August 22, 2013

Re: Reimbursement for the CPT code 92611

The letter is being submitted in response to the concerns of many healthcare professionals, regarding the reduction in reimbursement for the CPT code 92611, over the past 9 years. There are several practices in the United States that provide specialized services for dysphagia and evaluate this disorder with the procedure of a Modified Barium Swallow Study (92611), particularly in the setting of a mobile medical clinic.. According to the US Bureau of Labor Statistics, there were 123,200 speech pathologists employed in 2010. According to the estimates of the American Speech and hearing Association (ASHA) there are 280,000 SLPs world-wide, 68% are in North, South and Central America, 135,000 are in the US, 60,000 are in the EU, and 35,000 are in Brazil.  Speech Pathologists have been treating and managing oral feeding in children with Cerebral Palsy since the 1930s, the focus on swallowing disorders increased exponentially in the 1970s with published articles on clinical and bedside assessment and management and, subsequently, on the use of instrumental assessment procedures such as videofluoroscopy/Modified Barium Swallow Study (MBSS).

The MBSS is a radiological instrumental evaluation that incorporates a set of modifications in bolus size, texture, positioning, and radiographic focus to facilitate optimal visualization of the oral (mouth), pharyngeal-laryngeal (throat) structure and their function during the swallow. The MBS has been shown to be more accurate than a bedside swallow evaluation (BSE) in identifying if aspiration is occurring and the cause of aspiration. In addition, the MBSS can prevent unneeded trial and error treatment (Logemann et.al. 1998, Martin-Harris et. al, 1998) and can provide clinically useful information (Martin-Harris, Logemann, 2000).

Dysphagia - can be defined as a disorder of swallowing. Dysphagia can exist at any or all three stages of a swallow: oral (mouth), pharyngeal (throat), and/or esophageal (tube leading to the stomach). The procedure requires special training by the Speech Pathologist conducting the radiological examination and also the presence of a medical doctor with background training and education in Radiology. The procedure can take up to 45-80 minutes depending on the complexity of the disorder and medical condition of the patient, and this time includes pre-testing protocols, the procedure itself, and post testing protocol including interpretation, documentation and education.

This examination is necessary to assess each individual with a comprehensive examination to provide the patient with recommendations for increased safety while eating and appropriate nutritional intake for general health and healing. Swallowing and feeding disorders occur with multiple medical diagnoses across the age spectrum from premature infants to geriatric adults. Incidence and prevalence vary among diagnostic groups. Morbidity related to dysphagia can be a major concern. The mortality statistics from dysphagia-related causes are staggering: approximately 60,000 people annually die from complications or consequences of swallowing disorders. This represents more deaths than from liver disease, kidney disease, and HIV-AIDS combined, based on Centers for Disease Control (CDC) data. What’s more, the number of deaths that can be directly or indirectly attributed to swallowing disorders is nearly equal to the number of deaths due to diabetes – the sixth leading cause of death in the U.S. – according to the CDC.

The cost to treat dysphagia resulting in pneumonia is estimated to exceed $3 billion each year in the USA alone. One hundred and fifty thousand (150,000) nursing home patients require hospitalization for pneumonia each year. *Comprehensive management of Swallowing Disorders, Epideminiology of Swallowing Disorders, Murray, Thomas, Carrau, Richardo, Eibling, David, Chapter 1 , pg 4. Plural Publishing, 2006.*

The purposes of the instrumental examination are to enable the speech-language pathologist to:

