2012 Medicare Fee Schedule for Speech-Language Pathologists

American Speech-Language-Hearing Association

3rd Edition

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3rd Edition Revisions

- Page 1: Overview (Added information on *Middle Class Tax Relief and Job Creation Act of 2012*)
- Page 1: New Developments
    - Therapy Cap and Alternatives (Extension of and changes to therapy cap exceptions process)

General Information

This ASHA document provides an overview of the *2012 Medicare Physician Fee Schedule*, comments on relevant revisions, and a list of all procedures used by speech-language pathologists with their national average payment amounts. This document also describes three methods for accessing the exact payment figure based on your geographic location and includes a convenient link to ASHA's table of Medicare SLP coding rules.

Please check the ASHA Billing and Reimbursement Web site at www.asha.org/practice/reimbursement/medicare/feeschedule/ for the most up-to-date information.

For additional information, please contact the Health Care Economics and Advocacy Team by e-mail at reimbursement@asha.org.

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Overview

On November 1, 2011, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the 2012 Medicare Physician Fee Schedule (MPFS) that would have represented a 27.4% reduction from 2011 payments and affected all payments under the physician fee schedule. This reduction was then eliminated by Congress on a temporary basis, the latest and final action being the *Middle Class Tax Relief and Job Creation Act of 2012*, which President Obama signed into law on February 22, 2012. This eliminates the 27.4% reduction and extends the therapy cap exceptions process through December 31, 2012. As a result, the final 2012 conversion factor (CF) that is used as a multiplier of the total relative value units (RVUs) for each procedure remains $34.0376. It is anticipated that Congress will consider a more long-term solution to Medicare Part B reimbursement. Please continue to monitor ASHA's Billing & Reimbursement website at www.asha.org/practice/reimbursement/medicare/feeschedule/ for further updates on Congressional action.

New Developments

Therapy Cap and Alternatives

For 2012, CMS has calculated that the therapy cap will increase from $1,870 to **$1,880** shared between speech-language pathology and physical therapy services. Occupational therapy will continue with an unshared cap of $1,880. However, as a result of the *Middle Class Tax Relief and Job Creation Act of 2012*, the exceptions process has been extended through December 31, 2012.

In extending the therapy cap exceptions process, Congress added additional safeguards to the exceptions process, including:

- the use of an NPI for the physician reviewing the need for therapy;
- requirement of the KX modifier on claims above the cap; and
- requirement for medical manual review when therapy expenditures hit $3,700 (combined physical therapy/speech-language pathology) for services furnished on or after October 1, 2012.

The bill will also temporarily apply the therapy caps and exceptions to hospital outpatient departments for services provided beginning October 1, 2012, and ending December 31, 2012. For more information on the exceptions process, go to www.asha.org/practice/reimbursement/ExceptionProcess.htm

ASHA has been working with CMS-contracted research projects to develop alternatives to the cap over the past three years. For more information on the therapy cap, go to www.asha.org/advocacy/federal/cap/default/

SLP Group Treatment (CPT 92508) Value

ASHA submitted survey data to CMS and recently presented the survey data during a formal Medicare refinement panel process conducted by CMS to assist in reviewing public comments on CPT codes with interim final work RVUs and in developing final work values. After hearing ASHA's presentation stating that the typical group size is three for CPT 92508, the Medicare refinement panel agreed with ASHA and the American Medical Association's Relative Value Update Committee (RUC). That is, the Refinement Panel recommended that the work value be 0.43. In spite of this support, CMS maintained the current RVUs of 0.33 that are based on a group size of 4 using only anecdotal support for their position.

New and Revised Non-Speech Generating Device Evaluation Codes

The following CPT codes (92605 and 92618) are not covered by Medicare because the services are considered bundled with CPT 92506 (speech-language evaluation). CMS instructs SLPs to use 92506 when performing a non-speech generating device AAC evaluation.

CPT code 92605 for evaluation of a non-speech-generating augmentative/alternative communication device was revised to include a time factor, "face-to-face with patient; first hour." New code 92618 (each additional 30 minutes) cannot be reported as a stand-alone code.

