



# 2006 Medicare Fee Schedule for Speech-Language Pathologists

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On November 21, 2005, the *2006 Medicare Physician Fee Schedule* was published in the *Federal Register*. On February 1, 2006 the rates were increased by 4.4 percent (to the 2005 level) by the Deficit Reduction Act, retroactive to January 1, 2006. This ASHA document provides an overview of the fee schedule, comments on relevant revisions, and reproduces a listing of all the procedures used by speech-language pathologists, the actual national average payment amounts, and describes three methods for accessing the exact payment figure based on your geographic location.

Please check the ASHA Billing and Reimbursement Web site at [www.asha.org/members/issues/reimbursement/medicare](http://www.asha.org/members/issues/reimbursement/medicare) for the most up to date information on congressional action. For additional information, please contact Neela Swanson by e-mail at [nswanson@asha.org](mailto:nswanson@asha.org) or by phone at 800-498-2071, ext. 4387.

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## OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the 2006 Outpatient Medicare Physician Fee Schedule (MPFS) for Part B services in the November 21, 2005 *Federal Register*. The following analysis of the payment rates applies to Medicare Part B speech-language pathology services.

On February 1, 2006, Congress passed the Deficit Reduction Act (DRA), which froze the MPFS conversion factor, the multiplier that converts relative value units (RVUs), to payment amounts at 2005 levels. Therefore the conversion factor for 2006 will be \$37.8975, retroactive to January 1, 2006.

*“Physician work” by speech-language pathologists and audiologists:* CMS deferred its proposed elimination of the non-physician work pool (NPWP) until at least 2007. CMS had earlier proposed eliminating the NPWP beginning in 2006 that would have resulted in a 21% reduction for audiology fees over a 4-year period. The continued use of the NPWP keeps RVUs approximately the same as in 2005.

ASHA vigorously advocated against CMS's proposed elimination of the NPWP and will continue to work with both CMS and Congress to promote a more reasonable alternative. ASHA, through the Health Care Economics Committee (HCEC), took its case to CMS and the American Medical Association (AMA) Relative Value Update Committee (RUC) to demonstrate that moving the professions' activities from the technical component (or practice expense) to the professional component (or physician work) is appropriate, legally possible, and equitable for future valuations of audiology and speech-language pathology procedures.

## NEW DEVELOPMENTS

### Therapy caps:

The DRA also requires CMS to develop and exceptions process for medically necessary services above the cap. CMS has stated that it intends to recognize certain diagnosis as automatically exempt from the cap. Other medically necessary services above the cap, not recognized for automatic exemption, may be allowed if the provider makes a formal request to the contractor and provides additional documentation. CMS is expected to issue formal guidance by March 2006.

## New Auditory Rehabilitation CPT Codes

Four new auditory rehabilitation Current Procedural Terminology (CPT) codes are established for 2006. The ASHA Health Care Economics Committee (HCEC) recommended that the AMA establish the new codes and the AMA CPT Editorial Panel agreed. Two of the codes are for evaluation and two are for treatment. Because audiology is recognized as a diagnostic-only service by Medicare, CMS assigned RVUs only to the evaluation codes. Speech-language pathologists and audiologists may use the evaluation codes. CMS clarified that speech-language pathologists should use 92507 for reporting auditory rehabilitation.

CMS had undervalued the auditory rehabilitation status evaluation codes in the initial release of the fee schedule. After communications with ASHA, CMS issued corrections retroactively effective January 1, 2006.

**92626** Evaluation of auditory rehabilitation status, 1st hr  
RVUs: 2.26                      Fee: \$85.65

**92627** each additional 15 minutes  
RVUs: 0.57                      Fee: \$21.60

**92630** Auditory rehabilitation; pre-lingual hearing loss  
RVUs: 0.00 (audiologists not covered; SLPs use 92507)

**92633** Auditory rehabilitation; post-lingual hearing loss  
RVUs: 0.00 (audiologists not covered; SLPs use 92507)

## Neurobehavioral Status Exam CPT Code

Beginning in 2006, speech-language pathologists must use 92506 for all cognitive communication evaluations. CPT 96115 is replaced by a new procedure code (96116) that specifies use by psychologists or physicians only. The HCEC will work to establish use of this code by speech-language pathologists when performing evaluations that are primarily cognitive-communicative in nature.

## Laryngeal Function Studies CPT Code

Effective January 1, 2006, the CPT descriptor has been revised by adding “(i.e., aerodynamic testing and acoustic testing).”

