2016 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 2016 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.

Speech-language pathologists should always consult their local Medicare Administrative Contractor for final rates and coverage guidelines.

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 April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015. This legislation repealed the flawed sustainable growth rate (SGR) formula and prevented the 21% cut in reimbursement that would have gone into effect on April 1, 2015. Medicare Physician Fee Schedule (MPFS) rates will now receive a 0.5% payment update annually through 2019. Payments are then frozen with a 0.0% update from 2020 through 2025. Additional payment changes apply after 2025 based upon participation in alternative payment models (APMs).

Rates associated with individual Current Procedural Terminology (CPT® American Medical Association) codes may continue to fluctuate due to adjustments to practice expense and malpractice insurance values that are part of the fee calculation. Additionally, the Centers for Medicare & Medicaid Services (CMS) may request review and revaluation of certain codes that are flagged as potentially misvalued services.

This document includes regulations and rates for implementation on January 1, 2016, for speech-language pathologists providing services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include the therapy cap exceptions process and manual medical review, "incident to" services, 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 2016 Medicare Physician Fee Schedule (MPFS)

ASHA's Health Care Economics and Advocacy Team reviewed relevant sections of the 2016 MPFS. The narrative below is an analysis of the key issues for speech-language pathologists.

Reimbursement Rates

Speech-language pathologists will see some changes in 2016 reimbursement rates because of two factors: 1) the conversion factor (CF) established by a statutory formula and 2) 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 (p. 9–15) 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.

CMS predicts a 0% total impact of proposed fee changes for speech-language pathology services. ASHA's analysis corroborates the CMS assessments, revealing only small rate adjustments upwards or downwards. This is a positive sign of increased stability in speech-language pathology rates.

Conversion Factor (CF)

The CF is used to calculate MPFS reimbursement rates. CMS established a calendar year 2016 CF of **$35.8279**, which is slightly lower than the 2015 CF of $35.9335. See **Table 2** of the appendix (p. 10) for the national rates for speech-language pathology related CPT codes. This conversion factor reflects the elimination of the sustainable growth rate (SGR) formula discussed in the overview.

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.

See **Table 4** (p. 15) for a detailed chart of final 2016 RVUs.

Multiple Procedure Payment Reductions (MPPR)

The multiple procedure payment reducations (MPPR) policy for speech-language pathology and other services will continue in 2015. Under this system, per-code reimbursement is decreased when multiple codes are performed for a single beneficiary in the same day. This per-day policy applies to services provided by all therapy disciplines (i.e., 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.

Therapy Cap

For 2016, CMS has calculated that the therapy cap will increase from $1,940 to **$1,960** 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 extended by Congress until **December 31, 2017**. 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 extension. For more information on the therapy cap exceptions process and manual medical review process, go to ASHA's Exceptions Process website.

"Incident to" Services

"Incident to" services are those generally provided by auxillary personnel under the direct supervision of a physician, and billed under the physician National Provider Identifier (NPI) as the rendering provider of the service. The purposes of "incident to" billing is to provide services that are integral to the care provided by the physician. However, concerns regarding the provision of services by appropriately trained and supervised personnel have led to additional oversight for "incident to" billing. As a result, CMS has finalized the following language for clarity in the policy and to ensure appropriate physician supervision:

> *In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Services and supplies furnished incident to transitional care management and chronic care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by clinical staff. The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services to exclude all continuing education providers, rather than a select few.* (Code of Federal Regulations, §410.26(b)(5))

Speech-language pathologists are technically allowed to bill "incident to" a physician under current Medicare rules. However, the change to the language requires that a physician be onsite at the time the service is being provided, and that the billing is under the physician onsite on the date of service. Because speech-language pathologists have the ability to enroll as Medicare providers and transfer the payment of their services to several offices at once, "incident to" is not considered necessary, only convenient. "Incident to" billing is intended for the provision of integral, incidental services by providers that are not recognized for Medicare enrollment, such as technicians. Additionally, there is not a fiscal advantage for services provided by speech-language pathologists to be billed under a physician NPI; in fact, if the service is billed under a nurse practitioner, clinical nurse specialitist, or physician's assistant, the service is reduced by 15%.