Relative Value Unites (RVUs) for these codes are included in Table 7 for informational purposes only.

Revised CPT Codes for Developmental Testing

Two procedure codes rarely billed to Medicare were revised for 2012. The official descriptor of CPT

96110 has been revised as a screen rather than "Developmental testing; limited." Testing examples in the descriptor have always been screens. Based on the revision, Medicare is no longer covering the service, as is its policy for other screens. A code similar to the previous 96110 descriptor now appears in the HCPCS Level II coding system as G0451, "Developmental testing, with interpretation and report, per standardized instrument form," and is covered by Medicare.

CPT code 96111 was revised to remove the word "extended" from the descriptor. The code now reads "Developmental testing (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report".

Supervision Level for Videostroboscopy (31579) and Nasopharyngoscopy (92511)

Effective October 1, 2011, the medical policy section of the Medicare Fee Schedule database changed the physician supervision level for these two instrumental assessments. The decision to require personal supervision (effective January 1, 2011) was was withdrawn by CMS. Currently, there is no designated level of supervision. ASHA and representatives of the American Association of Otolaryngology-Head and Neck Surgery advocated with CMS staff in March and presented a rationale for a less stringent level of supervision. Note that the lack of a required supervision level can be otherwise restricted by state regulations or Medicare Local Coverage Determinations. For more information on this revision, go to the FAQs on ASHA's website at www.asha.org/Practice/reimbursement/medicare/Medicare-Supervision-Requirements-for-Videostroboscopy-and-Nasopharyngoscopy-Procedures/.

Multiple Procedure Payment Reduction (MPPR)

Under the MPPR policy, Medicare reduces payment for the second and subsequent therapy, surgical, and nuclear medicine procedures furnished to the same patient on the same day. It also applies to the technical component of multiple advanced imaging services such as CT, MRI, and ultrasound services.

Effective in 2011 and continuing in 2012, there are eight SLP procedures for which payment is affected under the MPPR policy in combination with occupational therapy and physical therapy procedures. In the proposed 2012 MPFS regulation, CMS asked for comments regarding possible extensions of the MPPR, including applying it to the technical component of diagnostic tests other than advanced imaging services. ASHA submitted comments regarding the bundled audiology CPT procedures that already include multiple procedure reductions. CMS determined that it is not expanding MPPR at this time but "will take the comments into consideration as we develop future proposals." For more information on MPPR and billing scenarios, see the MPPR section under "Payment Rules of the Medicare Physician Fee Schdule."

Revision of Relative Value Units (RVUs)

Speech-language pathologists' services are now recognized as professional work due to ASHA's legislative efforts that gave SLPs Medicare private practice status.

Since 2009, ASHA has presented data to the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee Health Care Professionals Advisory Committee (RUC HCPAC) for 13 speech-language pathology procedures because the profession's services are now reflected in the professional component. The codes reviewed are 92507, 92508, 92526, 92597, 92605, 92606, 92607, 92608, 92618 (new code in 2012), 92609, 92610, 92611, and 96105.

The 2011 MPFS was the first time that speech-language pathology codes included the professional work of speech-language pathologists. For example, see 92507, which now has a work relative value unit (RVU) of 1.30 that was 0.52 in 2010. The practice expense RVUs are reduced because the speech-language pathologist's time is no longer included. Work RVUs do not change over time while the practice expense RVUs fluctuate according to CMS payment formula policies. The year 2012 will be the third of a four-year transition in the reduction of practice expense RVUs.

Physician Quality Reporting System (PQRS)

CMS will continue the current speech-language pathology PQRS measures that allow reporting of eight National Outcomes Measures (NOMs) Functional Communication Measures related to stroke. The measures are for spoken language comprehension;

attention; memory; motor speech; reading; spoken language expression; writing; and swallowing. Reporting is voluntary from 2010 through 2015. For 2012-2014, the incentive payment for satisfactorily reporting on measures is 0.5% of all allowable Medicare charges per year. Starting in 2015, eligible professionals who do not satisfactorily report on quality measures will be subject to a payment reduction of -1.5%. PQRS participants need to report on at least 80% of patients that fit into a measure. See ASHA's Speech-Language Pathology and PQRS Webpage at www.asha.org/Members/research/NOMS/PQRI/ for FAQs and registration information.