## Telehealth Services

CMS is considering suggestions submitted by ASHA as it continues to formulate recommendations to congress. Congressional action is needed to allow speech-language and audiology telehealth services to be covered by Medicare. ASHA has described successful telehealth applications occurring in (1) aphasia, (2) voice, (3) cognitive-communication, (4)

<sup>a</sup> All CPT codes and descriptors are copyright 2005 American Medical Association

articulation, and (5) motor speech disorders. One example submitted by ASHA was an Oklahoma-based provider that rendered over 1,300 speech-language pathology telehealth treatment sessions over a three-year period. Legislation has been introduced (S. 1909) that would expand the definition of telehealth services.

## PAYMENT RULES OF THE MEDICARE FEE SCHEDULE

The Medicare Physician Fee Schedule (MPFS), also referred to as the Physician Fee Schedule or Medicare Fee Schedule, is based on the Current Procedural Terminology (CPT) codes in the Health Care Common Procedural Coding System (HCPCS).<sup>1</sup> The MPFS has set Medicare Part B<sup>2</sup> prospective payment rates since 1992 for speech-language pathologists, physicians, other private practitioners, and medical clinics. Reimbursement for outpatient rehabilitation services in such facilities as hospitals, skilled nursing facilities, and rehabilitation agencies was included in the MPFS in 1999. The MPFS includes both facility and non-facility rates. CMS determined that the higher non-facility rates apply to speech-language pathology and audiology services (as well as to physical therapy and occupational therapy) even when rendered in a facility.<sup>3</sup>

### Standard 20% Copayment

All Part B services require the patient to pay a 20% copayment. The fee schedule does not deduct the copayment amount. Therefore, the actual payment by Medicare is 20% less than shown in this fee schedule.

### Geographic Adjustment of the Fee Schedule

You may use the calculation example at the beginning of **Table 3** or you may request a fee schedule adjusted for your geographic area from the carrier or fiscal intermediary that processes claims. You may also select your geographic area by going to the CMS Web site at

<http://www.cms.hhs.gov/apps/pfslookup/step0.asp>.

Click start at the bottom of the page. From there you select HCPCS (CPT) codes and your locality for a list of your precise payment rates. In general, urban states and specific urban areas have payment rates that are 5% to 10% above the national average. Likewise, rural states are lower than the national average. (See **Table 3**)

### CPT Modifiers

Most CPT codes represent “typical” visit lengths or times to conduct a typical test unless the time is specified in the CPT descriptor. For significantly atypical procedures, a **modifier “-22”** can be used to indicate much longer than normal procedures and a **“-52” modifier** for an abbreviated procedure. Modifier “-22” should not be used frequently because a fiscal intermediary or carrier could make the determination that the procedure reflects typical service delivery. **Modifier “-59”** is used to establish one procedure as distinct from another procedure billed on the same day.

### Medicare Rehabilitation Modifiers

Part B services provided under plans of care for speech-language pathology or dysphagia services require a GN modifier as a suffix to the CPT code. The requirement applies to physician offices as well as facilities. Occupational therapy and physical therapy modifiers are GO and GP, respectively.

### Medicare CPT Coding Rules

Medicare and the AMA have established rules for using specific CPT codes. The Medicare rule always supersedes the AMA rule when billing Medicare. **Table 7** includes the full CPT descriptors and rules for their appropriate usage.

### National Correct Coding Initiative (NCCI) Edits

The goal of the National Correct Coding Initiative (NCCI or, more commonly, CCI) is to prevent payment of “mutually exclusive” code pairings or otherwise inappropriate pairs to be delivered to the same patient on the same day. Beginning January 1, 2006, the edits apply to all Part B settings, not just physician offices and hospitals. (See **Tables 4-6**)

### Use of Physical Medicine Codes (97000 series)

CMS does not allow speech-language pathologists to report physical medicine codes 97110 (Therapeutic exercises, each 15 minutes) and 97112 (Neuromuscular reeducation, each 15 minutes). Although CMS has not issued a formal policy statement regarding this issue, agency staff has stated its position, based on the

<sup>1</sup> HCPCS Level I: CPT Codes  
HCPCS Level II: Alphanumeric codes developed by CMS for equipment, supplies, and procedures not described in CPT Codes.

<sup>2</sup> Medicare Part B covers outpatient services and inpatient physician visits. Inpatient rehabilitation and diagnostic services are covered by Part B after depletion of the Part A 100-day skilled nursing facility stay or 90-day hospital stay or disqualification of skilled nursing status.

<sup>3</sup> *Federal Register*, July 22, 1999 (p. 39623)

descriptors and vignettes for the codes. Please note that cognitive therapy (97532) by speech-language pathologists is covered by Medicare. Several contractors also cover sensory integration (97533).

### Designation of Time

The CPT/HCPCS procedures for speech-language pathology do not include time designations except for evaluation for speech-generating device (92607) and each additional 30 minutes for the SGD evaluation (92608). Other procedures represent a typical visit length.

