demographic Data
- Co-morbidities
- Genetic Information
- Motivational Factors
- Self-Efficacy
- Life Stage

Outcomes Across the ICF

Impairment
- Laryngeal Imaging
- Motor Speech Exam
- Boston Naming Test
- Western Aphasia Battery

Activity
- Communication Effectiveness Index
- Functional Linguistic Communication Inventory
- Communication Activities of Daily Living-2
- ASHA’s National Outcomes Measurement System
- ASHA’s Functional Assessment of Communication Skills for Adults

Participation
- ASHA Quality of Communication Life Scale
- Code-Müller Protocols
- EAT-10
- Aphasia Communication Outcome Measure

The Experience of Disability

Health Condition (disorder / disease)

Body Functions & Structures → Activities → Participation

Environmental Factors

Patient-Reported Outcomes: Activity

How much DIFFICULTY do you currently have...
- telling someone about yourself in an emergency?
- making yourself understood during ordinary conversation?
- telling others your basic needs?
- answering yes/no questions about basic needs?
- reading instructions with several steps?

Unable | A lot of Difficulty | A little Difficulty | No Difficulty

Patient-Reported Outcomes: Participation

Even with help & services, how much are you limited in...
- getting groceries and other things for the home?
- going to movies, plays, sporting events, etc?

Think about how you currently get together with others, like going out or visiting with family and friends. Which one of the following best describes you?
- I do not have difficulty doing things socially with others.
- Even though it is hard, I keep doing things with people as usual.
- I no longer can do as much or the same kind of things with others.
- I hardly ever do the types of things I used to do, or hardly ever get together with others.
- I do not see family or friends, and I only see those who take care of me.
- I don’t know/Unknown
Hypothetical “Report Card” of Patient Satisfaction with Key Quality Indices

Overall Therapy Services Appointment Availability Progress Toward Goal Participation in Life Burden of Disability Complications & Adverse Events

National & International Outcomes Initiatives

International Consortium for Health Outcomes Measurement

The ICHOM Repository – a global resource of outcome measures and risk-adjustment factors by medical condition, compiled from the world’s leading quality registries

The Registry Compass – a profiling tool to guide registry development, by identifying and disseminating global best practices

ICHOM Communities – online platforms where experts exchange and discuss

ICHOM Courses – a series of courses focusing on outcomes measurement (to be offered in 2013)

Rehabilitation Measures Database

- Developed to help identify reliable and valid outcomes instruments
- Database provides evidence-based summaries that include concise descriptions of each instrument’s psychometric properties and instructions for administering and scoring.
- Either a copy of the instrument is available to download or information about obtaining the instrument is provided.

Center for Rehabilitation Outcomes Research, Rehabilitation Institute of Chicago
http://www.rehabmeasures.org/default.aspx

Patient-Centered Outcomes Research Institute

- Authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions.
- Supports the engagement and meaningful inclusion of patients at every step of the research process.
- Focuses on individual’s preferences and needs, and on outcomes that people care about such as survival, function, symptoms, & health related quality of life.

Patient Reported Outcomes Measurement Information System (PROMIS), funded by the National Institutes of Health (NIH), is a system of assessment tools that measure patient-reported health status for:
- physical
- mental
- social well-being
How can measurement improve quality and value in health care?

Learning Systems

“We seek the development of a learning healthcare system designed to generate and apply the best evidence for the collaborative health care choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; to ensure innovation, quality, safety, and value in health care.”

“By 2020, 90% of clinical decisions will be supported by accurate, timely, and up-to-date clinical information and will reflect the best available evidence and informed personal preference.”

Learning Systems

What works best for whom in which circumstances?
- Case-Mix Factors (Person Factors, Condition, Comorbidities)
- Service Delivery Factors (Assessment, Treatment, ICF, Dosage)
- Outcomes (Practitioner or Patient-Reported)

What is the value of a given service?
- Resource Utilization
- Direct Costs
- Longterm, indirect costs to individual, insurer, society

Transparency = Public Reporting

- Outcomes data and other quality metrics must be transparent to impact quality and support patient choice
- The push for transparency may be “the single most important step we can take to set health systems on a sustainable path.” (Porter, Larson, & Ingvar, 2012)
- Competition cannot unleash innovation, lower costs, or boost quality unless data are publicly reported so that the outcomes of care are transparent and available to be used to inform choice and to guide clinical decision-making.

Learning Health Care Systems

- Reduced unwarranted practice variation
- Reduced waste
- Continuous quality improvement
- Improved outcomes
- Improved health care value

Questions?