Telehealth Services

There are no new developments regarding telehealth services. Fees for such services performed by SLPs cannot be considered until the Medicare law is amended to permit payment for speech-language pathology services at a distant site.

Summary of Tables

Table 1 illustrates the impact on payment for speech-language pathology services when not accepting Medicare assignment.

Table 2 lists the speech-language pathology procedures that are subject to Medicare's multiple procedure payment reduction (MPPR) policy.

Tables 3, 4, & 5 provide billing scenarios under the multiple procedure payment reduction policy.

Table 6 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 7 lists the procedures in CPT Codebook order with the RVUs and national fee data.

Payment Rules of the Medicare Physician 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 Healthcare Common Procedural Coding System (HCPCS).[1] The MPFS has set Medicare Part B[2] 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.[3]

Private Practice Status for Speech-Language Pathologists

Since July 1, 2009, SLPs have enrolled as private practitioners under Medicare Part B. Please go to ASHA's Billing & Reimbursement Web site, www.asha.org/practice/medicare/slpprivatepractice, for more information.

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 request a fee schedule adjusted for your geographic area from the Medicare Administrative Contractor (MAC) that processes your claims. You can also access the rates for geographic areas by going to the CMS Web site at www.cms.gov/apps/physician-fee-schedule/overview.aspx. See the *Geographic Adjustment Calculations* section of this document (after Table 7) for further instructions. In general, urban states and areas have payment rates that are

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[1] HCPCS Level I: CPT Codes
HCPCS Level II: Alphanumeric codes developed by CMS for equipment, supplies, and procedures not described in CPT Codes.

[2] 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.

[3] *Federal Register*, July 22, 1999 (p. 39623)

5% to 10% above the national average.Likewise, rural states are lower than the national average.

CPT Modifiers

Untimed 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 **"-22"modifier** can be used to indicate that the work is substantially greater than typically required and a **"-52"modifier** for an abbreviated procedure. Modifier "-22" should not be used frequently because the Medicare contractor could make the determination that the procedure reflects typical service delivery. For claims with the "-22" modifier a description of the need for extended services should accompany the claim. **Modifier "-59"** is used to establish one procedure as distinct from another procedure billed on the same day.

Medicare Rehabilitation CPT Code 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 and private practices. 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. ASHA's Web site includes the full CPT descriptors and rules for their appropriate usage at www.asha.org/practice/reimbursement/medicare/SLP_coding_rules.htm. Note that many third party payers selectively adopt Medicare coding rules.

Use of Physical Medicine Codes (97000 series)

CMS staff have concluded that speech-language pathologists should not 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 officials have stated their position, based on the official descriptors and vignettes for the codes. Please note that cognitive therapy (97532) and sensory integration (97533) by speech-language pathologists are covered in all Medicare Local Coverage Determinations (LCDs). Highmark Medicare Services does include 97110, 97530, and 97535 in its SLP LCD. Palmetto GBA includes 97535 in its SLP LCD.

Designation of Time

Most CPT/HCPCS codes reported by speech-language pathologists are "untimed" (i.e., they do not include time designations). They represent a typical visit length and are billed as one unit. Exceptions for Medicare-covered codes are:

- Evaluation for speech-generating device (92607, first hour; 92608, each additional 30 minutes)
- Evaluation of auditory rehabilitation status (92626, first hour; 92627, each additional 30 minutes).
- Assessment of aphasia (96105, per hour)
- Standardized cognitive performance testing (96125, per hour)
- Cognitive skills development (97532, each 15 minutes)
- Sensory integration (97533, each 15 minutes)

Note: A timed code is billed only if face-to-face time spent in an evaluation is at least 51% of the time designated in the code's descriptor. An exception is 96125 where allowable time includes interpretation of test results and preparation of the report.

