2014 Medicare Fee Schedule for Speech-Language Pathologists

American Speech-Language-Hearing Association

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General Information

This document was developed by the American Speech-Language-Hearing Association (ASHA) to provide an analysis of the 2014 Medicare Physician Fee Schedule (MPFS), including comments on relevant policy changes, a list of Current Procedural Terminology (CPT® American Medical Association) codes used by speech-language pathologists with their national average payment amounts, and useful links to additional information.

Additional information regarding the MPFS—including background information, how providers should calculate Medicare payment, and speech-language pathology-specific payment and coding rules—can be found on ASHA's Outpatient MPFS website. For questions, contact reimbursement@asha.org.

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Overview

On November 27, 2013, the Centers for Medicare & Medicaid Services (CMS) released the final rule for the 2014 Medicare Physician Fee Schedule (MPFS) that included a 20.1% reduction to reimbursement rates. However, on December 26, 2013, President Obama signed into law the *Pathway for SGR Reform Act of 2013.* This law suspends the reduction, provides for a 0.5% increase in rates, and temporarily extends the therapy cap exceptions process , but only through **March 31, 2014**. Speech-language pathologists (SLPs) should monitor ASHA's Outpatient MPFS website for future Congressional action on MPFS rates and the therapy caps. This document includes regulations and rates for implementation on January 1, 2014, for SLPs providing services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include four new Current Procedural Terminology (CPT) codes replacing CPT 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing), the application of the therapy cap rules to services performed in critical access hospitals (CAHs), and new requirements for the Physician Quality Reporting System (PQRS). National payment rates for speech-language pathology-related services are also included.

Additional information regarding the MPFS—including background information, instructions for calculating Medicare payment, and speech-language pathology payment and coding rules—can be found on ASHA's Outpatient MPFS website. For questions, please contact reimbursement@asha.org.

Analysis of the 2014 Medicare Physician Fee Schedule (MPFS)

ASHA's Health Care Economics and Advocacy Team reviewed relevant sections of the 2014 MPFS. The narrative below is an analysis of the key issues for speech-language pathologists (SLPs).

Reimbursement Rates

SLPs will see some changes in 2014 reimbursement rates because of two factors: (a) the conversion factor (CF) established by a statutory formula and (b) changes in the "practice expense"—one of several costs factored into the value of any given procedure code—for speech-language codes. See the appendix (pp. 11–15) for a listing of speech-language pathology procedures and corresponding national payment rates. Visit ASHA's webpage on calculating Medicare fee schedule rates for information on how to access fees based on locality.

Conversion Factor (CF)

The CF is used to calculate MPFS reimbursement rates. CMS established a calendar year 2014 CF of **$35.8228**, which is 0.5% higher than the 2013 CF of $34.0230 and reflects Congressional action that averted a 20.1% decrease in rates. However, the suspension of the reduction is valid only through March 31, 2014. See **Table 2** of the appendix (p. 11) for the current 2014 national rates for speech-language pathology related CPT codes.

Relative Value Units (RVUs)

The value of each CPT code is calculated by separating the cost of providing the service into relative value units (RVUs) in three components: (1) professional work, (2) technical expenses (practice expense), and (3) professional liability (malpractice) insurance. The total RVUs for each service is the sum of the three components (components are adjusted for geographical differences); the total RVUs for any particular CPT code is multiplied by the CF to determine the corresponding fee.

In 2013, SLPs experienced the final year of a 4-year phase-in of practice expense value changes, the result of updated practice cost surveys. These surveys reflect data on average practice expenses and mostly affect indirect practice costs (e.g., office overhead, billing, rent, utilities).

These changes have decreased rates for many speech-language pathology procedures, mostly because the costs of operating a speech-language pathology practice are substantially less than operating costs of a medical practice.

However, SLPs' services are now recognized as professional work, due to ASHA's legislative efforts that gave SLPs Medicare private practice status. Since 2009, ASHA, through its Health Care Economics Committee, has presented data to the American Medical Association (AMA) Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC) for the majority of speech-language pathology procedures, because the profession's services are now reflected in the professional work component, rather than in practice expense. Professional work RVUs do not typically change over time, while practice expense values fluctuate according to CMS payment formula policies.