For speech-language pathologists that are not enrolled as Medicare providers and billing "incident to" a physician, services must be consistent with the regulations and performed with a physician onsite.

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 speech-language pathologists, was lacking in information regarding training, certification, and specialty board recognition many of our members possess. CMS indicated in response to comments that they will meet with specialty boards to determine if the data and standards are comparable to other credientialling organizations, and consider the addition of certification and specialty certification in future rules.

Physician Quality Reporting System (PQRS)

PQRS applies to speech-language pathologists in private practice, group practice, university clinics, and critical access hospitals who bill under Method II and 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 decreased and was phased out for claims in 2015.

All eligible providers in private or group practices submitting Medicare Part B claims as rendering providers with Individual National Provider Identification (NPI) numbers are subject to the claims adjustment. Eligible providers will see a -2.0% adjustment to claims submitted in 2018 if they do not meet benchmark requirements in 2016.

Qualified Clinical Data Registeries (QCDR)

In the 2014 final rule, CMS delinieated standards for the QCDR as an additional reporting option for eligible providers. ASHA is investigating the potential development of a QCDR for speech-language pathologists, to serve as a permanent method for reporting quality and outcomes for all payers as the health care payment landscape transitions from fee-for-service to payment based on quality, outcomes, and efficiency.

Benchmarks for Participation

The 2018 -2.0% payment adjustment is based on 2016 participation rates. CMS finalized the continuation of the claims-based reporting option, requiring nine measures covering at least three National Quality Strategy domains, or for eligible professionals without nine measures, reporting on as many measures that are applicable. Eligible professionals that report less than nine measures will continue to be subject to the measures applicability validation (MAV) process, which will determine if the provider reported on the appropriate measures. The 2016 MAV process has not yet been released.

Visit ASHA's PQRS webpage for more information regarding measures and the MAV process.

Measures for Reporting

Speech-language pathologists must report that they completed the positive action of the applicable measures for 50% of the qualifying Medicare patient visits:

Medication/Preventative Care Measures	
Measure #130	Documentation of Current Medications in the Medical Record
Measure #131	Pain Assessment and Follow-up
Measure #226	Tobacco Use: Screening and Cessation Intervention

Measure #130 should be reported with every Medicare patient visit. Medications should be collected at the first visit, reviewed by the speech-language pathologist, and reviewed with each subsequent visit. It is only required once per date of service on the claim with the therapy CPT codes. Documentation of medication does not

include a pharmacological review, but should include the name of the medication or supplement, dosage, frequency, and route.

Measure #131 should only be reported by speech-language pathologists covered by their state license scope of practice to perform standardized screenings and referrals for pain. It must be reported with every therapy visit.

Measure #226 requires the speech-language pathologist to ask the patient if they use tobacco products and, with affirmative answers, offer less than 3 minutes of counseling regarding the adverse effects to health. It is required once a year for the fluency, speech-sound production, speech and language, and voice evaluations (CPT codes 92521-92524).

For the technical specifications and instructions for each measure, see ASHA's PQRS webpage.

Value-Based Modifier (VM)

The value-based payment modifier is a method of including both cost and quality data for calculating payment. In 2013, the VM was applied to physicians and groups of physicians for payment adjustments starting in 2015, Consistent with the statute, CMS proposed to apply the VM to all eligible professionals for participation in 2015 and payment adjustments in 2017. In the 2015 final rule, CMS decided to postpone the application of the VM until 2018. With the passage of the MACRA in April, CMS proposed and finalized that the VM would not apply to speech-language pathologists.

Appendix

2015 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, speech-language pathologists. 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 2016 CF (**$35.8279**). Please see ASHA's Outpatient MPFS website 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 under speech-language pathology plan of care.

