2025-0125-QC

SLP DOCUMENTATION GUIDE

	COMPONENTS TO INCLUDE	EXAMPLE
HISTORY OF PRESENT ILLNESS (HPI)	What is the functional decline? When did the decline start? Why did the decline occur (the cause)? The cause of decline needs to be within the past 3 months (if greater, then need to account for why the delay and why therapy is still indicated). Ask yourself, "Why therapy now?"	Patient was referred to SLP due to change in functional performance of: cognition resulting in decreased safety awareness, significant deficits in ADLs, and decreased personal hygiene. Patient's OT referred patient secondary to decreased ability to recall strategies implemented by OT and decreased performance with ADLs as a result, beginning 1/4/21 due to suspected exacerbation of dementia.
SOCIAL HISTORY (ENVIRONMENTAL FACTORS)	Does the patient reside in an SLC? Does the patient live at home? What type, if any, of assistance does the patient have (i.e., family, caregiver aid, meds, finances, etc.)? Does the patient attend an ADC? Times/week?	Patient lives in a memory care unit with a roommate. Professional caregiver assistance available 7 days/week for 24 hours/day, by SLC staff.
PRIOR LEVEL OF FUNCTION (PLF)	All functional goals must have a PLF documented. The PLF should include functional tasks that were impacted, intensity and frequency of cueing levels, compensatory strategies, and GDS (Global Deterioration Scale) level if dementia diagnosis is present.	Swallowing: IDDSI regular solids; IDDSI thin liquids WFL, independently with use of cyclic ingestion. Cognition: Patient was able to complete and recall strategies for ADLs with rare, minimal assistance from staff. Pt. was previously staged at Level 5 via GDS in April 2020.
GOALS	Are all goals measurable, functional, and objective? Do all treated deficits have an established goal? All goals need to include a specific behavior/activity, frequency, and intensity of cueing, and functional component. If you identify a deficit but will not be establishing a goal in that area, need to provide a clear clinical rationale explaining why.	Patient will tolerate IDDSI – Thin, IDDSI – Regular food consistency via self-feed while utilizing the following compensatory strategies in the Oropharyngeal Phase: Effort Swallow: on every swallow: 10 out of 10 trials with consistent minimal verbal cues. Decreased Bolus Size: on every swallow: 10 out of 10 trials with consistent minimal verbal cues. The above goal(s) will be addressed in order to decrease suspected laryngeal residue post swallow, increase strength of swallow, and safe bolus size to decrease risk of aspiration/ choking, in 60 days. This goal was established on 1/25/21.
BILLING	Are the appropriate codes billed for the services provided? Documenting reps, time, or trials with all tasks is needed to justify units billed. Do units match treatment time? If a task takes increased time, is there explanation of why?	Timed Codes/Total Treatment Time: 40 min/60 min 1 unit of 92526 (Swallowing therapy) 1 unit of 97129 (Cognitive therapy) 1 unit of 97130 (Cognitive therapy)
HOME EXERCISE PROGRAM (HEP)	Has HEP/HAP or caregiver (CG) assisted program been issued? Should initiate early in course of care, and update/modify as needed per patient presentation. Doc specific exercises/activities, reps, frequency. What is patient/CG level of performance/ understanding? Is patient/CG compliance with HEP documented?	Reviewed HAP with CG: Review of calendar and daily events/time on whiteboard every AM prior to breakfast. CG required minimal, rare verbal cues and has reported 50% compliance.