For a detailed chart of final 2014 RVUs, contact reimbursement@asha.org.

Multiple Procedure Payment Reductions (MPPR)

The multiple procedure payment reducations (MPPR) policy for speech-language pathology and other services will continue in 2014. Under this system, per-code reimbursement is decreased when multiple codes are performed for a single beneficiary in the same day. Despite aggressive advocacy efforts by ASHA and other therapy organizations, Congress included in its Taxpayer Relief Act a 50% multiple procedure payment reduction on outpatient therapy services, effective for services rendered on or after April 1, 2013. This per-day policy applies to services provided by all therapy disciplines (speech-language pathology, physical therapy, and occupational therapy) in the same facility. Visit ASHA's website for more information on MPPR, including billing scenarios and a list of the speech-language pathology codes subject to MPPR.

New CPT Codes for Speech-Language Evaluations

Effective January 1, 2014, four new CPT codes will replace CPT code 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing). With this change, SLPs will be able to bill speech sound production, language, fluency, and voice and resonance evaluations using the following, more specific, codes:

- 92521: Evaluation of speech fluency (e.g., stuttering, cluttering)
- 92522: Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- 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)
- 92524: Behavioral and qualitative analysis of voice and resonance

During the process of re-valuing speech-language pathology-related codes to include the professional work component, the AMA RUC HCPAC recognized that 92506 reflected more than one procedure and requested ASHA to develop specific evaluation procedure codes to replace 92506 and more accurately and appropriately value the professional work performed. ASHA surveyed SLPs to obtain professional work values and presented the data to the AMA RUC HCPAC. The AMA RUC HCPAC then submitted the recommended professional work RVUs to CMS, which have been published in the 2014 MPFS. CMS accepted the recommended professional work RVUs for two of the codes, but decreased the RVUs for two others, as shown in the table below. ASHA will be meeting with CMS to discuss the reduced values.

CPT	Descriptor	AMA RUC/HCPAC Recommended RVU	CY2014 Work RVU
92521	Evaluation of speech fluency	1.75	1.75
92522	Evaluation of speech sound production	1.50	1.50
92523	Evaluation of speech sound production with evaluation of language comprehension and expression	3.36	↓3.00
92524	Behavioral and qualitative analysis of voice and resonance	1.75	↓1.50

Because 92506 included many different evaluation procedures, SLPs have been paid the same rate, whether they provided an evaluation for one disorder or many. The new codes essentially reflect smaller components of the original 92506, so SLPs should expect to see payments for each type of evaluation that are lower than past payments for 92506. See **Table 2** of the appendix (p. 11) for the national payment rates for CPT codes 92521–92524.

CMS has also added these new codes to the "always therapy" list, meaning that they are services that are only paid by Medicare when provided under a therapy plan of care. As such, the new codes are also subject to the therapy cap and MPPR as was 92506.

More information on the new codes is available on ASHA's New SLP CPT Codes website.

Billing for Non-Speech-Generating Device (SGD) Evaluations

CMS will not separately pay for CPT codes 92605 (Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour) and 92618 (each additional 30 minutes), because a non-speech-generating device (SGD) evaluation is considered a bundled service under 92506. Prior to publication of the 2014 MPFS proposed rule, ASHA requested that CMS allow payment for 92605 and 92618, due to the deletion of 92506. However, CMS did not address this request in the final rule and did not provide guidance regarding billing for non-SGD evaluations in the absence of 92506. ASHA will meet with CMS to obtain clarification on billing for non-SGD evaluations. Further updates on this issue will be posted on ASHA's New SLP CPT Codes website.

"Incident to" Billing

Medicare proposed, and has finalized in the 2014 rule, the alignment of "incident to" regulations with applicable state laws. Speech-language pathology services can, but are not required to, be billed incident to a physician or a non-physician practitioner services and must be provided by personnel qualified to provide the therapy services according to applicable state law. Speech-language pathology technicians or assistants are not recognized by Medicare to provide services independently or under the supervision of an SLP. ASHA agrees that all services, including those for Medicare beneficiaries, should be performed (a) by appropriate licensed and otherwise regulated personnel and (b) compliant with state laws. The proposed rule adds language to the regulations to state, "Services and supplies must be furnished in accordance with applicable State law" where necessary; this language is consistent with Medicare policy and ASHA's ethical guidelines.