### Relationship to Non-Medicare Payers

Many state Medicaid programs and private health plans, including HMOs and PPOs, have adopted the MPFS while designating their own conversion factor. Speech-language pathologists may request that payers negotiate their rates using such resources as the ASHA publication, *Negotiating Health Care Contracts and Calculating Fees: A Guide for Speech-Language Pathologists and Audiologists*, rather than adopt the MPFS rankings. This publication (Item #0112450) can be ordered from ASHA Product Sales at 1-888-498-6699 or online at <http://www.asha.org/shop>.

### ASHA Participation in American Medical Association Relative Value Committees

ASHA represents the speech-language pathology profession in both the American Medical Association (AMA) Relative Value Update Committee (RUC) and the AMA CPT Editorial Panel. The ASHA Health Care Economics Committee (HCEC) coordinates recommendations from ASHA members and related organizations in developing new procedures for adoption by the CPT Editorial Panel. The Committee also conducts surveys and holds consensus panel meetings to develop data that are presented to the AMA and CMS to develop fees.

Speech-language pathology members of the HCEC in 2006 are Becky Cornett, Bernard Henri, R. Wayne Holland (ASHA AMA CPT Editorial Panel Advisor), Dee Adams Nikjeh, and Nancy Swigert (Chair, HCEC). For further information, contact Steven White, Director of the Health Care Economics and Advocacy Team, at 800-498-2071, ext. 4126; or [swhite@asha.org](mailto:swhite@asha.org).

### 2006 MEDICARE RELATIVE UNITS & FEE CALCULATIONS (TABLE 2)

The MPFS uses a resource-based relative value system (RBRVS) that assigns a relative value to each current procedural terminology (CPT) procedure. The relative weighting factor (relative value unit or RVU) is derived from a resource-based relative value scale (see Table 2). The components of the RBRVS for each procedure are the (a) professional component (i.e., work as expressed in the amount of time, technical skill, physical effort, stress, and judgment for the procedure) required of physicians and certain other practitioners; (b) technical component (i.e., the practice expense expressed in overhead costs such as assistant's time, equipment, supplies); and (c) professional liability component.

Each relative value unit (RVU) is multiplied by a **2006 Conversion Factor** of **\$37.8975** to yield the fee. Payers other than Medicare that adopt these relative values may apply a higher or lower conversion factor. Rates are adjusted according to the geographic indices given in Table 3. Past and present payment rates already calculated for each locality are available at: <http://www.cms.hhs.gov/apps/pfslookup/step0.asp>. Click "start" at bottom of the page. Then select CPT codes and locality for a list of exact payment rates.

<b>2006 Conversion Factor: \$37.8975</b>
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<sup>a</sup> All CPT codes and descriptors are copyright 2005 American Medical Association

**TABLES**

**Table 1** is a topical list of procedure codes used by or of interest to speech-language pathologists. The codes are grouped to differentiate the categories according to major speech-language pathology practices.

**Table 2** lists the procedures in numerical order with the RVUs and national fee data.

**Table 3** lists the geographic adjustment indices for the fee schedule.

**Tables 4-6** list SLP CPT codes included in Correct Coding Initiative pairs.

**Table 7** lists all SLP CPT codes, full descriptors, and rules for their appropriate usage.

**TABLE 1: Topical List of Codes<sup>a</sup>**  
Use this topical list to locate codes in Table 2

Speech-Language Pathology	Physical Medicine and Rehabilitation <sup>4</sup>	Dysphagia	Instrumental Assessment <sup>5</sup>
92506	97150	92526	31575
92507	97530	92610	31579
92508	97532	92611	70371
92597	97533	92612	74230
92605	97535	92613	76536
92606		92614	92511
92607		92615	92520
92608		92616	
92609		92617	
96105			
96110			
96111			

<sup>4</sup> Except for CPT 97532 (cognitive skills development), speech-language pathologists' appropriate use of physical medicine and rehabilitation codes should be discussed with the Medicare contractor.

<sup>5</sup> Endoscopy and radiology services may require physician supervision based on State practice acts and Medicare local coverage determinations.

**TABLE 2: 2006 Medicare Physician Fee Schedule<sup>a</sup>**

## Modifiers:

**26** = “Professional component,” the portion of diagnostic test that involves a physician’s work and allocation of the practice expense.

**TC** = “Technical component,” for diagnostic tests, the portion of a procedure that does not include a physician’s participation. The TC value is the difference between the global values and the professional component (26).