"Limiting Charge"

Independent practice speech-language pathologists paid by Medicare as private practitioners under the fee schedule may elect to be "nonparticipating" even while enrolled as a Medicare supplier. This status allows payment at a higher rate than specified in the fee schedule if the SLP does *not* accept assignment. Medicare payment is made directly to the supplier, instead of the patient, when accepting assignment (except the 20% co-payment, for which all Part B patients are responsible).

Nonparticipating SLPs who do not accept assignment may add a *limiting charge* of up to 15% to the total fee schedule amount, as long as the 115% result does not surpass the SLP's customary fee for that particular CPT code. The net gain for the SLP is 9.25% (not 15%) because nonparticipating practitioners are reimbursed at 95% of the fee schedule amount.

The following calculations in **Table 1** illustrate fees without and with the limiting charge add-on.

Table 1: Impact of Assignment on Medicare Payments

	Scenario 1: *Participating Provider Accepts Assignment (not entitled to limiting charge add-on)*	**Scenario 2**: *Nonparticipating Provider Accepts Assignment (not entitled to limiting charge add-on)*	**Scenario 3**: *Nonparticipating Provider Does **Not** Accept Assignment (thus, entitled to limiting charge add-on)*
Fee Schedule Amount	$100	$100	$100
Total Allowed Payment	$100	$100 x 95% = $95	$100 x 95% x 115% = $109.25 (total allowed payment)
Medicare Pays	80% x $100 = $80	80% x $95 = $76	Patient reimbursed $76 (80% of $95)
Patient Pays	20% x $100 = $20	20% x $95 = $19	$109.25 - $76.00 = $33.25 (out-of-pocket)

National Correct Coding Initiative (NCCI) Edits

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 goal of the National Correct Coding Initiative is to prevent payment of "mutually exclusive" code pairings or otherwise inappropriate pairs to be delivered to the same patient on the same day. The edits apply to all Part B settings.

A subset of the CCI edits is the Outpatient Code Editor (OCE), which applies only to hospital outpatient services. Typically, the OCE edits for speech-language pathology are similar to those in the CCI system. The OCE revisions also occur quarterly, but one quarter after the revised CCI edits are implemented.

The CCI also includes a set of edits called Medically Unlikely Edits (MUEs), also for Medicare Part B and Medicaid claims. An MUE for a CPT or HCPCS Level II code is the maximum number of times that the code can be reported for the same patient on the same day. Not all codes have an MUE and/or CCI edit. Go to the ASHA Web site for tables listing current CCI and Medically Unlikely edits for speech-language pathology and swallowing at:

www.asha.org/practice/reimbursement/coding/CCI_edits_SLP.htm

Multiple Procedure Payment Reduction (MPPR)

CMS expanded its Multiple Procedure Payment Reduction (MPPR) to therapy services and applied it to any therapy discipline performed on the same day. Under MPPR, full payment is made for the therapy service or unit with the highest practice expense value (MPFS reimbursement rates are based on professional work, practice expense, and malpractice components) and payment reductions will apply for any other therapy performed on the same day. For the additional procedures provided on the same day, the practice expense (i.e., support personnel time, supplies, equipment, and indirect costs) of each fee will be reduced by 20% for services in office and other non-institutional settings and 25% for Part B services in instituational settings, effective January 1, 2011. The professional work and malpractice expense components of the payment will not be affected.

MPPR will primarily affect physical therapists and occupational therapists, that is, professions that commonly bill multiple procedures or a timed procedure billed more than once per visit. Eight SLP procedures are designated as applicable to MPPR (see Table 2). It is a per-day policy that applies across disciplines and across settings. For example, if an SLP and a physical therapist both provide treatment to the same patient on the same day, the MPPR applies to all codes billed that day, regardless of discipline.