Therapy Cap

2014 Therapy Cap and Manual Medical Review Threshold

For 2014, CMS has calculated that the therapy cap will increase from $1, 900 to **$1,920** for physical therapy and speech-language pathology services combined. The therapy cap is calculated using the Medicare rate for the services, including any deductible or coinsurance paid by the beneficiary.

The current exceptions process—utilizing the KX modifier for services exceeding the therapy cap—has been temporarily extended by Congress until March 31, 2014. The manual medical review process for therapy services provided above a $3,700 threshold and the extension of the therapy cap provisions to hospital outpatient departments was included in the temporary extension. Congress is expected to pass a permanent payment solution for 2014. ASHA will continue advocacy efforts with Congress and CMS regarding alternatives to the therapy caps and the current manual review process. For more information on the therapy cap exceptions process and manual medical review process, go to ASHA's Exceptions Process website.

Application to Critical Access Hospitals (CAHs)

Despite opposition from ASHA and several other commenters, CMS finalized their revised interpretation of the Social Security Act to allow permanent expansion of the therapy cap to CAHs. Hospitals have historically been exempt from therapy cap laws and regulations, but recent legislation expanded the therapy cap provisions to hospital services on a year-by-year basis. In previous legislation, CAHs remained exempt from the cap, though the dollar amount of the services provided were counted toward the total therapy cap dollars used by the beneficiary. CMS, in an attempt to include all therapy services in the therapy cap, determined CAHs did not fall under the definition of "outpatient hospital" because of their particular payment mechanism and could, therefore, be subject to the therapy cap, independent of legislative expansion. The result of this regulation is that CAHs will always be subject to the therapy cap provision, while outpatient hospitals are only subject to the cap and exceptions if the legislative provisions are renewed by Congress.

This change now requires that CAHs adhere to the therapy cap, the exceptions process, and manual medical review for therapy services. Information on these issues is available on ASHA's Exceptions Process website.

Physician Compare

ASHA has been working closely with CMS contractor Westat in regard to the Physician Compare website, the CMS provider search website intended for beneficiary use. In its comments, ASHA noted that the most recent iteration of the site that includes SLPs was lacking in information regarding training, certification, and specialty board recognition many of our members possess. CMS indicated that the Physician Compare website is primarily populated from the CMS Internet-based Provider Enrollment, Chain and Ownership System (PECOS), and providers should ensure that the information in PECOS is current and complete. For categories not captured in PECOS— such as language spoken, hospital affiliation, or other credentials—providers are encouraged to contact the Physician Compare contractor at physiciancompare@westat.com.

As proposed, Physician Compare will publicly report the PQRS data collected from 2014 claims for individual eligible providers as early as 2015.

Physician Quality Reporting System (PQRS)

PQRS applies to SLPs in private or group practice who submit fee-for-service claims. It began as a voluntary incentive payment program for reporting patient data. As the program has continued, however, the incentive payment has decreased to the current 0.5% incentive payment based on total claims. PQRS will remain an incentive program through 2014, but is simultaneously transitioning to a payment reduction program. Providers who reported nothing in 2013 will receive a 1.5% deduction on their Medicare Part B claims in 2015. In the final rule, CMS reiterated that the benchmark for satisfactory reporting to avoid 2016 penalties is 50% of all eligible patient encounters in 2014.

All eligible providers in private or group practices submitting claims as rendering providers with Individual National Provider Identification (NPI) numbers as rendering providers on the claim—providing services to Part B Medicare beneficiaries and billing for services under the MPFS—are subject to the -2.0% adjustment to claims submitted in 2016 if they do not meet benchmark requirements in 2014. The final rule includes a statement, without clarification, that suggests eligible providers in CAHs may also participate in PQRS due to changes in payment mechanisms. ASHA will be following up with CMS to determine if SLPs employed by CAHs will require PQRS participation as this is a significant deviation from current PQRS policy.