**No Modifier** = “Global value,” includes both professional and technical components.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in Table 3)
<b>31575<sup>6</sup></b>		Diagnostic laryngoscopy	1.10	1.91	0.09	3.10	\$117.48
<b>31579<sup>7</sup></b>		Diagnostic laryngoscopy with stroboscopy	2.26	3.79	0.18	6.23	\$236.10
<b>70371<sup>8</sup></b>		Pharyn. & speech eval., cine/video	2.39	2.39	0.16	3.39	\$128.47
<b>70371</b>	26	Pharyn. & speech eval., cine/video	0.84	0.28	0.04	1.16	\$43.96
<b>70371</b>	TC	Pharyn. & speech eval., cine/video	0.00	2.11	0.12	2.23	\$84.51
<b>74230<sup>8</sup></b>		Modified barium swallow	0.53	1.48	0.09	2.10	\$79.58
<b>74230</b>	26	Modified barium swallow	0.53	0.17	0.02	0.72	\$27.29
<b>74230</b>	TC	Modified barium swallow	0.00	1.31	0.07	1.38	\$52.30
<b>76536<sup>8</sup></b>		Ultrasound exam of head and neck	0.56	1.60	0.10	2.26	\$85.65
<b>76536</b>	26	Ultrasound exam of head and neck	0.56	0.18	0.02	0.76	\$28.80
<b>76536</b>	TC	Ultrasound exam of head and neck	0.00	1.42	0.08	1.50	\$56.85
<b>92506</b>		Speech, lang., aud. process evaluation	0.86	2.60	0.03	3.49	\$132.26
<b>92507</b>		Speech, lang., aud. process treatment	0.52	1.11	0.02	1.65	\$62.53
<b>92508</b>		Speech/hearing treatment, group	0.26	0.51	0.01	0.78	\$29.56
<b>92511</b>		Nasopharyngoscopy	0.84	3.32	0.03	4.19	\$158.79

<sup>6</sup> This procedure is for medical diagnosis by a physician

<sup>7</sup> State practice acts may require a supervising physician on the premises

<sup>8</sup> The 70000 series are radiology codes. The physician component includes an interpretation by radiologists. The practice expense component is for the radiologic technician and overhead. These codes are included here for information purposes and not for billing by speech-language pathologists.

<sup>a</sup> All CPT codes and descriptors are copyright 2005 American Medical Association

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in Table 3)
92520 <sup>9</sup>		Laryngeal function studies	0.75	0.51	0.03	1.29	\$48.89
92526		Swallowing treatment	0.55	1.64	0.02	2.21	\$83.75
92597		Voice prosthetic evaluation	0.86	1.69	0.03	2.58	\$97.78
92605		Evaluation for non-speech generating device	0.00	0.00	0.00	0.00	\$0.00
92606		Non-speech generating device services	0.00	0.00	0.00	0.00	\$0.00
92607		Evaluation for speech-generating device; first hour. (If less than 1 hr, use -52 modifier.)	0.00	3.09	0.05	3.14	\$119.00
92608		Evaluation for speech-generating device; additional 30 minutes	0.00	0.55	0.05	0.60	\$22.74
92609		Speech-generating device services	0.00	1.59	0.04	1.63	\$61.77
92610		Evaluate swallowing function	0.00	3.44	0.08	3.52	\$133.40
92611		Motion fluoroscopy/swallow	0.00	3.44	0.08	3.52	\$133.40
92612 <sup>9</sup>		Endoscopy swallow test (FEES)	1.27	2.75	0.04	4.06	\$153.86
92613		Physician interpretation (FEES)	0.71	0.40	0.05	1.16	\$43.96
92614 <sup>9</sup>		Laryngoscopic sensory test	1.27	2.51	0.04	3.82	\$144.77
92615		Physician interpretation, laryngoscopic sensory test	0.63	0.35	0.05	1.03	\$39.03
92616 <sup>9</sup>		FEES with laryngeal sense test (FEESST)	1.88	3.40	0.06	5.34	\$202.37
92617		Physician interpretation (FEESST)	0.79	0.44	0.05	1.28	\$48.51
92626 <sup>10</sup>		Evaluation of auditory rehab status; first hour	0.00	2.20	0.06	2.26	\$85.65

<sup>9</sup> State practice acts may require a supervising physician on the premises