* Visualize the structures of the upper airway and digestive tract, including the oral cavity, velopharyngeal port, pharynx, larynx, and esophagus.
* Assess the physiologic functioning of the muscles and structures involved in swallowing and to make observations, measures and inferences of symmetry, sensation, strength, pressures, tone, range, rate of motion, and coordination or timing of movement.
* Assess coordination and effectiveness of lingual, velopharyngeal, pharyngeal, and laryngeal movement during swallowing.
* Determine presence, cause, severity, and timing of aspiration by visualizing bolus control, flow and timing, and the response to bolus misdirection.
* Visualize the presence, location, and amount of secretions in the hypopharynx and larynx, the patient's sensitivity to the secretions and the ability of spontaneous or facilitated efforts to clear the secretions.
* Screen esophageal anatomy and function for evidence of dysphagia.
* Assist in determining the safest and most efficient route (oral vs. nonoral) of nutrition and hydration intake.
* Determine with specificity the relative safety and efficiency of various bolus consistencies and volumes.
* Determine the rate or method of oral intake delivery (i.e., selection of utensils, bolus placement, bolus modifications).
* Determine the postures, positioning, maneuvers, and/or other management/treatment techniques that enhance the safety and efficiency of feeding.

Since 2004 the 92611 CPT code has dropped nearly 40% from approximately $139.75 to $88.06. This instrumental examination/procedure requires specialization in training with the presence of 2 state licensed healthcare professionals with additional training in Radiology, this includes a speech pathologist and physician.. This procedure is necessary for appropriate diagnosis in the care of patients who suffer from dysphagia, and therefore the value of the code does not reflect the relative value of the procedure and higher level of requirements compared to other instrumental procedures.

The Indications for an Instrumental Examination established by the national organization ASHA are as follows:

1. An instrumental examination *is indicated* for making the diagnosis and/or planning effective management and treatment in patients with suspected, or who are at high risk for, oropharyngeal dysphagia based on the clinical examination when:
   * The patient's signs and symptoms are inconsistent with findings on the clinical examination. ([Baker et al., 1991](http://www.asha.org/policy/GL2000-00047/" \l "r11); Frederick et al., 1995; [Lindgren & Ekberg, 1988](http://www.asha.org/policy/GL2000-00047/" \l "r77)).
   * There is a need to confirm a suspected medical diagnosis and/or assist in the determination of a differential medical diagnosis. ([Buchholz, 1993](http://www.asha.org/policy/GL2000-00047/" \l "r15), [1994](http://www.asha.org/policy/GL2000-00047/" \l "r16), [1995](http://www.asha.org/policy/GL2000-00047/" \l "r17); [Celifarco et al., 1990](http://www.asha.org/policy/GL2000-00047/#r21); [Ekberg et al., 1986](http://www.asha.org/policy/GL2000-00047/#r33); [Ekberg et al., 1989](http://www.asha.org/policy/GL2000-00047/" \l "r34); [Gregory et al., 1992](http://www.asha.org/policy/GL2000-00047/" \l "r42); [Hayashi et al., 1997](http://www.asha.org/policy/GL2000-00047/" \l "r46); [Hogue et al., 1995](http://www.asha.org/policy/GL2000-00047/" \l "r49); [Khan & Campbell, 1994](http://www.asha.org/policy/GL2000-00047/" \l "r60); [Kluin et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r65); [Nilsson et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r100); [Papadopoulos et al., 1989](http://www.asha.org/policy/GL2000-00047/" \l "r104); [Putnam et al., 1992](http://www.asha.org/policy/GL2000-00047/#r110); [Riminton et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r113); [Shapiro et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r122), [1997](http://www.asha.org/policy/GL2000-00047/" \l "r123); [Silbergleit et al., 1991](http://www.asha.org/policy/GL2000-00047/" \l "r125); [Sliwa & Lis, 1993](http://www.asha.org/policy/GL2000-00047/" \l "r126); [Sonies & Dalakas, 1991](http://www.asha.org/policy/GL2000-00047/" \l "r128); [Watanabe et al., 1984](http://www.asha.org/policy/GL2000-00047/" \l "r139)).
   * Confirmation and/or differential diagnosis of the dysphagia is needed. ([Ali et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r2); [Aviv et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r8); [Bazemore et al., 1991](http://www.asha.org/policy/GL2000-00047/" \l "r13); [Celifarco et al., 1990](http://www.asha.org/policy/GL2000-00047/" \l "r21); [Coelho, 1987](http://www.asha.org/policy/GL2000-00047/" \l "r24); [DiVito, 1998](http://www.asha.org/policy/GL2000-00047/" \l "r31); [Horner et al., 1992](http://www.asha.org/policy/GL2000-00047/" \l "r54); [Jennings et al., 1992](http://www.asha.org/policy/GL2000-00047/" \l "r55); [Jones et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r56); [Kagel & Leopold, 1992](http://www.asha.org/policy/GL2000-00047/#r57); [Lazarus et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r73); [Lazarus & Logemann, 1987](http://www.asha.org/policy/GL2000-00047/" \l "r69); [Leopold & Kagel, 1996](http://www.asha.org/policy/GL2000-00047/" \l "r79); [Litvan et al., 1997](http://www.asha.org/policy/GL2000-00047/#r78); [Logemann et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r83), [1994](http://www.asha.org/policy/GL2000-00047/#r84); [Martin et al., 1997](http://www.asha.org/policy/GL2000-00047/" \l "r90); [Mirrett et al., 1994](http://www.asha.org/policy/GL2000-00047/#r94); [Newton et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r99); [Nilsson et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r101); [Pauloski, 1995](http://www.asha.org/policy/GL2000-00047/" \l "r106); [Plaxico & Loughlin, 1981](http://www.asha.org/policy/GL2000-00047/" \l "r108); [Pollack et al., 1992](http://www.asha.org/policy/GL2000-00047/" \l "r109); [Putnam et al., 1992](http://www.asha.org/policy/GL2000-00047/" \l "r110); [Robbins et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r114); [Skinner & Shorter, 1992](http://www.asha.org/policy/GL2000-00047/" \l "r127); [Sonies, 1997](http://www.asha.org/policy/GL2000-00047/" \l "r131); [Veis & Logemann, 1985](http://www.asha.org/policy/GL2000-00047/" \l "r135); [Yang et al., 1997](http://www.asha.org/policy/GL2000-00047/" \l "r142); [Zerhouni et al., 1987](http://www.asha.org/policy/GL2000-00047/" \l "r143)).
   * There is either nutritional or pulmonary compromise and a question of whether the oropharyngeal dysphagia is contributing to these conditions. ([Aviv et al., 1997a](http://www.asha.org/policy/GL2000-00047/" \l "r9), [1997b](http://www.asha.org/policy/GL2000-00047/" \l "r10); [Granger & Craig, 1990](http://www.asha.org/policy/GL2000-00047/" \l "r39); [Holas et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r50); [Keller, 1993](http://www.asha.org/policy/GL2000-00047/" \l "r59); [Kidd et al., 1995](http://www.asha.org/policy/GL2000-00047/" \l "r62); [Johnson et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r64); [Langmore et al., 1998](http://www.asha.org/policy/GL2000-00047/#r66); [Martin et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r89); [Schmidt et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r120); [Sheppard et al., 1988](http://www.asha.org/policy/GL2000-00047/" \l "r124); [Taniguchi & Moyer, 1994](http://www.asha.org/policy/GL2000-00047/" \l "r134); [Veldee & Peth, 1992](http://www.asha.org/policy/GL2000-00047/" \l "r136); [Volicer et al., 1989](http://www.asha.org/policy/GL2000-00047/" \l "r137); [Woratyla et al., 1995](http://www.asha.org/policy/GL2000-00047/" \l "r141)).