Table 2: SLP Procedures Subject to MPPR

CPT	Descriptor
92506	Evaluation of speech, language, voice, communication, and/or auditory processing
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder; individual
92508	Group, two or more individuals
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92609	Therapeutic services for the use of speech-generating device, including programming and modification
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

The following three MPPR scenarios illustrate full payment being made for the procedure with the higher practice expense. If there is a single speech-language pathology service daily it will usually be paid without a reduction because of consistently low physical therapy and occupational therapy procedure
practice expense values.

Table 3: MPPR Scenario 1

A patient is seen on the same day for a speech-language evaluation (92506) and a physical therapy evaluation (97001).

	92506	**97001**	**Total Payment w/o MPPR**	**2012 Total Payment w/MPPR**
Work	$21.22	$29.61	$50.83	No Reduction = $50.83
Practice Expense	$97.45	$22.45	$80.39	$97.45 + (80% x $22.45) = $115.41
Malpractice	$1.23	$1.23	$2.46	No Reduction = $2.46
Total	$119.90	$53.29	$173.19	$52.58 + $75.85 + $2.56 = **$168.70**

Table 4: MPPR Scenario 2

A patient is seen on the same day for speech-language treatment (92507) with a speech-language pathologist and 30 minutes of therapeutic exercises with a physical therapist (97110, each 15 minutes).

	92507	**97110 Unit 1**	**97110 Unit 2**	**Total Payment w/o MPPR**	**2012 Total Payment w/MPPR**
Work	$32.07	$11.10	$11.10	$54.27	No Reduction = $54.27
Practice Expense	$20.48	$10.86	$10.86	$42.20	$20.48 + (80% x $10.86) + (80% x $10.86) = $37.86
Malpractice	$1.73	$0.25	$0.25	$2.23	No Reduction = $2.23
Total	$54.28	$22.21	$22.21	$98.70	$54.27 + $37.86 + $2.23 = **$94.36**

Table 5: MPPR Scenario 3

A patient is seen on the same day for speech-language treatment (92507) and swallowing treatment (92526).

	92526	92507	Total Payment w/o MPPR	2012 Total Payment w/MPPR
Work	$33.06	$32.07	$65.13	No Reduction = $65.13
Practice Expense	$25.41	$20.48	$45.89	$25.41 + (80% x $20.48) = $41.80
Malpractice	$1.73	$1.73	$3.46	No Reduction = $3.46
Total	$60.20	$54.28	$114.48	$65.13 + $41.80 + $3.46 = **$110.39**

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 online at 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 or revising current ones 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 relative values for new and revised CPT codes.

Speech-language pathology members of the HCEC in 2012 are Gretchen Bebb, Bernard Henri, Robert Hillman, R. Wayne Holland (ASHA AMA CPT Editorial Panel Advisor), and Co-Chair, Dee Adams Nikjeh (ASHA AMA RUC Alternate Advisor). For further information, contact George Lyons, ex-officio of the HCEC and Director, Government Relations and Public Policy, at glyons@asha.org.

2012 Medicare Relative Value Units & Fee Calculations

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 7)**. 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.

Final 2012 Conversion Factor: $34.0376

Each relative value unit (RVU) is multiplied by the final 2012 Conversion Factor of $33.9764 to yield the fee. Rates are adjusted according to geographic indices. Past and present payment rates calculated for each locality are available at: www.cms.gov/apps/physician-fee-schedule/overview.aspx. See the *Geographic Adjustment Calculations* section of this document after Table 7 for further instructions.

Payers other than Medicare that adopt these relative values may apply a higher or lower conversion factor.

Table 6: Topical List of Codes◆

Speech & Language		Physical Medicine & Rehabilitation[4]	Dysphagia	Other Instrumental/Radiologic Assessments[5]
92506	92609	97532	92526	31575
92507	92626	97533	92610	31579
92508	92627	97535	92611	70371
92520	92630		92612	74230
92597	92633		92613	76536
92605	96105		92614	92511
92606	96110		92615	
92607	96111		92616	
92608	96125		92617	

[4] Except for CPT 97532 (cognitive skills development) and CPT 97533 (sensory integrative techniques),speech-language pathologists' appropriate use of physical medicine and rehabilitation codes should be discussed with the Medicare contractor or verified in the Local Coverage Determination.