<sup>10</sup> New in 2006. Speech-language pathologists may use these evaluation codes.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors in Table 3)
92627 <sup>10</sup>		Evaluation of auditory rehab status add-on (each 15 min.)	0.00	0.55	0.02	0.57	\$21.60
92630 <sup>11</sup>		Auditory rehab, pre-lingual hearing loss	0.00	0.00	0.00	0.00	0.00
92633 <sup>11</sup>		Auditory rehab, post-lingual hearing loss	0.00	0.00	0.00	0.00	0.00
96105		Assessment of aphasia, per hour	0.00	1.77	0.18	1.95	\$73.90
96110		Developmental testing, limited	0.00	0.18	0.18	0.36	\$13.64
96111		Developmental test, extended	2.60	1.05	0.18	3.83	\$145.15
96115		(Deleted from CPT system as of 2006)					
97150 <sup>12</sup>		Group therapeutic procedures, each 15 min	0.27	0.18	0.01	0.46	\$17.43
97530 <sup>12</sup>		Therapeutic activities, each 15 min.	0.44	0.32	0.01	0.77	\$29.18
97532		Cognitive skills development, each 15 min.	0.44	0.20	0.01	0.65	\$24.63
97533 <sup>12</sup>		Sensory integration, each 15 min.	0.44	0.24	0.01	0.69	\$26.15
97535 <sup>12</sup>		Self-care/home management training, each 15 min.	0.45	0.33	0.01	0.79	\$29.94

<sup>11</sup> Medicare will not reimburse for the new auditory rehabilitation codes. Speech-language pathologists should use 92507 instead.

<sup>12</sup> Medicare contractors may require physical medicine procedures performed by speech-language pathologists to be coded as speech-language pathology treatment (92507) or dysphagia treatment (92526).

**Geographic Adjustment Calculations**

The method for calculating geographic adjustments is illustrated below. You may also request a fee schedule from your carrier or intermediary. Precise payment rates by locality are available at:

<http://www.cms.hhs.gov/apps/pfslookup/step0.asp>.

- J Click on “List of HCPCS codes” (i.e., CPT codes)
- J Choose “All modifiers”
- J Select specific LOCALITY

Your selected CPT codes will be displayed with the payment amount.

**Example: Calculating geographic adjustments**

CPT Description and Geographic Index	Work RVUs	Practice RVUs	Malpractice RVUs	Total RVUs	2006 Conversion Factor	Adjusted Fee
CPT 92610 Evaluate swallowing ‡	0.00	3.44	0.08			
<b>Alabama index ‡</b>	<u>x1.000</u>	<u>x0.846</u>	<u>x0.752</u>			
Alabama RVUs ‡	0	+ 2.91024	+ 0.06016	= 2.9704	x 37.8975	= <b>\$112.57</b>

**TABLE 3: 2006 Geographic Cost Indices**

Carrier No.	Locality No.	Locality Name	Work	Practice Expense	Malpractice
00510	00	Alabama	1.000	0.846	0.752
00831	01	Alaska	1.017	1.103	1.029
00832	00	Arizona	1.000	0.992	1.069
00520	13	Arkansas	1.000	0.831	0.438
31140	03	Marin/Napa/Solano, CA	1.035	1.340	0.651
31140	05	San Francisco, CA	1.060	1.543	0.651
31140	06	San Mateo, CA	1.073	1.536	0.639
31140	07	Oakland/Berkley, CA	1.054	1.371	0.651
31140	09	Santa Clara, CA	1.083	1.540	0.604
31146	17	Ventura, CA	1.028	1.179	0.744
31146	18	Los Angeles, CA	1.041	1.156	0.954
31146	26	Anaheim/Santa Ana, CA	1.034	1.236	0.954
31140	99	Rest of California*	1.007	1.053	0.733
31146	99	Rest of California*	1.007	1.053	0.733
00824	01	Colorado	1.000	1.014	0.803
00591	00	Connecticut	1.038	1.170	0.900
00903	01	DC + MD/VA Suburbs	1.048	1.250	0.926
00902	01	Delaware	1.012	1.018	0.892