CPT Code	Descriptor	2016 National Fee	Notes
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	**$216.04**	This procedure may require physician supervision based on Medicare Administrative Contractors' (MACs') local coverage policies or state practice acts. See ASHA's website for more information.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	**$79.90**	
92508	group, 2 or more individuals	**$23.29**	
92511	Nasopharyngoscopy with endoscope (separate procedure)	**$113.93**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts. . See ASHA's website for more information.
92512	Nasal function studies (eg, rhinomanometry)	**$61.98**	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	**$76.67**	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	**$112.14**	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	**$93.51**	Do not bill 92522 in conjunction with 92523.
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	**$195.98**	Do not bill 92523 in conjunction with 92522.
92524	Behavioral and qualitative analysis of voice and resonance	**$90.29**	This procedure does not include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	**$86.70**	

CPT Code	Descriptor	2016 National Fee	Notes
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	**$73.09**	
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**	Code out of numerical sequence. 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	**$127.55**	
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	**$53.38**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	**$111.78**	
92610	Evaluation of oral and pharyngeal swallowing function	**$86.35**	
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	**$88.14**	
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;	**$188.81**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
92613	interpretation and report only	**$39.05**	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;	**$147.97**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.

CPT Code	Descriptor	2016 National Fee	Notes
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;	**$211.38**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
92617	interpretation and report only	**$42.64**	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	**$90.64**	SLPs may report this evaluation code.
92627	each additional 15 minutes (List separately in addition to code for primary procedure)	**$22.21**	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	**$108.56**	
96110	Developmental screening, with interpretation and report, per standardized instrument form	**$8.96**	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	**$130.77**	

CPT Code	Descriptor	2016 National Fee	Notes
96125	Standardized cognitive performance testing (e.g., 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	**$118.59**	
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	**$29.38**	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	**$35.47**	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	**$8.96**	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	2016 National Fee	Notes
31575	Laryngoscopy, flexible fiberoptic; diagnostic	**$117.16**	This procedure is for medical diagnosis by a physician.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$92.08**	This is a radiology code.
74230	Swallowing function, with cineradiography/videoradiography	**$128.26**	This is a radiology code.
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	**$117.52**	This is a radiology code.

Table 4. Detailed Relative Value Units (RVUs) for Speech-Language Pathology Services

This table contains RVUs only for those codes that are covered under the speech-language pathology benefit (Table 2). For geographically-adjusted RVUs, go to Addenda E in the CMS CY2016 PFS Final Rule Addenda Files [ZIP].

CPT Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
31579	2.26	3.45	0.32	6.03
92507	1.30	0.88	0.05	2.23
92508	0.33	0.31	0.01	0.65
92511	0.61	2.53	0.04	3.18
92512	0.55	1.14	0.04	1.73
92520	0.75	1.33	0.06	2.14
92521	1.75	1.3	0.08	3.13
92522	1.50	1.04	0.07	2.61
92523	3.00	2.34	0.13	5.47
92524	1.50	0.95	0.07	2.52
92526	1.34	1.03	0.05	2.42
92597	1.26	0.71	0.07	2.04
92607	1.85	1.63	0.08	3.56
92608	0.70	0.76	0.03	1.49
92609	1.50	1.57	0.05	3.12
92610	1.30	1.05	0.06	2.41
92611	1.34	1.03	0.09	2.46
92612	1.27	3.92	0.08	5.27
92613	0.71	0.32	0.06	1.09
92614	1.27	2.78	0.08	4.13
92615	0.63	0.29	0.04	0.96
92616	1.88	3.9	0.12	5.90
92617	0.79	0.35	0.05	1.19
92626	1.40	1.08	0.05	2.53
92627	0.33	0.28	0.01	0.62
96105	1.75	1.2	0.08	3.03
96111	2.60	0.92	0.13	3.65
96125	1.70	1.54	0.07	3.31
97532	0.44	0.30	0.01	0.75
97533	0.44	0.37	0.01	0.82
97535	0.45	0.52	0.02	0.99
G0451	0.00	0.24	0.01	0.25