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	COMPONENTS TO INCLUDE	EXAMPLE
PATIENT CAREGIVER EDUCATION	Is patient and/or caregiver education documented early on and frequently throughout entire course of care as appropriate? Is significant documentation of caregiver education present for a patient with documented cognitive impairment? Does each instance of education include the area of education, level of assist, and patient/caregiver response?	Educated caregiver with patient present regarding safe swallowing strategies of cyclic ingestion and environmental modification of seat change to decrease distractions and optimize patient's attention requiring moderate assistance. Additional training required due to safety, technique, and carryover. Report of adherence to education: 25-50%.
SKILLED CARE	Do all functional tasks have cueing type, frequency, intensity, purpose, and cueing descriptions? Is progression of treatment components evident, with no significant repetition noted with performance of interventions? Is there consistent documentation of response to interventions to demonstrate a higher level of skill? Are vitals documented per FOX's Cardiac Protocol? Is it clear to the reader that an unskilled worker or family member could not perform the same care as the SLP safely and effectively?	Cognition - Memory Recent: delayed recall of personally relevant information - memory log - patient taking notes of HEP and parameters for later recall (1 trial = 1 detail of HEP): 12 out of 15 trials with consistent maximum verbal, visual, and written cues; cueing description: repetition, verbal direction for clarity of notes, organization cues on paper for ease of reference throughout the day. Increased time needed due to education regarding the importance of "writing it down" memory strategy and application of strategy practice.
PROGRESS REPORT STATUS/GOALS	Are all baselines, updates, and goals present for all established goals AND for all areas addressed during reporting period? Same tasks should be compared and objectively measured to show gains/status change. If unable to assess, then need to document why and then complete reassessment on stated later date.	Baseline: Safety Awareness: answering safety questions within the home: 1 out of 3 trials with consistent maximum auditory, verbal, and visual cues; cueing description: scaffolding to safe solution. Most Recent Treatment: Safety Awareness: Patient identifying safety risks within situation that occurred this morning and then provided safe alternative solution to problem: 2 out of 2 trials with consistent moderate auditory, verbal, and visual cues; cueing description: scaffolding to safe solution; re-education on safety precautions and rules within the home. Goals: Patient will demonstrate executive function skills in the following area(s): Safety Awareness: answering safety questions within the home: 9 out of 10 trials with no cues/independently. The above goal(s) will be addressed in order to safely complete tasks/activities/ADLs within environment.

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SLP DOCUMENTATION GUIDE

	ASSESSMENTS	EXAMPLE
IE	Is my documentation detailed enough that it could only ever apply to one patient? It should outline the medical complexities of the case (including the patient's current deficits as well as any medical diagnoses potentially affecting recovery), the patient's potential to improve, why skilled therapy is indicated, what the plan of care is expected to achieve, and provide an explanation of the clinical decision making that will be ongoing. These components should be described in a way that makes it clear to anyone reading the documentation that a skilled SLP needs to be present to perform the indicated interventions.	Patient is an 88-year-old female with Parkinson's disease who was seen for a comprehensive speech, voice, swallowing, and cognitive-linguistic evaluation. Results of evaluation indicate symptoms consistent with moderate to severe oropharyngeal dysphagia via clinical swallow examination resulting in increased risk of aspiration and airway threat. Additionally, patient presents with results of impaired memory abilities which can negatively impact patient's safety and quality of life within SLC environment. Patient requires skilled SLP to train, implement and apply appropriate external memory strategies to increase recall of safety procedures in apartment to decrease fall risk and to utilize safe swallowing strategies to decrease risk of aspiration and to maximize nutrition and hydration.
PR	Need to include four components: current functional status, hindrances, how clinician adjusted care to overcome the hindrances, and why skilled care is required to continue. Each progress report assessment needs to be unique and non-repetitive from the previous progress report. The stated hindrances should vary from progress report to progress report. If a hindrance continues past one progress report, then it is necessary to include documentation as to why it continues to persist and to document a new plan to overcome.	Changes to patient's status include – Patient has decreased instances of coughing at meals with use of chin tuck strategy and cyclic ingestion (patient with no coughing instances at last treatment session as compared to 4 instances at IE). Hindrances to plan of care include – Patient has demonstrated difficulty recalling and sequencing steps to swallowing strategies; hindrances are being addressed with step-by-step instruction and spaced retrieval technique, implementation and training of SLC staff of safe swallowing strategies to increase safety and carryover. Plan of care cannot be trained to a caregiver due to the need to train and implement spaced-retrieval training for patient to recall swallowing strategies and to develop an external memory support to remind patient during meals of all strategies.
DC	Need to include three components: 1. What gains were made over the entire course of care? 2. What is the reason for D/C? 3. Has there been an HEP established?	Patient has made significant gains over the course of care, returning to an independent level for swallowing, cognition, and respiration. Patient has demonstrated independence and compliance with swallowing and voice HEP. Patient has achieved all goals and is functioning at PLF; no further SLP is indicated at this time.