[5] Endoscopy and radiology services may require physician supervision based on State practice acts and Medicare local coverage determinations.

Table 7: 2012 Medicare Physician Fee Schedule◆

Final 2012 Conversion Factor: $34.0376

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 section)
31575[6]		Diagnostic laryngoscopy	1.10	2.22	0.12	3.44	$117.09
31579[7]		Diagnostic laryngoscopy with stroboscopy	2.26	3.85	0.3	6.41	$218.18
70371[8]		Pharyn. & speech eval., cine/video	0.84	1.92	0.04	2.80	$95.31
70371[8]	26	Pharyn. & speech eval., cine/video	0.84	0.33	0.03	1.20	$40.85
70371[8]	TC	Pharyn. & speech eval., cine/video	0.00	1.59	0.01	1.60	$54.46
74230[8]		Modified barium swallow	0.53	2.19	0.04	2.76	$93.94
74230[8]	26	Modified barium swallow	0.53	0.2	0.03	0.76	$25.87
74230[8]	TC	Modified barium swallow	0.00	1.99	0.01	2.00	$68.08
76536[8]		Ultrasound exam of head and neck	0.56	3.02	0.04	3.62	$123.22
76536[8]	26	Ultrasound exam of head and neck	0.56	0.21	0.03	0.80	$27.23
76536[8]	TC	Ultrasound exam of head and neck	0.00	2.81	0.01	2.82	$95.99

[6] This procedure is for medical diagnosis by a physician
[7] This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
[8] 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.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors section)
92506		Speech, lang., aud. process evaluation	0.86	3.95	0.05	4.86	$165.42
92507		Speech, lang., aud. process treatment	1.30	0.83	0.07	2.20	$74.88
92508		Speech/hearing treatment, group	0.33	0.32	0.01	0.66	$22.46
92511[9]		Nasopharyngoscopy	0.84	3.61	0.03	4.25	$144.66
92512		Nasal function studies	0.55	1.24	0.03	1.82	$61.95
92520		Laryngeal function studies	0.75	1.28	0.04	2.07	$70.46
92526		Swallowing treatment	1.34	1.03	0.07	2.44	$83.05
92597		Voice prosthetic evaluation	1.26	1.11	0.07	2.44	$83.05
92605[10] **(revised)**		Evaluation for non-speech generating device, first hour	1.75	0.83	0.09	2.67	$0.00
92618[11] **(new code)**		Evaluation for non-speech generating device, additional 30 minutes	0.65	0.28	0.03	0.96	$0.00
92606[12]		Non-speech generating device services	1.40	0.91	0.07	2.38	$0.00
92607		Evaluation for speech-generating device;first hour. (If less than 1 hr, use -52 modifier.)	1.85	2.24	0.10	4.19	$142.62
92608		Evaluation for speech-generating device; additional 30 minutes	0.70	0.61	0.04	1.35	$45.95
92609		Speech-generating device services	1.50	1.40	0.07	2.97	$101.09
92610		Evaluate swallowing function	1.30	1.26	0.07	2.63	$89.52
92611		Motion fluoroscopy/swallow	1.34	1.47	0.08	2.89	$98.37
92612[13]		Endoscopy swallow test (FEES)	1.27	3.65	0.07	4.99	$169.85