   * The safety and efficiency of the swallow remains a concern. ([Arvedson et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r7); [Collins & Bakheit, 1997](http://www.asha.org/policy/GL2000-00047/" \l "r25); [Daniels et al., 1998](http://www.asha.org/policy/GL2000-00047/" \l "r28); [DePippo et al., 1992](http://www.asha.org/policy/GL2000-00047/" \l "r30); [Griggs et al., 1989](http://www.asha.org/policy/GL2000-00047/#r43); [Horner & Massey, 1988](http://www.asha.org/policy/GL2000-00047/" \l "r51); [Horner et al., 1990](http://www.asha.org/policy/GL2000-00047/" \l "r52), [1991](http://www.asha.org/policy/GL2000-00047/" \l "r53); [Kidd et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r61); [Linden & Siebens, 1983](http://www.asha.org/policy/GL2000-00047/" \l "r75); [Linden et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r76); [Morton et al., 1993](http://www.asha.org/policy/GL2000-00047/#r96), [1997](http://www.asha.org/policy/GL2000-00047/#r96); [Marie et al., 1997](http://www.asha.org/policy/GL2000-00047/" \l "r87); [Murray et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r98); [Rogers, 1993](http://www.asha.org/policy/GL2000-00047/#r115), [1994a](http://www.asha.org/policy/GL2000-00047/" \l "r115), [1994b](http://www.asha.org/policy/GL2000-00047/" \l "r116); [Splaingard et al., 1988](http://www.asha.org/policy/GL2000-00047/" \l "r132))
   * The patient is identified as a swallow rehabilitation candidate and specific information is needed to guide management and treatment.([Bisch et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r14); [Ekberg, 1986](http://www.asha.org/policy/GL2000-00047/" \l "r33); [Feinberg et al., 1992](http://www.asha.org/policy/GL2000-00047/" \l "r35); [Fujiu et al., 1995](http://www.asha.org/policy/GL2000-00047/" \l "r37); [Fujiu & Logemann, 1996](http://www.asha.org/policy/GL2000-00047/" \l "r38); [Griggs et al., 1989](http://www.asha.org/policy/GL2000-00047/" \l "r43); [Helfrich-Miller et al., 1986](http://www.asha.org/policy/GL2000-00047/" \l "r47); [Kahrilas et al., 1991](http://www.asha.org/policy/GL2000-00047/" \l "r58); [Larnet & Ekberg, 1995](http://www.asha.org/policy/GL2000-00047/" \l "r66); [Lazarra et al., 1986](http://www.asha.org/policy/GL2000-00047/" \l "r67); [Lazarus, 1993](http://www.asha.org/policy/GL2000-00047/" \l "r70); [Lazarus et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r71); [Logemann, 1994](http://www.asha.org/policy/GL2000-00047/" \l "r84); [Logemann & Kahrilas, 1990](http://www.asha.org/policy/GL2000-00047/" \l "r81); [Logemann et al., 1989](http://www.asha.org/policy/GL2000-00047/" \l "r80), [1995](http://www.asha.org/policy/GL2000-00047/" \l "r85); [Martin et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r88), [Mendelsohn & Martin, 1993](http://www.asha.org/policy/GL2000-00047/" \l "r93); [Mirrett et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r94); [Morton et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r96); [Omae et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r103); [Rasley et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r112); [Rosenbek et al., 1991](http://www.asha.org/policy/GL2000-00047/" \l "r118), [1996](http://www.asha.org/policy/GL2000-00047/" \l "r119); [Shanahan et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r121); [Welch et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r140)).
2. An instrumental examination *may be indicated* for making the diagnosis and/or planning effective treatment in patients with suspected dysphagia based on the clinical examination and the presence of one or more of the following:
   * The patient has a medical condition or diagnosis associated with a high risk for dysphagia, including but not limited to neurologic, pulmonary or cardiopulmonary, gastrointestinal problems; immune system compromise; surgery and/or radiotherapy to the head and neck; and craniofacial abnormalities. ([Gordon et al., 1987](http://www.asha.org/policy/GL2000-00047/" \l "r40); [Groher & Bukatman, 1986](http://www.asha.org/policy/GL2000-00047/" \l "r44); [Hartelius & Svensson, 1994](http://www.asha.org/policy/GL2000-00047/" \l "r45); [Kuhlemeier, 1994](http://www.asha.org/policy/GL2000-00047/" \l "r63)).
   * The patient has a previously diagnosed dysphagia and a change in swallow function is suspected. ([Barer, 1989](http://www.asha.org/policy/GL2000-00047/" \l "r12); [Crary, 1995](http://www.asha.org/policy/GL2000-00047/" \l "r26); [Lazarus et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r72); [McConnel et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r92); [Pauloski et al., 1994](http://www.asha.org/policy/GL2000-00047/" \l "r105); [Rademaker et al., 1993](http://www.asha.org/policy/GL2000-00047/" \l "r111); [Wade & Hewer, 1987](http://www.asha.org/policy/GL2000-00047/" \l "r138)).
   * The patient has a condition such as cognitive or communication deficits that preclude completion of a valid clinical examination.
   * The patient has a chronic degenerative disease or a disease with a known progression, or is in a stable or recovering condition for which oropharyngeal function may require further definition for management. ([Colice, 1992](http://www.asha.org/policy/GL2000-00047/" \l "r23); [Colice et al., 1989](http://www.asha.org/policy/GL2000-00047/" \l "r22); [de Larminat et al., 1995](http://www.asha.org/policy/GL2000-00047/" \l "r29); [Hillel et al., 1989](http://www.asha.org/policy/GL2000-00047/" \l "r48); [Kagel & Leopold, 1992](http://www.asha.org/policy/GL2000-00047/" \l "r57); [Litvan et al., 1997](http://www.asha.org/policy/GL2000-00047/" \l "r78); [Morton et al., 1997](http://www.asha.org/policy/GL2000-00047/" \l "r97); [Strand et al., 1996](http://www.asha.org/policy/GL2000-00047/" \l "r133); [Sonies & Dalakas, 1995](http://www.asha.org/policy/GL2000-00047/" \l "r130)).