\* States are served by more than one carrier

Carrier No.	Locality No.	Locality Name	Work	Practice Expense	Malpractice
00590	03	Fort Lauderdale, FL	1.000	0.988	1.703
00590	04	Miami, FL	1.000	1.046	2.269
00590	99	Rest of Florida	1.000	0.934	1.272
00511	01	Atlanta, GA	1.010	1.089	0.966
00511	99	Rest of Georgia	1.000	0.872	0.966
00833	01	Hawaii/Guam	1.005	1.111	0.800
05130	00	Idaho	1.000	0.868	0.459
00952	12	East St. Louis, IL	1.000	0.939	1.750
00952	15	Suburban Chicago, IL	1.018	1.115	1.652
00952	16	Chicago, IL	1.025	1.126	1.867
00952	99	Rest of Illinois	1.000	0.872	1.193
00630	00	Indiana	1.000	0.906	0.436
00826	00	Iowa	1.000	0.868	0.589
00650	00	Kansas*	1.000	0.878	0.721
00660	00	Kentucky	1.000	0.854	0.873
00528	01	New Orleans, LA	1.000	0.946	1.197
00528	99	Rest of Louisiana	1.000	0.847	1.058
31142	03	Southern Maine	1.000	1.013	0.637
31142	99	Rest of Maine	1.000	0.886	0.637
00901	01	Baltimore/Surrounding Counties, MD	1.012	1.078	0.947
00901	99	Rest of Maryland	1.000	0.980	0.760
31143	01	Metropolitan Boston	1.030	1.329	0.823
31143	99	Rest of Massachusetts	1.007	1.103	0.823
00953	01	Detroit, MI	1.037	1.054	2.744
00953	99	Rest of Michigan	1.000	0.921	1.518
00954	00	Minnesota	1.000	1.005	0.410
00512	00	Mississippi	1.000	0.839	0.722
00740	02	Metropolitan Kansas City, MO	1.000	0.975	0.946
00523	01	Metropolitan St. Louis, MO	1.000	0.955	0.941
00523	99	Rest of Missouri*	1.000	0.802	0.892
00740	99	Rest of Missouri*	1.000	0.802	0.892
00751	01	Montana	1.000	0.844	0.904
00655	00	Nebraska	1.000	0.875	0.454
00834	00	Nevada	1.003	1.043	1.068
31144	40	New Hampshire	1.000	1.027	0.942
00805	01	Northern NJ	1.058	1.220	0.973
00805	99	Rest of New Jersey	1.043	1.119	0.973
00521	05	New Mexico	1.000	0.887	0.895
00801	99	Rest of New York	1.000	0.917	0.677
00803	01	Manhattan, NY	1.065	1.298	1.504

\* States are served by more than one carrier

Carrier No.	Locality No.	Locality Name	Work	Practice Expense	Malpractice
00803	02	NYC Suburbs/Long I., NY	1.052	1.280	1.785
00803	03	Poughkeepsie/N NYC Suburbs, NY	1.014	1.074	1.167
14330	04	Queens, NY	1.032	1.228	1.710
05535	00	North Carolina	1.000	0.920	0.640
00820	01	North Dakota	1.000	0.860	0.602
00883	00	Ohio	1.000	0.933	0.976
00522	00	Oklahoma	1.000	0.854	0.382
00835	01	Portland, OR	1.002	1.057	0.441
00835	99	Rest of Oregon	1.000	0.925	0.441
00865	01	Metropolitan Philadelphia, PA	1.016	1.104	1.386
00865	99	Rest of Pennsylvania	1.000	0.902	0.806
00973	20	Puerto Rico	1.000	0.698	0.261
00524	01	Rhode Island	1.045	0.989	0.909
00880	01	South Carolina	1.000	0.893	0.394
00820	02	South Dakota	1.000	0.876	0.365
05440	35	Tennessee	1.000	0.879	0.631
00900	09	Brazoria, TX	1.020	0.961	1.298
00900	11	Dallas, TX	1.009	1.062	1.061
00900	15	Galveston, TX	1.000	0.952	1.298
00900	18	Houston, TX	1.016	1.014	1.297
00900	20	Beaumont, TX	1.000	0.860	1.298
00900	28	Fort Worth, TX	1.000	0.989	1.061
00900	31	Austin, TX	1.000	1.046	0.986
00900	99	Rest of Texas	1.000	0.865	1.138
00823	09	Utah	1.000	0.937	0.662
31145	50	Vermont	1.000	0.968	0.514
00973	50	Virgin Islands	1.000	1.014	1.003
00904	00	Virginia	1.000	0.940	0.579
00836	02	Seattle (King County), WA	1.014	1.131	0.819
00836	99	Rest of Washington	1.000	0.978	0.819
00884	16	West Virginia	1.000	0.819	1.547
00951	00	Wisconsin	1.000	0.918	0.790
00825	21	Wyoming	1.000	0.853	0.935

**TABLES 4-6: Medicare Correct Coding Initiative (CCI) Edits and OCE Edits<sup>13</sup>**

The Centers for Medicare and Medicaid Services (CMS) use an automated edit system to control specific code pairs that can be reported on the same day. The National Correct Coding Initiative (NCCI or, more commonly, CCI) has been in place since January 1, 1996, and is updated quarterly. The goals of CCI are to eliminate “mutually exclusive” code pairings and codes considered to be components of more comprehensive services or otherwise inappropriate to be delivered to the same patient on the same day.

**Prior to 2006, CCI edits were limited to services reimbursed by carriers (e.g., physician offices and private practice physical and occupational therapists). Now, all provider settings are affected.**

A complete list of code edits for Part B services other than those billed by hospitals is found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp>. The Outpatient Code Editor (OCE) applies only to hospital outpatient services. Typically, the OCE edits for speech-language pathology and audiology are similar to those in the CCI system. The OCE revisions also occur quarterly but one quarter after the revised CCI edits are implemented. See <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp> for the full OCE edits. See box after Table 6 for assistance in deciphering the list of code edits on the CMS Web site.