The final rule retired several measures, including the registry-only Functional Communication Measures for patients with late-effect cerebrovascular disease. To ensure all eligible professionals have an opportunity to participate in PQRS, there are "general" measures that include representative CPT codes across disciplines. In 2014, SLPs will participate by adding non-payable Healthcare Common Procedure Coding System (HCPCS) G-codes on the claim form for eligible patients visits, determined by CPT code, for 2 the two general measures listed below:

Medication/Preventative Care Measures	
Measure #130	Documentation of Current Medications in the Medical Record
Measure #131	Pain Assessment and Follow-up

The final rule includes different benchmark requirements based on qualification for receiving the 0.5% incentive payment or avoiding the deductions later. The -2.0% payment adjustment will be applied to 2016 Part B payments to health care providers who did not report on at least three measures (or fewer if measures are not applicable) for 50% of the eligible services during the 2014 calendar year. The benchmark for qualifying for incentive payments in 2014 includes reporting at least 50% of the eligible services for nine measures or as many measures as are available for a given professional. Any providers who report fewer than nine measures will be subject to the measures applicability validation (MAV) process, which will determine if the provider reported on the appropriate measures. In 2013, Measure #130 and Measure #131 were not assessed in the MAV process; however, the 2014 MAV process has not yet been released. SLPs are cautioned that, in order for them to report Measure #131, the state licensure scope of practice must allow SLPs to assess for pain, a standardized tool must be routinely performed, and follow-up referral sources for positive results must be established. SLPs should not report on Measure #131 for the sole purpose of meeting PQRS requirements.

Documentation of current medications in the medical record (Measure #130) must be reported on 50% of the eligible patients for each visit. Visit ASHA's PQRS Measures Available for SLPs to Report on Claims website for educational materials.

Avoid Penalties	Receive Incentives
Report 50% of qualifying patients for **three** measures (or as many as available)	Report 50% of qualifying patients for **nine** measures (or as many as available)

Appendix

2014 Medicare Physician Fee Schedule for Speech-Language Pathology Services

Table 1. Topical List of Codes

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

Speech & Language		Physical Medicine & Rehabilitation	Dysphagia (Including Instrumental Assessments)	Other Instrumental/Radiologic Assessments
92507	92608	97532	92526	31575
92508	92609	97533	92610	31579
92520	92618	97535	92611	70371
92521	92626		92612	74230
92522	92627		92613	76536
92523	92630		92614	92511
92524	92633		92615	
92597	96105		92616	
92605	96110		92617	
92606	96111			
92607	96125			

The following table contains full descriptors and national payment rates for speech-language pathology-related services. Calculations were made using the 2014 CF (**$35.8228**), reflecting a 0.5% increase to MPFS rates due to Congressional action to avert a 20.1% reduction. However, the suspension of the reduction is only valid through **March 31, 2014**. SLPs should monitor ASHA's Outpatient MPFS website for future Congressional action on MPFS rates.

Please see ASHA's Outpatient MPFS site for other important information on Medicare CPT coding rules and Medicare fees calculations, including information on how to find rates by locality.

Table 2. National Medicare Part B Rates for Speech-Language Pathology Services

Speech-language pathology services are paid at non-facility rates, regardless of setting. All claims should be accompanied by the –GN modifier to indicate services provided by an SLP.

CPT Code	Descriptor	National Fee Valid through 3/31/2014	Notes
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	**$217.09**	This procedure may require physician supervision based on Medicare Administrative Contractors' (MACs') local coverage policies or state practice acts.
~~**92506**~~	~~Evaluation of speech, language, voice, communication, and/or auditory processing~~	-	***Deleted***, effective January 1, 2014, and replaced with 92521-92524. See New CPT Codes (p. 5).
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	**$80.60**	
92508	group, 2 or more individuals	**$23.64**	
92511	Nasopharyngoscopy with endoscope (separate procedure)	**$138.28**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
92512	Nasal function studies (eg, rhinomanometry)	**$61.62**	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	**$75.23**	
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	**$114.27**	***New code***. See New CPT Codes (p. 5)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	**$92.78**	***New code***. See New CPT Codes (p. 5)
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)	**$192.73**	***New code***. See New CPT Codes (p. 5) If only language comprehension and expression (receptive and expressive language) are evaluated, use this procedure with the -52 modifier to indicate a reduced service.