We believe existing data supports the following conclusions:

1. The declining reimbursement for the 92611 has devalued the procedure and the healthcare professionals trained to conduct the exam.
2. Lack of reimbursements costs have limited companies from being able to provide staff to conduct the MBSS, due to budget constraints and the valued cost of the licensed professional and additional training.
3. Growing number of aging population and increased need for proper evaluation of dysphagia to reduce overall cost of medical diagnosis such as pneumonia.
4. Service that is usually performed on an inpatient basis are now being performed more on an outpatient basis due to reduced stays and this increases the need for outpatient availability, including mobile units.
5. The Modified Barium Swallow Study is the gold standard for evaluating dysphagia and is more widely used across the USA, for accurate diagnosis.
6. The Modified Barium Swallow Study provides the most information for accurate diagnosis and treatment planning than any other instrumental assessment, including FEES
7. A patient needing an MBSS from home care or long term care facility requires transportation to a facility that can conduct this procedure and staff must be available to accompany them. Cost of transportation can range from $15.00 to $17.00 per mile to the nearest hospital location.
8. The Modified Barium Swallow Study requires training and education and is performed by a specialized group of therapists who treat dysphagia. Whether it be with the geriatric population or the pediatric population. CMS states in Chapter 15 of the Medicare manual on dysphagia services state that practioners who perform dysphagia services are expected to have specific competencies in upper aerodigestive tract structure and function as well as oral, pharyngeal, laryngeal, and respiratory function.
9. The Modified Barium Swallow Study is performed over 30,000 a year in the USA
10. MBSS code is bundled with a physician Radiology code, as it is required by CMS that a physician have personal supervision of this exam, unlike other instrumental assessments receiving a higher reimbursement level for the evaluation of dysphagia.

We would like the 92611 CPT code to be reviewed in value considering the complexity, the higher level of training and staff required, radiological component, and the medical necessity for those suffering from dysphagia which leads to additional complex medical conditions.