Tables 4–6 below are derived from information in the CMS web links above.

**TABLE 4: CCI Speech-Language Pathology Procedures<sup>a</sup>**

CPT Procedure	Paired With (one)	Can be performed on same date? Yes/No		If so, use what modifier? <sup>14</sup>
		MD Office	Other Settings <sup>12</sup>	
31579 (videostrobe)	70371, 92520	Y	Y	-59
92508 (SLP group)	92507	Y	Y	-59
92520 (laryng funct)	70371 (rad. speech eval)	Y	Y	-59
92526 (dysphag tx)	92520 (laryngeal function)	Y	Y	-59
92526 (dysphag tx)	G0283 (=97014), 97032	N	N	N/A
92607 (SGD eval)	92507, 92508, 92609	Y	Y	-59
92607 (SGD eval)	92597 (voice prosth eval), 97755	N	N	N/A
92608	97755	N	N	N/A
92609	92506, 92507, 92508	Y	Y	-59
92609	97775	N	N	N/A
92610	92511	Y	Y	-59
92611 (MBS)	92511, 92610	Y	Y	-59
92611 (MBS)	76120, 76125	N	N	N/A
92612 (FEES)	31575, 92511, 92520, 92614	N	N	N/A

<sup>13</sup> Hospital outpatient coding edits are determined by the Outpatient Code Editor (OCE) system which usually includes the same therapy edits as CCI edits. New OCE edits are implemented in hospitals one quarter after implemented as CCI edits.

<sup>14</sup> The -59 modifier denotes that the procedure is distinct or independent from other services performed on the same day. **The modifier is attached to the 2<sup>nd</sup> column CPT code, when applicable.**

CPT Procedure	Paired With (one)	Can be performed on same date? Yes/No		If so, use what modifier? <sup>14</sup>
		MD Office	Other Settings <sup>12</sup>	
92612 (FEES)	92610, 92611	Y	Y	-59
92613	92520	N	N	N/A
92613, 92615, 92617 (physician report)	92610, 92611	Y	Y	-59
92614 (sensory test)	92610, 92611	Y	Y	-59
92614	31575, 92511, 92520	N	N	N/A
92615	92520, 92613	N	N	N/A
92616 (FEESST)	31575, 92511, 92520, 92612, 92614	N	N	N/A
92616 (FEESST)	92610, 92611	Y	Y	-59
92617	92520, 92613, 92615	N	N	N/A
96105 (aphasia assessment)	96110 (dev testing, ltd), 96111 (dev testing, extended)	N	N	N/A

**Note:** Any edit pair not listed in Tables 4 or 5 may be billed on the same day without the -59 modifier.

**TABLE 5: CCI SLP Codes Paired with Physical Medicine Codes<sup>a</sup>**

CPT Procedure (one)	Paired With (one)	Modifier Used
92507, 92508, 92526	97032, 97110, 97112, 97150, 97530, 97532 <sup>15</sup>	-59

Use of the -59 modifier is not intended to permit speech-language pathologists to bill for physical medicine procedures (97000 codes). **The purpose of the modifier, in this case, is to allow billing of 97000 procedures performed by OTs and PTs on the same day that SLPs are billing 92507, 92508, or 92526.**

**TABLE 6: Recent CCI Edits No Longer in Effect<sup>a</sup>**

CPT Procedure	Paired With	Deletion Date
92506	92507 or 92508	10/1/04

<sup>15</sup> Regarding 97532 (cognitive skills development), Medicare allows usage by speech-language pathologists, but not on the same day as 92507.

**For those who visit the CMS CCI and OCE site, note that tables include a “modifier indicator” in the last column:**

- 0 = CPT modifier cannot be used to bypass the edit pair
- 1 = CPT modifier can be used to bypass the edit pair and allow payment for both codes. For speech-language pathologists and audiologists, “-59” is the modifier to use, when appropriate.
- 9 = Code pair has been deleted from the CCI or OCE system

The next to last column indicates the date the edit pair was deleted from the system, if applicable

**TABLE 7: Medicare Coding Rules for Speech-Language Pathologists<sup>a</sup>**

Note many third party payers selectively adopt Medicare coding rules.