[9] This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
[10] CMS instructs SLPs to use 92506 for this service. RVUs have been assigned for the benefit of non-Medicare payers. (*Federal Register*, December 31, 2002, p. 80010)
[11] This is an add-on code for 92605. CMS instructs SLPs to use 92506 for a non-SGD evaluation. RVUs have been assigned for the benefit of non-Medicare payers.
[12] CMS instructs SLPs to use 92507 for this service. RVUs have been assigned for the benefit of non-Medicare payers.
[13] This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors section)
92613		Physician interpretation (FEES)	0.71	0.36	0.04	1.11	$37.78
92614[14]		Laryngoscopic sensory test	1.27	3.13	0.07	4.47	$152.15
92615		Physician interpretation, laryngoscopic sensory test	0.63	0.33	0.03	0.99	$33.70
92616[14]		FEES with laryngeal sense test (FEESST)	1.88	4.02	0.10	6.00	$204.23
92617		Physician interpretation (FEESST)	0.79	0.39	0.04	1.22	$41.53
92626[15]		Evaluation of auditory rehab status; first hour	1.40	1.11	0.07	2.58	$87.82
92627[15]		Evaluation of auditory rehab status add-on (each 15 min.)	0.33	0.30	0.01	0.64	$21.78
92630[16]		Auditory rehab, pre-lingual hearing loss	0.00	0.00	0.00	0.00	$0.00
92633[16]		Auditory rehab, post-lingual hearing loss	0.00	0.00	0.00	0.00	$0.00
96105		Assessment of aphasia, per hour	1.75	1.20	0.04	2.99	$101.77
96110[17] **(revised)**		Developmental screening	0.00	0.00	0.00	0.00	$0.00
96111 (revised)		Developmental test	2.60	0.89	0.16	3.65	$124.24
96125		Standardized cognitive performance testing, per hour	1.70	1.14	0.07	2.91	$99.05
97532		Cognitive skills development, each 15 min.	0.44	0.30	0.01	0.75	$25.53
97533[18]		Sensory integration, each 15 min.	0.44	0.38	0.01	0.83	$28.25

[14] This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
[15] Speech-language pathologists may report these evaluation codes.
[16] Medicare will not reimburse for auditory rehabilitation codes. CMS guidance instructs speech-language pathologists to use 92507 (*Federal Register*, November 21, 2005, p. 70281).
[17] CPT 96110 has been revised to a screen and Medicare will no longer cover the service, as is its policy for other screens. HCPCS Level II code G0451, "Developmental testing, with interpretation and report, per standardized instrument form," may be used instead. Rate information for G0451 is located at the end of this table.
[18] MACs may require physical medicine procedures performed by speech-language pathologists to be coded as speech-language pathology treatment (92507) or dysphagia treatment (92526).

CPT/HCPCS	Mod	Description	Physician Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Non-Facility Total RVUs	Fee (see geographic adjustors section)
97535[18]		Self-care/home management training, each 15 min.	0.45	0.52	0.01	0.98	$33.36
G0451[19] **(new code)**		Developmental testing, with interpretation and report, per standardized instrument form	0.00	0.28	0.01	0.29	$9.87

[19] This new HCPCS Level II code can be used in place of CPT 96110 Developmental screen. 96110 will no longer be paid by Medicare.

Geographic Adjustment Calculations

Precise payment rates bylocality are available at: **www.cms.gov/apps/physician-fee-schedule/overview.aspx**.

Local rates are also available on your payer's website (Medicare Administrative Contractor – MAC).

To See Payment Rates:

- ✓ Click "Start Search" and "Accept" the terms of agreement, if asked
- ✓ Select the year
- ✓ Select "Pricing Information"
- ✓ Choose your "HCPCS (CPT code) criteria"
- ✓ Select "Specific Locality"
- ✓ Enter the code or codes you are looking for, choose "All modifiers"
- ✓ Select your locality
- ✓ The first column of results, "Non-facility price", applies to *all* SLP services, whether in a facility or not.
- ✓ The results can be printed, downloaded and saved, or e-mailed.

To See Geographic Practice Cost Index (GPCI):

- ✓ Click "Start Search" and "Accept" the terms of agreement, if asked
- ✓ Select the year
- ✓ Select "Geographic Practice Cost Index"
- ✓ Choose your "Carrier/Medicare Administrative Contractor Option"
    - ✓ Select "Specific Locality"if you want to see only the GPCI in your area
    - ✓ Select your locality
- ✓ Click "Submit"
- ✓ In the table, PE = Practice Expense and MP = Malpractice
- ✓ The results can be printed, downloaded and saved, or e-mailed.