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SLP BILLING GUIDE

ALLOWABLE IN ALL REGIONS				
CPT CODE	**DESCRIPTION**	**RULES**	**TIMED/ UNTIMED**	**BILLABLE UNITS**
92610	**Evaluation of Swallow Function**	N/A	Untimed	1
92526	**Treatment of Swallowing Dysfunction and/or Oral Function for Feeding**	Can't bill on same day as 97110	Untimed	1
92521	**Evaluation of Speech Fluency** (e.g., stuttering, cluttering)	N/A	Untimed	1
92522	**Evaluation of Speech Sound Production** (e.g., articulation, phonological process, apraxia, dysarthria)	Can't bill on same day as 92523	Untimed	1
92523	**Evaluation of Speech Sound Production** (e.g., articulation, phonological process, apraxia, dysarthria) with **Evaluation of Language Comprehension** and expression (e.g., receptive and expressive language) This code should be used for informal cognitive-communication evaluations or screening tools i.e., SLUMS, SBT, etc."	Can't bill on same day as 92522	Untimed	1
92524	**Behavioral and Qualitative Analysis of Voice and Resonance**	N/A	Untimed	1
92507	**Speech/Hearing Therapy:** Treatment/intervention and follow-up services for disorders of speech, articulation, fluency and voice, language skills, and the cognitive aspect of communication.	Can't bill on same day as 97129/ 97130	Untimed	1
92607	**Evaluation for Prescription of Speech-Generating Device** (1st hr): Includes eval of language comprehension and production across modalities. May also include eval of motor skills and nonverbal communication strategies. Includes eval of the ability to operate and effectively use a speech generating device or aid.	Must use -59 with 92609, 92507	Untimed	1
92608	**Evaluation for Prescription of Speech-Generating Device** (each additional 30 mins): Includes eval of language comprehension and production across modalities. May also include eval of motor skills and nonverbal communication strategies. Includes eval of the ability to operate and effectively use a speech generating device or aid.	Must use -59 with 92609, 92507	Untimed	1
92609	**Therapeutic Services for Speech-Generating Devices:** Adaptation and training for use of speech-generating devices including development of operational competence in using a device or aids, including customizing the features of the device and providing opportunities for developing skill in all aspects of device use.	Must use -59 with 92606, 92507	Untimed	1
96105	**Assessment of Aphasia** (per hour): Must be a full standardized battery with the scoring protocol completed i.e., Western Aphasia Battery.	N/A	Untimed	1
96125	**Standardized Cognitive Performance Testing**: preparing the report. Must be a full standardized battery with scoring protocol completed i.e., RIPA-G, CLQT+.	N/A	Untimed	1
97129/ 97130	**Cognitive Skills Development:** Intervention used to improve cognitive skills (i.e., attention, memory, problem solving, executive functioning) with direct (one-on-one) patient contact by the clinician.	Can't bill on same day as 92507	Timed	8-Minute Rule
97550	**Caregiver Training in Strategies and Techniques** to facilitate the patient's functional performance in the home or community (e.g., activities of daily living, instrumental ADLs, transfers, mobility, communication, swallowing, feeding, problem-solving, safety practices) without the patient present, face-to-face; initial 30 minutes	N/A	Untimed	1
97551	**Caregiver Training in Strategies and Techniques** to facilitate the patient's functional performance in the home or community (e.g., activities of daily living, instrumental ADLs, transfers, mobility, communication, swallowing, feeding, problem-solving, safety practices) without the patient present, face-to-face; each additional 15 minutes.	N/A	Timed	8-Minute Rule

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ONLY ALLOWABLE IN NJ, PA, DE, MD				
CPT CODE	**DESCRIPTION**	**RULES**	**TIMED/ UNTIMED**	**BILLABLE UNITS**
97533	**Sensory Integration:** To enhance sensory processing and promote adaptive responses to environmental demands, w/direct (1:1) patient contact by the clinician. A deficit in processing input from a sensory system (i.e., vestibular, proprioceptive, tactile) may decrease the patient's ability to make adaptive sensory, motor, and behavioral responses to environmental demands.	N/A	Timed	8-Minute Rule
97110	**Therapeutic Exercise:** Related to strengthening, endurance, flexibility, and range of motion. Therapeutic exercise may be performed with a patient either actively, actively assisted, or passively participating. Therapeutic exercises may be used to strengthen muscles (e.g., jaw).	Can't bill on same day as 92526 and/ or 92507	Timed	8-Minute Rule
97530	**Therapeutic Activities:** Involves the use of dynamic activities to improve functional performance in a progressive manner. They require the skills of a clinician and are designed to address a specific functional need of the patient. Must be a clear correlation between the type of activity performed and the patient's underlying functional deficit(s).	Can't bill on the same day as 92507	Timed	8-Minute Rule
97535	**Self-Care Management:** Includes ADLs and compensatory training, meal prep, safety procedures, and instructions in use of adaptive equip, direct 1:1 contact by the clinician. The patient must have a condition for which therapy in ADLs is reasonable and necessary, and training must be reasonably expected to restore or improve the functioning of the patient.	N/A	Timed	8-Minute Rule

For FOX Units, refer to the SLP Billing and Coding presentation located in MedBridge

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