Code	Descriptor	Special Rules
92506	Evaluation of speech, language, voice, communication, and/or auditory processing	Evaluation of aural rehabilitation is no longer part of 92506; speech-language pathologists and audiologists should use 92626 and 92627 <sup>16</sup>
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Includes training & modification of voice prosthetics. <sup>17</sup> Medicare directs SLPs to use 92507 for auditory rehabilitation. <sup>18</sup>
92508	Group, two or more individuals	Generally limited to 4 individuals. Limit of 25% of total SLP tx sessions is applicable to Part B patients in some intermediary Local Coverage Determinations. (For SNF Part A residents, up to 25% of each discipline’s rehabilitation tx minutes per week.) <sup>19</sup>
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)	
92526	Treatment of swallowing dysfunction and/or oral function for feeding	There is no dysphagia <i>group</i> therapy code. Use 92508. <sup>20</sup>
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Under Medicare, applies to tracheoesophageal prostheses, artificial larynges, as well as voice amplifiers. Use 92507 for training and modification of voice prostheses. <sup>21</sup>

<sup>16</sup> Federal Register, November 21, 2005, p. 70281

<sup>17</sup> Federal Register, December 31, 2002, p. 80016

<sup>18</sup> Federal Register, November 21, 2005, p. 70281

<sup>19</sup> Federal Register, July 30, 1999, p. 41662.

<sup>20</sup> Personal communication with CMS rehabilitation staff.

<sup>21</sup> Voice amplifiers classified as prosthetic devices: DMERC Region B Bulletin, September 2001, p. 5; DMERC Region C Advisory, Autumn 2001, p. 14.

Code	Descriptor	Special Rules
92605	Evaluation for prescription for non-speech generating AAC devices	CMS requires use of 92506 instead, for this type of evaluation. <sup>22</sup>
92606	Therapeutic services for use of non-speech generating devices, including programming and modification	CMS requires use of 92507 instead, for these therapy services. <sup>23</sup>
92607	Evaluation for prescription of speech-generating AAC device (SGD), first hour	SGDs generate synthesized or digital speech. Include -52 modifier if less than one hour.
92608	SGD evaluation [92607], each additional 30 minutes	May be reported on ensuing days until the evaluation is completed. <sup>24</sup>
92609	Therapeutic services for use of speech-generating device, including programming and modification	
92610	Evaluation of oral and pharyngeal swallowing function	
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	Should be billed with radiology procedure 74230. 92610 is usually reported prior to this procedure
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (FEES)	This is the complete endoscopic procedure. Level of physician supervision varies by state. Use 92700 if performed without cine or video recording.
92613	Physician interpretation and report	Optional procedure by physician
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording	This is not a swallow evaluation; sensory testing only.
92615	Physician interpretation and report	Optional procedure by physician
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording (FEESST)	This is the complete endoscopic procedure for swallowing and sensory testing combined. Level of physician supervision varies by state.
92617	Physician interpretation and report	Optional procedure by physician
92626	Evaluation of auditory rehabilitation status, first hour	
92627	each additional 15 minutes	
92630	Auditory rehabilitation; pre-lingual hearing loss	SLPs must use 92507 in lieu of this code <sup>25</sup>
92633	Auditory rehabilitation; post-lingual hearing loss	SLPs must use 92507 in lieu of this code <sup>26</sup>

<sup>22</sup> *Federal Register*, December 31, 2002, p. 80010

<sup>23</sup> *Federal Register*, December 31, 2002, p. 80010

<sup>24</sup> *CPT Assistant*, March 2003, p. 5

<sup>25</sup> *2006 Medicare Fee Schedule*

<sup>26</sup> *ibid.*

Code	Descriptor	Special Rules
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	There is no firm rule regarding time necessary to qualify for subsequent one-hour codes. Recommend use of -52 modifier if less than 30 minute segment.
96110	Developmental testing, limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	
96111	Developmental testing, extended (includes motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour	See note regarding time at 96105, above.
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes	15 minute rule: see at end of table Cannot report 97532 if report 92507 on same day. <sup>27</sup>
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes <sup>28</sup>	SLPs should confirm that this code is included in the contractor's local coverage determination (LCD)

**For CPT codes designated as 15 minutes**, multiple coding represents minimum face-to-face treatment, as follows:

- 1 unit: 8 minutes to < 23 minutes
- 2 units: 23 minutes to <38 minutes
- 3 units: 38 minutes to < 53 minutes
- 4 units: 53 minutes to < 68 minutes
- 5 units: 68 minutes to < 83 minutes
- 6 units: 83 minutes to < 98 minutes

**Untimed codes:** If the CPT descriptor has no time designation, the procedure is billed as a session without regard to time.

**Code modifiers:** -52 or -22 can be appended to the CPT code to indicate that the session was unusually short or long, respectively. The payer has the option to adjust the payment accordingly. If either of these modifiers are used too often, the payer may consider the incidence to not be "unusual." **For restrictions on certain CPT code pairs billed on the same day, see the CCI tables.**

<sup>27</sup> Regarding 92507: CMS Program Memorandum AB-00-14 (March 2000)

<sup>28</sup> Included in many intermediary SLP Local Coverage Determinations.