CPT Code	Descriptor	National Fee Valid through 3/31/2014	Notes
92524	Behavioral and qualitative analysis of voice and resonance	**$96.72**	***New code***. See New CPT Codes (p. 5) This procedure does not include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	**$87.77**	
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	**$73.44**	
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	**$0.00**	CMS will not pay for this code, because it was considered a bundled service included in 92506. ASHA requested that CMS allow payment for 92605 and 92618 due to the deletion of 92506; however, CMS has not changed its policy. ASHA will meet with CMS to obtain clarification on billing for non-SGD evaluations.
92618	each additional 30 minutes (List separately in addition to code for primary procedure)	**$0.00**	See note for 92605.
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	**$0.00**	CMS will not pay for this code, because it is considered a bundled service included in 92507.
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	**$130.04**	
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	**$53.73**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	**$112.48**	
92610	Evaluation of oral and pharyngeal swallowing function	**$85.97**	
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	**$92.06**	
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;	**$179.11**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.

CPT Code	Descriptor	National Fee Valid through 3/31/2014	Notes
92613	interpretation and report only	**$38.33**	The procedure requires that the SLP has not performed the endoscopic evaluation, but is asked to interpret the report. SLP should not use this code if he/she performs the endoscopy. Use of this code may be limited based on MACs' local coverage policies.
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	**$151.53**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
92615	interpretation and report only	**$34.39**	The procedure requires that the SLP has not performed the endoscopic evaluation, but is asked to interpret the report. SLP should not use this code if he/she performs the endoscopy. Use of this code may be limited based on MACs' local coverage policies.
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;	**$213.50**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
92617	interpretation and report only	**$42.63**	The procedure requires that the SLP has not performed the endoscopic evaluation, but is asked to interpret the report. SLP should not use this code if he/she performs the endoscopy. Use of this code may be limited based on MACs' local coverage policies.
92626	Evaluation of auditory rehabilitation status; first hour	**$90.99**	SLPs may report this evaluation code.
92627	each additional 15 minutes (List separately in addition to code for primary procedure)	**$21.85**	This is an add-on code for 92626. SLPs may report this evaluation code.
92630	Auditory rehabilitation; prelingual hearing loss	**$0.00**	This code will not be paid for. CMS instructs SLPs to use 92507 for auditory rehabilitation.
92633	postlingual hearing loss	**$0.00**	CMS instructs SLPs to use 92507 for auditory rehabilitation.
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	**$101.74**	

CPT Code	Descriptor	National Fee Valid through 3/31/2014	Notes
96110	Developmental screening, with interpretation and report, per standardized instrument form	**$8.24**	Medicare does not pay for screenings. See Code G0451 at the end of this table.
96111	Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report	**$130.04**	
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	**$114.63**	
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	**$26.87**	
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	**$29.37**	Except for CPT 97532, SLPs' appropriate use of the 97000 series codes should be verified with the MAC.
97535	Self-care/home management training (eg, activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	**$35.11**	Except for CPT 97532, SLPs' appropriate use of the 97000 series codes should be verified with the MAC.
G0451	Developmental testing, with interpretation and report, per standardized instrument form	**$8.24**	This Medicare-specific HCPCS Level II code can be used in place of CPT 96110, which is not paid by Medicare.

Table 3. National Medicare Part B Rates for Other CPT Codes of Interest to SLPs

The procedures in this table are for information purposes and are not for billing by SLPs.

CPT Code	Descriptor	National Fee Valid through 3/31/2014	Notes
31575	Laryngoscopy, flexible fiberoptic; diagnostic	**$116.07**	This procedure is for medical diagnosis by a physician.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$94.21**	This is a radiology code.
74230	Swallowing function, with cineradiography/videoradiography	**$93.86**	This is a radiology code.
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	**$123.59**	This is a radiology code.